WELCOME TO THE
IHSS TRAINING ACADEMY

CORE: ASSESSMENT AND AUTHORIZATION

The IHSS Training Academy provides courses that are designed to enhance the participant's skills in completing individual assessments and authorization of IHSS services.

This two-day training has been designed to promote consistent assessment and assignment of functional levels and of authorization for needed IHSS services. This course utilizes lecture, discussion, group, and individual activities to deliver course content.

Topics will include:

- Uniformity and Functional Index Scales
- Annotated Assessment Criteria
- Gathering Information from Consumers
- Assessment Challenges
- Documentation
- Cultural Implications and Resources
- Authorizing Services
- Hourly Task Guidelines
- Determining Exceptions and Documenting
- Variable Assessment Intervals
- Universal Precautions

Objectives:

By the end of this training, participants will be able to:

1. Define uniformity in the IHSS program and how it can be accomplished utilizing Functional Index Ranking, IHSS regulations, Annotated Assessment Criteria, Hourly Task Guidelines, and individualized assessments.
2. Identify IHSS program rules that direct assessment and authorization of services.
3. Describe successful best practice techniques for interviewing and communicating with consumers, families, and providers in order to obtain an accurate individualized assessment.
4. Explain the importance of awareness and sensitivity to various cultures and how it impacts the assessment process.
5. Explain the importance of documentation in creating a clear picture of a consumer's needs and in substantiation of the authorization process, including exceptions.
6. Explain the IHSS regulation definitions of Task Categories and how to apply them.
7. Demonstrate the process of authorization of service hours using the Hourly Task Guidelines, including an ability to identify appropriate exceptions.

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HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

MPP 30-757.1(a):

- When assessing time for services (both within and outside the time guidelines), the time authorized shall be based on the recipient's individual level of need necessary to ensure his/her health, safety, and independence based on the scope of tasks identified for service.
- In determining the amount of time per task, the recipient's ability to perform the tasks based on his/her functional index ranking shall be a contributing factor, but not the sole factor. Other factors could include the recipient's living environment, and/or the recipient's fluctuation in needs due to daily variances in the recipient's functional capacity (e.g., "good days" and "bad days").
- In determining the amount of time per task, universal precautions should be considered. Universal precautions are protective practices necessary to ensure safety and prevent the spread of infectious diseases. Universal precautions should be followed by anyone providing a service, which may include contact with blood or body fluids such as saliva, mucus, vaginal secretions, semen, or other internal body fluids such as urine or feces. Universal precautions include the use of protective barriers such as gloves or facemask depending on the type and amount of exposure expected, and always washing hands before and after performing tasks. More information regarding universal precautions can be obtained by contacting the National Center for Disease Control.

Task Definition	Grid	Factors/Exception Examples
Meal Preparation (MPP 30-757.131) Preparation of meals which includes planning menus; removing food from refrigerator or pantry; washing/drying hands before and after meal preparation; washing, peeling, and slicing vegetables; opening packages, cans, and bags; measuring and mixing ingredients; lifting pots and pans; trimming meat; reheating food; cooking and safely operating stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-size pieces.	<table><tr><th></th><th>Low</th><th>High</th></tr><tr><td>Rank 2</td><td>3.02</td><td>7.00</td></tr><tr><td>Rank 3</td><td>3.50</td><td>7.00</td></tr><tr><td>Rank 4</td><td>5.25</td><td>7.00</td></tr><tr><td>Rank 5</td><td>7.00</td><td>7.00</td></tr></table>	**Factors For Consideration Include, But Not Limited To:** • The extent to which the recipient can assist or perform tasks safely. • Types of food the recipient usually eats for breakfast, lunch, dinner, and snacks and the amount of time needed to prepare the food (e.g., more cooked meals versus meals that do not require cooking). • Whether the recipient is able to reheat meals prepared in advance and the types of food the recipient eats on days the provider does not work. • The frequency the recipient eats. • Time for universal precautions, as appropriate. **Exceptions Include, But Not Limited To:** • If the recipient must have meals pureed or cut into bite-sized pieces. • If the recipient has special dietary requirements that require longer preparation times or preparation of more frequent meals. • If the recipient eats meals that require less preparation time (e.g., toast and coffee for breakfast).
Meal Cleanup (MPP 30-757.132) Loading and unloading dishwasher; washing, rinsing, and drying dishes, pots, pans, utensils, and culinary appliances and putting them away; storing/putting away leftover foods/liquids; wiping up tables, counters, stoves/ovens, and sinks; and washing/drying hands. **Note**: This does not include **general** cleaning of the refrigerator, stove/oven, or counters and sinks, as these IHSS services are assessed as "domestic services" (MPP 30-757.11).	<table><tr><th></th><th>Low</th><th>High</th></tr><tr><td>Rank 2</td><td>1.17</td><td>3.50</td></tr><tr><td>Rank 3</td><td>1.75</td><td>3.50</td></tr><tr><td>Rank 4</td><td>1.75</td><td>3.50</td></tr><tr><td>Rank 5</td><td>2.33</td><td>3.50</td></tr></table>	**Factors for Consideration Include, But Not Limited To:** • The extent to which the recipient can assist or perform tasks safely. o **EX:** A recipient with a Rank 3 in "meal cleanup" who has been determined able to wash breakfast/lunch dishes and utensils and only needs the provider to clean up after dinner would require time based on the provider performing cleanup for the dinner meal only. o **EX:** A recipient who has less control of utensils and/or spills food frequently may require more time for cleanup. • The types of meals requiring the cleanup. o **EX:** A recipient who chooses to eat eggs and bacon for breakfast would require more time for cleanup than a recipient who chooses to eat toast and coffee. • If the recipient can rinse the dishes and leave them in the sink until provider can wash them. • The frequency that meal cleanup is necessary. • If there is a dishwasher appliance available. • Time for universal precautions, as appropriate. **Exceptions Include, But Not Limited To:** • If the recipient must eat frequent meals which require additional time for cleanup. • If the recipient eats light meals that require less time for cleanup.

HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

Bowel and Bladder Care (MPP 30-757.14(a))

Assistance with using, emptying, and cleaning bed pans/bedside commodes, urinals, ostomy, enema and/or catheter receptacles; application of diapers; positioning for diaper changes; managing clothing; changing disposable barrier pads; putting on/taking off disposable gloves; wiping and cleaning recipient; assistance with getting on/off commode or toilet; and washing/drying recipient's and provider's hands.

Note: This does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program or colostomy irrigation, as these are assessed as "paramedical services" (MPP 30-757.19).

	Low	High
Rank 2	0.58	2.00
Rank 3	1.17	3.33
Rank 4	2.91	5.83
Rank 5	4.08	8.00

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The frequency of the recipient's urination and/or bowel movements.
- If there are assistive devices available which result in decreased or increased need for assistance.
  - **EX**: Situations where elevated toilet seats and/or Hoyer lifts are available may result in less time needed for "bowel and bladder" care if the use of these devices results in decreased need for assistance by the recipient.
  - **EX**: Situations where a bathroom door is not wide enough to allow for easy wheelchair access may result in more time needed if its use results in an increased need.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient has frequent urination or bowel movements.
- If the recipient has frequent bowel or bladder accidents.
- If the recipient has occasional bowel or bladder accidents that require assistance from another person.
- If the recipient's morbid obesity requires more time.
- If the recipient has spasticity or locked limbs.
- If the recipient is combative.

Feeding (MPP 30-757.14(c))

Includes assistance with consumption of food and assurance of adequate fluid intake consisting of feeding or related assistance to recipients who cannot feed themselves or who require other assistance with special devices in order to feed themselves or to drink adequate liquids.

Includes assistance with reaching for, picking up, and grasping utensils and cup; cleaning recipient's face and hands; washing/drying hands before and after feeding.

Note: This does not include cutting food into bite-sized pieces or puréeing food, as these are assessed as part of "meal preparation" (MPP 30-757.131).

	Low	High
Rank 2	0.70	2.30
Rank 3	1.17	3.50
Rank 4	3.50	7.00
Rank 5	5.25	9.33

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The amount of time it takes the recipient to eat meals.
- The type of food that will be consumed.
- The frequency of meals/liquids.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the constant presence of the provider is required due to the danger of choking or other medical issues.
- If the recipient is mentally impaired and only requires prompting for feeding him/herself.
- If the recipient requires frequent meals.
- If the recipient prefers to eat foods that he/she can manage without assistance.
- If the recipient must eat in bed.
- If food must be placed in the recipient's mouth in a special way due to difficulty swallowing or other reasons.
- If the recipient is combative.

Routine Bed Baths (MPP 30-757.14(d))

Cleaning basin or other materials used for bed/sponge baths and putting them away; obtaining water/supplies; washing, rinsing, and drying body; applying lotion, powder, and deodorant; and washing/drying hands before and after bathing.

	Low	High
Rank 2	0.50	1.75
Rank 3	1.00	2.33
Rank 4	1.17	3.50
Rank 5	1.75	3.50

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- If the recipient is prevented from bathing in the tub/shower.
- If bed baths are needed in addition to baths in the tub/shower.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient is confined to bed and sweats profusely requiring frequent bed baths.
- If the weight of the recipient requires more or less time.
- If the recipient is combative.

HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

Dressing (MPP 30-757.14(f))

Washing/drying of hands; putting on/taking off, fastening/unfastening, buttoning/unbuttoning, zipping/unzipping, and tying/untying of garments, undergarments, corsets, elastic stockings, and braces; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.

	Low	High
Rank 2	0.56	1.20
Rank 3	1.00	1.86
Rank 4	1.50	2.33
Rank 5	1.90	3.50

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The type of clothing/garments the recipient wears.
- If the recipient prefers other types of clothing/garments.
- The weather conditions.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient frequently leaves his/her home, requiring additional dressing/undressing.
- If the recipient frequently bathes and requires additional dressing or soils clothing, requiring frequent changes of clothing.
- If the recipient has spasticity or locked limbs.
- If the recipient is immobile.
- If the recipient is combative.

Menstrual Care (MPP 30-757-14(j))

Menstrual care is limited to external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes, using, and/or disposing of barrier pads, managing clothing, wiping and cleaning, and washing/drying hands before and after performing these tasks.

EX: In assessing menstrual care, it may be necessary to assess additional time in other service categories such as "laundry," "dressing," "domestic, "bathing, oral hygiene, and grooming" (MPP 30-757).

EX: In assessing menstrual care if the recipient wears diapers, time for menstrual care would not be necessary. This time would be assessed as part of "bowel and bladder" care.

	Low	High
*Functional rank does not apply	0.28	0.80

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- If the recipient has a menstrual cycle.
- The duration of the recipient's menstrual cycle.
- If there are medical issues that necessitate additional time.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient has spasticity or locked limbs.
- If the recipient is combative.

Ambulation (MPP 30-757.14(k))

Assisting a recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving/retrieving assistive devices, such as a cane, walker, or wheelchair, etc., and washing/drying hands before and after performing these tasks. "Ambulation" also includes assistance to/from the front door to the car (including getting in and out of the car) for medical accompaniment and/or alternative resource travel.

	Low	High
Rank 2	0.58	1.75
Rank 3	1.00	2.10
Rank 4	1.75	3.50
Rank 5	1.75	3.50

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The distance the recipient must move inside the home.
- The speed of the recipient's ambulation.
- Any barriers that impede the recipient's ambulation.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient's home is large or small.
- If the recipient requires frequent help getting to/from the bathroom.
- If the recipient has a mobility device, such as a wheelchair that results in a decreased need.
- If the recipient has spasticity or locked limbs.
- If the recipient is combative.

Moving in and out of Bed - Renamed to Transfer (MPP 30-757.14(h))

Assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, couch, wheelchair, walker, or other assistive device generally occurring within the same room.

Note: Transfer does not include:

- Assistance on/off toilet, as this is evaluated, as "bowel and bladder" care specified at MPP 30-757.14(a).
- Changing the recipient's position to prevent skin breakdown and to promote circulation. This task is assessed as part of "repositioning/rubbing skin" at section MPP 30-757.14(g).

	Low	High
Rank 2	0.50	1.17
Rank 3	0.58	1.40
Rank 4	1.10	2.33
Rank 5	1.17	3.50

Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The amount of assistance required.
- The availability of equipment, such as a Hoyer lift.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient gets in and out of bed frequently during the day or night due to naps or use of the bathroom.
- If the weight of the recipient and/or condition of his/her bones requires more careful, slow transfer.
- If the recipient has spasticity or locked limbs.
- If the recipient is combative.

HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

<table>
<tr><th>Task Definition</th><th>Grid</th><th>Factors/Exception Examples</th></tr>
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Bathing, Oral Hygiene, and Grooming (MPP 30-757.14 (e))

Bathing (Bath/Shower) includes cleaning the body in a tub or shower; obtaining water/supplies and putting them away; turning on/off faucets and adjusting water temperature; assistance with getting in/out of a tub or shower; assistance with reaching all parts of the body for washing, rinsing, and drying and applying lotion, powder, deodorant; and washing/drying hands.

Oral Hygiene includes applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

Grooming includes hair combing/brushing; hair trimming when recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care when these services are not assessed as "paramedical services" for the recipient; and washing/drying hands.

Note: This does not include getting to/from the bathroom. These tasks are assessed as mobility under "ambulation" (MPP 30-757.14(k)).

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	Low	High
Rank 2	0.50	1.92
Rank 3	1.27	3.15
Rank 4	2.35	4.08
Rank 5	3.00	5.10

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Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- The number of times the recipient may need help to bathe.
- If the recipient requires assistance in/out of tub/shower.
- If the recipient needs assistance with supplies.
- If the recipient requires assistance washing his/her body.
- If the provider must be present while the recipient bathes.
- If the recipient requires assistance drying his/her body and/or putting on lotion/powder after bathing.
- If the recipient showers in a wheelchair.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the provider's constant presence is required.
- If the weight of the recipient requires more or less time.
- If the recipient has spasticity or locked limbs.
- If a roll-in shower is available.
- If the recipient is combative.

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Repositioning/Rubbing Skin (MPP 30-757.14(g))

Includes rubbing skin to promote circulation and/or prevent skin breakdown; turning in bed and other types of repositioning; and range of motion exercises which are limited to:

- General supervision of exercises which have been taught to the recipient by a licensed therapist or other health care professional to restore mobility restricted because of injury, disuse, or disease.
- Maintenance therapy when the specialized knowledge and judgment of a qualified therapist is not required and the exercises are consistent the patient's capacity and tolerance.
  - Such exercises include carrying out of maintenance programs (e.g., the performance of repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain a range of motion in paralyzed extremities; and assistive walking).

Note: "Repositioning and rubbing skin" does not include:

- Care of pressure sores (skin and wound care). This is assessed as part of "paramedical" specified at MPP 30-757.19.
- Ultraviolet treatment (set up and monitor equipment) for pressure sores and/or application of medicated creams to skin. These tasks are assessed as part of "assistance with prosthetic devices" at MPP 30-757.14(i).

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	Low	High
*Functional rank does not apply	0.75	2.80

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Factors for Consideration Include, But Not Limited To:

- The extent to which the recipient can assist or perform tasks safely.
- If the recipient's movement is limited while in the seating position and/or in bed, and the amount of time the recipient spends in the seating position and/or in bed.
- If the recipient has circulatory problems.
- Time for universal precautions, as appropriate.

Exceptions Include, But Not Limited To:

- If the recipient has a condition that makes him/her confined to bed.
- If the recipient has spasticity or locked limbs.
- If the recipient has or is at risk of having decubitus ulcers which require the need to turn the recipient frequently.
- If the recipient is combative.

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HTG QUICK REFERENCE TASK TOOL (ATTACHMENT C)

Task Definition	Grid	Factors/Exception Examples
Care and Assistance with Prosthetic Devices and Assistance with Self-Administration of Medications (MPP 30-757.14(i)) Assistance with taking off/putting on, maintaining, and cleaning prosthetic devices, vision/hearing aids, and washing/drying hands before and after performing these tasks. Also includes assistance with the self-administration of medications consisting of reminding the recipient to take prescribed and/or over-the-counter medications when they are to be taken, setting up Medi-sets and distributing medications.	<table><tr><th></th><th>Low</th><th>High</th></tr><tr><td>*Functional rank does not apply</td><td>0.47</td><td>1.12</td></tr></table>	**Factors for Consideration Include, But Not Limited To:** ▪ The extent to which the recipient is able to manage medications and/or prosthesis independently and safely. ▪ The amount of medications prescribed for the recipient. ▪ If the recipient requires special preparation to distribute medications (e.g., cutting tablets, putting medications into Medi-sets, etc.). ▪ If the recipient has cognitive difficulties that contribute to the need for assistance with medications and/or prosthetic devices. ▪ Time for universal precautions, as appropriate. **Exceptions Include, But Not Limited To:** ▪ If the recipient takes medications several times a day. ▪ If the pharmacy sets up medications in bubble wraps or Medi-sets for the recipient. ▪ If the recipient has multiple prosthetic devices. ▪ If the recipient is combative.

HTG DOCUMENTATION WORKSHEET

Category	Documentation of Hours **Important: This Worksheet Should Be Used in Conjunction with Time Per Task Tools** **For All Tasks Include Time for Clean Techniques/Universal Precautions When Required**
Domestic (Housework) **FI Rank (Enter)** ____ **Guideline** **6.00 hours per month per household**	**Task** / **Total Need** / **Adjustments** / **Authorized** Routine housework Additional time Reason for assistance: Additional information to document Need and Adjustments (include shared living factors and other factors such as size of dwelling, Alt. Resources, etc.): Reason for more or less time than guideline (extra bedding changes, etc.):
Laundry **In-home** ☐ **Out-of-home** ☐ **FI Rank (Enter)** ____ **Guideline In-Home** **1.00 hour per week** **Guideline Out-of-Home** **1.50 hours per week** ***Note: Laundry facilities <u>on premises</u> of apartment complex, mobile home park, etc. are considered in-home (DSS Policy).***	**Task** / **Total Need** / **Adjustments** / **Authorized** Routine laundry Additional time Reason for assistance: Additional information to document Need and Adjustments (include laundry done separately, etc.): Reason for more or less time than guideline (extra laundry due to incontinence, etc.):
Shopping and Errands **FI Rank (Enter)** ____ **Guideline Food Shopping** **1.00 hour per week** **Guideline Other Shopping/ Errands** **0.50 hours per week**	**Task** / **Total Need** / **Adjustments** / **Authorized** Food shopping Other shopping/errands Reason for assistance: Additional information to document Need and Adjustments (include distance to nearest store consistent with needs and economy, need for shopping to be done separately, etc.): Reason for more or less time than guideline:

Meal Preparation

FI Rank (Enter)		
	Low	**High**
Rank 2	**3.02**	**7.00**
Rank 3	**3.50**	**7.00**
Rank 4	**5.25**	**7.00**
Rank 5	**7.00**	**7.00**

Note: Compare Total Need with above range.

Needs help with ☐ **Breakfast** ☐ **Lunch** ☐ **Dinner**

Meal	Example of Typical Meal	Need Per Meal	# of Days Per Week	Total Need
Breakfast				
Lunch				
Dinner				
Snacks				

Reason for assistance:

Shared living exceptions (required when services not prorated):

Additional information to document exceptions to guidelines and identification of Alt. Resources such as MOW:

Meal Cleanup

FI Rank (Enter)		
	Low	**High**
Rank 2	**1.17**	**3.50**
Rank 3	**1.75**	**3.50**
Rank 4	**1.75**	**3.50**
Rank 5	**2.33**	**3.50**

Note: Compare Total Need with above range.

Note: Assessed time should reflect actual schedule/frequency with which provider performs meal cleanup. Example: Consumer rinses all dishes and provider washes three times per week.

Meal	Frequency (Daily, 3 times per week, etc.)	Assessed Time Per Occurrence	Total Need
Breakfast			
Lunch			
Dinner			

Reason for assistance:

Shared living exceptions:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Ambulation

FI Rank (Enter)		
	Low	**High**
Rank 2	**0.58**	**1.75**
Rank 3	**1.00**	**2.10**
Rank 4	**1.75**	**3.50**
Rank 5	**1.75**	**3.50**

Note: Compare Total Need with above range.

Walking Inside Home				
From/To	**Time Assessed**	**# of Times Per Day**	**# of Days Per Week**	**Total Need Per Week**

Retrieving Assistive Device(s)				
Device	**Time Assessed**	**# of Times Per Day**	**# of Days Per Week**	**Total Need Per Week**

Assistance From House To Car And Car To House For Medical Appt. & Alt. Resource				
	Time Assessed	**# of Times Per Month**	**Total Need Per Month**	**Total Need Per Week (Monthly Need ÷ 4.33)**
From House to Car				
From Car to House				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Bathing, Oral Hygiene, and Grooming

FI Rank (Enter)		
	Low	**High**
Rank 2	**0.50**	**1.92**
Rank 3	**1.27**	**3.15**
Rank 4	**2.35**	**4.08**
Rank 5	**3.00**	**5.10**

Note: Compare Total Need with above range.

Task	**Need Per Occurrence**	**# of Times Per Day**	**# of Days Per Week**	**Total Need**
Assistance with getting in/out of tub/shower				
Oral hygiene				
Grooming				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Routine Bed Baths

FI Rank (Enter)		
	Low	High
Rank 2	0.50	1.75
Rank 3	1.00	2.33
Rank 4	1.17	3.50
Rank 5	1.75	3.50

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Bed baths				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Dressing

FI Rank (Enter)		
	Low	High
Rank 2	0.56	1.20
Rank 3	1.00	1.86
Rank 4	1.50	2.33
Rank 5	1.90	3.50

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with clothing, shoes, socks/stockings				
Assistance with putting on/taking off corsets, elastic stockings, braces, etc.				
Bringing tools to consumer				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Bowel and Bladder Care

FI Rank (Enter)		
	Low	High
Rank 2	0.58	2.00
Rank 3	1.17	3.33
Rank 4	2.91	5.83
Rank 5	4.08	8.00

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with getting on/off toilet/commode				
Wiping/cleaning consumer				
Assist with using, emptying, cleaning bedpans/commodes, urinals, etc.				
Application of diapers				
Changing barrier pads				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Menstrual Care

Functional Index Rank does not apply.

	Low	High
	0.28	0.80

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need*
External application of sanitary napkins				
Using/disposing barrier pads				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

****Remember that hours on SOC 293 are weekly. For menstrual care, in most cases, divide weekly need by 4.33 to authorize correct need.***

Transfer

FI Rank (Enter)		
	Low	High
Rank 2	0.50	1.17
Rank 3	0.58	1.40
Rank 4	1.10	2.33
Rank 5	1.17	3.50

Note: Compare Total Need with above range.

Assistance From Standing, Sitting, Or Prone Position To Another				
Task	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need
Transfer From One Piece Of Equipment Or Furniture To Another				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Feeding

FI Rank (Enter)		
	Low	High
Rank 2	0.70	2.30
Rank 3	1.17	3.50
Rank 4	3.50	7.00
Rank 5	5.25	9.33

Note: Compare Total Need with above range.

Feeding Or Related Assistance With Consumption Of Food And Fluid Intake				
Task	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need
Breakfast				
Lunch				
Dinner				
Snacks				
Other Fluids				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Repositioning / Rubbing Skin

Functional Index Rank does not apply.

	Low	High
	0.75	2.80

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Rubbing skin to promote circulation				
Turning in bed				
Repositioning				
Range of motion exercises				
Assistive walking				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Care and Assistance with Prosthetic Devices and Assistance with Self-Administration of Medications

Functional Index Rank does not apply.

	Low	High
	0.47	1.12

Note: Compare Total Need with above range.

Assistance With Taking Off/Putting On Prosthetic Devices And Vision And Hearing Aids

Device	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

Maintaining/Cleaning Prosthetic Devices And Vision And Hearing Aids

Device	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

Setting Up Medications

	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

Assistance With Self-Administration Of Medications

	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Accompaniment to Medical Appts.

Appt. Type (Specify doctor, dentist, etc.)	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Remember that SOC 293 hours reflect weekly need, so monthly need must be divided by 4.33 to arrive at weekly need. (Example: 1.00 hour each way 1 time per month would be a monthly need of 2.00 hours ÷ 4.33 = .46 weekly)

Accompaniment to Alt. Resources

Note: Assessed only when transport is to/from site where Alt. Resources provide IHSS-type services in lieu of IHSS. Example: Transport to Senior Center where consumer receives meal.

Name of Alt. Resource	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Remember that SOC 293 hours reflect weekly need, so monthly need must be divided by 4.33 to arrive at weekly need. (Example: 1.00 hour each way 1 time per month would be a monthly need of 2.00 hours ÷ 4.33 = .46 weekly)

Heavy Cleaning

Task	Hours Assessed

Reason for assistance:

<table>
<tr>
<td>Remove Ice, Snow

Note: Limited to removal of snow, or other hazardous substances from entrances and essential walkways when access to the home is hazardous.</td>
<td>
<table>
<tr><th>Task</th><th>Hours Assessed*</th></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
</table>
Reason for assistance:

*Remember that this service is seasonal and should not be authorized on a yearly basis.
</td>
</tr>
<tr>
<td>Yard Hazard Abatement

Note: Limited to light work in the yard for removal of high grass or weeds and rubbish when constituting a fire hazard.</td>
<td>
<table>
<tr><th>Task</th><th>Hours Assessed*</th></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
</table>
Reason for assistance:

*Remember that this service should not be routinely authorized on an ongoing basis.
</td>
</tr>
</table>

IHSS TRAINING ACADEMY

CORE: ASSESSMENT AND AUTHORIZATION

TIME CONVERSION CHART

Minutes	Converted
1	0.02
2	0.03
3	0.05
4	0.07
5	0.08
6	0.10
7	0.12
8	0.13
9	0.15
10	0.17
11	0.18
12	0.20
13	0.22
14	0.23
15	0.25
16	0.27
17	0.28
18	0.30
19	0.32
20	0.33
21	0.35
22	0.37
23	0.38
24	0.40
25	0.42
26	0.43
27	0.45
28	0.47
29	0.48
30	0.50

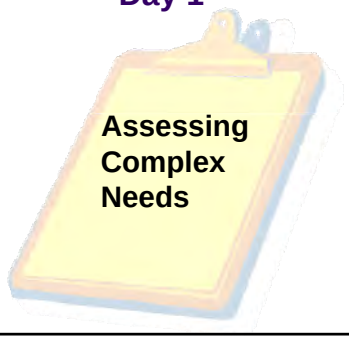
Minutes	Converted
31	0.52
32	0.53
33	0.55
34	0.57
35	0.58
36	0.60
37	0.62
38	0.63
39	0.65
40	0.67
41	0.68
42	0.70
43	0.72
44	0.73
45	0.75
46	0.77
47	0.78
48	0.80
49	0.82
50	0.83
51	0.85
52	0.87
53	0.88
54	0.90
55	0.92
56	0.93
57	0.95
58	0.97
59	0.98
60	1.00

Instructions for Using the Chart to Convert Minutes to Decimals:

1. Determine daily minutes for task.
2. Determine number of times per week.
3. Determine weekly minutes (daily minutes x number of times per week).
4. Utilize the Time Conversion Chart if minutes are less than 60 per week.
5. If minutes exceed 60 per week, divide total minutes by 60 to get weekly hours and minutes to be authorized for purchase.

Welcome to the California Department of Social Services' In-Home Supportive Services Training Academy

Assessment and Authorization: Day 1

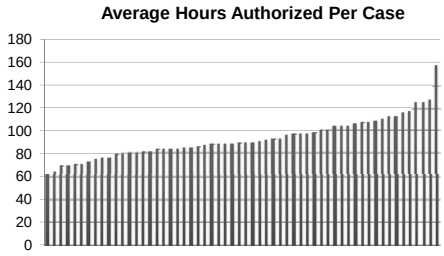


Assessing Complex Needs

Why IHSS Training?

- Need for consistency in authorization practices
- Increasing complexities of IHSS with three programs:
  - PCSP (Personal Care Services Program)
  - IPO (IHSS Plus Option)
  - Residual
- Need for standardized training for staff performing assessments
- Legislative mandate

Variance in Statewide Authorization of Hours



The monthly average statewide is approx. 86.5 hrs. State data, June 2012.

Quality Assurance Legislation

- Statewide social worker training to improve and standardize assessment process.
- Develop hourly task guidelines.
- Workgroup currently addressing regulations through revision process and creating emergency regulations.
- Enhance state and local fraud and data evaluation activities.
- Establishment of dedicated QA function at county level with state monitoring.

Prerequisites for Uniformity

- Consumer's needs are evaluated the same way.
- Workers all over the state apply the same standards when assessing function.
- The rankings of the scales are applied the same.

Outcomes of Uniformity

- When consumers with similar needs receive similar services, ***all consumers have an equal opportunity to experience independence and safety.***
- Assessment standards ***promote consistency and fairness*** – across the state and within counties.

Functional Index Scale
[MPP 30-756]

1. **Independent**
2. **Verbal Assistance**
3. **Some Human Help Needed**
4. **Lots of Human Help Needed**
5. **Cannot Perform**

Functional Index Scales Include

- Housework
- Laundry
- Shopping and Errands
- Meal Preparation/ Cleanup
- Ambulation
- Bathing, Oral Hygiene, and Grooming/ Routine Bed Bath
- Dressing/Prosthetic Devices
- Bowel, Bladder, and Menstrual Care
- Transfer
- Eating
- Respiration
- Memory
- Orientation
- Judgment

Clarification: FI Rank 2

- Service authorization decisions differ.
- For all other ranks, consumers should have a "Total Need" in the associated task.
- For FI Rank 2, need may take an inconsequential amount of service ***or*** take an extreme amount of time.

Clarification: FI Rank 2

If Consumer

- needs simple reminding
- is compliant
- reminding can be given while the provider is completing other tasks

Then

- no time would be authorized.

Clarification: FI Rank 2

If Consumer

- prompting takes the undivided attention of the provider

Then

- time should be authorized.

Note: When continual prompting is no longer effective, then a reassessment to a higher FI Rank may be necessary.

Clarification: FI Rank 2

- If no time is authorized for a rank of 2:
  - Even though 0 hours is below the HTG ranges, there is no reason to document an exception.
- If time is authorized for a rank of 2:
  - The HTG ranges are the basis for documenting exceptions.

Gathering Information from Consumers





Performance Based Assessment

Observe consumer for assessment data related to:

- Safety
- Independence
- Abilities
- Performance in key functional areas

Interview Success in a Complex Assessment

- Avoiding Bias –
  - Don't express your own opinions – consumers will change their answers to make you happy.
  - Don't suggest answers if consumer wants your help – repeat the question, pause and let them take a moment.
  - Avoid leading probes that might suggest an answer.

From *"Doing the Interview: How to Really Ask Those Questions and Enjoy It"*

Interview Success in a Complex Assessment

- Use Probes for Clarity and Completeness
  - "*You said…. What do you mean by that?"*
  - *"I'm not sure I understand. Could you give me more information?"*
  - *"Could you explain, tell me more about that?"*

From *"Doing the Interview: How to Really Ask Those Questions and Enjoy It"*

Interview Success in a Complex Assessment

- Tread Carefully – but don't avoid embarrassing subjects
  - Build rapport at beginning of interview.
  - Reassure consumer you are not embarrassed.
  - Ask questions straight-forwardly and without hesitation.
  - Explain these are questions you ask everyone.

From *"Doing the Interview: How to Really Ask Those Questions and Enjoy It"*

Other Assessment Cues

Verbal

- Tone/inflection of voice
- Discrepancies between what consumers say and what they do

Environmental Observations

- Discrepancies between the way the environment looks and what consumer reports as service needs

Sensory Cues

- Smell
- Tactile information – sticky floors, surfaces

Your Body Speaks Your Mind

Between 60-80% of our message is communicated through our Body Language, only 7-10% is attributable to the actual words of a conversation.

Whenever there is a conflict between verbal and non-verbal, we almost always believe the non-verbal messages without necessarily knowing why.

Other Resources for Assessment Information

- Family Members
- Providers
- Informal Support System
- MSSP and other County Case Management Programs
- Day Programs
- Health Care Certification
- Regional Centers
- Senior Centers
- Senior Apartment
  - Staff

Key Points to Remember

- Habits may differ from actual ***abilities.***
- Focus on ***functioning***, rather than on a medical diagnosis.
- Assistive devices often promote ***independence*** – don't necessarily indicate additional impairment.
- Authorization of services is based on the consumer's ***individual level of need***.
- Assessment should focus on ***needs versus wants*** of the consumer.

Assistive Devices
Durable Medical Equipment (DME)

- Importance of DME:
  - Promotes the consumer's independence.
  - Improves quality of life and satisfaction.
  - Can greatly affect the consumer's functional ability.
- Assess the consumer's use of and possible need for DME.
- Must have medical prescription for payment of DME.
- Document DME and how it affects the consumer's independence when assigning functional scores and authorizing services.

H Line Exercise: Consumer with Assistive Devices

- Using the scenario provided, determine the H Line for the areas identified:
  - Domestic
  - Meal Preparation and Clean-up
  - Bathing and Grooming
  - Dressing
- Record your answers and report out

Assessment Challenges

1. Providers or family that want to speak for the consumer.
2. Consumers who understate their need.
3. Consumers who overstate their need.

Assessment Challenges

- Angry consumers
- Hostile consumers
- Emotionally distraught consumers

Assessment Challenges

- People dealing with grief/loss issues
- Consumers dealing with impact of chronic illness

Assessment Challenges

- The most common cause of dementia is Alzheimer's
- Three stages – early, middle and late
- Progressive nature is variable

H Line Exercise

- Using the scenario provided, determine the H Line for the areas identified:
  - **Kimberly**
    - Domestic
    - Meal Preparation
    - Transfer
    - Bowel and Bladder
  - **Alice**
    - Domestic
    - Meal Preparation
    - Ambulation
    - Bathing and Grooming
- Record your answers and report out

Assessment Challenges

- Hearing impairments
- Visual impairments

Cultural Implications: Assessment of the IHSS Consumer

Stereotyping vs. Generalizing

Things to Consider

- Importance of individuality
- Influences on beliefs
- Importance of understanding own cultural context and influences
- Cultural understanding leads to greater sensitivity

Variations in Communication

- Conversational style and pacing
- Eye contact
- Personal space
- Touch
- Time orientation

Exercise

Using an Interpreter

- Must be 18 years of age
- Give instructions to interpreter
  - Consumer's own words
  - Be thorough and accurate
- Focus conversation on the consumer
- Observe consumer's non-verbal
- Use simple language – no slang
- Check for understanding

MPP 21-115.16

Importance of Good Documentation

Good Documentation

- Provides historical record.
- Provides continuity for case transfers.

- Substantiates authorization at state hearings.
- Shows adherence to laws, regulations and policies.
- Aids in the investigation of potential fraud.

Create a Clear Picture of the Situation

- Avoid documenting unnecessary information.
- Record the facts and avoid judging statements.
- Keep to the point and purpose of the visit.
- The files are open – all information may be read by the consumer.
- Do not document mental illness diagnosis unless it has been confirmed.

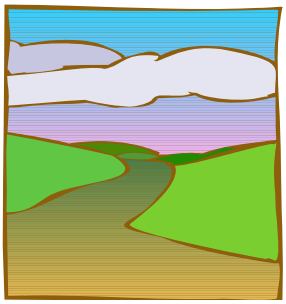
Exercise

Assessing Needs

Emily

Exercise: Assessing Needs

- Read scenario – share roles
- Complete SOC 293 H Line *ONLY*
- Put H Line FI scores on flipchart for report out
- Be prepared to discuss the assessment data you have to support FI scores identified



End of Day 1

Thanks for your participation!

2: Annotated
Assessment Criteria

ATTACHMENT B

ANNOTATED ASSESSMENT CRITERIA

Annotated Assessment Criteria is designed to assist you in the application of rankings specified in Manual of Policies and Procedures (MPP) Section 30-756 which are applied to evaluate a recipient's capacity to perform certain In-Home Supportive Services (IHSS) tasks safely. The Annotated Assessment Criteria describes each functional rank in more detail as it applies to an individual's capacity to perform certain types of tasks specified in MPP Section 30-757, and it provides sample observations you might make for each ranking, characteristics of a recipient who might be ranked at each level, and questions which might elicit the information needed to determine the appropriate rank. These samples are lists of possible indicators, not definitive standards.

General

Following are general questions that may be asked of applicants to help determine whether need exists:

* How frequently have you been seen by a doctor?
* Has the doctor limited your activities?
* When does your family come to see you and how do they feel about your condition?
* What can family/friends/neighbors do to help you?
* Who has been helping you up to this point?
* Why are you asking for help now?
* How have circumstances changed?
* How long have you been having difficulty?
* What is limiting your activities?
* How do you feel about the status of your health?
* How long do you think you will need this service?
* How would you manage if your provider called in sick one day?

Information to be given and reinforced periodically:

* A clear explanation of the recipient's responsibilities in the county's delivery system.
* IHSS is a program which provides only those services necessary for the recipient's safety which the recipient is unable to perform.

Observations

A number of observations are applicable to all functions. These involve observing the recipient getting up from a chair, ambulating, standing, reaching, grasping, bending, and carrying; and observing the recipient's endurance and mental activity. In the following text, the first eight observable behaviors above are referred to as "movement." All of these functions can usually be observed by noting how the recipient admitted you into the housing unit and shaking his/her hand

when arriving; asking the recipient to show you the housing unit; asking the recipient to show you all his/her medications; asking him/her to get his/her Medi-Cal card for you; and asking him/her to sign the application. If the above-listed functions have not been adequately demonstrated in the course of the interview, it is sometimes helpful to ask the recipient for a glass of water. Since the ranking of functioning is hierarchical, observations and questions in a lower rank are likely to apply to a higher one. Observations lead to a general assumption as to the appropriate level of functioning, and follow-up questions elicit information as to what assistance is necessary for the level of functioning observed. This listing is not all-inclusive, nor does the presence of one behavior on the list necessarily create the basis for the ranking. All your senses are involved in gaining cues to determine the recipient's functioning as a whole

General

The following are general regulatory standards that apply to all functions. The standards for each function are defined in more detail in individual scales that follow.

Rank 1: Independent: Able to perform function without human assistance although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his/her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

Rank 2: Able to perform a function but needs verbal assistance such as reminding, guidance, or encouragement. No hands-on assistance is required in rank 2.

Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.

Rank 4: Can perform a function but only with substantial human assistance.

Rank 5: Cannot perform the function with or without human assistance.

Rank 6: Paramedical Services needed. (**ALL** functions in the task are met by Paramedical).

Variable Functioning

If the recipient's functioning varies throughout the month, the functional rank should reflect the functioning on reoccurring bad days. It is not solely based on a "worst" day scenario (e.g., a recipient who suffers from arthritis will have days when pain is significant and days when pain is mild; therefore, in this case you would rank a recipient based on the reoccurring days where the frequency of pain is significant).

ATTACHMENT B

DEFINITION OF SERVICES LISTED ON THE SOC 293 "H" LINE

Domestic Services

Sweeping, vacuuming, and washing/waxing floors; washing kitchen counters and sinks; cleaning the bathroom; storing food and supplies; taking out garbage; dusting and picking up; cleaning oven and stove; cleaning and defrosting refrigerator; bringing in fuel for heating or cooking purposes from a fuel bin in the yard; changing bed linen; changing light bulbs; and wheelchair cleaning and changing/recharging wheelchair batteries.

The following is the application of functional rank specific to Domestic services with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to perform all domestic chores without a risk to health or safety. Recipient is able to do all chores though s/he might have to do a few things every day so that s/he doesn't overexert her/himself.

- **Observations:** Observe if the home is neat and tidy. Observe if the recipient's movement is unimpaired.
- **Example:** Recipient with no signs of impairment moves easily about a neat room, bending to pick up items and reaching to take items from shelves.
- **Question:** Are you able to do all the household chores yourself, including taking out the garbage?

Rank 2: Able to perform tasks but needs direction or encouragement from another person. Recipient is able to perform chores if someone makes him/her a list or reminds him/her.

- **Observations**: Observe if the recipient seems confused or forgetful and has no observable physical impairment severe enough to seem to limit his/her ability to do housework; if there is incongruity in what you observe, such as dirty dishes in cupboard.
- **Example:** Young man apparently physically healthy, but obviously confused and forgetful, is being reminded that it is time for him to sweep and vacuum.
- **Questions**: How do you manage to keep your apartment clean? Has anyone been helping you up to this time?

Rank 3: Requires physical assistance from another person for some chores (e.g., has a limited endurance or limitations in bending, stooping, reaching, etc.).

- **Observations:** Observe if the recipient has some movement problems as described above; has limited endurance; is easily fatigued; or has severely limited eyesight. Observe if the home is generally tidy, but needs a good cleaning; if it is apparent that the recipient has made attempts to clean it, but was unable to.
- **Example:** Small frail woman answers apartment door. Apartment has some debris scattered on carpet and quite-full trashcan is sitting in kitchen area. The remainder of apartment is neat.
- **Questions:** Have you been doing the housework yourself? What have you been doing about getting your housework done up until now?

Rank 4: Although able to perform a few chores (e.g., dust furniture or wipe counters) help from another person is needed for most chores.

* **Observations:** Observe if the recipient has limited strength and impaired range of motion. Observe if the house needs heavy cleaning.
* **Example:** Recipient walking with a cane is breathing heavily in cluttered living room. The bathtub and toilet are in need of cleansing. The recipient's activities are limited because of shortness of breath and dizziness.
* **Questions:** What household tasks are you able to perform? Has your doctor limited your activities?

Rank 5: Totally dependent upon others for all domestic chores.

* **Observations:** Observe if dust/debris is apparent; if there is garbage can odor; if the bathroom needs scouring; if household chores have obviously been unattended for some time. Observe if the recipient has obvious limited mobility or mental capacity.
* **Examples:** Bed-bound recipient is able to respond to questions and has no movement in arms or legs. Frail elderly man is recovering from heart surgery and forbidden by doctor to perform any household chores.
* **Questions:** Are there any household tasks you are able to perform? What is limiting your activities? Who has been helping you to this point?

Laundry

Gaining access to machines, sorting laundry, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry, folding and sorting laundry, mending and ironing. (Note: Ranks 2 and 3 are not applicable to determining functionality for this task.)

The following is the application of functional rank specific to Laundry services with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to perform all chores.

* **Observations:** Observe if the recipient's movement seems unimpaired; if s/he seems able to ambulate, grasp, bend, lift, and stand adequately; if s/he is wearing clean clothes.
* **Example:** Recipient is apparently physically fit. The recipient's movements during interview indicate that s/he has no difficulty with reaching, bending, or lifting.
* **Questions:** Are you able to wash and dry your own clothes? Are you also able to fold and put them away?

Rank 4: Requires assistance with most tasks. May be able to do some laundry tasks (e.g., hand wash underwear, fold and/or store clothing by self or under supervision).

* **Observations:** Observe if the recipient has some impairment in movement, is nodding, displays forgetfulness, or has severely limited eyesight; if the recipient's clothing is stained or spotted.
* **Example:** Frail woman is unable to transfer wet wash to the dryer, particularly, sheets and towels. Housemate encourages her to help with sorting and folding, etc.
* **Questions:** Are you able to lift and transfer wet articles in the laundry? How have you handled this laundry up to now? Who has been doing your laundry for you up to this time? Has the doctor suggested that you do some simple tasks with your arms and hands?

Rank 5: Cannot perform any task, is totally dependent on assistance from another person.

* **Observations:** Observe if there are severe restrictions of movement.
* **Example:** Quadriplegic recipient is seated in wheelchair, obviously unable to perform laundry activities.
* **Questions:** Who does your laundry now? What has changed in your circumstances that resulted in your asking for help now?

Shopping and Errands

Compiling list; bending, reaching, lifting, and managing cart or basket; identifying items needed; transferring items to home and putting items away; telephoning in and picking up prescriptions; and buying clothing. (Note: Ranks 2 and 4 are not applicable to determining functionality for this task.)

The following is the application of functional rank specific to Shopping and Errands with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Can perform all tasks without assistance.

* **Observations:** Observe if movement seems unimpaired and the recipient seems oriented.
* **Example:** Social worker questions elderly man whose responses indicate that he is able to do his own shopping and can put groceries and other items away. Although his movements are a little slow, it is evident that he is capable of performing this task.
* **Question:** How do you take care of your shopping and errands?

Rank 3: Requires the assistance of another person for some tasks (e.g., recipient needs help with major shopping needed but can go to nearby store for small items, or the recipient needs direction or guidance).

* **Observations:** Observe if the recipient's movement is somewhat impaired; if the recipient has poor endurance or is unable to lift heavy items; if s/he seems easily confused or has severely limited eyesight; if there is limited food on hand in refrigerator and cupboard.

* **Example:** Recipient goes to corner market daily to get a few small items. Someone else makes a shopping list.
* **Questions:** Do you have difficultly shopping? What are the heaviest items you are able to lift? Do you usually buy the items you planned to purchase? Do you have any difficulty remembering what you wanted to purchase or making decisions on what to buy? (Ask recipient's significant other whether the recipient has difficulty making decision on what to buy or if recipient's mental functioning seems impaired.)

Rank 5: Unable to perform any tasks for self.

* **Observations:** Observe if movement or mental functioning is severely limited.

* **Example:** Neighbors help when they can. Teenaged boy comes to recipient's door and receives money and list from recipient to purchase a few groceries.
* **Questions:** Has someone been shopping for you? How do you get your medications?

Meal Preparation/Meal Cleanup

Meal Preparation includes such tasks as planning menus; removing food from refrigerator or pantry; washing/drying hands before and after meal preparation; washing, peeling, and slicing vegetables; opening packages, cans, and bags; measuring and mixing ingredients; lifting pots and pans; trimming meat; reheating food; cooking and safely operating stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-size pieces.

Meal Cleanup includes loading and unloading dishwasher; washing, rinsing, and drying dishes, pots, pans, utensils, and culinary appliances and putting them away; storing/putting away leftover foods/liquids; wiping up tables, counters, stoves/ovens, and sinks; and washing/drying hands.

Note: Meal Cleanup does not include general cleaning of the refrigerator, stove/oven, or counters and sinks. These services are assessed under Domestic services.

The following is the application of functional rank specific to Meal Preparation/Meal Cleanup with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Can plan, prepare, serve, and cleanup meals.
* **Observations:** Observe if the recipient's movement seems unimpaired.
* **Example:** Recipient cooks and freezes leftovers for reheating.
* **Questions:** Are you able to cook your own meals and cleanup afterwards? Are you on a special diet? If yes, describe.

Rank 2: Needs only reminding or guidance in menu planning, meal preparation, and/or cleanup.
* **Observations:** Recipient seems forgetful. There is rotten food, no food in refrigerator, or a stockpile of candy bars only. Recipient's clothes are too large, indicating probable weight loss. There are no signs of cooking.

* **Example:** Elderly recipient is unable to plan balanced meals, has trouble knowing what to eat so eats a lot of desserts and snacks, sends granddaughter to purchase fast foods. Recipient leaves dishes near the sofa where s/he eats; s/he reuses dirty dishes if not reminded to wash and dry them.
* **Question:** Are you able to prepare and cleanup your own meals?

Rank 3: Requires another person to prepare and cleanup main meal(s) on less than a daily basis (e.g., recipient can reheat food prepared by someone else, can prepare simple meals, and/or needs some help with cleanup but requires another person to prepare and cleanup with more complex meals which involve, peeling, cutting, etc., on less than a daily basis).

* **Observations:** Observe if the recipient's movement is impaired; if s/he has poor strength and endurance or severely limited eyesight; if s/he appears adequately nourished and hydrated.
* **Example:** Recipient can reheat meals, make a sandwich, and get snacks from the package. Recipient has arthritis that impairs her/his grasp; s/he is unable to wash dishes because s/he cannot hold on to dishes.
* **Questions:** What type of meals are you able to prepare for yourself? Can you lift casserole dishes and pans? Can you reheat meals that were prepared for you ahead of time? Are you able to wash dishes? Can you wipe the counter and stove?

Rank 4: Requires another person to prepare and cleanup main meal(s) on a daily basis.

* **Observations:** Recipient has movement and endurance problems and has very limited strength of grip.
* **Example:** Recipient is unable to stand for long periods of time. Recipient can get snacks from the refrigerator like fruit and cold drinks, can get cereal, or make toast for breakfast, etc.
* **Questions:** Can you stand long enough to operate your stove, wash, dry, and put away dishes and/or load/unload the dishwasher?

Rank 5: Totally dependent on another person to prepare and cleanup all meals.

* **Observations:** Observe if the recipient has severe movement problems or is totally disoriented and unsafe around the stove.
* **Example:** Recipient has schizophrenia. Recipient believes that when s/he gets wet the water has the power to enable people to read her/his mind. Provider cuts up food in bite-sized portions and carries tray to bed-bound recipient.
* **Questions:** Are you able to prepare anything to eat for yourself? Does your food and drink need to be handled in any special way? Can you wash dishes?

Rank 6: **ALL** functions in the task are met by Paramedical.

ATTACHMENT B

Ambulation

Assisting the recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving and retrieving assistive devices, such as a cane, walker, or wheelchair, etc.; and washing/drying hands before and after performing these tasks. Ambulation also includes assistance to/from the front door to the car **(including getting in and out of the car)** for medical accompaniment and/or alternative resource travel.

The following is the application of functional rank specific to Ambulation with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Requires no physical assistance though recipient may experience some difficulty or discomfort. Completion of the task poses no risk to his/her safety.

* **Observations:** Observe if the recipient is steady on feet, able to maneuver around furniture, etc. Observe if the recipient needs to grab furniture or walls for support. Have the recipient show you the home and observe ambulation.
* **Questions:** Do you ever have any difficulty moving around? Have you ever had to use a cane or walker? Do you feel safe walking alone in your home?

Rank 2: Can move independently with only reminding or encouragement (e.g., needs reminding to lock a brace, unlock a wheelchair or to use a cane or walker).

* **Observations:** Observe if the recipient can use his/her walker or cane of his/her own volition; if recipient can rely appropriately on an appliance; if there is an assistive device visible in a corner rather than right beside the recipient when s/he is sitting; how well the recipient is able to move about with an assistive device; if there is any modifications observable in the home such as grab bars, etc.
* **Questions:** Do you ever have trouble handling your device? Are there times when you forget and get somewhere and need help getting back or do not wish to use your device? What happens then? Have you experienced any falls lately? Describe.

Rank 3: Requires physical assistance from another person for specific maneuvers (e.g., pushing wheelchair around sharp corner, negotiating stairs or moving on certain surfaces).

* **Observations:** Observe if the recipient needs to ask you for assistance; if the recipient appears to be struggling with a maneuver that could put her/him at risk if unattended; if recipient appears strong enough to handle the device; if there are architectural barriers in the home.
* **Questions:** Are there times when you need to rely on someone else to help you get around the house? What kind of help do you need and when? What happens when there is no one to help you? Are there certain times of day or night when movement is more difficult for you? Are all areas of your home accessible to you?

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Rank 4: Requires assistance from another person most of the time. Is at risk if unassisted.

- **Observations:** Observe if the recipient is able to answer the door; get back safely to his/her seat; if there is clutter on the floor, scattered rugs, or stairs; if there is obvious fatigue or labored breathing; if there are bruises, scabs, bumps, or burns (signs of falls) on the recipient.
- **Questions:** Is there someone in the home helping you now? If so, what is the level of assistance?

Rank 5: Totally dependent upon others for movement. Must be carried, lifted, or assisted into a wheelchair or gurney at all times.

- **Observations:** Observe if the recipient appears to be immobile; if s/he appears to be uncomfortable or in pain; if s/he has any fears related to being moved; if s/he makes needs known.
- **Questions:** Who is available to help you when you need to be moved? Do you feel s/he is able to do so without causing you undue pain or discomfort? Is there anything that needs to be changed to make you more comfortable?

Bathing, Oral Hygiene, and Grooming/Routine Bed Bath

Bathing (Bath/Shower) includes cleaning the body in a tub or shower; obtaining water/supplies and putting them away; turning on/off faucets and adjusting water temperature; assistance with getting in/out of tub or shower; assistance with reaching all parts of the body for washing, rinsing, drying, and applying lotion, powder, deodorant; and washing/drying hands.

Oral Hygiene includes applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

Grooming includes combing/brushing hair; hair trimming when the recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care (excluding toenail clipping) when these services are not assessed as Paramedical services for the recipient; and washing/drying hands.

Note: Bathing, Oral Hygiene, and Grooming does not include getting to/from the bathroom. These tasks are assessed as mobility under Ambulation services.

Routine Bed Bath includes cleaning basin or other materials used for bed sponge baths and putting them away; obtaining water and supplies; washing, rinsing, and drying body; applying lotion, powder, and deodorant; and washing/drying hands before and after bathing.

The following is the application of functional rank specific to Bathing, Oral Hygiene, and Grooming/Routine Bed Baths with suggestions that may help inform the determination as to rank:

ATTACHMENT B

Rank 1: Independent: Able to bathe, brush teeth, and groom self safely without help from another person.

* **Observations:** Observe if the recipient's mobility is unimpaired; if the recipient is clean and well groomed; if there is assistive equipment in the bathroom.
* **Questions:** Do you ever require any assistance with Bathing, Oral Hygiene, or Grooming? Are you able to get in and out of the tub or shower safely? Have you ever fallen?

Rank 2: Able to bathe, brush teeth, and groom self with direction or intermittent monitoring. May need reminding to maintain personal hygiene.

* **Observations:** Observe if the recipient has body odors, unwashed hair, dirt or grime on body, un-manicured fingernails; if the recipient is unshaven, displays a lack of oral hygiene or general poor grooming habits; if the recipient is unaware of his/her appearance.
* **Questions:** Are there times when you forget to bathe, brush your teeth, and groom yourself, or it seems just too much bother? Does anyone help you organize your bath or shower?

Rank 3: Generally able to bathe and groom self, but needs assistance with some areas of body care (e.g., getting in and out of shower or tub, shampooing hair, or brushing teeth).

* **Observations:** Observe if the recipient has weakness or pain in limbs or joints; difficulty raising arms over head, frailty, general weakness, unsteady gait indicating a safety risk; if the bathroom is not set up to meet the recipient's safety needs (e.g., grab bars, tub bench); if recipient's grooming indicates an unaddressed need.
* **Example:** Recipient has fear associated with lack of movement.
* **Questions:** Are there areas of bathing, oral hygiene, or grooming that you feel you need help with? What? When? How do you get into the shower or tub? Do you ever feel unsafe in the bathroom? Have you ever had an accident when bathing? What would you do if you did fall?

Rank 4: Requires direct assistance with most aspects of bathing, oral hygiene, and grooming. Would be at risk if left alone.

* **Observations:** Observe if the recipient requires assistance with transfer; has poor range of motion, weakness, poor balance, fatigue; skin problems (e.g., indications of a safety risk). Determine how accessible and modified the bathroom is to meet the recipient's needs.
* **Questions:** How much help do you need in taking a bath and washing your hair? If there were no one to help you, what would be left undone? Do you experience any loss of sensation to your body? Do you have any fears related to bathing? Have you fallen when getting into or out of the tub or shower? What would you do if you did fall?

Rank 5: Totally dependent on others for bathing, oral hygiene, and grooming.

* **Observations:** Observe if there is any voluntary movement and where; if the recipient exhibits good skin color, healthy, clean skin and hair; if bathing schedules/activities are appropriate for the recipient's specific disability/limitations.

* **Questions:** Are you satisfied with your bathing, oral hygiene, and grooming routines? Does anything frighten or scare you when you are bathed?

Dressing/Prosthetic Devices:

Dressing/Prosthetic Devices: Putting on/taking off, fastening/unfastening, buttoning/unbuttoning, zipping/unzipping, and tying/untying of garments, undergarments, corsets, elastic stockings, braces, and prosthetic devices; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.

The following is the application of functional rank specific to Dressing/Prosthetic Devices with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to put on, fasten, and remove all clothing. Clothes self appropriately for health and safety.

* **Observations:** Observe if the recipient is appropriately dressed; if clothing is buttoned, zipped, laced; if the recipient has no difficulty with small hand movements as demonstrated by his/her ability to sign the application.
* **Questions:** Do you ever have any difficulty getting dressed (e.g., buttoning or zipping clothing, etc.).

Rank 2: Able to dress self; but requires reminding or direction.

* **Observations:** Observe the appropriateness of the recipient's dress for room temperature or if the recipient's clothing is bizarre (e.g., wearing underwear outside of clothing); if the clothing is buttoned, zipped, laced; if the clothing is relatively clean, is mended if necessary, is the correct size for recipient; if the recipient is blind; if the recipient is alert and aware of his/her appearance.
* **Questions:** Are there times when it seems just too much of a bother to get dressed for the day? Does anyone ever comment to you on how you are dressed? Are you warm enough or too warm? Could you use some help in getting your clothes organized for the day?

Rank 3: Unable to dress self completely without the help of another person (e.g., tying shoes, buttoning, zipping, putting on hose, brace, etc.).

* **Observations:** Observe if the recipient's clothes are correctly fastened; if the recipient apologizes or seems embarrassed about the state of his/her dress; if the recipient asks you for any assistance; if the recipient is disabled in his/her dominant hand; if the recipient has impaired range of motion, grasping, small hand movement; if the recipient needs special clothing.
* **Questions:** Are there any articles of clothing you have difficulty putting on or fastening? Do you need help with clothing items before you feel properly dressed? Do you need to use a special device in order to get dressed? Do you use Velcro® fastening?

Rank 4: Unable to put on most clothing items by self. Without assistance the recipient would be inappropriately or inadequately clothed.

* **Observations:** Observe if the recipient's range of motion and other movements are impaired. Observe if the recipient is dressed in bed clothes, robe, and slippers rather than street clothes; if the recipient appears too cold or too warm for the room temperature; if the recipient seems willing to try to adapt to alternate methods of dressing.
* **Questions:** Do you feel unable to get out or have people visit because you are unable to get adequately dressed? Do you ever feel too hot or too cold because you cannot put on or take off the necessary clothing to make you feel more comfortable? Has your health ever been affected because you have not been able to dress appropriately for the weather or temperature?

Rank 5: Unable to dress self at all, requires complete assistance from another.

* **Observations:** Observe if the recipient is capable of voluntary movement? If the recipient's clothing appears comfortable and clean; if the recipient appears satisfied with the degree of dress. Determine if the recipient would prefer a dress and shoes rather than a robe and slippers all of the time.
* **Questions:** How do you change your clothing? Do you ever feel too warmly or too coolly dressed? Is your clothing comfortable and clean enough? Do you get changed as often as you feel necessary?

Bowel, Bladder, and Menstrual Care

Bowel, Bladder, and Menstrual Care: Assisting with using, emptying, and cleaning bedpans/bedside commodes, urinals, ostomy, enema, and/or catheter receptacles; application of diapers; positioning for diaper changes; managing clothing; changing disposable barrier pads; putting on/taking off disposable gloves; wiping and cleaning recipient; assisting with getting on/off commode or toilet; and washing/drying hands. Menstrual care is limited to the external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes, using and/or disposing of barrier pads, managing clothing, wiping, cleaning, and washing/drying hands.

Note: This task does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program, or colostomy irrigation. These tasks are assessed as Paramedical services. In assessing Menstrual care, it may be necessary to assess additional time in other service categories such as Laundry, Dressing, Domestic, Bathing, Oral Hygiene, and Grooming. Also, if a recipient wears diapers, time for menstrual care should not be necessary

The following is the application of functional rank specific to Bowel, Bladder, and Menstrual care with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to manage Bowel, Bladder, and Menstrual care with no assistance from another person.

* **Observations:** Observe if recipient's movement is unimpaired and odor of urine present; if the recipient has had colon cancer, observe if the recipient wears a colostomy or ostomy bag or if there are ostomy or colostomy bags present.

* **Questions:** Do you need any help when you have to use the toilet? Do you also use a bedside commode, urinal, or bedpan? Do you have any problems getting to the bathroom on time?

Rank 2: Requires reminding or direction only.

* **Observations:** Observe if the recipient seems disoriented or confused; if urine smells are detectable; if furniture is covered with barrier pads or plastic; if adult diapers are in the recipient's bedroom or bathroom; if the recipient takes diuretics such as Lasix®; if the recipient's clothing is stained, indicating that there is an incontinence problem.
* **Questions:** In the past month, have you had difficulty getting to the toilet/commode on time? If yes, how often? Does someone remind you?

Rank 3: Requires minimal assistance with some activities but the constant presence of the provider is not necessary.

* **Observations:** Observe if there are moderate movement impairments; if there is severe limitation of use of the recipient's hands; if the recipient needs a boost to transfer.
* **Questions:** Do you have any problems using the bathroom or managing your clothes? Does anyone help you? If yes, what kind of assistance do you need and how often? Are you able to empty your urinal/commode (if used)? Do you have accidents? How often do the accidents occur? Are you able to cleanup after them?

Rank 4: Unable to carry out most activities without assistance.

* **Observations:** Observe the severity of the recipient's movement problems; if the recipient is unable to transfer unassisted; the recipient's or provider's statement as to the quantity or frequency of daily laundry and any indication that hand laundry is done daily. Observe if there is a large amount of unwashed laundry with the odor of urine or fecal matter. Observe if there are meds such as stool softeners visible.
* **Questions:** Who helps you? How? Is s/he available every time you need help? Do you need more help at certain times of the day/night?

Rank 5: Requires physical assistance in all areas of care.

* **Observations:** Observe if the recipient has any voluntary movement; if the recipient is bedfast or chair bound; if the recipient is able to make her/his needs known.
* **Questions:** Who helps you? What is your daily routine? Do you also need assistance with activities we classify as Paramedical Services?

Rank 6: **ALL** functions in the task are met by Paramedical

ATTACHMENT B

Transfer

Transfer: Assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, couch, wheelchair, walker, or other assistive device generally occurring within the same room.

Note: Transfer does not include assistance on/off toilet. This task is assessed as part of Bowel, Bladder, and Menstrual Care. Care of pressure sores (skin and wound care). This task is assessed as part of Paramedical services.

The following is the application of functional rank specific to Transfer with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to do all transfers safely without assistance from another person though recipient may experience some difficulty or discomfort. Completion of task poses no risk to his/her safety.

- **Observations:** Observe if the recipient's movement is unimpaired; if s/he is able to get out of a chair unassisted when s/he shows you the house; if s/he shifts weight while sitting.
- **Questions:** Do you ever need a boost to get out of bed or out of the chair? When? How often? Do you ever have difficulty moving around?

Rank 2: Able to transfer, but needs encouragement or direction.

- **Observations:** Observe if the recipient seems confused and has trouble getting out of a chair (probably more problematic in getting out of bed). Determine if the recipient is bed bound on bad days.
- **Questions:** Does anyone help you get out of bed in the morning? How does s/he help you?

Rank 3: Requires some help from another person (e.g., routinely requires a boost).

- **Observations:** Observe the length of time it takes the recipient to answer door; the sounds heard as the recipient comes to door; if the recipient asks you for a boost when s/he gets up to get medications, or is shaky when using assistive device; if the recipient is obese and has a great deal of difficulty getting up.
- **Questions:** Do you always have difficulty getting out of a chair? Who helps you? How? How often? Do you also have trouble getting out of bed? What kind of help do you need? (Expressing interest in how the recipient has solved one problem usually encourages her/him to tell you ways s/he have solved other problems.)

Rank 4: Unable to complete most transfers without physical assistance. Would be at risk if unassisted.

- **Observations:** Observe if the recipient uses an assistive device for mobility; if the recipient's joints are deformed from arthritis or some other disease; if the recipient is wearing a cast or brace; if someone in house assists the recipient to get up if s/he uses a walker or is in a wheelchair; if there are bruises, scabs, or bumps or burns on the recipient.

* **Questions:** Who helps you? How? How often? Both in getting into and out of bed, in and out of chair/wheelchair? Do you need more help at certain times of the day/night?

Rank 5: Totally dependent upon another person for all transfers. Must be lifted or mechanically transferred.

* **Observations:** Observe if the recipient appears to be immobile; if s/he appears to be uncomfortable or in pain; if s/he has any fears related to being moved; if the recipient makes needs known.
* **Questions:** Who is available to help you when you need to be moved? Do you feel they are able to do so without causing you undue pain or discomfort? Is there anything that needs to be changed to make you more comfortable?

Eating

Assisting with consumption of food and assurance of adequate fluid intake consisting of eating or related assistance to recipients who cannot feed themselves or who require other assistance with special devices in order to feed themselves or to drink adequate liquids. Eating task includes assistance with reaching for, picking up, and grasping utensils and cup; cleaning face and hands; and washing/drying provider's hands.

Note: This does not include cutting food into bite-sized pieces or puréeing food, as these tasks are assessed in Meal Preparation services.

The following is the application of functional rank specific to Eating with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to feed self.

* **Observations:** Observe if there is no impairment in grasp indicated when the recipient signs the application or handles medicine bottles; if there is a cup or glass next to the recipient's chair; observe how the recipient takes a drink.
* **Questions:** Do you need any help eating? (Since deterioration usually occurs in a hierarchical manner and feeding oneself is the last function to lose, questions may not be necessary if the recipient is able to dress self and scores 1 in Bowel and Bladder Care except in cases where the recipient seems mentally impaired.)

Rank 2: Able to feed self, but needs verbal assistance such as reminding or encouragement to eat.

* **Observations:** Observe if the recipient appears depressed, despondent, or disoriented; if the recipient's clothes seem large for the recipient, indicating possible recent weight loss; if there is rotten food, no food in refrigerator, or a stockpile or Twinkies®, only; if there are not any signs of cooking.
* **Questions:** What have you eaten today? How many meals do you eat each day? Do you have trouble with a poor appetite? What is the difficulty? Are there times you forget to eat? Does it sometimes seem like it takes too much effort to eat? Do you have trouble deciding what to eat?

Rank 3: Assistance needed during the meal (e.g., to apply assistive device, fetch beverage or push more food within reach, etc.), but constant presence of another person is not required.

* **Observations:** Observe if manual dexterity is impaired, particularly of dominant hand; if there are straws or cups with spill-proof lids; if the recipient has difficulty shaking hands; if s/he has severely limited eyesight.
* **Questions:** Do you need help in feeding yourself? Do you need to use special utensils to feed yourself? Do you feel that you get enough to eat? Do you have difficulty reaching food on your plate or reaching your glass?

Rank 4: Able to feed self some foods, but cannot hold utensils, cups, glasses, etc., and requires constant presence of another person.

* **Observations:** Food stains on clothing; shakiness of hands; deformity of hands with limitation in ability to grasp or hold trays, towels, bibs.
* **Questions:** Does someone help you eat? How? How often? Do you eat with the rest of the family? Can you feed yourself finger foods? Are you able to use a fork or spoon? Do you have difficulty chewing or swallowing? If so, how do you deal with the problem?

Rank 5: Unable to feed self at all and is totally dependent upon assistance from another person.

* **Observations:** Observe if the recipient has no use of upper extremities; if there are trays, towels, bibs, etc., near the recipient.
* **Questions:** What is your daily routine for eating meals?

Rank 6: **ALL** functions in the task are met by Paramedical.

Respiration

Respiration is limited to non-medical services such as assistance with self-administration of oxygen and cleaning oxygen equipment and IPPB machines.

The following is the application of functional rank specific to Respiration with suggestions that may help inform the determination as to rank:

Rank 1: Does not use respirator or other oxygen equipment or is able to use and clean independently.

* **Observations:** Observe the oxygen equipment present; if the recipient coughs or wheezes excessively or if breathing is labored.
* **Question:** Are you able to clean and take care of the equipment yourself?

Rank 5: Needs help with self-administration and/or cleaning.

* **Observations:** Observe the same things above and if when the recipient ambulates if s/he has difficulty with breathing or breathing is laborious. Observe the recipient's meds; if the recipient has weakness or immobility in conjunction with breathing problems; if there is a referral from an oxygen supplier indicating the recipient is not taking care of the equipment properly.

* **Questions:** Are you able to clean and take care of the equipment yourself? If not, how does it get done? How often do you use the equipment? Have you had difficulty administering your own oxygen or using your breathing machine? (If yes, refer for Paramedical service.) Who cleans equipment after you use it?

Rank 6: **ALL** functions in the task are met by Paramedical.

MENTAL FUNCTIONING

Memory

Recalling learned behaviors and information from distant and recent past.

The following is the application of functional rank specific to Memory with suggestions that may help inform the determination as to rank:

Rank 1: No problem: Memory is clear. Recipient is able to give you accurate information about his/her medical history; is able to talk appropriately about comments made earlier in the conversation; has good recall of past events. The recipient is able to give you detailed information in response to your questions.

* **Observations:** Observe if recipient's responses to your questions indicate that s/he has good recall; knows his/her doctors' names; knows his/her own telephone number or the number of a close friend; is clear about sources of income and assets; knows who close relatives are and where they live. Observe if the recipient is mentally capable of following through on activities of daily living; if s/he has good social skills; if recipient's thought process seems clear and s/he is able to keep track during a conversation.
* **Example:** An elderly women living alone in her home responds quickly and confidently to your questions to establish her eligibility for IHSS and determine her need for services. The recipient is reasonably organized. His/her medications are in place. There are stamped bills in the mailbox. The trash appears to be picked up regularly. There is a grocery list ready for the IHSS provider.
* **Questions:** Who is your doctor? What medicine do you take regularly? What is your address and telephone number? When were you born? Where were you born? What is the date today? How long have you lived in this house? Where did you live before you lived here? What serious illnesses or surgeries have you had? How long ago was each illness or surgery?

Rank 2: Memory loss is moderate or intermittent: Recipient shows evidence of some memory impairment, but not to the extent where s/he is at risk. Recipient needs occasional reminding to do routine tasks or help recalling past events.

* **Observations:** Observe if the recipient appears forgetful and has some difficulty remembering names, dates, addresses, and telephone numbers; if the recipient's attention span and concentration are faulty; if the recipient fidgets, frowns, etc., possibly indicating a struggle to recall; if the recipient repeats statements and asks repetitive questions; if recipient occasionally forgets to take medication or cannot recall when s/he

last took medication and if the problem is corrected with the use of a Medi-Set (pill distribution box) set up by someone else. Observe if the recipient may become bewildered or appears overwhelmed when asked about details; if the recipient's recall process aggravates mental confusion or causes intermittent memory loss; if the recipient becomes moderately confused when daily routine is altered.

* **Example:** Elderly man has to be prompted occasionally by his wife when he tries to respond to your questions. He apologizes for or tries to conceal memory lapses.
* **Questions:** What year were you born? How old are you now? How old were you when your first child was born? What medicines do you take? Tell me what you usually do during the day. Who telephones or comes to see you often? What do you have to eat for dinner tonight?

Rank 5: Severe memory deficit: Recipient forgets to start or finish activities of daily living that are important to his/her health and/or safety. Recipient cannot maintain much continuity of thought in conversation with you.

* **Observations:** Observe if the recipient has a blank or benign look on her/his face most of the time; if s/he is continually placing and replacing objects in the room to avoid answering your questions; if s/he gives inappropriate responses to questions; if the recipient's voice and/or train of thought trails off in middle of conversations; if s/he starts an activity and forgets to finish it; if the recipient consistently forgets to take medications or takes them inappropriately, even with a Medi-Set. Determine if the recipient has a history of leaving stove burners on or the water running in the sink and/or tub causing overflows. Observe if the recipient cannot remember when s/he ate last or what s/he ate; if s/he is unable to remember names of close relatives; has loss of verbal ability; is impaired intellectually; displays abnormal and potentially dangerous behavior.
* **Example:** Middle-aged man suffering from Alzheimer's disease is totally unable to respond to your questions. He becomes very agitated for no good reason; arises from chair as if to leave room and stares in bewilderment; needs to be led back to his chair. He seems unconcerned with events in daily life and cannot articulate his need for services. His daily routine follows a set, rigid pattern. He relates to the situation on a superficial basis.
* **Questions:** What are the names and relationships of your closest relatives? Did you eat breakfast today? What did you eat? Can you tell me what I'm holding in my hand? How old are you? What is your birth date? Ask housemate: What happens when the recipient is left alone? Does s/he remember any events from the previous day, hour, or minute? Does s/he remember who you are? Does s/he remember how to operate the stove, shave self, or perform other tasks safely?

ATTACHMENT B

Orientation

Awareness of time, place, self, and other individuals in one's environment.

The following is the application of functional rank specific to Orientation with suggestions that may help inform the determination as to rank:

Rank 1: No problem: Orientation is clear. Recipient is aware of where s/he is and can give you reliable information when questioned about activities of daily living, family, etc.; is aware of passage of time during the day.

* **Observations:** Observe if the recipient appears comfortable and familiar with his/her surroundings. Recipient makes and keeps good eye contact with you. His/her facial expression is alert and is appropriate to the situation. The recipient is spontaneous and direct. The recipient shows interest in maintaining a good personal appearance. The recipient is obviously in touch with reality; is aware of time and place; readily responds to questions about his/her living arrangement, family, etc.; is fully aware of the reason for your visit. Determine if the recipient is physically able to leave home unassisted and if the recipient can find his/her way back without getting lost and can get around using public transportation.
* **Example:** Recipient is ready and waiting for your visit. S/he initiates social amenities such as offering coffee, a chair to sit on, etc. The recipient introduces family members and/or is able to identify family pictures when asked and has the documents ready that you asked him/her to locate.
* **Questions:** Do you have relatives living close by? Why are you asking for help at this time? How have you managed to care for yourself until now? Do you have someone who helps around the home?

Rank 2: Occasional disorientation and confusion is apparent but recipient does not put self at risk: Recipient has general awareness of time of day; is able to provide limited information about family, friends, age, daily routine, etc.

* **Observations:** Observe if the recipient appears disheveled and the surroundings are chaotic. Observe if objects are misplaced or located in inappropriate places; if there is moldy food in and out of kitchen; if the recipient does not notice that the home is over heated or under heated until you mention it; if the recipient appears to be less confused in familiar surroundings and with a few close friends; if the recipient is able to maintain only marginal or intermittent levels of social interaction; if the recipient is able to provide some information but is occasionally confused and vague; if the recipient is not always aware of time, surroundings and people; if the recipient is able to respond when redirected or reminded.
* **Example:** Twice in the past year the recipient has called her daughter at 2:00 a.m. and was not aware that it was the middle of the night. When told what time it was, the recipient apologized and went back to bed. When you enter the recipient's apartment, the elderly woman asks, "Why are you here today? You said you'd be here Tuesday." You respond, "This is Tuesday." The recipient seems unprepared for your visit and has difficulty settling down for the interview. She participates with some difficulty. She is not comfortable outside of her immediate environment and rarely ventures out. Her mail is left

unopened occasionally, and her clothing and some perishable food items are not properly stored.

* **Questions:** What day is today? How many rooms do you have in your home? Where is the closest grocery store? Do you know who I am and why I am here? Do you go out alone? Do you ever get lost when you go out of the house alone? Do you know the name of the bus you take when you go to the store and where the bus stop is to go home? What month, year, season, holiday, etc.?

Rank 5: Severe disorientation which puts recipient at risk: Recipient wanders off; lacks awareness or concern for safety or well being; is unable to identify significant others or relate safely to environment or situation; has no sense of time of day.

* **Observations:** Observe if the recipient shuffles aimlessly throughout house; if s/he exhibits inappropriate behaviors such as giggling or making comments that are irrelevant to the conservation; if s/he handles objects carelessly; appears unkempt, displays poor personal hygiene; has a manner of dress that is inappropriate or bizarre; if when the social worker attempted to shake the recipient's hand, s/he tried to bite social worker's hand. Observe if the recipient is very confused, unaware of time, place, and/or individuals; goes to the mailbox and cannot find her/his way back to the apartment; does not recognize the apartment manager when the manager tries to help the recipient find her/his way back to the apartment and the recipient becomes highly agitated. Observe if the recipient appears to be disoriented and experiences hallucinations and displays a dazed and confused state of mind; is unable to answer simple questions appropriately; if the recipient's sleep-wake cycle may be abnormal; if the recipient confuses immediate living relatives (son/daughter) with dead relatives (husband, etc); if emotional instability is present.
* **Example:** Family member or friend must answer door, as recipient is unable to maneuver in home without wandering. The recipient must be directed to chair. The recipient exhibits no awareness of the purpose of the social worker's visit. The recipient is unable to concentrate; s/he either does not respond to questions or speaks unintelligibly.
* **Questions:** What is your name? Where do you live? What is the date today? What year is it? Where are you? Where are you going? If the recipient is unable to respond or responds inappropriately, ask housemate: What is the nature of ___'s mental problem? What can the recipient do for self? What does the recipient do if left alone?

Judgment

Making decisions so as not to put self or property in danger. Recipient demonstrates safety around stove. Recipient has capacity to respond to changes in the environment (e.g., fire, cold house). Recipient understands alternatives and risks involved and accepts consequences of decisions.

The following is the application of functional rank specific to Judgment with suggestions that may help inform the determination as to rank:

ATTACHMENT B

Rank 1: Judgment unimpaired: Able to evaluate environmental cues and respond appropriately.

* **Observations:** Observe if home is properly maintained, and in safe repair; if recipient's responses show decision-making ability is intact; if recipient dresses appropriately for the weather; if recipient is able to form correct conclusions from knowledge acquired through experience; if recipient is capable of making independent decisions and is able to interact with others.
* **Example:** Recipient takes pride in managing his/her own affairs and does so appropriately. The recipient has a list of numbers to call in case of emergency; takes measures to guard safety such as locking doors at night, not allowing strangers into home, etc.
* **Questions:** Do you have a list of numbers to call in case of an emergency? Do you have friends or family who could help out in a crisis situation? What would you do if your provider were unable to come to work one day?

Rank 2: Judgment mildly impaired: Shows lack of ability to plan for self; has difficulty deciding between alternatives, but is amenable to advice; social judgment is poor.

* **Observations:** Observe if the home is in disrepair (leaking faucets, broken appliances, inadequate lighting, etc.); if debris has been allowed to accumulate in walk-way areas; if food in the home is of poor nutritional value; if the recipient is unable to recognize that there are alternatives or unable to select between them and is unable to plan or foresee consequences of decisions. Observe if the recipient is not capable of making decisions without advice from another, is able to understand options when explained, makes correct choices; knows enough to turn stove and heat on and off.
* **Example:** Recipient wastes money on useless items while allowing needed repairs to go unattended. The recipient "makes do" with the condition of home even if it is inconvenient for the recipient. The recipient appears to be a "collector," has difficulty throwing anything out even though access through home is limited. The recipient can't decide which provider s/he wants. The grocery list to provider contains mostly junk food. The recipient stopped homebound meals when s/he decided they weren't tasty rather than add salt. S/he refuses to use walker or cane.
* **Questions:** Who would you call in case of emergency? If someone you did not know came to your door at night, what would you do? What are you able to do for yourself? Do you need anyone to help you? Who would you depend on to assist you if you needed a household repair done such as if your heater did not work?

Rank 5: Judgment severely impaired: Recipient fails to make decisions or makes decisions without regard to safety or well-being.

* **Observations:** Observe if safety hazards are evident: clothing has burn holes; faulty wiring, leaking gas, burned cookware, etc. Observe if utilities may be shut off; food supply is inadequate or inedible. If the recipient is a pet owner, observe if there are animal feces in home. Observe if the recipient is obviously unaware of dangerous situations, not self-directing, mentally unable to engage in activities of daily living; goes outside with no clothing on; if neighbors saw smoke from apartment several times; if they entered and extinguished fires on stove; if someone from the community calls to report that the recipient is defecating or urinating on the front yard. Observe if the recipient cannot

decide to eat, dress, or take medications; if the recipient seems preoccupied, confused, or frightened; if the recipient is unaware or too frail or feeble to make decisions to maintain self safely at home; if s/he takes a shower with clothes on; drinks spoiled milk, etc.

* **Example:** Recipient has open access to home to anyone who approaches. The recipient seems unaffected by stench or odors due to garbage, feces, urine, etc; exhibits no concern over obvious safety hazards (e.g., debris piled on stove, papers scattered near heater, etc.); lets injuries such as burns go unattended. In the past year, the recipient has recurrently started dinner and fell asleep and awoke to a smoke-filled kitchen.
* **Questions:** What would you do if you saw something on fire in your house? If you needed to get to the doctor what would you do? Ask Housemate: What happens when __ is left alone? Can s/he recognize situations that would lead to danger? Is s/he capable of making rational decisions?

3: Assessment
Tools

SPECIAL INSERT

Doing the Interview: How to Really Ask Those Questions and Enjoy it

Colleen King

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An edited version of a presentation given at "Assessment Revisited: Practical Approaches to Assessing the Elderly." A conference presented by the University of Minnesota Long-Term Care DECISIONS Resource Center, Minneapolis, Minnesota.

Colleen King presented this paper and additional insights at "Assessment Revisited: Practical Approaches to Assessing the Elderly," the Center conference held in September in Minneapolis.

Through years of experience in both supervising and training interviewers and through my own experience as an interviewer I have developed a style of interviewing I call, *conversations with a purpose.* This style of interviewing is conversational, relaxed, but structured within the boundaries of appropriate interviewing. Even in the most open-ended type of assessment there will be boundaries of correctness that each individual administrating the tool must stay within. I have tried to develop a style that will insure that the viability of the tool will not be compromised, allow you to stay within the boundaries of the tool, and make the assessment workable and enjoyable for the individual administrating the tool.

The comprehensive assessment interview can be a valuable tool in assessing the needs of older people. If done correctly the assessment can be an enjoyable and rewarding experience for both the client and the assessor. If done incorrectly the assessment can be biased, frustrating, and a waste of everyone's valuable time. In the next few pages I would like to challenge you to an enjoyable experience. Conversations with older people are never boring. You should have confidence in the assessment tool and know the information you collect will help you provide for the needs of the individuals you desire to help.

I would like to talk about the most common mistakes and how to correct them. The most common mistakes made in any kind of assessment interview, either interviews with fixed questions or more open-ended interviews, are:

- Failure to ask the questions on the tool.
- Not spending time to develop rapport with the client.
- Bias or leading the client.
- Inappropriate probing.
- Avoiding difficult situations.

The responsibility of the assessment lies in your hands. With proper training, a better understanding of the tool, and support from peers; your job can be worth your time.

ASK THE QUESTIONS

The key to your successful comprehensive assessment of a client is knowing and understanding your assessment tool. The assessment tool was designed with the purpose of permitting a fuller and better understanding of the care needs of the older person. If your assessment is done correctly you should be able to:

- determine eligibility of the client.
- better respect the rights of the client.
- design a care plan that will fit the needs of the client.
- become more familiar with future needs of the client.
- provide information to planners that will allow them to more accurately determine the needs on a community basis.

For the client's sake, the assessment tool should be taken seriously. If it's not worth your time to ask the questions correctly, it is not worth the client's time to try to answer the questions honestly. Without the assessment tool you are not going to get accurate data. You may think you know how I feel, but unless you ask me you are only guessing. If I have recently lost a spouse and you skip the questions dealing with mood and outlook because you assume you know the answers, you have lost valuable information about me. You do not know if I am handling the situation within the normal range of grief, or if I am not facing the

situation and may need help. You just assume I am depressed. Depression, sadness and grief are very different. It is far better to learn how to talk to the grieving client and how to ask questions in difficult situations than to answer for the client. To design a care plan on guessing is not fair to the client. These tools have been developed to help you meet the needs of the client.

A common problem is not asking the questions when they are embarrassing to the assessor. The interviewer is often uncomfortable talking about incontinence or income or both. Older people don't mind describing toileting issues if discussed matter-of-factly. If questions are handled in a respectful manner people will not mind discussing these issues. If you have developed rapport with the client early on you will not feel as embarrasssed. The client will understand that what you are doing is important and you will feel confidence in the rapport established. The purpose of the comprehensive assessment is not to embarrass, but to provide a care plan. Incontinence is a common problem with older people and is not embarrassing. If an individual becomes embarrassed by questions it is your responsibility to comfort that person.. Inform them, "I talk to a variety of people in many different situations and all questions are important in determining a care plan. All questions may not be relevant to you or your situation, but they are all an important part of the assessment."

Before a comprehensive assessment is done each assessor should know:

- What each question means, and how to reword the question to adapt to odd or difficult situations.
- What are the boundaries of each question? When would I be leading or biasing; how much do I help the client understand the question? In the ADL's usually there is a definition of dressing, and eating, and you must not neglect giving the full elements of this definition. You must know what to do when the client says, "I can do everything but button the back of my dress." An example of more strict boundaries might be in the mental status questions where often you are instructed not to change or alter the questions at all.
- How to answer questions to reassure the client of the worth and value of the assessment.

If you do not have a working knowledge of the tool you should ask for help. If you do not believe in and value the tool, you should talk to someone who has confidence in the tool. There should be someone available to assist you. If you understand what you are doing and have confidence in what you are doing, your comprehensive assessments will be enjoyable and valuable. Before you use the assessment tool:

- Role play with another employee.
- Make notes of difficult questions and how to handle them.
- Be prepared to answer questions about the tool.
- Know how to handle difficult situations.

SPEND TIME TO DEVELOP RAPPORT

After you have a working knowledge and confidence in your tool the next thing to learn is developing rapport with the client. The time you spend in the beginning to develop rapport can make or break an assessment. If the client feels comfortable with you, he/she will speak more openly with you. Spending time to develop rapport can make the interview go more quickly, you will gather more valuable information, and the conversation will be more enjoyable. You develop rapport by:

- Speaking in a conversational tone.
- Spending time talking about something other than the assessment (small talk).

Reassuring clients that this is important and worth their time. The information will be used to prepare a care plan that fits their needs.

- Not being afraid to answer questions. Approach questions as an opportunity to explain further, not as an obstacle to overcome.
- Listening to the client and making a mental note of speech patterns. This will help you pace the assessment to the characteristics of the client. It is important early on to note whether the client is talkative or quiet.
- Letting clients know you are enjoying talking with them; it will help them relax.
- Observing the client's behavior in the presence of others. If there are other family members in the room, this will give you an opportunity to view how openly the client speaks in front of others.
- Spending some time talking about the assessment before you begin. Tell the client the type of questions you will be asking and why, i.e. "I will ask you some general questions about activities you may be involved in. This will help us work together to figure out your needs and how we can be helpful to you."
- Always being professional, but not being afraid to enjoy yourself. You can laugh and be relaxed while doing your job. If you are relaxed the client will know that they too can be relaxed.

The time you spend developing rapport with the client will help you better understand the client. This knowledge of the client will help you direct the conversation, know when to probe more, give you an idea of how talkative the client is and how much time the assessment will take. Social workers and nurses are trained to make people feel comfortable and are excellent interviewers. Do not become paralyzed by the assessment form or forget the skills you already have. Integrate the skills you have with the assessment tool. Do not be overwelmed by the assessment tool and forget the sensitive listening skills you have. Set the assessment tool aside when needed and listen to the client. If you have developed rapport early on, this will come naturally.

AVOIDING BIAS

This is an area where most professionals will err. You know the issues so well, and you are so familiar with the needs of older people that you are probably right more than you are wrong when you guess or assume. The problem is not when you are right, but when you are wrong. The assessment tool was not designed for the professional to guess, but for the professional to ask and find out what the client will answer. A bias is any influence that changes an answer or an opinion from what it might have been without that influence. It is important to be aware of your own bias and how that would conflict with the assessment. Once you say to the client, "so what you are trying to say is," you have given your opinion and biased the assessment.

It is important to be aware of interviewing errors. It is easy to relax your objective attitude and thus bias responses. To avoid influencing or biasing, follow these rules:

- DO NOT express your own opinions or how you think the client should respond (i.e. "I think everyone should have physical therapy"). Clients will change their answers to please you or change their answer to what you believe to be the correct answer. Try to reassure the client that we really do want their opinions. We are interested in what they experience or feel about a certain situation. The whole purpose of a comprehensive assessment is defeated when you answer for a client, lead the client or bias the client's responses.
- DO NOT suggest answers even if the client wants your help. Help the client sort out their opinions or responses; don't give them the answer. Repeat the question, read it through slowly, pause, and tell the client to "take a moment and think about it." If you

take your time and do not rush the client, you will be less likely to suggest an answer. The client will appreciate your kindness and patience.

- DO NOT use leading probes. Any probe which suggests an answer is a leading probe and can bias the interview. Do not make the assumption that you know what the client is talking about; let the client explain. Don't lead the client to an answer or response you think seems right or fits their situation.
- DO NOT rush the client. Some people need time to sort out their responses. If the clients are not answering, do not take this as if they are objecting to the assessment, but allow them a moment to think through their answers. If you jump in too soon, you will try to answer for them. You may think the client does not understand or does not like the question when he/she is just trying to think of the answers. Do not appear impatient; appear interested. You can acknowledge that "it is sometimes difficult to decide these answers."

The obvious and most unfair way to bias the assessment is not to ask the questions. ASK THE QUESTIONS: give the clients the opportunity to tell you their opinion, responses, and what type of care they do want or don't want. The only way you will find this out is if you let the client tell you. The last ten people you talked to might have felt a certain way, but this next person is different. If you don't ask the questions you will never know. It is like voting. If fifteen individuals voted "yes" they want their taxes increased, you would hardly assume I too would vote "yes" and not even ask me? Ask me; I have a right to my opinions!

HOW TO PROBE

One of the most common mistakes in probing is to use an inappropriate probe, that is, a probe that either leads or would bias the interview. Correct probing is probably the most difficult part of the comprehensive assessment. Inappropriate probing will occur when the assessor is having difficulty obtaining a response from the client or when a question is asked and the assessor does not know how to answer it. A correct probe is a prompt which encourages further conversation without biasing the response. The probes you would use most often are:

- Probing for correctness.
- Probing for clarity.
- Probing for completeness.

Probing for correctness is used where you want the client to answer within a category or within set responses. The best way to probe for correctness is:

- Repeat the question and the responses. When doing this, change your tone or where you pause, and it may sound different; speak slowly; and look up at the client. Try to add small talk before you repeat the question.
- Explain to the client that you are restricted by these responses. Use probes like, "if you had to choose, which one would you choose," or, "taking everything into consideration, which one would be closest to you." Always avoid probes that lead to a positive or negative end of the scale. If the client has been very ill and you ask, "Is your health excellent, good, fair or poor?" You would never probe with, "So is your health fair or poor?" Always give the client the opportunity to reflect on the full range of answers. It would be better to say, "Let me read the choices again, they are: excellent, good, fair, or poor."

If you probe in a pleasant, conversational manner your probes will not seem repetitive or obtrusive. Keep telling the client how important it is to get their views and what they feel are their needs.

Probing for clarity often entails asking the clients for a more specific response or an explanation to their answers. The client has answered your question, but you need to clarify what is meant by that answer. Always try to help the client when probing for clarity; let the client know what you don't understand and what you need clarified. The most common probes for clarity are:

- "What do you mean by that? You said that you were tired a lot; tell me what that means to you." You want the client to open up and talk to you. Does tired mean bored or sleepy, or you can't get out of the chair to answer the telephone when it rings. If the client doesn't explain tired to you, it is left to your interpretation of what tired means to you. It is much better to find out what it means to that client.
- "Could you explain that, tell me more about that?" If you are interested in what the client is saying and the conversation is going smoothly, asking the client to explain or tell you more will seem natural.
- "I'm not sure I understand." . Simply direct the client's comments by letting him/her know what you do not understand.

On many mental health batteries, the answers do require probing. For example, you ask, "Do you see things that others don't see?" and the client answers, "Yes." Before deciding to refer to a mental health specialist, a probe "Can you tell me more about what you see?" would be helpful. The client might say, "I've always been intuitive and perceptive, and people say I understand their feelings when others don't." That's very different from a hallucination.

DIFFICULT SITUATIONS

Most of the time you will find clients will want to talk about their situation. They will be as anxious as you for a care plan. There are, however, times when the situation is extreme and the client could be overcome with grief or anger. Do not shy away from these situations. You will probably feel more uncomfortable than the client. As a trained professional, you should be able to handle a social interaction which requires attention. Personally, anger is easier for me to handle than grief and extreme sadness. I find the sad situations take a lot more out of me than dealing with anger. If the client becomes overcome with sorrow or begins to cry, handle the situation no matter how difficult it is for you. By following a few guidelines you will find that these situations are not as difficult as you might imagine them to be.

First: Don't ignore the client. Don't pretend they are not crying. Simply be direct, polite and sensitive. Put down your pencil and acknowledge the situation. Use Comments like: "I'm sure that is very difficult for you", or "I'm so sorry." Try reassuring them it is safe to express their grief, loneliness, pain or sadness with you. Even a comment like, "It's O.K. to cry; we all cry," or, "I understand," is effective. Try to remember a time when your eyes swelled up and you could not hold back the tears. Those moments often are most embarrassing. Try to make the client feel comfortable and at ease with their embarrassment.

Second: Don't pity the client. Grief, pain, loneliness and sadness are a part of all of us. The client does not need or want pity. Be respectful, sensitive and handle the situation. If possible personalize it: "My grandmother felt the same way," "That was very difficult for my grandfather too," or, "I understand your fear; my grandmother was very frightened of a nursing home." Don't make up stories, but if you have some understanding of the situation, this would be the time to express it to the client. React to this situation the way you would want someone to react if it was your grandparents or parents. You do not have to indulge the situation, but a brief moment of compassion and understanding is expected.

Third: If at all possible continue on with the assessment. The situation would have to be extreme not to be able to continue. I strongly urge you not to abandon the client or the comprehensive assessment. It leaves the client with a feeling of failure of unfinished business. Comments like, "I hope I didn't upset you?" will help. If you handled the situation correctly, most clients will respond by saying, "No you've been very kind," and you might say, "May we continue with the conversation?" Most clients will be happy to go on and appreciate your kindness and patience. Remember that even though the client may seem sad while talking to you, it still can be a comfort to express feelings. Often the assessor is the one who feels uncomfortable and tries to rush or terminate the interview. Be tolerant of pauses while the client is upset. A good neutral remark is "I know this is difficult and we do appreciate your help."

When dealing with the angry client, it is best to handle the anger before you attempt the interview. If the anger isn't dealt with, it will continue throughout the interview and you will be in constant battle. Handling the angry client in the beginning gives you control and sets the pace of the interview. Handle anger or the angry client with the following techniques:

- Gently confront the client, "You seem to be very upset and I am not sure why. If I have done something to upset you please tell me." If you haven't done anything to upset the client (which is most likely) then say, "I think it is best if we talk about why you are upset before we continue." The client may not be feeling well, or may have a very good reason for being upset. Whatever the situation may be you must get the anger out in the open for you to control the conversation.
- If you are just dealing with an angry person and can not get them to open up, explain what you are doing and that your only purpose is to gather information to help design a care plan. You wish them no harm and would appreciate their cooperation. If said in a calm and pleasant manner most people will cooperate.

COMMON PROBLEMS

GETTING THE CLIENT TO TAKE THE MENTAL STATUS QUESTIONS SERIOUSLY: Although this group of questions are, for the most part, easy to ask and record, they may be inherently difficult because some people will think you are testing their mental capabilities. Again, treat these questions with respect and a straightforward attitude and do not make the client think that answering them is a pass/fail type of situation. If they have trouble with this and it bothers them, try to reassure them that they're doing fine and you're almost done. This is a common problem that will occur over and over. If you are going to take the comprehensive assessment seriously you will have to learn how to handle these situations. People will reject the mental status questions for these reasons:

- They do not know the answers and are behaving defensively.
- They know the answers and feel foolish.
- They are unsure why you are asking them these questions. Is there supposed to be a problem, or do you think that there is something wrong with them?

Handle these situations with care and respect. Reassure the client by saying, "You are being very helpful, I certainly do not want to make you feel uncomfortable. These are questions that are commonly asked of people in your situation. I talk to a lot of different people in many situations. Some questions may seem too easy and some may seem too difficult. I will write down whatever you say. We are almost done and can move quickly through this section if you like." Or else say, "I'm so sorry you feel like I am testing you. I really am not. This portion of our discussion is asked to everyone I talk to. I ask the same questions in the same order to everyone. There is no pass/fail, I write down what you say. Surely you must understand that I talk to a lot of different people in different situations.

This portion of the assessment was designed to reach a large population of people in similiar situations as yours. Some questions may seem too easy, but some questions may seem too hard. Regardless of your situation, these questions are important and I would appreciate your help. I will go quickly through this section."

Do not let the client believe you think these questions are silly, ridiculous, not necessary, or a formality that you are forced to use. All questions must be taken seriously to be effective. It is very important that the assessor never lose respect for the comprehensive assessment, and you should never allow the client to lose respect for it. If you establish the ground rules the client will follow.

The assessment is important and so are <u>all</u> the questions. The same respect should be given these questions and you should handle them the same way you would handle questions that are embarrassing to you.

<u>THE TALKATIVE CLIENT:</u> Every question you ask gives talkative clients an opportunity to tell you a story about their life, their children or events in the world. When you are spending time to develop rapport you will obviously spot the talkative client. Knowing that, the best strategy is to set ground rules. Tell the client what you are going to do, how long it will take and what you need from her. "I have about an hour and a half for this discussion. I will ask you some general questions about your daily life and some more specific questions. It would be very helpful for the consistency of this discussion to stick to this form and ask the questions in the order they appear. I will also be the person working with you when services begin." Or, if more accurate, "my job is to work with you at the beginning to identify your problems and concerns, but another worker will work with you later." This will help establish ground rules, influence the client in letting him/her know what to expect in a future relationship with the case manager, and decide how much bonding is desirable.

Then within these constraints, the worker can say, "This is interesting, I'd like to hear more detail about your reactions to home care the next time I see you because it is so important. Right now, because of our time today, I would like to continue with the assessment interview," or, "Today we need to finish this form, but when services begin another worker will work with you and that would be important information to tell her." If you do have time and, most importantly, if the information would be helpful, you should encourage further information especially when relevant to the care plan. You can say, "I've made a note of that; you like your shower in the evening," or "It's helpful to know you like to play bridge, I've made a note about that." Of course, you should never say you made a note of something unless you actually made a note of it. And you should not say it will make a difference, if nobody will ever look at it again. I have been told that a good case manager makes these notes and <u>uses</u> them often.

<u>THE CLIENT WHO WANTS TO INTERVIEW YOU:</u> Some clients will be as interested in you or your job as you are in completing the assessment. Try to handle personal questions with a sense of humor. If the question is innocent enough answer it. If the personal questions persist or interfere with the process of the assessment gently tell the client, "I appreciate your interest. However, the importance of the assessment is to better understand <u>your</u> opinions on home care and how you feel. This is your opportunity to tell me." If clients want to know if you have children, tell them. If clients want to know your opinion on health care, <u>do not</u> tell them. Remember not to bias the assessment by leading or giving your opinions. Tell the client, "It is important to determine what your needs and opinions are. We are instructed not to express our opinions because it is very important that we do not influence you. That would be unfair to you and the people we talk to."

WHEN I KNOW THE CLIENT IS EMBARRASSED I JUST CAN'T ASK.

QUESTIONS ABOUT INCONTINENCE: If the client is embarrassed, it is your responsibility to reassure the client you are not embarrassed. The purpose is to provide for the needs of the client. Do not guess at what the needs are; ask the question. In my experience it is usually the interviewer who is more embarrassed than the client. If you are the one who is embarrassed, you will have to find a way to overcome your embarrassment. If the comprehensive assessment is to be taken seriously all questions must be asked. Ask these questions straightforwardly and without hesitation. If the client is embarrassed reassure them of the importance of asking all the questions. Try saying, "I certainly did not want to make you feel uncomfortable. I talk to a lot of people with many different needs. The importance of these questions is better understanding you and your needs to provide a care plan that is right for you." If said without embarrasment or hesitation on your part the client will feel reassured.

COMMENTS FROM CLIENTS

Some clients, no matter how much time you spend with them developing rapport, will also need reassurance. They are by nature suspicious people and will not trust you. Do not shy away from them; they just need a little more time and a little more reassurance. If you answer their questions they will eventually cooperate. They may just be toying with you to see how many questions you will answer. Do not let them have control, but do answer their questions and move quickly to the assessment tool. I have tried to think of some common questions and examples of responses to those questions. Sometimes there is no right answer. Just say something to let the client know it is fine for them to question you about what you are doing, and you will be happy to answer any of their questions. For some people it will be answering one question and for the next person you may have to answer five questions. There is no magic number—each individual is different. A good rule is to answer as many questions as needed to complete the comprehensive assessment.

"THESE QUESTIONS ARE STUPID"

I am sorry you feel that way. As I explained earlier, this tool was designed to determine the needs of people in similiar situations as yourself. Not all the questions will apply to you, as I talk to a variety of people and everyone is not the same. I just don't want to answer for you and not give you the opportunity to express yourself. If we come to a question that does not apply, just tell me and we can skip that question, but it is important to get this information from you.

"HOW DO I KNOW YOU WON'T USE THE INFORMATION AGAINST ME?"

There is no way I could use any information against you. My only purpose is to better understand what your needs are and if you qualify for certain programs. I have the opportunity to get to know you and what you may want or may not want in designing a care plan for you. You have the opportunity to have input into your needs. The conversation will go quickly, and you may even find it enjoyable.

"YOU ARE GOING TO DO WHAT YOU WANT ANYWAY WHY BOTHER"

Actually that is not true. This tool was designed with you in mind. The purpose is to ask you and not assume we know what you want or need. There are of course programs that you may not qualify for, but we would like to determine what your needs are and what you want. If we were going to make decisions without you I would not be here. I would like the opportunity to spend some time with you and sort through this. I think it will be very good for you. Why don't we get started and if you have any questions please feel free to stop me.

"THAT'S A PERSONAL QUESTION"

Yes, many of the questions I ask will be personal. As I explained the purpose of this discussion is to better understand your needs and provide a care plan just for you. I appreciate you helping me out and answering these questions. I talk to a lot of people and everyone is an individual.

"MY INCOME IS NONE OF YOUR BUSINESS"

Well, income is a very important question and part of this assessment. Many programs are based on income. In deciding a care plan and your needs, I must determine if such a plan is affordable or if you are eligible for this. If you feel uncomfortable telling me, maybe you would like to write it down for me?

"JUST WHAT ARE YOU REALLLY GOING TO USE ALL THIS INFORMATION FOR?"

The information will be used to provide a care plan that fits your individual needs. This assessment will help us determine your eligibility for certain programs. I can't tell you what you need unless I first sit down and talk to you. An assessment is the fairest way to determine your needs. You have as much say in this as I do.

"JUST WHO GETS TO SEE THIS?"

I will be looking it over, and with your permission the nurse in the program will look at it and a summary of information goes to the main office at the state level of the program. We are very strict with this information and value your openess to talk to me. I keep all the forms in a locked filing cabinet.

ROLE PLAY SITUATIONS

Questions are from the GERIATARIC ASSESSMENT TESTING AND EVALUATION SYSTEM (GATES), from Florida

INTERVIEWER: I'm going to start with some general questions. Some of these questions may seem too easy and some may seem too difficult. Don't worry, just answer the questions the best you can. We will start with: what is today's date?
CLIENT: August 17th, 1990.
INTERVIEWER: What day of the week is it?
CLIENT: Well, it's Monday isn't it?
INTERVIEWER: What do you want me to write down?
CLIENT: Monday.
INTERVIEWER: What is the name of this place?
CLIENT: This is my house. This is getting ridiculous.
INTERVIEWER: We have a few more questions left in this section. What is your telephone number?
CLIENT: 884-2894
INTERVIEWER: How old are you?
CLIENT: How old are you?
INTERVIEWER: I asked you first.
CLIENT: 67 and you?
INTERVIEWER: 39. When were you born?
CLIENT: You mean my birthdate?
INTERVIEWER: Yes.
CLIENT: May 22nd,1923
INTERVIEWER: Who is the President of the United States now?
CLIENT: Are you trying to see if I am crazy?
INTERVIEWER: Absolutely not, I am sorry you feel this way. These questions are part of our standardized assessment that is asked of everyone. I ask the same questions in the same order to

everyone. We are almost done.
CLIENT: Well, it is Bush isn't it?
INTERVIEWER: What would you like me to write down?
CLIENT: I would like you to tell me who is Bush.
INTERVIEWER: It would be inappropriate for me to answer for you. My job is to write down whatever you say. This section can be difficult, but it is an important part of the assessment. You are doing fine, we only have three questions left in this section and then we can move on to another section. Now what do you want me to write down for: who is the President of the United States right now?
CLIENT: I am sure it is Bush.
INTERVIEWER: Who was the President before him?
CLIENT: Before who?
INTERVIEWER: Before the current President.
CLIENT: I almost got you to tell me didn't I?
INTERVIEWER: You are definitely keeping me on my toes.
CLIENT: Wasn't that Carter?
INTERVIEWER: What would you like me to write down?
CLIENT: It is so frustrating when you can't remember.
INTERVIEWER: You can take a moment and think about it. I don't want you to feel rushed.
CLIENT: I just don't know.
INTERVIEWER: What was your mother's maiden name?
CLIENT: Her name was Susan.
INTERVIEWER: Her last name?
CLIENT: Same as mine.
INTERVIEWER: Last question in this section. Subtract 3 from 20 and keep subtracting 3 from each new number all the way down.
CLIENT: All the way down to what?
INTERVIEWER: Down until you can no longer subtract 3.
CLIENT: Let me get my calculator out of the drawer.
INTERVIEWER: No calculators.
CLIENT: I did not think there would be math questions. This is getting very difficult. I am a smart man, but I never was any good at math.
INTERVIEWER: Would you like to give it a try?
CLIENT: No!
INTERVIEWER: This next set of questions I know you will enjoy. I am going to ask you some questions about how you have been feeling and you can answer "yes" or "no" to each question. This section goes real quickly.

If the interviewer keeps an attitude that is up and positive it will help the client through the difficult questions. I find being honest and straightforward always works best. Don't be afraid to tell the client, "I can't answer for you, but I will write down whatever you want me to write down." Let the client know that you have a job to do and a boss to answer to by saying, "We have been told that it is unfair for me to bias or lead you or answer for you. When we were trained to do these discussions we were told how important it is that we write down only your responses. The purpose of this is to better understand your needs and opinions. All questions may not even apply to you or your situation, but please allow me to ask them and if you would try to answer them I would appreciate it. This can really be an enjoyable conversation".

Questions are from the PREADMISSION SCREENING (PAS) ASSESSMENT FORM from Minnesota:
INTERVIEWER: I'm going to ask you some general questions about how you have been feeling in the past two months. You can answer "yes" or "no" to each of these questions and if you have any questions please feel free to stop me at any time. My first question is: Have you had continued lack of interest in most activities and/or continued low, sad or depresed moods?
CLIENT: Oh yes, I have no interests, I just sit here all day I never see anyone, no one cares, my life is just awful.
INTERVIEWER: Is there anything you are still interested in or activities you still enjoy?
CLIENT: I never miss L.A. Law, I do my jigsaw puzzles every week and my one granddaughter and I visit every Friday morning.
INTERVIEWER: Your visits with your granddaughter sound like they are very enjoyable for you.
CLIENT: Yes, I look forward every Friday to see her.
INTERVIEWER: Have you been sad or depressed in the past two months?
CLIENT: When you are old and sick life isn't good. People forget you or try to make you feel stupid like there is something wrong with you. Like you are doing with some of these questions.
INTERVIEWER: I am so sorry you feel that way. I can honestly say I was not trying to make you feel stupid. I have enjoyed this conversation, I think you are a bright and interesting person. My only objective is to design a care plan that will fit your individual needs. I have never passed any kind of judgement or opinion about you. The questions I ask, I ask to everyone in the same order. The only purpose of this assessmont is to better understand you and your needs. I feel badly that I have made you feel uncomfortable. Let's try to continue with this and let me know if I make you feel uncomfortable again. Was it the question about sad or depressed moods that bothered you?

Questions are from the CLIENT ASSESSMENT AND PLANNING SYSTEM (CAPS) form from

on:

INTERVIEWER: I would like to talk to you about some of the personal tasks you do during the day. We will talk about shopping, eating, dressing, bathing and toileting. For each topic I will give you several examples and you tell me which one is closest to your situation. If you need me to repeat the options, I, of course, will be happy to. First, let's talk about dressing. What would be closest to your situation : 1) Can dress and undress without assistance or supervision; 2) Can dress and undress, but may need to be reminded or supervised to do so on some days; 3) Needs assistance from another person to do parts of dressing and undressing; 4) Dependent on others to do all dressing and undressing.

NT: I can do everything but reach that snap in the back or zip dresses with back zippers all the way up. So I guess you would say number 3.

Interviewer would mark number 1.

INTERVIEWER: Now I would like to talk about toileting and the situation that would be closest to you.

CLIENT: Just mark down that everything is fine.

INTERVIEWER: I would like the opportunity to read you the options and then you can tell me which one to mark.

CLIENT: Well, this is embarrassing. I don't like to talk about this and I don't think it is necessary.

INTERVIEWER: Please do not be embarrassed; there is nothing to be embarrassed about. I talk to a different people in different ons. Some people have problems in some areas and some people have problems in some other area. All I need to know is: 1) Can you toilet without physical assistance or supervision. May need grab bars/ raised toilet seat or (can manage own closed drainage system); 2) Needs stand-by assistance for safety or encouragement. May need minimal physical assistance with parts of the task, such as clothing, adjustment, washing hands; 3) Needs substantial physical assistance with parts of tasks, such as wiping, cleansing, clothing adjustment. You may need a protective garment; 4) Cannot get to the toilet unassisted or (you need someone else to manage care of catheter); 5) Physically unable to be toileted. Now, Mr. Jones which of those situations is closest to your situation? I think it would be easier to hand the client a card with the options on it. The interviewer would still have to read the options, but the client can read along. Having cards makes it easier for clients who get embarrassed and for clients with short-term memory loss.

WHAT CAN BE DONE TO HELP YOU DO YOUR JOB?

In research, we have developed the rules and boundaries for each questionnaire we use. Assessing the tool as questions arise, and the program may develop rules and standards as it goes along. When you have questions about what a question means, how to probe a question or how to determine an answer, ask! If there isn't an established answer there should be. You can help set standards that will help you and other social workers and nurses do their job better and easier. Would cards with explanations on them for dressing and toileting help? If the wording is incorrect, let's change it. The comprehensive assessment should be read the way it is written, if it is written correctly. If it is not being understood and reliable information is not being gathered, then let's change the wording. Your help and feedback is necessary. You are the one in the field asking the questions; only you can tell us what is being understood, where the problems are, and how we can help you with your job.

THE INTERVIEW

Interview Skills

Establishing Rapport – Warmth, Empathy and Genuineness

- **Warmth** – conveys a feeling of interest, concern, well-being and affection to another individual. It promotes a sense of comfort and well-being in the other person. Examples: "Hello. It's good to meet you." "I'm glad we have the chance to talk about this." "It's pleasant talking with you."
- **Empathy** – being in tune with how a consumer feels, as well as conveying to that consumer that you understand how she/he feels. Does not mean you agree. Helps consumer trust that you are on their side and understand how they feel. It also is a good way to check to see if you are interpreting what you observe correctly. Mirroring non-verbal can send empathetic messages. Example of leading phrases: "My impression is that…" "It appears to me that…" "Is what you're saying that…" "You seem to be…." "I'm hearing you say that…"
- **Genuineness** – means that you continue to be yourself, despite the fact that you are working to accomplish goals in your professional role. Being yourself and not pretending to be something you are not conveys honesty and makes consumers feel like you are someone they can trust.

General Interviewing Skills

Before the Interview – review the case and think about the possible things you will need to assess with this consumer. Are there any cues from the initial information that help you to come up with an approach to the interview? For example: Is the consumer a native English speaker, blind, mentally-impaired?

Pre-interview Planning – Be Prepared

- Review case file and gather cues about consumer
- Formulate questions based on cues
- Plan interview approach

Meeting the Consumer – Establish Rapport

- Introductions should be formal and cordial
- Small talk to get the conversation going
- Pay attention to verbal and non-verbal cues

Begin Assessment Interview – Explain Process

- Explain purpose of interview
- Explain your role to the consumer
- Ask the consumer for feedback – do they understand the process and purpose?

Concluding the Interview

- Clarify – Next steps
- Explain – Additional paperwork needed before authorization of services
- Discuss – Notification process of authorized hours
- Answer – Questions the consumer may have

The Interview: Choosing the Right Questions

Direct or Closed-ended Questions –

- Are questions that seek a simple "yes" or "no" answer.
- Specifically ask for information. For example: "Are you coming tomorrow?" or "Do you eat three times a day?"
- These questions do not encourage or allow for an explanation of why the answer was chosen, or for an elaboration of thought or feeling about the answer.
- They can be leading –they ask a question in narrow terms such that they seem to be "hinting" at the answer.

Open-ended Questions –

- Cannot be answered by yes or no.
- These questions begin with 'who', 'what', 'where', 'when' or 'how.'
- They give consumers more choice in how they answer and will encourage them to describe the issue in their own words.
- Open-ended questions seek out the consumer's thoughts, feelings, ideas and explanations for answers.
- They encourage elaboration and specifics about a situation. For example: "How are you able to bath yourself?"

Indirect Questions –

- Ask questions without seeming to.
- They are not stated as a question.
- In these the interviewer is asking a question without stating it in question format. For example: "You seem like you are in a great deal of stress today."

Open-ended Questions for Interviews

Open-ended questions cannot be answered by yes or no. These questions usually begin with "who", "what", "why", "where", and "when."

1. How have you been managing at home since I saw you last/since you got home from the hospital?
2. What do you need in the way of help right now?
3. Let's talk about things you are able and not able to do.
4. Help me understand....
5. What do you mean by_____?
6. Would you tell me more about...?
7. What else can you tell me that might help me understand?
8. Could you tell me more about what you're thinking?
9. I'd be interested in knowing...
10. Would you explain...?
11. Is there something specific about _____that you are asking for?
12. Would you explain that to me in more detail?
13. I'm not certain I understand...Can you give me an example?
14. I'm not familiar with_____, can you help me to understand?
15. What examples can you give me?
16. You say that you're not able to [cook/bathe/..._] . How have you been managing [your meals/bathing/...]?
17. When you say _____, what do you mean?
18. I'd like to help you get the best possible service; what more can you tell me that will help me understand your need?

Adapted from: *Understanding Generalist Practice*, Kirst-Ashman and Hull Nelson-Hall Publisher

The Interview: Other Assessment Cues

Non-verbal Assessment Cues:

Your Body Speaks Your Mind

- Between 60-80% of our message is communicated through our body language, only 7-10% is attributable to the actual words of a conversation.
- Whenever there is a conflict between verbal and non-verbal, we almost always believe the non-verbal messages without necessarily knowing why.

Eye Contact

It is important to look a consumer directly in the eye. Hold your head straight and face the consumer. This establishes rapport and conveys that you are listening to the consumer. This is not staring, but being attentive. However, be conscious of cultural differences and respect them.

Facial Expressions

These are the strongest non-verbal cues in face-to-face communication. Be aware of your own non-verbal – what are my habits that could be interpreted wrongly. Make certain that your facial expressions are congruent with your other non-verbal behavior. (Crossing arms, hands on hips, other…not portraying your interest) What do I see in the other person's face? If unclear, ask for interpretation.

Body Positioning

Posture, open arms versus crossed. When interviewing consumers look for cues in their body positioning, and be aware of your own. Sitting in an attentive manner communicates you are interested.

Environmental Cues:

- Discrepancies between the way the environment looks and what consumer reports as service needs.
- Importance of observations (i.e., house condition, cleanliness of consumer, tour house, etc.).

Sensory Cues:

- Data obtained by smelling.
- Tactile information – sticky floors, surfaces.

The Interview: Clarifying Information

It is important to probe for details and clarify information in order to get the best outcomes from the interview. Look for:

1. **Conflicting information.**
   - What is observed is not consistent with information given
     For example, consumer says she can't feed herself but she has been knitting, an activity that demonstrates manual dexterity. Perhaps the consumer's difficulty is in lack of strength; probing questions would be needed to tease out the basis of the statement that she cannot feed herself. Also, consider good days versus bad days. You may be seeing the consumer whose condition and abilities fluctuate.

   - What the consumer says is inconsistent
     For example, he says that he has no trouble bathing himself and he tells you that he is unable to walk without someone's constant assistance because he can't hold onto the handrails of a walker or a cane and he's unsteady on his feet. Perhaps the consumer who is at risk of falling is extremely modest and doesn't want anyone to see his naked body.

   - What the consumer says and the family says are in conflict.
     For example, the consumer says that he needs no help in dressing. The daughter with whom he lives and who is also his primary caretaker says that she dresses him every day. Probing questions are needed to determine whether the daughter is dressing her father because it's faster than to let him do it himself or if he is unable to dress himself. Issues to be considered would include his ability to reach, balance when standing, and perform tasks that require manual dexterity such as buttoning and zipping.

2. **Unrealistic expectations of the program.**
   For example, the consumer had fallen and broken her hip. When she fell, she had lain on the floor for 7 hours until a neighbor heard her calling for help. The consumer just returned home from a rehab facility for therapy following hip replacement. She wants round-the-clock care so that if she falls again, she will get immediate help. Her concerns are understandable, but not within the Program scope. An alternative would be to make referrals to organizations that can provide her with a panic button so that she can summon assistance in the event of another fall.

3. **Safety issues.**
   For example, a consumer says she is independent bathing. Thought she's unsteady on her feet, she says that she holds onto the towel rack to aid in stability. You look in the bathroom and confirm that what she's using to stabilize her is not a properly installed grab bar but a towel rack that is starting to come loose from the wall behind the bathtub. She needs help getting into and out of the tub and a grab bar and shower bench. If she discusses this with her physician and obtains a prescription for these items, it's possible that Medi-Cal will pay for these safety devices. Without assistance into and out of the tub, she's at risk of falling.

How to Probe to Clarify Information

When probing to clarify information the goal is to check that you have heard the consumer correctly, you are clear on the details of the information, and you have a complete picture of the situation. The following are a few methods that can be used to verify information and to decrease the risk of misunderstanding what the consumer has said.

1. Paraphrasing – Feedback the consumer's ideas in your own words. For example, the consumer says that he doesn't go to church anymore because he can't be far from a toilet after taking his diuretic. You say, "I see, you take a diuretic in the morning and have to be close to the toilet. How long does that last?"

2. Stating your observations – Tell the consumer your observations about his behavior, actions and environment to find out if they are on target. For example, if you see that he can't get out of the chair without help, say so.

3. Demonstration – Have the consumer to show you an activity. For example, you wonder how well the consumer transfers. You ask the consumer to show you the apartment. That gives you the opportunity to see the consumer transfer without specifically asking the consumer to demonstrate.

4. Asking clarifying questions – These questions are questions that get to details. For example:
   - "What do you mean by that? You said that you were tired a lot; tell me what the mean to you." If the consumer doesn't explain what they mean it is open to interpretation.
   - "Could you explain that, tell me more about that?"
   - "I'm not sure I understand." The simply directs the consumer's comments by letting him know you do not understand.

The Interview: Handling Difficult Situations

Most of the time the interview will go smoothly, but there are times when things will come up that will make getting good information more difficult. Here are some hints to help make each situation more successful.

1. The angry consumer – It is best to try to handle the anger at the beginning of the interview. This shows the consumer you care, and aren't there just to get your agenda accomplished. It never helps to ignore the anger; it will be a constant barrier to getting useful information.
   - Acknowledge the anger by gently confronting the consumer by saying something like, "You seem very upset and I am not sure why. Could we talk about what is upsetting you before we start?"
   - To get an angry person to open up explain (or re-explain) your purpose and that you need them to help you so you can best understand their needs and how the program can help them.
2. The consumer who is very sad / grieving – If the consumer is overcome by sadness and starts to cry.
   - Don't ignore or pretend they are not upset, crying. In some cases, it may not be obvious about the reasons for the sadness/grief, which may not become apparent until you ask a specific question that triggers the grief/sadness. Be direct but polite and sensitive. Let them talk briefly about the reason for the sadness/grief. You may say something like, "I'm sure that is very difficult for you", or "I'm sorry."
   - Try to be reassuring and let them know it is safe to express their feelings. A comment like, "It is OK to cry; we all cry," or, "I understand," can be effective.
   - Validate the situation by saying something like, "I have had other consumers who have the same reaction. It is hard." or, "These are difficult issues you're are dealing with, it is very normal."
   - If the consumer is too distraught about a recent death or other stressful event to focus on the issues you need to discuss for your assessment, it might be most appropriate to offer to reschedule the interview.

3. The consumer who rambles without focus – These consumers often want to tell long stories and often have a difficult time getting to 'the point'.
   - Remind the consumer of the goal of the interview. "That is very interesting Mrs. Jones, I really need to find out the details of how you get along each day so that I can help you get the services that you need. Can you tell me specifically how you prepare your meals?"
   - Rephrase the question in a more closed ended question, "I understand there have been many issues with your personal care. Do you need help with bathing?", if so you can then probe for specifics.

4. The consumer who answers with only a word or two – This can be very difficult because without information it is hard to get a good picture of the consumer's need.
   - Use open ended questions to try to get the consumer to give you a better picture.
   - Ask the consumer to paint you a picture of their day, "tell me what your day normally looks like." It is difficult to answer a question like this with one or two words and may get them to open up, or will allow you opportunities to probe for further information.

5. The consumer who is embarrassed – Some of the questions asked during the interview may be embarrassing to consumers. Especially those related to bowel and bladder care, and menstruation.
   - Reassure the consumer and acknowledge these may be embarrassing questions but that you need the information so they can get the assistance they need. "I know this may be embarrassing for you but I need to find out exactly what your needs are. Now you had said you have problems getting around. I'm wondering if that makes if difficult for you to get to the bathroom in time and causes you to have accidents."

6. Communication blocks:
   - Hearing difficulties –
     - Ask the consumer if they have a hearing aide. If they do check to see if it is in and if it is on. If the consumer cups his/her hand over the ear, the hearing aid will whistle if it is turned on.
     - Talk slowly without jargon.
     - If the person doesn't seem to understand, paraphrase yourself.
     - Ask if one ear is better that another and position yourself on that side.
     - You may need to follow up with a family member to get clarification of information.

   - Language barriers –
     - If they understand and speak some English make sure you go slowly, give them plenty of time to think of their answers and do not compound your questions.
     - Follow State regulations (MPP 21-115) and county procedures to arrange for an interpreter if the consumer does not speak English and you do not speak his/her language.

ALTERNATIVE RESOURCES TO CONSIDER

Adult Day Care offers non-medical services to adults 60 and older who are in need of some supervision and assistance. Day care activities are held at senior centers and include music, exercise, arts and crafts, discussion groups and outings. Some centers provide transportations, if necessary.

Adult Protective Services (APS) services adults 65 and older as well as disabled adults 18 to 65 who are harmed or threatened with harm. APS investigates cases of neglect, abandonment, and physical, fiduciary or sexual abuse. After a report of suspected abuse comes into the Call Center (800) 510-2020, an assessment is made by a social worker, and recommendations are made as to how the situation can be improved. Coordination with law enforcement begins as soon as criminal abuse is identified. Referrals to other programs often follow, along with emergency provisions of food, shelter or in-home aid. *(These may be considered alternative resources if any personal care services are provided by these referrals.)*

AIS Call Center has one easy phone number – (800) 510-2020 – that is the gateway for information and assistance. This is also the number to report elder or dependent adult abuse, or to apply for a variety of services for older adults, persons with disabilities and their families.

Alzheimer's Day Centers give respite to family caregivers assisting persons with Alzheimer's disease. These specialized day programs provide valuable interaction for seniors with Alzheimer's disease and related memory problems.

Brown Bag Program delivers surplus food items each month to low-income adults age 60 and older, helping to supplement their food budgets. Food is gleaned by volunteers (mostly seniors themselves) and donated by farmers, warehouses, packing companies and retail food chains.

Family Caregiver Support Program targets the needs of those who care for a family member. Services include support groups, respite, counseling and help with identifying resources. *(Can be considered as Alternative Resource as long as PCSP is provided; i.e. grooming, bathroom, feeding, changing diapers, etc.)*

Home-Delivered Meals are offered to adults 60 and older who are homebound due to illness or disability, who ask to have meals delivered to them. A social worker will visit to assess the need. If appropriate for the program, a hot meal is delivered each weekday and frozen meals are provided for the weekends. The cost is a voluntary donation.

Multipurpose Senior Services Program (MSSP) is for seniors age 65 and above who are eligible for Medi-Cal and at risk of nursing home placement. Care management services are provided to help clients – many with medical problems – to live safely in the community.

Nutrition Centers provide hot, nutritious lunches during the week, for adults age 60 and older. Besides promoting better nutrition, these centers reduce the isolation of many older adults who may live alone.

Ombudsman Program provides advocates for residents in long-term care facilities. These advocates maintain a presence in the facilities; respond to, and resolve complaints; act as mediators; support residents rights; and witness certain legal documents. Visits by Ombudsmen are unannounced, and all discussions with residents are confidential.

Project CARE is a community network program that provides an early warning of distress for frail, ill or disabled persons living at home. Services include daily "Are you OK?" phone checks, Postal Alert, Gatekeeper, minor home repairs and more.

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 information
(PRINT NAME)
related to my physical and/or mental condition to the In-Home Supportive Services program as it pertains to my need for domestic/related and personal care services.

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

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

TO: LICENSED HEALTH CARE PROFESSIONAL* –

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

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

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

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

Applicant/Recipient Name: | IHSS Case #:

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

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

1. Is this individual unable 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.)?	☐ YES ☐ NO
2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?	☐ YES ☐ NO

If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below, *and complete the rest of the form including the certification in PART D at the bottom of the form.*

If you answered "YES" to both Question #1 AND #2, respond to Questions #3 and #4 below, *and complete the certification in PART D at the bottom of the form.*

3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program:

4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months? ☐ YES ☐ 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/or certified as a Medi-Cal provider, 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.

CDSS
WILL LIGHTBOURNE
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

November 10, 2011

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[X] Federal Law or Regulation Change
[ ] Court Order
[X] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

ALL-COUNTY LETTER (ACL) NO.: 11-76

TO: ALL COUNTY WELARE DIRECTORS
IHSS PROGRAM MANAGERS

SUBJECT: **IN-HOME SUPPORTIVE SERVICES (IHSS) HEALTH CARE CERTIFICATION FORM SOC 873 EXCEPTIONS**

REFERENCE: All-County Letter (ACL) No. 11-55 DATED JULY 27, 2011

This All-County Letter (ACL) instructs counties on the implementation of Assembly Bill (AB) 106 (Chapter 32, Statutes of 2011) as it relates to the exceptions to the rule requiring a certification be obtained from a licensed health care professional prior to the authorization for In-Home Supportive Services (IHSS) applicants.

BACKGROUND

Senate Bill (SB) 72 (Chapter 8, Statutes of 2011) added section 12309.1 to the Welfare and Institutions Code (WIC) that requires the development of a certification form. The California Department of Social Services (CDSS), in consultation with the California Department of Health Care Services and stakeholders, developed the In-Home Supportive Services Program Health Care Certification Form (SOC 873). The completed SOC 873 must be received prior to the authorization of IHSS services for new applicants and to allow the continuation of IHSS services for current recipients. SB 72 allowed for two exceptions to this rule as it relates to applicants, one of which was amended by AB 106.

WIC 12309.1(a)(2) states "the certification shall be received prior to service authorization, and services shall not be authorized in the absence of the certification." However, there are two exceptions that permit the authorization of services prior to the receipt of the SOC 873 or alternative documentation. Those exceptions are:

1) IHSS services may be authorized when services have been requested on behalf of an individual being discharged from a hospital or a nursing home and those services are needed to enable the individual to return safely to their own home or into the community.
2) Services may be authorized temporarily pending receipt of the certification when the county determines that there is a risk of out-of-home placement.

These authorization exceptions are temporary in nature and ultimately the SOC 873 or alternative documentation must be obtained within 45 calendar days from the date the certification is requested by the county.

GRANTING EXCEPTIONS FOR APPLICANTS

When an individual applies for IHSS services prior to being released from a hospital or a nursing home and the county determines IHSS services are needed for that individual to return home safely, IHSS can be granted temporarily prior to receipt of the SOC 873 or alternative documentation. In addition, when the county determines there is an imminent risk of out-of-home placement without immediate service authorization, IHSS services can be temporarily authorized pending receipt of the SOC 873. For example, an Adult Protective Services worker advises the county that an IHSS applicant is at imminent risk of out-of-home placement without IHSS services in place. If the county determines that waiting up to 45 calendar days for the SOC 873 to be returned would place an IHSS applicant at risk of out-of-home placement, services can be granted temporarily pending receipt of the SOC 873 or alternative documentation.

When granting one of the above exceptions, the county must request the SOC 873 as soon as administratively possible but no later than the date of the in-home assessment. If the SOC 873 or alternative documentation is not provided within 45 days from the date it was requested (or within 90 days if a good cause extension has been granted -- see below), the case must be terminated prospectively with a timely 10-day notice using Notice of Action (NOA) code 507. If the completed SOC 873 is received by the county within the 45-day timeframe and indicates no need for services, the county must terminate the case prospectively with a timely 10-day notice using NOA code 443. Applicants granted an exception will be considered temporarily eligible pending receipt of the SOC 873. If the SOC 873 or alternative documentation is received after the 45th day, counties can follow their standard operational procedures to determine whether to rescind the termination or require a new application.

For applicants who have been granted an exception, the 45-day time limit can be extended an additional 45 calendar days for good cause: for a total of 90 calendar days. Good cause means a substantial and compelling reason beyond the exempted applicant's control. In order to be eligible for a good cause extension, the exempted applicant must show good faith efforts in trying to obtain the SOC 873 or alternative documentation. Counties have the discretion to determine on a case-by-case basis when good cause exists. Exempted applicants must notify the county of the need for a good cause extension no later than 45 calendar days from the date the county requested the SOC 873. (Recipients must also notify the county of the need for a good cause extension no later than 45 calendar days from the date of the in-home assessment.) After the 45th day, a good cause extension can no longer be granted.

CMIPS INSTRUCTIONS FOR EXCEPTIONS

When entering an exception case into CMIPS, counties must enter an "E" in the Medical Certfication (MC) Code field and enter the date the SOC 873 was requested from the applicant in the MC Date field. Once the MC Code and MC Date are entered, counties can continue to authorize the case as usual.

NOTICES

When an exception to the health care certification requirements has been granted, counties shall notify the applicant that his/her application for IHSS has been temporarily approved and of the requirement to submit a completed SOC 873 within 45 calendar days of the date the certification is requested. If hours are being authorized prior to an in-home assessment, because the applicant is being discharged from a medical facility, counties must send the "In-Home Supportive Services Program Notice of Provisional Approval Health Care Certification Exception Granted" (SOC 876) in lieu of a regular NOA (NA 690). The SOC 876 (attached) lists the provisional hours assessed for each of the service categories and does not provide appeal rights because the authorized hours shown will be based on a preliminary assessment rather than the required in-home assessment. The SOC 876 must be completed manually by the counties. Following the in-home assessment, counties must notify the applicant of the assessed hours by sending the NA 690, which provides appeal rights. Counties are reminded that if the applicant's discharge planner needs a copy of the SOC 876, the county may provide this to the discharge planner with the applicant's written consent.

If hours are being authorized after an in-home assessment has been completed, but before the SOC 873 has been received, an NA 690 should be sent using the following NOA message number 508:

> "Your application has been temporarily approved pending receipt of your health care certification form. Your eligibility will be discontinued if the form is not received within 45 days of the date it was requested or if the form indicates you have no need for In-Home Supportive Services. (WIC 12309.1)"

FORMS/CAMERA-READY COPIES AND TRANSLATIONS

For a camera-ready copy of English and Spanish forms, contact the Forms Management Unit at: fmudss@dss.ca.gov. If your office has internet access, you may obtain these forms from the California Department of Social Services (CDSS) web page at: www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

Please note CDSS is in the process of translating the SOC 876 into the threshold languages: Spanish, Armenian and Chinese. Copies of the translated forms and publications in all other required languages can be obtained at: www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

For questions on translated materials, please contact Language Services at (916) 651-8876.

Your County Forms Coordinator will distribute translated forms to each program and location. Each county must provide bilingual/interpretive services and written translations to non-English or limited-English proficient populations, as required by the Dymally-Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and/or by state regulation (MPP Division 21, Civil Rights Nondiscrimination, section 115).

Questions about accessing the forms may be directed to the Forms Management Unit at fmudss@dss.ca.gov; questions about translations may be directed to the Language Services Unit at LTS@dss.ca.gov.

For questions, please contact Marshall Browne, Manager, Policy & Litigation Branch, Operations and Technical Assistance Unit, at (916) 651-5248, or by e-mail at: Marshall.Browne@dss.ca.gov.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Attachment

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 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 (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, 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 by _____ (DATE).

If you do not provide the county with a health care certification by this date, the IHSS you have been getting on a temporary basis will stop. If you cannot provide the certification 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	AUTHORIZED # OF HOURS
DOMESTIC SERVICES (per month)	
RELATED SERVICES (PER WEEK)	
- Prepare meals	
- Meal clean-up	
- Routine laundry	
- Shopping for food	
- Other shopping/errands	
NON-MEDICAL PERSONAL SERVICES (PER WEEK)	
- Respiration assistance	
- Bowel and/or bladder care	
- Feeding	
- Routine bed baths	
- Dressing	
- Menstrual care	
- Assistance with walking (including getting in/out of vehicles)	
- Transferring: moving in/out of bed, on/off seats, etc.	
- Bathing, oral hygiene, grooming	
- Rubbing skin, repositioning	
- Assistance with prosthesis, help setting up medication	
ACCOMPANIMENT (PER WEEK)	
- To/from medical appointments	
- To/from alternative resources	
PROTECTIVE SUPERVISION (PER WEEK)	
TEACHING/DEMONSTRATION SERVICES (PER WEEK)	
PARAMEDICAL SERVICES (PER WEEK)	
HOURS OF SERVICE AUTHORIZED *FOR ONE MONTH ONLY*	
- Heavy cleaning	
- Yard hazard abatement	
Total weekly hours of service authorized	
Multiply by 4.33 (average # of weeks per month) to convert to monthly hours	
Add monthly authorized domestic services hours (from above)	
TOTAL HOURS OF SERVICE AUTHORIZED PER MONTH	

4: Communication Tools

COMMUNICATING IN DIFFICULT SITUATIONS

1. Listen for full understanding of the person's perspective. Allow them the opportunity to give you a clear picture of what they are trying to say.

2. Put the person at ease using non-verbal cues that show interest and concern.

3. Take the time you need to really understand the situation. In the long run, spending a few more minutes now will save time in avoiding conflict.

4. Respond to concerns the consumer may have in an affirming manner. Restate their concerns in a way that shows you have heard their issues.

5. Focus on the overall goal of the situation. Avoid personalization of the issues. Keep the conversation professional.

6. Understand what you do Today will have an Effect on Tomorrow. The more effective you are in dealing with the issue at hand, the less the issue will grow and consume your energies.

HANDLING HOSTILITY

The following are suggestions for handling consumer hostility:

1. Don't get angry or defensive. Recognize your own reactions. Remember that this is a professional, not personal, issue.

2. Don't patronize or lecture. Saying things such as, "why don't you just calm down" will only escalate the problem and is disrespectful to the consumer.

3. Allow the consumer to voice his/her concerns. Respond with acceptance and understanding. Be empathetic. Listen to understand the situation from the consumer's perspective.

4. Be positive – don't attack them. Show them respect for their discomfort.

5. Greet anger with calmness – set the mood for calm discussion and resolution.

6. Understand the facts regarding the situation that is upsetting the consumer. If you don't have the facts, state what you will need to find out and when you will get back to them.

7. Focus on present and future. Avoid allowing the consumer to get stuck in the past. Emphasize what can be done positively in the future, not what has happened in the past.

8. Ask questions – "How can I help?" Often the consumer knows what they want from you. If you understand their wants you will be able to discuss future possibilities with that in mind.

9. Summarize for clarification and understanding.

10. Be honest about your next steps. If you can't fix the problem outright, don't make promises that you cannot keep. If there are consequences to the behavior, let the consumer know.

Adapted from: *Understanding Generalist Practice*, Kirst-Ashman and Hull Nelson-Hall Publishers and *Connecting with self and others*, Sherod Miller et.al. Interpersonal Communications Programs, Inc.

THINGS TO CONSIDER WHEN DEALING WITH SOMEONE WHO IS HOSTILE

1. Try to evaluate as honestly as you can by reasoning with yourself whether his/her anger is justified.

2. Put hostile people in perspective. You are probably nothing but an afterthought to them, so don't take their antics personally. They're not concerned about you because they're too busy worrying about themselves.

3. Take your pick – positive or negative. You cannot concentrate on constructive, creative alternatives or solutions while you cling to negative feelings. Vent your emotions to a fellow worker or your supervisor and cool off. Think about the result you really want, the consequences or outcome that will benefit the consumer the most.

4. Don't expect hostile people to change. They will not, and in a way that is good because their behavior is predictable. They may not change but by choosing a better approach you can change the outcome.

5. Learn to respond as well as listen. Ask questions instead of making accusations. If you let others save face, you give them room to change their minds.

6. Request feedback. Use open-ended questions to let emotional people vent their feelings before you try to reason with them and explore options.

7. Be straightforward and unemotional. The more you remain calm and matter-of-fact, the sooner you gain another's confidence. People want to feel you are leveling with them, that they can trust you. Remember that respect from other begins with self-respect.

8. Be gracious. Someone else's rudeness does not give us the right to be rude. Treat the other with the kindness you would like to be shown and allow them to feel important. When our own egos are healthy, we are rich; we can afford to be generous.

SOME FACTS ABOUT GRIEF

Two simple *Definitions* of grief are:
1. The conflicting feelings caused by the end of or change in a familiar pattern or behavior.
2. A normal, natural and painful emotional reaction to loss.

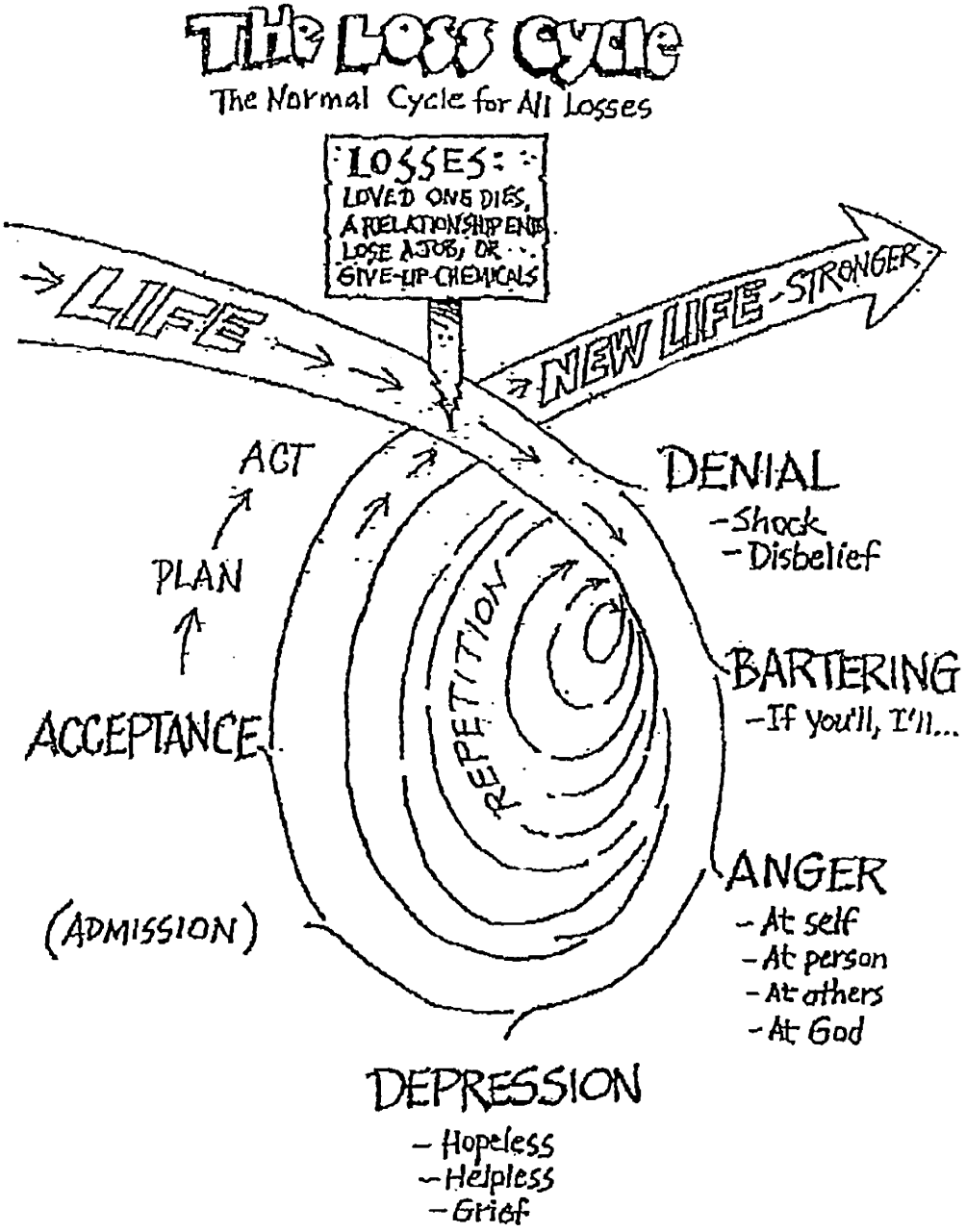
Causes of Grief
- Passing of a human life, as well as for the
- Death of a relationship (divorce),
- Loss of health and function and loss of independence, and
- Loss of a pet.

Grieving involves intense feelings - love, sadness, fear, anger, relief, compassion, hate, or happiness, to name a few. These feelings are intense, disorganizing and can be long-lasting. Grieving has been described as drowning in a sea of painful emotions.

Stages of Grief.
1. Shock – Immediately following the death of a loved one, it is difficult to accept the loss. A feeling of unreality, a feeling of being out-of-touch.
2. Emotional Release – Awareness of enormity of loss is realized accompanied by intense pangs of grief. In this stage a grieving individual sleeps badly and weeps uncontrollably.
3. Panic – Feelings of mental instability, wandering around aimlessly, forgetting things, physical symptoms.
4. Guilt – Feelings of guilt about failures in relationship, ability to change situation, to save deceased.
5. Hostility / Anger – Feelings of anger over the situation, cause of death and sometimes even at the deceased.
6. Inability to Get Back to Normal – Difficulty in regaining normality of daily living. Difficulty in concentrating on the day-to-day activities. The grieving person's entire being, emotional, physical and spiritual, is focused on the loss that just occurred.
7. Acceptance of Loss – Life balance slowly returns. There are no set timeframes for healing. Each individual is different.
8. Hope – The pains of grief are still present but the grieving person is able to find hope for the future. The individual is able to move forward in life with good feelings knowing they will always remember and have memories of the loved one.

Note: Consumers may pass through each stage more than once, and may be in more than one stage at a time. There is no particular order in which they may work through these stages. Even if they appear to have reached the end, another loss may trigger them to go back in to another stage.

Helping Consumers through the Grief Process
- Encourage consumer to take their time going through the grief process. Support them and family not to try to rush the process.
- Explain to the consumer that because this is a time of instability and high emotions, it is not a good time to make major life decisions.
- Encourage use of support groups for drug and alcohol if consumer / family have history of dependency.
- Help consumer to understand that they will have good days and bad days.
- Encourage them to seek out people who can listen to their stories and remember their loved ones.
- Reinforce that grief is a very personal and individual process – no one experiences it the same way.


The Loss Cycle
The Normal Cycle for All Losses
LOSSES:
LOVED ONE DIES,
A RELATIONSHIP ENDS,
LOSE A JOB, OR...
GIVE-UP CHEMICALS
LIFE
NEW LIFE - STRONGER
DENIAL
- Shock
- Disbelief
BARTERING
- If you'll, I'll...
ANGER
- At self
- At person
- At others
- At God
DEPRESSION
- Hopeless
- Helpless
- Grief
(ADMISSION)
ACCEPTANCE
PLAN
ACT
REPETITION

GENERAL ETIQUETTE
for
Interacting with People with Disabilities

If you are interacting with people with disabilities for the first time, BE YOURSELF! As in any new situation, everyone will feel more comfortable if you relax.

The Basics

- Ask before you help. Just because someone has a disability, don't assume they need help. If the setting is accessible, people with disabilities can usually get around fine.
- Be sensitive about physical contact. Some people with disabilities depend on their arms for balance. Grabbing them could knock them off balance. Avoid patting a person on the head or touching his wheelchair, scooter or cane. People with disabilities consider their equipment part of their space.
- Talk with the person with a disability, not their spouse, assistant, interpreter, or others nearby.
- Maintain eye contact and body language that you would normally use during any other conversation.
- Treat adults as adults. Address people with disabilities by their first names only when extending that same familiarity to all others.
- Relax . Don't be embarrassed if you happen to use common expressions such as "See you later" or "Did you hear about this?" that seems to relate to a person's disability.
- Don't make assumptions. If you have a question about what to do, what language or terminology to use, or what assistance, if any, they might need, the person with the disability should be your first and best resource. Do not be afraid to ask their advice.
- Respond graciously to requests. When people who have a disability ask for an accommodation, it is not a complaint. It shows they feel comfortable enough to ask for what they need. If they get a positive response, they will tell others about the good service they received.
- The most important thing to focus on during a conversation with a person who has a disability is the overall goal, which is simply communication between two individuals. Ultimately, it is what is communicated that will be important, not how it is communicated.

LANGUAGE TIPS

There are some general hints which can help make your communication and interactions with people with all types of disabilities more successful.

- The preferred terminology is "disability" or “disabled”, not "handicap" or "handicapped."
- Never use terms such as "retarded", "dumb", "psycho", "moron", or "crippled." They are very demeaning and disrespectful to people with disabilities.
- Remember to put people first. It is proper to say "person with a disability", rather than "disabled person."
- If you are unfamiliar with someone, or their disability, it is better to wait until they describe their situation to you than to make your own assumptions about them.
- Many types of disabilities have similar characteristics, and your assumptions may be wrong.
- An important thing to remember in any conversation with someone who has a disability is: "assume nothing."
- Use your normal speaking speed.
- It is always a good idea to speak clearly, without mumbling or slurring words.
- Don't be overly friendly, paternalistic, or condescending when speaking to a person with a disability.
- Most people, even if they are unable to speak to you in a "normal" manner, have normal or above-average intelligence.
- Your use of abnormal speech or simplistic language will lessen the chances of having a successful conversation.
- Be patient not only with the person with the disability, but with yourself.
- Frustration may come from both sides of the conversation, and needs to be understood and dealt with by both parties.
- Once again, the most important thing to focus on during a conversation with a person who has a disability is the overall goal. It is simply communication between two individuals.
- Since about 20% of people in our society have some type of disability, you never really know when that will be a factor in one of your conversations.

SPECIFIC DISABILITIES

The following summary of the characteristics of different types of disabilities contains many true statements, but no absolute truths. Remember that every person with a disability is an individual. While this summary is about disabilities, it is important to remember that you are not interacting with disabilities; you are interacting with individuals with disabilities. Remember also that they are people first. It is most important to ask the individual what terminology they prefer, or if they need assistance. With this in mind, the following general guidelines are offered.

PEOPLE WHO ARE BLIND

Things to Know

- Most persons who are blind have some sight, rather than no sight at all.
- Many people who are blind are mobile and independent. Some people who are blind view blindness not as a disability as much as an inconvenience.
- While many people who are blind can use Braille, the majority of persons who are blind do not.
- A person may have a visual disability that is not obvious. Be prepared to offer assistance – for example, in reading when asked.

Things to Do

- Introduce yourself. Identify who you are and what your job or role is. Be sure to introduce him to others who are in the group or enters the room so that he's not excluded.
- If you have met before, remind them of the context; they won't have the visual cues to jog their memory.
- Be descriptive when giving directions. Saying "over there" has little meaning to someone who cannot see you point. "Four doors after turning right from the elevator" would be much more helpful.
- Always ask someone if they need your assistance and how you can assist them.
- Lead someone who is blind only after they have accepted your offer to do so.
- Allow them to hold your arm, rather than you holding them. It is important to let people with vision impairments control their own movements.
- Many techniques are used as tools for independence, but individuals with disabilities use only things that work for them.
- If the person has a guide dog, walk on the side opposite the dog. As you are walking, describe the setting, noting any obstacles such as stairs ('up' or 'down') or a big crack in the sidewalk. Other hazards include revolving doors, half-opened filing cabinets or doors, and objects protruding from the wall at head level such as hanging plants or lamps. If you are going to give a warning, be specific. Shouting, "Look out!" does not tell the person if he should stop, run, duck or jump.

- Remember to describe sights or objects from their perspective, not yours. Tell them when you have brought new items into their environment, describing what they are and, most importantly, where you have put them.
- Offer to read written information-such as the menu, merchandise labels or bank statements to customers who are blind. Count out change so that they know which bills are which.
- If you need to leave a person who is blind, inform him first and let him know where the exit is, then leave him near a wall, table, or some other landmark. The middle of a room will seem like the middle of nowhere to him.

Things to Avoid
- Do not move items (furniture, personal items) after their position has been learned by the person. This can be frustrating and, in some cases, dangerous for the person with a disability.
- Do not use references that are visually oriented like, "over there near the green plant."
- Don't touch the person's cane or guide dog. The dog is working and needs to concentrate. The cane is part of the individual's personal space. If the person puts the cane down, don't move it. Let him know if it's in the way.

Things to Consider
- Persons who are blind have more often been told what to do rather than asked what they would prefer doing. This attitude is not acceptable towards any person.

PEOPLE WITH LOW VISION

Things to Know
- Persons with low vision may not be wearing dark glasses or using a cane and therefore are not easily identifiable.
- A person with low vision may need written material in large print.
- It is easiest for most people with low vision to read bold white letters on a black background.

Things to Do
- Ask the person what size and type font they prefer to read.
- Remember that you can use a copy machine to enlarge print.
- Good lighting is very important.
- Have a simple (drug store brand) magnifying glass available.
- Use a thick point black marker when writing down information. Check with the person to determine what size to write letters/numbers so they can see it.
- Keep walkways clear of obstructions.

Things to Avoid

- Very shiny paper or walls can produce a glare that disturbs people's eyes.
- Avoid using all uppercase letters because it is more difficult for people with low vision to distinguish the end of a sentence.
- Do not move items (furniture, personal items) after their position has been learned by the person. This can be frustrating and, in some cases, dangerous for the person with a disability.

DEAF AND/OR HEARING IMPAIRED

Things to Know

- Most persons who are deaf or hearing impaired have some hearing, rather than no hearing at all.
- Sign language is not another form of English; it is an official language with its own grammar, syntax and rules.
- Not all persons who are deaf use sign language.
- Lip-reading, while helpful without sound clues, is only 30-50% effective, and sometimes less. Not all persons who are deaf lip-read.
- Long conversations with persons who can lip-read can be very fatiguing to the person who has the disability.
- English is a second language for many deaf people. Reading and writing English may be challenging for some deaf people.
- Not all persons who are deaf speak.
- Some deaf and hard of hearing persons have service animals that alert them to certain sounds.
- People who are hard of hearing, however, communicate in English. They use some hearing but may rely on amplification and/or seeing the speaker's lips to communicate effectively.
- The majority of late deafened adults do not communicate with sign language, do use English, and may be candidates for writing and assistive listening devices to help improve communication.
- People with cochlear implants, like other people with hearing loss, will usually inform you what works best for them.

Things to Do

- Find out how the person communicates best.
- If the person uses an interpreter, address the person, not the interpreter.
- If the person reads lips, speak in a normal, not exaggerated, way.
- Short simple sentences are best. If the person lip-reads, avoid blocking their view of your face. Make sure the lighting is good.

- Gain the person's attention before starting a conversation. Depending on the situation, you can extend your arm and wave your hand, tap her on the shoulder or flicker the lights.
- If there is some doubt in your mind whether you were understood, rephrase your statement and assure that understanding has been reached.
- Be aware of situations where a person may be waiting for a service (transportation, a table, the start of an activity) where the common way to communicate is an announcement or the calling of the person's name. Advise them when their name is called.
- When talking, face the person. A quiet, well-lit room is most conducive to effective communication. If you are in front of the light source such as a window with your back to it, the glare may obscure your face and make it difficult for the person who is hard of hearing to speech read.
- Speak clearly. Most people who are hard of hearing count on watching people's lips as they speak to help them understand.
- If you need to contact the deaf or hearing impaired person, make sure you take note of the preferred method of notifying them.

Things to Avoid

- There is no need to shout at a person who is deaf or hard of hearing. If the person uses a hearing aid, it will be calibrated to normal voice levels; your shout will just sound distorted.
- Do not become impatient or exasperated with the person if it takes longer to communicate.
- Make sure there are no physical barriers between you and the person you are in conversation with. If the person is using hearing aids, avoid conversations in large, open and noisy surroundings. Avoid chewing gum, smoking or obscuring your mouth with your hand while speaking.

Things to Consider

- Persons who may deal very well one-on-one in communication may have a hard time with two or more speakers, especially if there are many interruptions and interjections.
- Showing impatience to someone who is deaf or hearing impaired may cause the less assertive person to back off from telling you his or her needs.
- When someone asks, "What did you say?" the answers, "Never mind," "Nothing," or "It's not important," are very common replies. These are insulting and demeaning because they communicate that the person is not worth repeating yourself for.

PEOPLE WHO USE WHEELCHAIRS OR HAVE MOBILITY IMPAIRMENTS

Things to Know

- There are many reasons (not just being paralyzed) which might require someone to use a wheelchair. These might include loss of stamina or equilibrium, or a temporary condition like a fracture or recovery from surgery.
- There are a wide range of physical capabilities among people who use wheelchairs. This means that persons who use them may require different degrees of assistance, or no assistance at all.
- Some persons do not use wheelchairs exclusively, but may also use canes, leg braces and, in some cases, no assistive devices at all, or only for short periods.
- All wheelchairs are not the same. Different sizes and shapes meet different needs. Some wheelchairs move manually and others are motorized. Just because one person can access an area in his or her wheelchair does not mean that everyone with a wheelchair may be able to do so.
- If you offer a seat to a person who has limited mobility, keep in mind that chairs with arms and without wheels are easier for some people to use.
- People who do not have a visible disability may have needs related to their mobility. For example, a person with a respiratory or heart condition may have trouble walking long distances or walking quickly. Be sure that there are ample benches for people to sit and rest on.
- Some people have limited use of their hands, wrists or arms. Be prepared to offer assistance with reaching for, grasping or lifting objects, opening doors and display cases, and operating vending machines and other equipment.

Things to Do

- If you are asked to fold, carry, or store a wheelchair, treat it with the same respect that you would if you were holding someone's eyeglasses. They are similar in many ways. Wheelchairs can break, they are difficult to have repaired on short notice and on weekends, and it is extremely disruptive to the user when they are out of commission.
- When you meet someone seated in a wheelchair, extend your hand to shake if that is what you normally do. A person who cannot shake hands will let you know. They will appreciate being treated in a normal way.
- Keep the ramps and wheelchair accessible doors to your building unlocked and unblocked.
- If the service counter present is too high for a wheelchair user to see over, step around to provide service. Have a clipboard ready for filling out forms.
- When speaking to someone who uses a wheelchair, remember to give the person a comfortable viewing angle of yourself. Having to look straight up is not a comfortable viewing angle.
- Falls are a big problem for people who have limited mobility. Be sure to set out adequate warning signs after washing floors. Also put out mats on rainy or snowy days to keep the floors as dry as possible.

Things to Avoid

- Wheelchair users are people, not equipment. Don't lean over someone in a wheelchair to shake another person's hand or ask a wheelchair user to hold coats.
- Do not approach someone who is using a wheelchair and start pushing him or her without asking.
- When communicating, do not stand too close to the person in a wheelchair. Give him or her some space.

Things to Consider

- It is a very common experience for persons who use wheelchairs to be told that some place is accessible when it is not. Listen carefully when anyone who uses a wheelchair tells you that some area which you thought was accessible is not.
- Do not assume that the person using a wheelchair needs assistance. Ask the person if there is anything special you can provide.

CONDITIONS WHICH CAUSE DIFFICULTY WITH SPEECH

Things to Know

- There are many reasons for having difficulty with speech. Deafness, Cerebral Palsy, stroke, head injury, physical malformation of speech mechanisms, and general speech impairment are just a few.
- It is not unusual in stressful situations for someone's speech to become harder to understand.

Things to Do

- Give the person your full attention. If you have trouble understanding, don't nod.
- Just ask him to repeat. In most cases, the person won't mind and will appreciate your effort to hear what he has to say.
- If you do not understand what a person is saying, bring it to his or her attention immediately and ask how the two of you may communicate more effectively. If it is a stressful situation, try to stay calm. If you are in a public area with many distractions, consider moving to a quiet or private location.
- Consider writing as an alternative means of communication.
- If there is no solution to the communication problem that can be worked out between you and the person, consider asking if there is a person who could translate or interpret what he or she is saying.

Things to Avoid

- Do not pretend to understand when you really do not.
- Do not become exasperated or impatient with the communication process.
- Do not interrupt or finish sentences for the person with a disability.

- Don't tease or laugh at a person with a speech disability. The ability to communicate effectively and to be taken seriously is important to all of us.

Things to Consider
- Many persons with difficulty speaking find themselves in situations where people treat them as if they are drunk, developmentally disabled, or mentally ill.
- Many persons with difficulty speaking are accustomed to being avoided, ignored, or even hung up on by phone.
- Accessibility for persons with difficulty in speech lies within your power. Your patience and communication skills are as important to someone with speech that is difficult to understand as a grab bar or a ramp is to someone who uses a wheelchair.

PERSONS OF SHORT STATURE

Things to Know
- There are 200 diagnosed types of growth related disorders that result in a person being 4 feet 10 inches or less in height.
- For an adult, being treated as cute and childlike can be a tough obstacle.

Things to Do
- Be aware of having necessary items within the person's reach to the maximum extent possible.
- Communication can be easier when people are at the same level. Persons of short stature have different preferences. You might kneel to be at the person's level; stand back so you can make eye contact without the person straining her neck (this can be hard to do in a crowded room); or sit in a chair. Act natural and follow the person's cues.

Things to Avoid
- As with people who have other disabilities, never pet or kiss a person of short stature on the head.

DEVELOPMENTAL DISABILITY (DD)

Things to Know
- Developmental Disability refers to conditions occurring before adulthood which sometimes result in below average intelligence, impaired motor functioning, or other disabling conditions.
- A low intelligence test score alone does not necessarily indicate that a person is developmentally disabled.
- What is seen by most people is behavior reflecting slow, arrested, or incomplete development before a person reaches the age of eighteen.

- Some people with developmental disabilities have a hard time using what they have learned and applying it from one setting or situation to another.
- It is important to remember that, even though someone is an adult, there are certain characteristics which are described as childish or childlike, leading to the erroneous conclusion that a person has a "mental age of 4 or 5." A person who is 30 years old with a mental age of five has had 25 more years of life experience upon which to base his or her behavior.
- Because each person with a developmental disability is an individual, there is no "overall" description one can give to alert that a person is developmentally disabled.
- Every person with a developmental disability will display characteristics differently, with varying levels of intensity.
- Not all people with developmental disabilities look disabled, nor will they act in the same way when making contact with people.
- People with developmental disabilities often rely on routine and on the familiar to manage work and daily living. Be aware that a change in the environment or in a routine may require some attention and a period of adjustment.

Things to Do

- It can be difficult for people with developmental disabilities to make quick decisions. Be patient and allow the person to take their time.
- A calm, patient attitude on your part will prove to be your most effective tool.
- Speak to the person in clear sentences, using simple words and concrete rather than abstract concepts. Help her understand a complex idea by breaking it down into smaller parts.
- Clear signage with pictograms can help a person who has developmental disabilities to find her way around.
- Be aware that a "yes" response may be inappropriately given out of fear of disapproval or in an attempt to please.
- If a person with a developmental disability is lost, be aware that residents of board and care homes may have their names printed on their clothes, collar or similar location.

Things to Avoid

- Don't use baby talk or talk down to people who have developmental disabilities.
- Gauge the pace, complexity, and vocabulary of your speech according to theirs.
- People with developmental disabilities may not have any speech, or may have very limited speech.
- Avoid frightening a person with developmental disabilities, as they may be unable to respond because of fear. They may, however, respond to questions, especially those requiring a "yes" or "no" answer.

Things to Consider

- Remember that the person is an adult and, unless you are informed otherwise, can make her own decisions.
- Medication may slow their speech or reactions, or cause them to walk in a manner which arouses suspicion.
- People with developmental disabilities may be anxious to please. During an interview, the person may tell you what she thinks you want to hear. In certain situations, such as law enforcement or a doctor's examination, it can have grave consequences if your interview technique is not effective. Questions should be phrased in a neutral way to elicit accurate information. Verify responses by repeating each question in a different way.

CEREBRAL PALSY (CP)

Things to Know

- Cerebral Palsy is a condition that results from damage to the central nervous system before birth, or early in life.
- "Cerebral" refers to the brain and "Palsy" to a disorder of movement or posture. It is neither progressive nor communicable, and has little or no relation to intelligence.
- Cerebral Palsy is characterized by an inability to fully control motor functions. A person with Cerebral Palsy may have spasms; involuntary movement; disturbance of gait or mobility; seizures; abnormal sensation and perception; impairment of sight, hearing, or speech; and mental retardation.

Things to Do

- A person who may appear to be drunk, sick or have a medical emergency might in fact have CP or another disability. Get the facts before acting on your first impression, whether the situation is business, social or law enforcement.

Things to Avoid

- Do not make assumptions about the intelligence of persons with Cerebral Palsy.
- Many people with CP have slurred speech and involuntary body movements.
- Your impulse may be to discount what they have to say, based on their appearance. Monitor your responses and interact with the person as you would with anyone else.

Things to Consider

- Over a half million people in the United States have Cerebral Palsy. Many are wheelchair users and you may refer to the previous section concerning wheelchairs for additional information.

TOURETTE SYNDROME

Things to Know

- People with Tourette syndrome may make vocalizations or gestures such as tics that they cannot control.
- A small percentage of people with Tourette syndrome involuntarily say ethnic slurs or obscene words.
- A person with Tourette syndrome will benefit from the understanding and acceptance others.

Things to Do

- If a person with Tourette makes vocalizations during a conversation, simply wait for her to finish, then calmly continue.

Things to Consider

- The more the person tries to contain these urges, the more the urges build up. It may be helpful for a person with Tourette to have the option to leave the meeting or conversation temporarily to release the build-up in a private place.

EPILEPSY (SEIZURE DISORDER)

Things to Know

- Epilepsy is a symptom of a disorder of the central nervous system occurring either as a result of head trauma or as a condition present from birth, which may result in seizures.
- Epilepsy is not a disease, nor is it progressive, related to intelligence, or necessarily related to another disability.
- One person in a hundred has epilepsy; however, 80% of those diagnosed will have good control of seizures through medication.
- Be aware that beepers and strobe lights can trigger seizures in some people.
- There are three seizure patterns. The Grand Mal convulsion consists of a loss of consciousness, stiffening, muscle rigidity and spasms. The Petit Mal seizure may not be readily recognized, as it usually consists of a lapse of from 5-25 seconds and gives the appearance of daydreaming or staring. The Psychomotor seizure may be seen only as staring or confusion, dizziness or fear, or other behavior such as lip smacking or erratic arm movements.

Things to Do

- At the scene of a seizure, your best action would be to keep the person from getting injured by removing objects from the area which might cause injury (chairs, tables, etc.).
- If the person is still unconscious after a seizure, turn him or her on their side, with the face downward.

- When a seizure has ended, the person may feel disoriented and embarrassed.
- Try to ensure that he has privacy to collect himself.

Things to Avoid
- Do not restrain the movements of a person having a seizure.
- Do not put anything between the teeth.
- Do not give the person anything to drink.

Things to Consider
- Medical aid for epilepsy is usually not necessary unless a seizure lasts longer than 15 minutes.
- The person may not remember what has happened, and may require your assistance for a short period of time while getting reoriented.
- Seizures usually draw a crowd of onlookers. This is an excellent opportunity to set an example for others by your conduct, and educate the uninformed as to successful intervention techniques.

AUTISM

Things to Know
- Autism is a severely, incapacitating, lifelong developmental disability that appears during the first three years of life.
- In its broad definition, autism or autistic-like symptoms occur in about five out of every thousand children.
- Autism is four times more common in males than in females, and is found throughout the world in families of all racial, ethnic and social backgrounds. Symptoms of autism include:
  - Slow development or lack of physical, social, and learning skills.
  - Immature rhythm of speech and limited understanding or use of words.
  - Abnormal responses to sensations: sight, hearing, touch, pain, balance, smell, taste, etc. Abnormal ways of relating to people, objects and event.

Things to Do
- Quite often, when you come into contact with people with autism, they will be in their neighborhood or where family or friends are near.
- There are no hard and fast rules for dealing with people who have autism. Be aware of the symptoms of autism.
- A calm, persistent approach should work best.

Things to Avoid

- Resist the natural tendency to counter aggression or non-compliance with physical control, since merely touching someone with autism might cause them to flee.
- Attempting to confine a person who is autistic might cause great fear and resistance.

Things to Consider

- At first glance, the actions of persons with autism may seem to be hostile, antagonistic, bizarre or drug-induced.
- People with autism sometimes feel pain when others would not, and at other times feel no pain.
- Your attention may be drawn to people who are autistic by their "odd" behavior.
- People with autism may show a fascination with something inanimate (especially wheels or circular objects), walk into traffic without looking, or be engaged in other aggressive or self-injurious behavior.

PSYCHIATRIC DISABILITIES (MENTAL ILLNESS)

Things to Know

- People with psychiatric disabilities may at times have difficulty coping with the tasks and interactions of daily life.
- The disorder may interfere with their ability to feel, think, and relate to others.
- Most people with psychiatric disabilities are not violent.
- The biggest obstacle is societal attitudes about mental illness.
- Mental Illness covers a broad range of psychiatric disabilities such as schizophrenia, manic depression, severe depression, and most anxiety disorders.
- Some of these mental illnesses can be treated with medicine but, because they do not recognize that they are ill, people who have mental illness frequently stop taking their medication.

Things to Do

- Stress can affect the person's ability to function. Try to keep the pressure of the situation to a minimum.
- In a crisis, stay calm and be supportive as you would with anyone. Ask how you can help, and find out if there is a support person who can be sent for. If appropriate, you might ask if the person has medication that he needs to take.
- Call for professional assistance if necessary.

Things to Avoid

- Resist the natural tendency to counter aggression or non-compliance with physical control, since merely touching someone with a mental disability might cause them to flee or react violently.
- Tones of voice, actions, or appearance which are threatening to a person with a mental disability could trigger an unexpected or unwanted reaction.

Things to Consider

- Neurological disorders and the broad range of mental illnesses present challenges for medical professionals, family members, friends, and the people affected by the disabilities.
- Your interactions and conversations with people who have such disabilities may be frustrating or unnerving at times.
- By remaining calm, friendly, and helpful you should be able to attain your objective despite the complications which are involved.
- People who have psychiatric disabilities have varying personalities and different ways of coping with their disability. Some may have trouble picking up on social cues; others may be super-sensitive. One person may be very high energy, while someone else may appear sluggish. Treat each person as an individual. Ask what will make him most comfortable and respect his needs to the maximum extent possible.

ALZHEIMER'S DISEASE

Disabilities which do not manifest themselves with physical symptoms can present unexpected complications when interacting with anyone you do not know. What might be considered a "normal" conversation could change without warning or apparent cause.

Things to Know

- Alzheimer's disease normally affects people who are older.
- Childlike characteristics or symptoms may suddenly appear, and memory loss is the most common sign that Alzheimer's disease is present.
- People who have Alzheimer's disease often wander away from their residences, and may have very plausible explanations of where they think they are going.

TRAUMATIC BRAIN INJURY (TBI)
ACQUIRED BRAIN INJURY (ABI)

Head injuries can occur in accidents which sometimes appear minor. A person with a TBI may not recognize that their characteristics or actions change when the injury's symptoms are manifested. Even if there are normally no signs of a TBI present, a sudden change in speech pattern or volume, a burst of anger, or an indecipherable sentence could be an indication that a head injury has occurred.

Things to Know

- People with brain injury may have a loss of muscle control or mobility that is not obvious. For example, a person may not be able to sign her name, even though she can move her hand.
- A person with a brain injury may have poor impulse control. The person may make inappropriate comments and may not understand social cues or "get" indications that she has offended someone. In her frustration to understand, or to get her own ideas across, she may seem pushy. All of these behaviors arise as a result of the injury.
- A person with a brain injury may be unable to follow directions due to poor short-term memory or poor directional orientation. She may ask to be accompanied, or she may use a guide dog for orientation, although she does not appear to be mobility impaired.
- The person may have trouble concentrating or organizing her thoughts, especially in an over-stimulating environment, like a crowded movie theater or transportation terminal. Be patient. You might suggest going somewhere with fewer distractions.

Things to Do

- Head injuries can be so varied that there are no easy rules for dealing with the symptoms they cause.
- Be alert for unusual characteristics, actions or phrases; if they present, assume that there may be some type of disability present.
- If you are not sure that the person understands you, ask if she would like you to write down what you were saying.
- A calm, friendly approach works best while interacting with anyone.

Things to Avoid

- Resist the natural tendency to counter aggression or non-compliance with physical control, since merely touching someone with a head injury might cause them to flee or react violently.
- Tones of voice, actions, or appearance which are threatening to a person with a head injury could trigger an unexpected or unwanted reaction.

Things to Consider

- Neurological disorders and the broad range of head injuries present challenges for medical professionals, family members, friends, and the people affected by the disabilities.
- Your interactions and conversations with people who have such disabilities may be frustrating or unnerving at times.
- By remaining calm, friendly, and helpful you should be able to attain your objective despite the complications which are involved.

HIDDEN DISABILITIES

Not all disabilities are apparent. A person may have trouble following a conversation, may not respond when you call or wave to them, may make a request that seems strange to you, or may say or do something that seems inappropriate. The person may have a hidden disability, such as low vision, a hearing impairment, a learning disability, traumatic brain injury, mental retardation, or mental illness. Don't make assumptions about the person or their disability. Be open-minded.

A WORD ABOUT CONFIDENTIALITY

You may really care or you may just be curious about a person with a disability who is in crisis, suddenly ill, or does not "show" for unexplained reasons. In spite of your concern, please respect the privacy of a person with a disability. Allow him to discuss his situation if and when he feels comfortable doing so.

LEARNING MORE

Lack of knowledge or misinformation may lead you to shy away from interacting with persons with certain disabilities. Preconceptions about mental illness, AIDS, Cerebral Palsy, Tourette syndrome, Alzheimer's disease and other disabilities often lead to a lack of acceptance by those around the person. Remember that we are all complex human beings; a disability is just one aspect of a person. Learning more about the disability may alleviate your fears, and can pave the way for you to see the person for who they really are. Keep practicing, and enjoy the experience.

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WORKING WITH VISUALLY IMPAIRED CONSUMERS IN IHSS

Aid codes for blind aid are "20", "26", "28", etc.

- Best corrected vision for statutory blindness 20/200 or visual field <15°

Most common causes of blindness:

- Lack of oxygen and other delivery impairments at birth
- Macular degeneration (degenerative blemishes on the retina), which results in "tunnel vision"
- Glaucoma (increased pressure and hardening of the eyeball)
- Diabetes (diabetic retinopathy)
- Cataract (lens becomes opaque) – now often corrected or improved by surgery
- Retinal detachment (retina is light-sensitive cells at back of eyeball. If they detach from the optic nerve, visual image cannot reach the brain.)
- Diseases of the cornea

Things to Know

- Most persons who are blind have some sight, rather than no sight at all.
- Many people who are blind are mobile and independent. Some people who are blind view blindness not as a disability as much as an inconvenience.
- While many people who are blind can use Braille, the majority of persons who are blind do not.
- A person may have a visual disability that is not obvious. Be prepared to offer assistance – for example – in reading when asked.

Things to Do

- Introduce yourself. Identify who you are and what your job or role is. Be sure to introduce any others who are with you.
- If you have met before, remind consumer of the context; as they won't have the visual cues to jog their memory.
- Be descriptive when giving directions. Saying "over there" has little meaning to someone who cannot see you point.
- Always ask someone if they need your assistance and how you can assist them.
- Lead someone who is blind only after they have accepted your offer to do so. Allow them to hold your arm, rather than you holding them. It is important to let people with vision impairments control their movements.
- Many techniques are used as tools for independence, but individuals with disabilities use only things that work for them.
- If the person has a guide dog, walk on the side opposite the dog. As you are walking, describe the setting, noting any obstacles, such as stairs ("up" or "down") or a big crack in the sidewalk.
- If you are going to give a warning regarding a hazard, be specific. Shouting, "Look out!" does not tell the person if he should stop, run, duck or jump.
- Remember to describe sights or objects from their perspective, not yours. Tell them when you have brought new items into their environment, describing what they are and, most importantly, where you have put them.

- Offer to read written information.
- If you need to leave a person who is blind, inform him first.

Things to Avoid

- Do not move items (furniture, personal items) after their position has been learned by the person. This can be frustrating and, in some cases, dangerous for the person with a disability.
- Do not use references that are visually oriented like "over there near the green plant."
- Don't touch the person's cane or guide dog. The dog is working and needs to concentrate. The cane is part of the individual's personal space. If the person puts the cane down, don't move it. Let him know if it's in the way.

Things to Consider

- Persons who are blind have more often been told what to do rather than asked what they would prefer doing. This attitude is not acceptable towards any person.

People with Low Vision

Things to Know

- Persons with low vision may not be wearing dark glasses or using a cane and therefore are not easily identifiable.
- A person with low vision may need written material in large print.
- It is easiest for most people with low vision to read bold white letters on a black background.

Things to Do

- Ask the person what size and type font they prefer to read.
- Remember that you can use a copy machine to enlarge print.
- Good lighting is very important.
- Have a simple (drug store brand) magnifying glass available.
- Use a thick point black marker when writing down information. Check with the person to determine what size to write letters/numbers so they can see it.
- Keep walkways clear of obstructions.

Things to Avoid

- Avoid using all uppercase letters because it is more difficult for people with low vision to distinguish the end of a sentence.
- Do not move items (furniture, personal items) after their position have been learned by the person. This can be frustrating and, in some cases, dangerous for the person with a disability.

Assessment of home care needs of the blind and vision-impaired:

- Legal blindness covers a wide range of vision. Don't assume about consumer capabilities.
  - Ask consumer how much vision they do have.
  - As in any IHSS interview, carefully observe the consumer to determine their abilities. Do not assume complete blindness or helplessness.

- Allow the consumer to describe his/her vision and how it impacts function.
- Examples might be to hand them a pen, if they do not reach for it then tell them you are handing them a pen and that you will need them to sign their name.
- Always look directly at the consumer as you or they are speaking and note if they respond to your movements, smiles etc.

- Ask the consumer about adaptations to the home and adaptive training they may have received. (Example: stove knobs marked in braille)
  - What kind?
  - How much mobility training?
  - Have they developed their own systems or do they use tools which allow them to complete some tasks?
  - Those with intensive schooling are often Braille capable and very adept to getting around.
  - Those who are blind from birth may have mental health issues overlay basic blindness or experience isolation due to never having sight.
  - Those with late or adult onset tend to have a slower diminution of sight, allowing time to adapt.
  - Those new to the loss may have some depression and may not yet availed themselves of training nor be aware of what is available to them.

- Community resources:
  - Department of Vocational Rehabilitations
  - OCB
  - Living Skills Centers
  - Guide dogs
  - Special mobility training
  - Non-profit organization serving the blind
  - Special services from utilities
  - Large print books

- Explore other health problems and their impact on functioning.

- IHSS Tasks – Some things to consider:
  - Domestic: Examine floors and counter surfaces for sign of vermin too small for consumer to see, crumbs, grease or mold. Check refrigerators for spoiled food.
  - Meals & Cleanup: Same as above. Explore for vermin. They currently may be cooking out of necessity. Make sure that this can be done safely.
  - Laundry: Observe spots and stains on clothing and linens. Consumers often have trouble with use of bleach, pre-spotting, coordination of colors, storing clothing in matching sets to facilitate dressing.
  - Dressing: How is clothing stored? Are clothes stored in matching styles, colors? Consumers feel seams to determine right-side out and label to tell back from front. These are some of the skills taught in the training programs.
  - Feeding: Consumers rely on things being in place. Ask what system they are currently using for their meals.
  - Bathing and Grooming: Most men use an electric razor. Observe hairstyle as a factor in grooming time. Provider may need to do set-ups.

- Accompaniment to MD Visits: Can be approved only for consumers who need physical assistance. Many impaired persons are adept at using public transportation.
- Paramedical: Can be involved with administration of insulin injections/ testing.
- Setting up medi-sets can be helpful. For low vision consumers, have they asked their pharmacy to provide large print prescriptions?

- Determine if adaptive items are used by the consumer to facilitate independence for any of the above tasks. If not and consumer is interested, refer to a low vision living skills center.

Other Resources

- The Pub 13 Rights and Responsibilities Pamphlet is available in large print, Braille and in audio versions. www.cdss.ca.gov/civilrights/PG594.htm
- CDSS website: Handbook and services for the visually impaired. http://www.cdss.ca.gov/cdssweb/PG1941.htm

CULTURAL IMPLICATIONS

Cultural Implications for IHSS Assessment:

1. Any general cultural awareness does not fit every situation. If there are any concerns, the consumer should be consulted.

2. Most cultural beliefs are influenced by culture, age, and length of time in the U.S.

3. Culture can be defined as the integrated patterns of behaviors that include language, thoughts, communications, actions, customs, beliefs, values, and/or institutions of racial, ethnic, religious, and/or social groups.

4. Culture is only one of a number of influences on behaviors in the face of illness and other life transitions.

5. Culturally appropriate care includes sensitivity to issues related to race, gender, sexual orientation, social class, economic situation, age, and disability.

6. It is important that the social worker understand their own cultural context and influences so he/she can be aware of their own cultural filters.

7. Knowledge allows you to move forward to assess your consumers with awareness and sensitivity.

8. Having knowledge about a specific cultural/ethnic group does not ensure cultural appropriateness; however, without knowledge and understanding, being culturally appropriate most likely will not occur.

9. Stereotyping – one makes an assumption about a person based on group membership without learning whether or not the individual in question fits that assumption.

10. Generalizing – begins with an assumption about a group but leads to a quest for further information as to whether the assumption fits the individual.

Cultural Variations in Communication:

- Conversational style and pacing
  - Silence is interpreted differently by different cultures. In some, it is a sign of respect, while in others a person will find you rude or even interpret silence as a "no" response.
  - Styles of answers can be different in cultures ranging from blunt and to the point to indirect and storytelling styles.
  - In some cultures, directness, insistence and emphasis can look like anger to others.

- Eye contact
  - Avoiding eye contact has many reasons and can be easily misinterpreted.

- Personal space
  - There are many different comfort levels. In some cultures, standing close is comfortable and in others giving ample space is important for personal comfort.

- Touch
  - Different parts of the body are taboo in different cultures such as touching the head and feet. In addition, it is important to be conscientious about gender differences in comfort with touch. In some cultures, there is great sensitivity regarding opposite gender caregivers.

- Time orientation
  - Differences include being strictly oriented to clock time versus embracing personal and subjective time. The importance of being 'on time' can vary.

Adapted from *Culture and Clinical Care.* Edited by J. Lipson and S. Dibble, UCSF Nursing Press, 2005.

ATTRIBUTES, KNOWLEDGE, AND SKILLS NECESSARY FOR THE SOCIAL WORKER TO DEVELOP CULTURAL COMPETENCY

Attributes:

- genuineness, accurate empathy, non-possessive warmth and a capacity to respond
- flexible to a range of possible solutions
- acceptance of ethnic differences between people
- willingness to work with consumers of different ethnic groups
- articulation/clarification of the worker's personal values, stereotypes, and biases about their own and other's ethnicity/social class
- resolution of feelings about one's own professional image in a field that is systematically oppressed and may exclude people of color or other differences

Knowledge of:

- culture (history, values, traditions, family systems, artistic expressions) of cultural group
- the impact of class and race on behavior, attitudes, and values
- help seeking behaviors of consumers
- the role of language, speech patterns, and communication styles
- the impact of social service policies on consumers
- resources that can be utilized and how to access them
- recognizing ways that professional values may conflict with or accommodate the needs of minority consumers
- power relationships within the community, agency, or institution and their impact on the consumer

Skills:

- techniques for learning about culture
- ability to communicate accurate information on behalf of the consumer
- ability to openly discuss cultural differences and respond to culturally based cues
- ability to assess the meaning that ethnicity has for individual consumers
- ability to differentiate between the symptoms of intrapsychic stress and stress arising from the social structure
- interviewing techniques that are culturally sensitive
- ability to utilize the concepts of empowerment on behalf of the consumer and community
- ability to recognize and combat racism, racial stereotypes, and myths in individuals and institutions
- ability to evaluate new techniques, research, and knowledge as to its validity and applicability in working with cultural differences

How to do this:

- Skills and knowledge are gained through education, training, practice and self-reflection.
- Personal attributes can be developed through exposure to the positive aspects of minority cultures.
- Knowledge and skills must be coupled with a willingness to let consumers determine their own future, within program parameters.

Adapted from *Toward a Culturally Competent System of Care* by T. Cross, B. Bazron, K. Dennis, M. Isaacs, March 1989.

USING AN INTERPRETER

Many times, assessments are conducted by a social worker who is fluent in the consumer's language. But at times, you have to conduct an assessment or other interactions with a consumer and/or provider through an interpreter. The consumer has the right to choose who his/her interpreter is, but if the consumer needs assistance, it is important to select someone who is certified or otherwise has been arranged for by the county.

There are several techniques you may employ when using an interpreter. While behaviors may vary by cultural group, demonstrating respect is recognized and valued by all people. When using an interpreter, consider the following strategies:

- Even if it is the wish of the consumer, do not use a child under the age of 18 as an interpreter except in extenuating circumstances when requested to do so by the consumer and when no other interpreter is available. For additional information, see ACL 06-20, ACL 03-56 and MPP Section 21-115.16.
- Before the interview begins, inform the interpreter that you need him/her to translate all that the consumer says and to say to the consumer all of what you say.
- Always display professionalism and let the consumer know you are interested in their situation by being polite and formal.
- Ask the interpreter to use the consumer's own words as much as possible.
- Ask the interpreter to refrain from inserting his/her own ideas or interpretations, and from omitting information.
- When communicating with the consumer through an interpreter, look directly at the consumer when you speak, not at the interpreter.
- Address questions to the consumer, not the interpreter.
- Observe the consumer's non-verbal communication, such as facial expressions, voice intonations, and body movements.
- Avoid raising your voice in an attempt to clarify your statements.
- Do not use hand gestures to emphasize statements; they may prove to be culturally insulting or even frightening.
- Use simple, nontechnical language and avoid using acronyms.
- Do not use slang.
- Check the consumer's understanding and accuracy by asking him/her to repeat the message or instructions in his/her own words with help from the interpreter.
- Provide instruction in the proper sequence and discuss one topic at a time.
- Avoid using double negatives.
- Avoid using leading questions that may encourage the consumer to say what he thinks you want to hear.
- Whenever appropriate, ask open-ended questions rather than questions requiring a "yes" or "no" response.

21-115 PROVISION FOR SERVICES TO APPLICANTS AND RECIPIENTS WHO ARE NON-ENGLISH SPEAKING OR WHO HAVE DISABILITIES 21-115
(Continued)

HANDBOOK CONTINUES

In the example above, one full time Spanish-speaking worker in any program would satisfy the requirements for all programs, provided that the worker would be available to interpret for the other two programs.

HANDBOOK ENDS HERE

.15 When the percentage of non-English cases in a program and/or location is less than five percent, the agency shall ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, qualified employees of other agencies or community resources.

.16 Applicants/recipients may provide their own interpreter; however, the CWD shall not require them to do so. Only under extenuating circumstances or at the specific request of the applicant/recipient shall a CWD allow a minor (under the age of 18 years) to temporarily act as an interpreter. This provision does not apply to interpretive services for persons who are deaf.

.2 Forms and other written material required for the provision of aid or services shall be available and offered to the applicant/recipient in the individual's primary language when such forms and other written material are provided by CDSS. When such forms and other written material contain spaces (other than "for agency use only") in which the CWD is to insert information, this inserted information shall also be in the individual's primary language.

.3 Each CWD shall ensure that administrative practices do not have the effect of denying non-English speaking persons and individuals with disabilities equal access to and participation in the available programs and activities.

.4 Auxiliary Aids

.41 CWDs shall provide auxiliary aids and services to persons who are deaf or hearing impaired, or persons with impaired speech, vision or manual skills where necessary to afford such persons an equal opportunity to participate in, and enjoy the benefits and services of programs or activities. Auxiliary aids and services may include brailled material, taped text, qualified interpreters, large print materials, telecommunication devices for the deaf (TDDs) and other effective aids and services for persons with impaired hearing, speech, vision or manual skills. Compliance with this section can be accomplished through use of volunteer services from community organizations and individuals who are able to provide prompt effective services without undue delays using qualified interpreters.

.42 CWDs shall provide an opportunity for individuals with disabilities to request auxiliary aids and services of their choice. CWDs shall give primary consideration to the requests of individuals with disabilities.

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

June 30, 2006

ALL COUNTY LETTER NO. 06-20

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY CIVIL RIGHTS COORDINATORS

SUBJECT: INTERPRETIVE SERVICES

The purpose of this All-County Letter (ACL) is to remind counties of their continued obligation to comply with the California Department of Social Services (CDSS) Manual of Policies and Procedures (MPP) Division 21 regulations regarding the provision of effective language services to all applicants/recipients in their primary language. The provision of effective language services shall be prompt, without undue delay. These requirements apply regardless of whether the county provides an interpreter (qualified bilingual employees, paid interpreters, qualified employees of other agencies, or use of community resources) or the applicant/recipient chooses to provide his/her own interpreter.

Counties must comply with MPP Section 21-107 regarding the dissemination of information and ensure that applicants/recipients are advised of their right to free interpretive services. It is always the county's obligation to affirmatively offer interpretive services (Section 21-115.15). Once the county has been informed that the applicant/recipient needs an interpreter, the county must offer and provide an interpreter at each client contact. The county's obligation to provide interpretive services may be met using a variety of methods, which may include bilingual staff, county interpreters, and contracted interpreters (including language line).

Applicants/recipients may use their own interpreter, but must not be compelled or encouraged to do so (Section 21-115.16). Before applicants/recipients decide to use their own interpreter, the county is required to advise them at initial intake and at each redetermination of (1) the right to free interpretive services; (2) potential problems of using the client's own interpreter, including the possibility of ineffective communication, inaccurate interpretation, and the need to disclose private information to the interpreter; (3) the availability of county-provided interpretive services, whether or not a client chooses to provide his own interpreter; and (4) the right to accept county-provided interpretive services at any time, even when a client-provided interpreter is present.

If the applicant/recipient chooses to provide his or her own interpreter, but at any time informs the county that he or she wishes to utilize the county-provided interpreter, the county must provide free interpretive services, without undue delay. The county *shall not* conduct substantive, program-related conversations with the applicant/recipient until qualified interpretive services are available.

The county may allow a minor to temporarily act as interpreter only at the request of the applicant/recipient, or under other extenuating circumstances. The county must document the use of a minor and the reason(s) for it in the case record. Examples of extenuating circumstances warranting the temporary use of a minor as interpreter include, but are not limited to:

- The County Welfare Department (CWD) telephones or visits the applicant/recipient's home for initial contact and finds a non-English or limited-English speaking client, while a minor in the home speaks English. Under these circumstances, the CWD contact may use the minor as an interpreter only to determine the language of the client and to schedule a date and time to return with a county provided interpreter. When the matter is time sensitive, the county is encouraged to use a telephone interpreter.

- A non-English or limited-English speaking applicant/recipient enters the CWD with a minor child who speaks English and the county does not immediately have access to a county provided interpreter in the applicant/recipient's primary language. Under these circumstances, the minor may only be used as a temporary interpreter to schedule a date and time to return to the CWD when a county provided interpreter will be available. When the matter is time sensitive, the county is encouraged to use a telephone interpreter.

- When a CWD employee encounters a health and safety issue such as a car accident or crime scene, where immediate communication is imperative, a minor may be used temporarily until a qualified interpreter arrives at the scene or communicates with the applicant/recipient via telephone, cell phone, etc.

In all instances, the use of a minor as the applicant's/recipient's interpreter should be temporary, only until a county interpreter is made available.

In addition to providing free interpretive services, the county must document the following in the case record file for each contact with the applicant/recipient:

- The county offered free interpretive services;

- Who provided the interpretive services;

- The county informed the applicant/recipient of potential problems for ineffective communication when using the applicant's/recipient's own interpreter;

- The county offered county-provided interpretive services if the applicant/recipient provided interpreter is not available;

- A minor temporarily acting as an interpreter did so at the specific request of the applicant/recipient or there were other extenuating circumstances, with an explanation of those circumstances;

- The applicant/recipient signed a consent for the release of information when using his or her own interpreter;

- The county informed the applicant/recipient of his/her right to accept county-provided interpretive services at any time, even when a client provided interpreter is present. (Section 21-115.16; 116.22 through .24)

If you have any questions regarding this letter, you may contact the Civil Rights Bureau at (916) 654-2107, or toll free at 1-866-741-6241.

Sincerely,

Original Document Signed By:

TOM LEE
Acting Deputy Director
Human Rights and Community Services Division

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

REASON FOR THIS TRANSMITTAL
[ ] State Law Change [ ] Federal Law or Regulation Change [ ] Court Order or Settlement Agreement [ ] Clarification Requested by One or More Counties [X] Initiated by CDSS - Policy Clarification

October 29, 2003

ALL COUNTY LETTER NO. 03-56

TO: ALL COUNTY WELFARE DIRECTORS
ALL CIVIL RIGHTS COORDINATORS

SUBJECT: REQUIREMENTS FOR LANGUAGE SERVICES

REFERENCE: MANUAL OF POLICIES AND PROCEDURES, DIVISION 21

This ACL serves to clarify the responsibilities of County Welfare Departments under California Department of Social Services (CDSS) regulations in providing effective language services with respect to six areas: 1) Bilingual Staffing, 2) Interpreter Services, 3) Minors Used as Interpreters, 4) Use of Translated Forms, Notices and Materials, 5) Informing Signs, and 6) Documentation.

1. Bilingual Staffing: Pursuant to Manual of Policies and Procedures (MPP) Division 21-115.1, counties are required to have qualified and certified bilingual public contact staff who speak the languages spoken by a substantial number of clients and who serve those non- or limited-English-speaking clients, including clients who use American or other sign language. A substantial number is five percent of the clients served in a program at an office.

   For example, in the local office of a county where clients are applying for and/or receiving Food Stamps and seven percent of those clients speak Tagalog, seven percent of the public contact staff in each job classification in the Food Stamp Program in that office must be certified Tagalog-speaking staff to serve the Tagalog-speaking clients. Counties may have different percentages of non-English-speaking staff at each separate office, and the number of bilingual staff must be determined for each separate office. In addition, counties must measure the substantial number by individual language, not language groups (i.e., Southeast Asian languages).

2. Interpreter Services: Pursuant to MPP Division 21-115.15 and .16, when a non- or limited-English-speaking client population is less than a substantial number (less than five percent) in a program at a location, counties must offer and provide interpreter services, upon request, in the language the client has specified for oral communication. This means that if a client comes to the office, is contacted by telephone, or is visited in his or her home, and speaks limited or no English, and has requested an interpreter, an interpreter must be provided. For example, in a county with a small Russian-speaking population where bilingual staffing is not required, when a Russian-speaking client's child is removed from her home as a result of alleged abuse, and the client requests an interpreter, the county is required to provide a Russian-speaking interpreter when communicating with the client—by phone or in person.

   Interpreter services can be provided in person or by phone using a bilingual staff person who is acting as an interpreter, a contracted interpreter, an interpreter from an outside agency, or a family member or friend.

3. Minors Used as Interpreters: Pursuant to MPP Division 21-115.16, counties are prohibited from using minor children as interpreters except temporarily under extenuating circumstances or at the specific request of the client. Extenuating circumstances may include using a minor child to determine the language of the adult so that an appropriate interpreter or bilingual staff person could be called, or when the adult is experiencing a medical emergency.

4. Use of Translated Documents: Pursuant to MPP Division 21-115.2, when a county uses a form, notice or other written material required by CDSS in the county's delivery of services, benefits and programs, and that translated form, notice or other written material has been provided by CDSS, the county must use the translated form, notice or material when serving a non- or limited-English-speaking client.

   This rule regarding use of translated written materials provided by CDSS applies regardless of the number of non- or limited-English-speaking clients who are served by the county. For example, in a county with less than 5 percent Chinese-speaking clients, the Application for Social Services (SOC 295) that has been translated into Chinese by CDSS must be provided in Chinese to the Chinese-speaking applicants. The same rule applies whether Chinese is less than 5 percent or 5 percent or more: When the translated document is a required form and is provided by CDSS, counties must provide the translated form.

   In addition, if using a translated notice of action, any added information that is unique to the recipient of the notice must be in the language of the client. This means that an explanation of the action that is not printed on the notice must be in the language of the notice. If the notice of action is translated into a non-English language, the informing notice on the reverse side (NA Back) must also be in the translated language.

5. Informing Signs: Pursuant to MPP 21-107.211 and .212, counties must post a sign that informs clients that they may request assistance in their primary language. That requirement can be met by using the Pub 86 poster "Everyone is Different, but Equal Under the Law." However, counties are encouraged to also post separate "I Speak" posters inviting non-English-speaking clients to easily identify their language.

   In addition to the signs offering translation services, if a particular county office serves a substantial number of clients who speak a non-English language, all directional and instructional signs must be translated and posted in that particular language. For example, if a county office that serves a substantial number of Spanish-speaking clients posts a sign stating "Employment Classes Every Thursday at 6 p.m.," the county must also have a sign in Spanish stating "Clases de Empleo Cada Jueves a las 6 p.m."

6. Documentation: Pursuant to MPP Division 21-116.2, counties are required to ask clients their preferred language for oral and written communication and document the preferred language(s) in the client's file. Once known, the county is then required to document the following information or actions regarding language services in a client's file:

   a. Client's acceptance or refusal of written material in his/her language after asking the client's preference.
   b. How bilingual services are provided. If, for example, a bilingual staff person is used, it must be documented in the file.
   c. Temporary use of a minor as an interpreter, and the circumstances requiring temporary use of the minor.
   d. That the county informed a client providing his or her own interpreter of the potential problems for ineffective communication.
   e. Client consent to the release of information to the interpreter if the county uses an interpreter other than a county employee.

   This documentation is assessed when the Civil Rights Bureau does its periodic compliance review. In addition, if a client complains that he or she did not receive appropriate language services, this documentation could provide evidence of the client's preferred language for oral and written communication and that language services were provided.

Each of these important areas related to effective language services is addressed in the civil rights compliance reviews which take place according to MPP Division 21-201. Staff and manager interviews, site visits and case file reviews are performed to determine full compliance with the requirements of state regulations.

If you have questions about translated forms, notices, or materials, you may contact Language Services, at (916) 445-6778, or go to the Language Services web page at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm. If you have questions regarding this letter, you may contact Christine Webb-Curtis, Chief, Civil Rights Bureau, at (916) 654-2107.

Sincerely,

Original Document Signed By

JEANNE RODRIGUEZ
Deputy Director
Human Resources Management Division

alzheimer's association

basics of alzheimer's disease

What it is and what you can do

the compassion to care. the leadership to conquer.

what is alzheimer's disease?

Alzheimer's (AHLZ-high-merz) is a disease of the brain that causes problems with memory, thinking and behavior. It is not a normal part of aging.

Alzheimer's gets worse over time. Although symptoms can vary widely, the first problem many people notice is forgetfulness severe enough to affect their ability to function at home or at work, or to enjoy lifelong hobbies.

The disease may cause a person to become confused, lost in familiar places, misplace things or have trouble with language.

It can be easy to explain away unusual behavior, especially for someone who seems physically healthy. Instead, seek a diagnosis as early as possible.

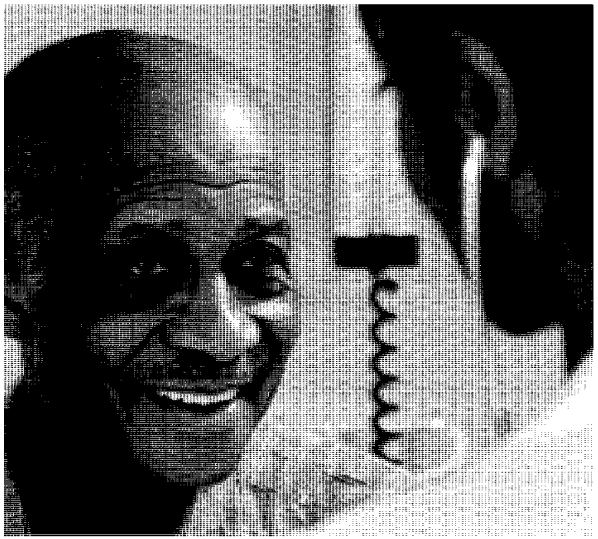
***Basics of Alzheimer's Disease* is intended for anyone who would like to learn more about this disease and related dementias.**

1. when memory loss is a warning sign

Many people worry about becoming more forgetful as they grow older. Our brains change as we age, just like the rest of our bodies.

Most of us eventually notice some slowed thinking and problems remembering certain things. However, serious memory loss, confusion, and other major changes in the way our minds work are not a typical part of aging.

Many conditions can disrupt memory and mental function. Symptoms may improve when the underlying cause is treated.



Contact the Alzheimer's Association if you need assistance finding a doctor with experience evaluating memory problems.

Possible causes of memory problems include:

- Depression
- Medication side effects
- Excess alcohol use
- Thyroid problems
- Poor diet
- Vitamin deficiencies
- Certain infections
- Alzheimer's disease and related dementias

Anyone experiencing significant memory problems should see a doctor as soon as possible. Methods for early diagnosis are improving dramatically, and treatment options and sources of support can improve quality of life.

An early diagnosis helps individuals receive treatment for symptoms and gain access to programs and support services. It may also allow them to take part in decisions about care, living arrangements, money and legal matters.

What's the difference?

Signs of Alzheimer's/dementia	Typical age-related changes
Poor judgment and decision making	Making a bad decision once in a while
Inability to manage a budget	Missing a monthly payment
Losing track of the date or the season	Forgetting which day it is and remembering later
Difficulty having a conversation	Sometimes forgetting which word to use
Misplacing things and being unable to retrace steps to find them	Losing things from time to time

2. 10 warning signs of alzheimer's disease

It may be hard to know the difference between a typical age-related change and the first sign of Alzheimer's disease. Ask yourself: Is this something new? For example, if the person was never good at balancing a checkbook, struggling with this task is probably not a warning sign. But if his or her ability to balance a checkbook has changed significantly, it is something to share with a doctor.

Some people recognize changes in themselves before anyone else does. Other times, friends and family are the first to notice changes in the person's memory, behavior or abilities.

To help identify problems early, the Alzheimer's Association has created a list of warning signs for Alzheimer's. Individuals may experience one or more of these signs in different degrees.

1. Memory loss that disrupts daily life

One of the most common signs of Alzheimer's disease, especially in the early stages, is forgetting recently learned information. Others include forgetting important dates or events; asking for the same information over and over; and increasingly needing to rely on memory aides (e.g., reminder notes or electronic devices) or family members for things they used to handle on their own.

What's a typical age-related change?
Sometimes forgetting names or appointments, but remembering them later.

2. Challenges in planning or solving problems

Some people may experience changes in their ability to develop and follow a plan or work with numbers. They may have trouble following a familiar recipe or keeping track of monthly bills. They may have difficulty concentrating and take much longer to do things than they did before.

What's a typical age-related change?
Making occasional errors when balancing a checkbook.

3. Difficulty completing familiar tasks at home, at work or at leisure

People with Alzheimer's disease often find it hard to complete daily tasks. Sometimes, people have trouble driving to a familiar location, managing a budget at work or remembering the rules of a favorite game.

What's a typical age-related change?
Occasionally needing help to use the settings on a microwave or to record a television show.

4. Confusion with time or place

People with Alzheimer's can lose track of dates, seasons and the passage of time. They may have trouble understanding something if it is not happening immediately. Sometimes they may forget where they are or how they got there.

What's a typical age-related change?
Getting confused about the day of the week but figuring it out later.

5. Trouble understanding visual images and spatial relationships

For some people, having vision problems is a sign of Alzheimer's. They may have difficulty reading, judging distance and determining color or contrast, which may cause problems with driving.

What's a typical age-related change?
Vision changes related to cataracts.

alzheimer's association®

KNOW the 10 SIGNS

EARLY DETECTION MATTERS

6. New problems with words in speaking or writing

People with Alzheimer's may have trouble following or joining a conversation. They may stop in the middle of a conversation and have no idea how to continue or they may repeat themselves. They may struggle with vocabulary, have problems finding the right word or call things by the wrong name (e.g., calling a watch a "hand clock").

What's a typical age-related change?
Sometimes having trouble finding the right word.

7. Misplacing things and losing the ability to retrace steps

A person with Alzheimer's disease may put things in unusual places. They may lose things and be unable to go back over their steps to find them again. Sometimes, they may accuse others of stealing. This may occur more frequently over time.

What's a typical age-related change?
Misplacing things from time to time, and retracing steps to find them.

8. Decreased or poor judgment

People with Alzheimer's may experience changes in judgment or decision making. For example, they may use poor judgment when dealing with money, giving large amounts to telemarketers. They may pay less attention to grooming or keeping themselves clean.

What's a typical age-related change?
Making a bad decision once in a while.

If you notice any of these warning signs, please see a doctor. Doctors' ability to diagnose Alzheimer's disease and related dementias is improving dramatically.

9. Withdrawal from work or social activities

A person with Alzheimer's may start to remove themselves from hobbies, social activities, work projects or sports. They may have trouble keeping up with a favorite sports team or remembering how to complete a favorite hobby. They may also avoid being social because of the changes they have experienced.

What's a typical age-related change?
Sometimes feeling weary of work, family and social obligations.

10. Changes in mood and personality

The mood and personality of people with Alzheimer's can change. They can become confused, suspicious, depressed, fearful or anxious. They may be easily upset at home, at work, with friends or in places where they are out of their comfort zone.

What's a typical age-related change?
Developing very specific ways of doing things and becoming irritable when a routine is disrupted.

Note: Mood changes with age may also be a sign of some other condition. Consult a doctor if you observe any changes.

3. alzheimer's disease and other types of dementia

Dementia (dih-MEN-shuh) is a general term for the loss of memory and other intellectual abilities serious enough to interfere with daily life. Alzheimer's is the most common form of dementia.

More than 5 million Americans have Alzheimer's disease. That includes 13 percent of those over age 65 and nearly 50 percent of those 85 and older. By 2050, the number of individuals with the disease may reach 16 million. Because 70 percent of those with Alzheimer's live at home, its impact extends to millions of family members, friends and caregivers.

Other types of dementia

Alzheimer's accounts for 60 to 80 percent of dementia cases. Other disorders that can cause memory loss, confusion and other symptoms associated with dementia include:

Vascular dementia, often considered the second most common type of dementia, refers to impairment caused by reduced blood flow to parts of the brain. One type may develop after a single major stroke blocks blood flow to a large area of brain tissue. Another kind, formerly called multi-infarct dementia, can occur when a series of very small strokes clog tiny arteries. Individually, these strokes are too minor to cause significant symptoms, but over time their combined effect becomes noticeable.

Vascular dementia symptoms can be similar to Alzheimer's disease. They include problems with memory and confusion and difficulty following instructions. In some cases, the impairment associated with vascular dementia can occur in "steps" rather than in the slow, steady decline usually seen in Alzheimer's.

Mixed dementia is a condition in which Alzheimer's disease and one or more other dementias occur together. Evidence shows that this type of dementia is much more common than once believed.

Parkinson's disease affects control of movement, resulting in tremors, stiffness and impaired speech. Many individuals with Parkinson's also develop dementia in later stages of the disease.

Dementia with Lewy bodies often starts with wide variations in attention and alertness. Individuals affected by this illness often experience visual hallucinations as well as muscle rigidity and tremors similar to those associated with Parkinson's disease.

Physical injury to the brain caused by an automobile accident or other trauma can damage or destroy brain cells and cause symptoms of dementia such as behavioral changes, memory loss and other cognitive difficulties.

Huntington's disease is an inherited, progressive disorder that causes irregular movements of the arms, legs and facial muscles; personality changes; and a decline in the ability to think clearly.

Creutzfeldt-Jakob disease (CJD) (CROYZ-felt YAH-kob) is a rare, rapidly fatal disorder that impairs memory and coordination and causes behavior changes. Recently, variant Creutzfeldt-Jakob disease (vCJD) was identified as the human disorder believed to be caused by eating meat from cattle affected by mad cow disease.

Frontotemporal dementia is a term describing several conditions (such as Pick's disease and primary progressive aphasia) in which front and side areas of the brain are especially affected. Personality and behavior changes are often the first symptoms.

Normal pressure hydrocephalus (NPH) is caused by a buildup of fluid in the brain. The cause of most cases is unknown. Symptoms include difficulty walking, memory loss and inability to control urine. NPH can sometimes be corrected with surgery to drain the excess brain fluid.

Mild cognitive impairment (MCI) is a term some doctors use to describe a situation in which a person may have problems with memory or another thinking skill that is serious enough to show up on tests, but not severe enough to interfere with daily life. Research has shown that individuals with MCI have an increased risk of progressing to Alzheimer's disease, especially when their main area of difficulty involves memory. But a diagnosis of MCI does not always mean the person will develop Alzheimer's.

4. how alzheimer's affects the brain

The changes that take place in the brain begin at the microscopic level long before the first signs of memory loss.

What goes wrong in the brain

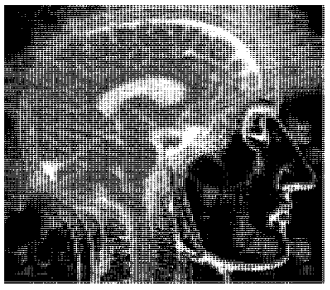
The brain has 100 billion nerve cells (neurons). Each nerve cell connects to many others to form communication networks. In addition to nerve cells, the brain includes cells specialized to support and nourish other cells.

Groups of nerve cells have special jobs. Some are involved in thinking, learning and memory. Others help us see, hear and smell. Still others tell our muscles when to move.

Brain cells operate like tiny factories. They receive supplies, generate energy, construct equipment and get rid of waste. Cells also process and store information and communicate with other cells. Keeping everything running requires coordination as well as large amounts of fuel and oxygen.

Scientists believe Alzheimer's disease prevents parts of a cell's factory from running well. They are not sure where the trouble starts. But just like a real factory, backups and breakdowns in one system cause problems in other areas. As damage spreads, cells lose their ability to do their jobs and, eventually, die.

Take a closer look



Learn how Alzheimer's affects the brain and its functions — take our interactive brain tour at alz.org/brain.

The role of plaques and tangles

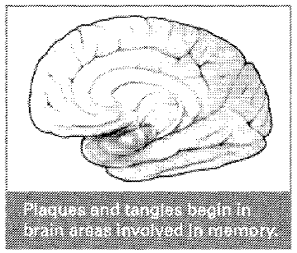
The brains of individuals with Alzheimer's have an abundance of plaques and tangles. Plaques are deposits of a protein fragment called beta-amyloid that build up in the spaces between nerve cells. Tangles are twisted fibers of another protein called tau that build up inside cells.

Though autopsy studies show that most people develop some plaques and tangles as they age, those with Alzheimer's tend to develop far more. They also tend to develop them in a predictable pattern, beginning in the areas important for memory before spreading to other regions.

Scientists do not know exactly what role plaques and tangles play in Alzheimer's disease. Most experts believe that they somehow play a critical role in blocking communication among nerve cells and disrupting processes the cells need to survive.

The destruction and death of nerve cells causes memory failure, personality changes, problems in carrying out daily activities and other symptoms of Alzheimer's disease.

How Alzheimer's spreads in the brain



Illustrations:

Alzheimer's Disease Education and Referral Center, a service of the National Institute on Aging

5. causes and risk factors

While scientists know that Alzheimer's disease involves the failure of nerve cells, why this happens is still unknown. However, they have identified certain risk factors that increase the likelihood of developing Alzheimer's.

Age

The greatest known risk factor for Alzheimer's disease is increasing age. Most individuals with the illness are 65 and older. One in eight people in this age group has Alzheimer's. Nearly half of people age 85 and older have Alzheimer's.

Family history and genetics

Another risk factor is family history. Research has shown that those who have a parent, brother or sister with Alzheimer's are more likely to develop the disease than individuals who do not have a first-degree relative with Alzheimer's. The risk increases if more than one family member has the illness.

Scientists have identified three genes that *guarantee* individuals will develop Alzheimer's, but only a very small percentage of people with Alzheimer's (about 1 percent) carry these genes. The ε4 form of the gene apolipoprotein E (APOE-ε4) is carried by about 25 percent of individuals and increases the risk of developing Alzheimer's, *but does not guarantee* that individuals will develop the disease. Experts believe the vast majority of cases of Alzheimer's are caused by a complex combination of genetic and nongenetic influences.

Latinos and African-Americans at risk

Research shows that older Latinos are about one-and-a-half times as likely as older whites to have Alzheimer's and other dementias. Older African-Americans are about twice as likely to have Alzheimer's and other dementias as older whites. The reason for these differences is not well understood, but researchers believe that higher rates of vascular disease in these groups may also put them at greater risk for developing Alzheimer's. A growing body of evidence suggests that risk factors for vascular disease — including diabetes, high blood pressure and high cholesterol — may also be risk factors for Alzheimer's.

Other risk factors

Age, family history and genetics are all risk factors we can't change. Research is beginning to reveal clues about other risk factors that we may be able to influence. There appears to be a strong link between serious head injury and future risk of Alzheimer's. It's important to protect your head by buckling your seat belt, wearing your helmet when participating in sports and fall-proofing your home.

One promising line of research suggests that strategies for overall healthy aging may help keep the brain healthy and may even offer some protection against Alzheimer's. These measures include eating a healthy diet, staying socially active, avoiding tobacco and excess alcohol, and exercising both body and mind.

Some of the strongest evidence links brain health to heart health. The risk of developing Alzheimer's or vascular dementia appears to be increased by many conditions that damage the heart and blood vessels. These include heart disease, diabetes, stroke, high blood pressure and high cholesterol. Work with your doctor to monitor your heart health and treat any problems that arise.

Studies of donated brain tissue provide additional evidence for the heart-head connection. These studies suggest that plaques and tangles are more likely to cause Alzheimer's symptoms if strokes or damage to the brain's blood vessels are also present.

Aluminum

During the 1960s and 1970s, aluminum emerged as a possible suspect in causing Alzheimer's disease. This suspicion led to concerns about everyday exposure to aluminum through sources such as cooking pots, foil, beverage cans, antacids and antiperspirants. Since then, studies have failed to confirm any role for aluminum in causing Alzheimer's. Almost all scientists today focus on other areas of research, and few experts believe that everyday sources of aluminum pose any threat.

6. how to find out if it's alzheimer's disease

People with memory loss or other possible Alzheimer's warning signs may find it hard to recognize they have a problem and may resist following up on their symptoms. Signs of dementia may be more obvious to family members or friends.

The first step in following up on symptoms is finding a doctor with whom a person feels comfortable. (The Alzheimer's Association can help find the right one.)

There is no single type of doctor that specializes in diagnosing and treating memory symptoms or Alzheimer's disease. Many people contact their regular primary care physician about their concerns. Primary care doctors often oversee the diagnostic process themselves.

In many cases, the doctor may refer the patient to a specialist such as a:

- Neurologist who specializes in diseases of the brain and nervous system
- Psychiatrist who specializes in disorders that affect mood or the way the mind works
- Psychologist with special training in testing memory and other mental functions

There is no single test that proves a person has Alzheimer's. The workup is designed to evaluate overall health and identify any conditions that could affect how well the mind is working.

Experts estimate that a skilled physician can diagnose Alzheimer's with more than 90 percent accuracy. Physicians can almost always determine that a person has dementia, but it may sometimes be difficult to determine the exact cause.

Steps to diagnosis include:

Understanding the problem

Be prepared for the doctor to ask:

- What kind of symptoms have been occurring
- When they began
- How often they happen
- If they have gotten worse

Reviewing medical history

The doctor will interview the person being tested and others close to him or her to gather information about current and past mental and physical illnesses. It is helpful to bring a list of all the medications the person is taking. The doctor will also obtain a history of key medical conditions affecting other family members, especially whether they may have or had Alzheimer's disease or related disorders.

Evaluating mood and mental status

Mental status testing evaluates memory, ability to solve simple problems and other thinking skills.

This testing gives an overall sense of whether a person:

- Is aware of symptoms
- Knows the date, time and where he or she is
- Can remember a short list of words, follow instructions and do simple calculations

The doctor may ask the person his or her address, what year it is or who is serving as president. The individual may also be asked to spell a word backward, draw a clock or copy a design. The doctor will also assess mood and sense of well-being to detect depression or other illnesses that can cause memory loss and confusion.

Physical exam and diagnostic tests

A physician will:

- Evaluate diet and nutrition
- Check blood pressure, temperature and pulse
- Listen to the heart and lungs
- Perform other procedures to assess overall health

Blood and urine samples will be collected and other laboratory tests may be ordered. Information from these tests can help identify disorders such as anemia, infection, diabetes, kidney or liver disease, certain vitamin deficiencies, thyroid abnormalities, and problems with the heart, blood vessels or lungs. All of these conditions may cause confused thinking, trouble focusing attention, memory problems or other symptoms similar to dementia.

Neurological exam

A doctor, sometimes a neurologist specializing in disorders of the brain and nervous system, will closely evaluate the person for problems that may signal brain disorders other than Alzheimer's.

The physician will also test:

- Reflexes
- Coordination
- Muscle tone and strength
- Eye movement
- Speech
- Sensation

The doctor is looking for signs of small or large strokes, Parkinson's disease, brain tumors, fluid accumulation on the brain and other illnesses that may impair memory or thinking.

The neurological exam may also include a brain imaging study. The most common types are magnetic resonance imaging (MRI) or computed tomography (CT). MRIs and CTs can reveal tumors, evidence of small or large strokes, damage from severe head trauma or a buildup of fluid. Researchers are studying other imaging techniques so they can better diagnose and track the progress of Alzheimer's. Medicare will cover a positron emission tomography (PET) scan as an aid in diagnosis in certain cases.

7. when the diagnosis is alzheimer's

Once testing is complete, the doctor will make an appointment to review results and share his or her conclusions. A diagnosis of Alzheimer's reflects a doctor's best judgment about the cause of a person's symptoms, based on the testing performed.

You may want to ask the doctor:

- *Why* the diagnosis is Alzheimer's
- *Where* the person may be in the course of the disease
- *What* to expect in the future

Find out if the doctor will manage care going forward and, if not, who will be the primary doctor. The doctor can then schedule the next appointment or provide a referral.

Alzheimer's disease is life-changing for both the diagnosed individual and those close to him or her. While there is currently no cure, treatments are available that may help relieve some symptoms. Research has shown that taking full advantage of available treatment, care and support options can make life better.

Consider:

- How to provide increasing levels of care as the disease progresses
- How the individual and family members will cope with changes in the person's ability to drive, cook and perform other daily activities
- How to ensure a safe environment

It is also important to begin making legal and financial plans. A timely diagnosis often allows the person with dementia to participate in this planning. The person can also decide who will make medical and financial decisions on his or her behalf in later stages of the disease

To learn more about planning for the future, contact the Alzheimer's Association or visit alzheimersnavigator.org to create a customized action plan of information, support, and community resources.

8. stages of the disease

Alzheimer's disease gets worse over time. Experts have developed "stages" to describe how a person's abilities change from normal function through advanced Alzheimer's.

It's important to keep in mind that stages are general guides, and symptoms vary greatly. Every person is unique, but there are some common patterns of the illness. Those with Alzheimer's live an average of four to eight years after diagnosis, but some live as long as 20 years.

This seven-stage framework is based on a system developed by Barry Reisberg, M.D., clinical director of the New York University School of Medicine's Silberstein Aging and Dementia Research Center.

Reliable support

Your local Alzheimer's Association chapter can connect you with the resources you need to cope with the challenges of Alzheimer's. Many chapters also provide special programs tailored to their communities, including services for African-Americans, Asian-Americans, Latinos, rural residents and those who live alone.

Our 24/7 Helpline (800.272.3900) operates around the clock to provide information, referral and care consultation by master's-level professionals in 170 languages.

Stage 1: No impairment

Normal function

The person does not experience any memory problems. An interview with a medical professional does not show any evidence of symptoms.

Stage 2: Very mild decline

May be normal age-related changes or the earliest signs of Alzheimer's

The individual may feel that he or she is having memory lapses — forgetting familiar words or the location of everyday objects. But no symptoms can be detected during a medical exam or by friends, family or co-workers.

Stage 3: Mild cognitive decline

Early-stage Alzheimer's may be diagnosed in some, but not all, individuals at this point

Friends, family or co-workers begin to notice difficulties. During a detailed medical interview, doctors may be able to detect problems in memory or concentration. Common difficulties at this stage include:

- Noticeable problems coming up with the right word or name
- Trouble remembering names when introduced to new people
- Noticeably greater difficulty performing tasks in social or work settings
- Forgetting material that one has just read
- Losing or misplacing a valuable object
- Increasing trouble with planning or organizing

Stage 4: Moderate cognitive decline

Mild or early-stage Alzheimer's

At this point, a careful medical interview should be able to detect clear-cut problems in several areas:

- Forgetfulness of recent events
- Impaired ability to perform challenging mental arithmetic (e.g., counting backward from 100 by 7s)
- Greater difficulty performing complex tasks, such as planning dinner for guests, paying bills or managing finances
- Forgetfulness about one's own personal history
- Becoming moody or withdrawn, especially in socially or mentally challenging situations

Stage 5: Moderately severe cognitive decline

Moderate or mid-stage Alzheimer's

Gaps in memory and thinking are noticeable, and individuals begin to need help with day-to-day activities. At this stage, those with Alzheimer's may:

- Be unable to recall their own address or phone number or the high school or college they attended
- Become confused about where they are or what day it is
- Have trouble with less challenging mental arithmetic (e.g., counting backward from 40 by subtracting fours)
- Need help choosing proper clothing for the season or occasion
- Still remember significant details about themselves and their family
- Continue to eat or use the toilet unassisted

Stage 6: Severe cognitive decline

Moderately severe or mid-stage Alzheimer's

Memory continues to worsen, personality changes may take place and individuals need significant help with daily activities. The person may:

- Lose awareness of recent experiences as well as their surroundings
- Remember their own name but have difficulty with their personal history
- Distinguish familiar and unfamiliar faces but have trouble remembering the name of a spouse or caregiver
- Need help dressing properly and may, without supervision, make mistakes such as putting pajamas over daytime clothes or shoes on the wrong feet
- Experience major changes in sleep patterns — sleeping during the day and becoming restless at night
- Need help handling details of the toilet (e.g., flushing the toilet, wiping or disposing of tissue properly)
- Have increasingly frequent trouble controlling their bladder or bowels
- Experience major personality and behavioral changes, including suspiciousness and delusions (e.g., believing the caregiver is an impostor) or compulsive, repetitive behavior like hand-wringing or tissue shredding
- Tend to wander or become lost

Wandering

Six out of 10 people with Alzheimer's disease will wander and become lost. If not found within 24 hours, up to half of those who wander risk serious injury or death.

Medic Alert® + Alzheimer's Association Safe Return® is a 24-hour emergency response service that provides assistance when a person with dementia becomes lost or has a medical emergency. Alzheimer's Association Comfort Zone® is a comprehensive Web-based location management system that allows families to monitor a person with Alzheimer's.

Visit alz.org/safety to learn more.

Stage 7: Very severe cognitive decline

Severe or late-stage Alzheimer's

In the final stage of this disease, individuals lose the ability to respond to the environment, to carry on a conversation and, eventually, to control movement. They may still say words or phrases.

At this stage, individuals need help with much of their daily personal care, including eating or using the toilet. They may also lose the ability to smile, to sit without support and to hold their heads up. Reflexes become abnormal. Muscles grow rigid. Swallowing is impaired.

9. treating the symptoms

Currently, there is no cure for Alzheimer's and no way to stop the underlying death of brain cells. But drugs and non-drug treatments may help with both cognitive and behavioral symptoms.

A comprehensive care plan for Alzheimer's disease:

- Considers appropriate treatment options
- Monitors treatment effectiveness as the disease progresses
- Changes course and explores alternatives as necessary
- Respects individual and family goals for treatment and tolerance for risk

Cognitive symptoms

FDA-approved treatments

Two types of drugs are currently approved by the U.S Food and Drug Administration (FDA) to treat cognitive symptoms of Alzheimer's disease.

The first type, cholinesterase (KOH-luh-NES-ter-ays) inhibitors, prevents the breakdown of acetylcholine (a-SEA-til-KOH-lean), a chemical messenger important for memory and learning. By keeping levels of acetylcholine high, these drugs support communication among nerve cells.

Three cholinesterase inhibitors are commonly prescribed:

- Donepezil (Aricept®), approved in 1996 to treat mild-to-moderate Alzheimer's, and in 2006 for the severe stage
- Rivastigmine (Exelon®), approved in 2000 for mild-to-moderate Alzheimer's
- Galantamine (Razadyne®), approved in 2001 for mild-to-moderate stages

The second type of drug works by regulating the activity of glutamate, a different messenger chemical involved in information processing:

- Memantine (Namenda®) is the only currently available drug in this class

The effectiveness of both types of treatments varies from person to person. While they may temporarily help symptoms, they do not slow or stop the brain changes that cause Alzheimer's to become more severe over time.

Vitamin E

Doctors sometimes prescribe vitamin E for cognitive symptoms of Alzheimer's disease. One large federally funded study showed that vitamin E slightly delayed loss of ability to carry out daily activities and placement in residential care.

Scientists think that vitamin E may work because it is an antioxidant (an-tee-OX-uh-dent), a substance that may protect cells from certain kinds of chemical wear and tear.

No one should use vitamin E to treat Alzheimer's disease except under the supervision of a physician. The doses used in the federal study were relatively high, and vitamin E can negatively interact with other medications, including those prescribed to prevent blood from clotting.

Key Terms

Symptoms

Cognitive: Symptoms that affect memory, awareness, language, judgment and ability to plan, organize and carry out other thought processes.

Behavioral: A group of additional symptoms that occur to at least some degree in many individuals with Alzheimer's. In early stages, people may experience personality changes such as irritability, anxiety or depression. In later stages, individuals may develop sleep disturbances; wandering impulses; agitation (physical or verbal aggression, general emotional distress, restlessness, pacing, shredding paper or tissues, yelling); delusions (firmly held belief in things that are not real); or hallucinations (seeing, hearing or feeling things that are not there).

Treatments

FDA-approved: Medication approved by the U.S. Food and Drug Administration (FDA) that specifically treats a symptom of Alzheimer's disease.

Non-drug: A strategy other than medication that helps relieve a symptom of Alzheimer's disease.

Behavioral symptoms

Many find behavioral changes to be the most challenging and distressing effect of Alzheimer's disease. These include anxiety, agitation, aggression and sleep disturbances. They can have an enormous impact on care and quality of life for individuals living in both family situations and long-term residential care.

As with cognitive symptoms of Alzheimer's, the chief underlying cause of behavioral and psychiatric symptoms is the progressive damage to brain cells. Other possible causes of behavioral symptoms include:

- **Drug side effects**
  Side effects from prescription medications may be at work. Drug interactions may occur when taking multiple medications for several conditions.
- **Medical conditions**
  Symptoms of infection or illness, which may be treatable, can affect behavior. Pneumonia or urinary tract infections can bring discomfort. Untreated ear or sinus infections can cause dizziness and pain.
- **Environmental influences**
  Situations affecting behavior include moving to a new private residence or residential care facility; misperceived threats; or fear and fatigue from trying to make sense of a confusing world.

There are two types of treatments for behavioral symptoms: non-drug treatments and prescription medications. Non-drug treatments should be tried first.

Non-drug treatments

Steps to developing non-drug treatments include:

- Identifying the symptom
- Understanding its cause
- Changing the caregiving environment to remove challenges or obstacles

Identifying what has triggered behavior can often help in selecting the best approach. Often the trigger is a change in the person's environment, such as:

- New caregivers
- Different living arrangements
- Travel
- Admission to a hospital

- Presence of houseguests
- Being asked to bathe or change clothes

Because people with Alzheimer's gradually lose the ability to communicate, it is important to regularly monitor their comfort and anticipate their needs.

Prescription medications

Medications can be effective in managing some behavioral symptoms, but they must be used carefully and are most effective when combined with non-drug strategies. Medications should target specific symptoms so that response to treatment can be monitored. Prescribing any drug for a person with Alzheimer's is medically challenging. Use of drugs for behavioral and psychiatric symptoms should be closely supervised.

Behavior: Some Tips for Caregivers

Create a calm, safe environment that may be better suited for the person's abilities:

- Eliminate clutter, noise, glare and excessive background noise
- Develop soothing rituals with regular daily routines, comforting objects, gentle music and a reassuring touch
- Provide opportunities for exercise and satisfying activities geared to the person's abilities
- Monitor personal comfort: ensure a comfortable temperature and check regularly for pain, hunger, thirst, constipation, full bladder, fatigue, infection and skin irritation
- Be sensitive to frustration about expressing wants and needs
- Rather than argue or disagree, redirect the person's attention
- Simplify tasks and routines
- Avoid open-ended questions; ask yes or no questions instead
- Allow enough rest between stimulating events, such as visits from friends or neighbors
- Use labels to cue or remind the person
- Equip doors and gates with safety locks
- Remove guns

10. hope for the future

The Alzheimer's Association is the largest nonprofit funding resource for Alzheimer's research. Since 1982, we have awarded over $292 million to more than 2,000 research investigations worldwide.

When Alois Alzheimer first described the disease in 1906, a person in the United States lived an average of about 50 years. Few people reached the age of greatest risk. As a result, the disease was considered rare and attracted little scientific interest.

That attitude changed as life span increased and scientists began to realize how often Alzheimer's strikes people in their 70s and 80s. The Centers for Disease Control and Prevention recently estimated average life expectancy to be 78.5 years.

Today, Alzheimer's is at the forefront of biomedical research, with 90 percent of what we know discovered in the last 20 years. Some of the most remarkable progress has shed light on how Alzheimer's disease affects the brain. Better understanding of its impact may lead to better ways to treat it.

Clinical studies drive progress

Although many ideas about Alzheimer's treatment and prevention begin in the laboratory, the final stage of testing involves clinical (human) studies. New treatments are evaluated in humans only if laboratory tests and animal studies show good results.

In early clinical studies, a treatment is tested for safety in a small group of volunteers. Later studies, involving thousands of participants, test how well the treatment works. Hundreds of researchers are currently exploring potential methods of treating and preventing Alzheimer's in dozens of studies around the globe.

Choosing to participate in a clinical trial is an important personal decision. Treatment studies typically last at least several months, and prevention research can run for years. Most treatment studies require the involvement

of a caregiver as well as the person with the disease. And joining a study is not a surefire way to get an experimental drug, as most studies randomly assign participants to receive either the drug or an inactive treatment, called a placebo. Still, many people find hope and comfort in participating. Others are motivated knowing that they are helping future patients by contributing to medical research.

Visit alz.org/trialmatch to learn more about Alzheimer's Association TrialMatch®, a clinical studies matching service that connects individuals living with Alzheimer's, caregivers, healthy volunteers and physicians with current Alzheimer's-related clinical trials.

New directions in treatment and prevention

One promising target is beta-amyloid (BAY-tuh AM-uh-loyd). This protein fragment builds up into the plaques considered one hallmark of the disease. Researchers have developed several ways to clear beta-amyloid from the brain or prevent it from forming. Experimental drugs that zero in on beta-amyloid are now being tested.

Many other new approaches to treatment are also under investigation worldwide. We don't yet know which of these strategies may work, but scientists say that, with the necessary funding, the outlook is good for developing treatments that slow or stop Alzheimer's.

While there is no known way to prevent Alzheimer's disease, research suggests that the steps people take to maintain brain health may also reduce the risk of Alzheimer's. Eating a low-fat diet rich in fruits and vegetables, exercising regularly, and staying mentally and socially active may all help protect the brain.

Some of the strongest evidence links brain health to heart health. This connection makes sense, because the brain is nourished by one of the body's richest networks of blood vessels, and the heart is responsible for pumping blood through these blood vessels to the brain. It's especially important for people to do everything they can to keep weight, blood pressure, cholesterol and blood sugar within recommended ranges to reduce the risk of heart disease, stroke and diabetes.

11. we can help

The Alzheimer's Association is the trusted resource for reliable information, education, referral and support to the millions of people affected by the disease, their families and caregivers, and healthcare professionals.

- Our nationwide network of more than 70 chapters is the core of our support lifeline.
- Our 24/7 Helpline, **800.272.3900**, provides information, referrals and care consultation in more than 170 languages and dialects.
- Our website, **alz.org**, provides comprehensive information about Alzheimer's disease and how the Association can help those affected.
- Our online Safety Center, **alz.org/safety**, features information, tips and resources to assist you with safety inside and outside of the home, wandering and getting lost, and driving and dementia.
- Our support groups, conducted at hundreds of locations nationwide, provide people with Alzheimer's and their families a confidential, open forum to share concerns and receive support.
- ALZConnected (**alzconnected.org**), powered by the Alzheimer's Association, is a social networking community that connects people with Alzheimer's, their caregivers and others affected by the disease.
- Alzheimer's Association Alzheimer's Navigator™ (**alzheimersnavigator.org**) is an online assessment program that creates customized action plans and works in conjunction with Alzheimer's Association Community Resource Finder (**communityresourcefinder.org**), an online search engine for locating community programs, services and resources.
- Educational workshops led by trained professionals on topics such as caregiving, brain health, Alzheimer's basics and living with dementia, as well as a number of free e-learning courses available at **elearning.alz.org**.
- The Alzheimer's Association Green-Field Library is the nation's largest resource center devoted to Alzheimer's disease and dementia.

Alzheimer's Association Educational Materials

Whether you're an individual with Alzheimer's, a caregiver, health professional or someone who wants to learn more about the disease, the Alzheimer's Association can help. Visit **alz.org** or call **800.272.3900** to request our consumer education materials that provide information about all aspects of Alzheimer's.

Popular Titles Include:

For individuals with Alzheimer's

- *If You Have Alzheimer's Disease: What you should know, what you should do*
- *Younger-Onset Alzheimer's: I'm too young to have Alzheimer's disease*

For Spanish-speaking audiences

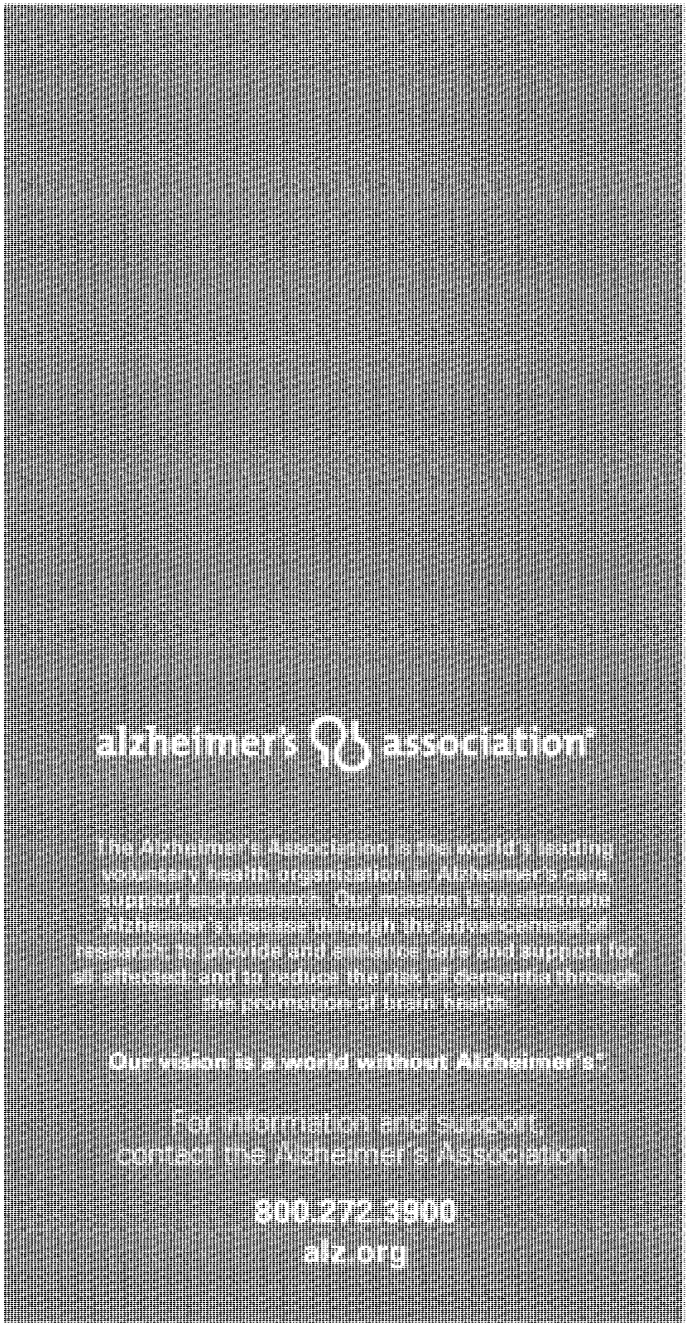
- *The Latino Family and Alzheimer's Disease: A bilingual telenovela*
- *If You Have Alzheimer's Disease: What you should know, what you should do*

For African-American audiences

- *Staying Strong: Stress relief for the African-American caregiver*
- *Is It Alzheimer's or Just Signs of Aging? 10 signs every African-American should know*

For caregivers

- *Behaviors*
- *Communication*
- *Activities at Home*
- *End-of-Life Decisions*
- *Caregiver Stress*
- *Legal Plans*
- *Money Matters*



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alzheimer's association

behaviors

How to respond when dementia causes unpredictable behaviors

the compassion to care, the leadership to conquer

how should i handle erratic behaviors?

Alzheimer's disease and related dementias can cause a person to act in different and unpredictable ways. Some individuals with Alzheimer's become anxious or aggressive. Others repeat certain questions or gestures. Many misinterpret what they hear.

These types of reactions can lead to misunderstanding, frustration and tension, particularly between the person with dementia and the caregiver. It is important to understand that the person is not acting that way on purpose.

Behavior may be related to:

- **Physical discomfort**

  Illnesses or medication

- **Overstimulation**

  Loud noises or a busy environment

- **Unfamiliar surroundings**

  New places or the inability to recognize home

- **Complicated tasks**

  Difficulty with activities or chores

- **Frustrating interactions**

  Inability to communicate effectively

The Alzheimer's Association offers suggestions for handling behaviors such as:

Use this three-step approach to help identify common behaviors and their causes:

1. Examine the behavior

- What was the behavior? Was it harmful to the individual or others?
- What happened just before the behavior occurred? Did something trigger it?
- What happened immediately after the behavior occurred? How did you react?
- Could something be causing the person pain?
- Consult a physician to identify any causes related to medications or illness.

2. Explore potential solutions

- What are the needs of the person with dementia? Are they being met?
- Can adapting the surroundings comfort the person?
- How can you change your reaction or your approach to the behavior? Are you responding in a calm and supportive way?

3. Try different responses

- Did your new response help?
- Do you need to explore other potential causes and solutions? If so, what can you do differently?

1. aggression

Aggressive behaviors may be verbal (shouting, name calling) or physical (hitting, pushing). These behaviors can occur suddenly, with no apparent reason, or can result from a frustrating situation. Whatever the case, it is important to try to understand what is causing the person to become angry or upset.

How to respond:

Try to identify the immediate cause
Think about what happened right before the reaction that may have triggered the behavior.

Rule out pain as a source of stress
Pain can cause a person with dementia to act aggressively.

Focus on feelings, not facts
Rather than focusing on specific details, consider the person's emotions. Look for the feelings behind the words or actions.

Don't get upset
Be positive and reassuring. Speak slowly in a soft tone.

Limit distractions
Examine the person's surroundings, and adapt them to avoid other similar situations.

Try a relaxing activity
Use music, massage or exercise to help soothe the person.

Shift the focus to another activity
The immediate situation or activity may have unintentionally caused the aggressive response. Try something different.

2. anxiety or agitation

A person with Alzheimer's may feel anxious or agitated. He or she may become restless and need to move around or pace. Or, the person may become upset in certain places or focused on specific details.

How to respond:

Listen to the frustration
Find out what may be causing the anxiety, and try to understand.

Provide reassurance
Use calming phrases. Let the individual know you are there.

Involve the person in activities
Try using art, music or other activities to help engage the person so he or she can relax and be distracted from anxiety.

Modify the environment
Decrease noise and distractions, or relocate.

Find outlets for energy
The person may be looking for something to do. Take a walk, or go for a car ride.

3. confusion

A person with Alzheimer's may not recognize familiar people, places or things. He or she may forget relationships, call family members by other names or become confused about where home is. The purpose of common items, such as a pen or fork may also be forgotten. These situations are difficult for caregivers and require patience and understanding.

How to respond:

Stay calm
Although being called by a different name or not being recognized can be painful, try not to make your hurt apparent.

Respond with a brief explanation
Don't overwhelm the person with lengthy statements and reasons. Instead, clarify with a simple explanation.

Show photos and other reminders
Use photographs and other thought-provoking items to remind the person of important relationships and places.

Offer corrections as suggestions
Avoid explanations that sound like scolding. Try "I thought it was a fork," or "I think he is your grandson Peter."

Try not to take it personally
Remember, Alzheimer's disease causes your friend or family member to forget, but your support and understanding will continue to be appreciated.

4. repetition

A person with Alzheimer's may do or say something over and over again — like repeating a word, question or activity. In most cases, he or she is probably looking for comfort, security and familiarity.

The person may also pace or undo what has just been done. These actions are rarely harmful to the person with Alzheimer's, but can be stressful for the caregiver.

How to respond:

Look for a reason behind the repetition
Try to find out if there is a specific cause or trigger for the behavior.

Focus on the emotion, not the behavior
Rather than reacting to what the person is doing, respond to how he or she is feeling.

Turn the action or behavior into an activity
If the person is rubbing his or her hand across the table, provide a cloth and ask for help with dusting.

Stay calm, and be patient
Reassure the person with a calm voice and gentle touch.

Provide an answer
Give the person the answer that he or she is looking for, even if you have to repeat it several times. It may help to write it down and post it in a prominent location.

Engage the person in an activity
The individual may simply be bored and need something to do. Provide structure and engage the person in a pleasant activity such as taking a walk or working on a puzzle together.

Use memory aids
If the person asks the same questions over and over, offer reminders that are meaningful to the individual like notes, clocks, calendars or photographs.

Accept the behavior, and work with it
If it isn't harmful, don't worry about it. Find ways to work with it.

5. suspicion

Memory loss and confusion may cause a person with Alzheimer's to perceive things in new, unusual ways. Individuals may become suspicious of those around them, even accusing others of theft, infidelity or other improper behavior. Sometimes a person may also misinterpret what he or she sees and hears.

How to respond:

Don't take offense
Listen to what is troubling the person, and try to understand that reality. Then be reassuring, respond to the feeling and let the person know you care.

Don't argue or try to convince
Allow the individual to express ideas. Acknowledge his or her opinions.

Offer a simple answer
Share your thoughts with the individual, but keep it simple. Don't overwhelm the person with lengthy explanations or reasons.

Switch the focus to another activity
Engage the individual in an activity, or ask for help with a chore.

Duplicate any lost items
If the person often searches for a specific item, have several available. For example, if the individual is always looking for his or her wallet, purchase two of the same kind.

6. wandering and getting lost

It's common for a person with dementia to wander and/or become lost. In fact, more than 60 percent of individuals with Alzheimer's will wander at some point. They may try to go home when already there or attempt to recreate a familiar routine, such as going to school or work.

How to respond:

Encourage activity
Keeping the person with Alzheimer's active and engaged will discourage wandering behavior by reducing anxiety and restlessness. Involve the person in daily activities such as doing dishes, folding laundry or preparing dinner.

Inform others
Make sure friends, family and neighbors know that the person has Alzheimer's and that wandering may occur.

Make the home safe
Install deadbolt or slide-bolt locks on exterior doors, and limit access to potentially dangerous areas. Never lock the person with dementia in a home unsupervised.

Sign up for MedicAlert® + Alzheimer's Association Safe Return® and Alzheimer's Association Comfort Zone®
MedicAlert + Safe Return is a 24-hour, nationwide emergency response service for individuals with dementia who wander or have a medical emergency. Comfort Zone is a Web application that allows family members to monitor a person's location. Visit alz.org/safety to learn more about these services.

For more information about dementia and safety, visit **alz.org/safety**.

7. trouble with sleep

People with dementia may have problems sleeping or experience changes in their sleep schedule. Scientists don't completely understand why these sleep disturbances occur. As with changes in memory and behavior, sleep changes somehow result from the impact of Alzheimer's on the brain.

How to respond:

Make a comfortable environment
The person's sleeping area should be at a comfortable temperature. Provide nightlights and other ways to keep the person safe, such as appropriate door and window locks. Discourage watching television during periods of wakefulness at night.

Maintain a schedule
As much as possible, encourage the person with dementia to adhere to a regular routine of meals, waking up and going to bed. This will allow him or her to sleep more restfully at night.

Talk to a doctor
Discuss sleep disturbances with a doctor to help identify causes and possible solutions. Most experts encourage the use of non-drug measures rather than medication.

Avoid stimulants
Alcohol, caffeine and nicotine can all affect ability to sleep. Avoid them as much as possible to promote better sleep at night.

10 quick tips responding to behaviors

1. Remain flexible, patient and calm.
2. Explore pain as a trigger.
3. Respond to the emotion, not the behavior.
4. Don't argue or try to convince.
5. Use memory aids.
6. Acknowledge requests, and respond to them.
7. Look for the reasons behind each behavior.
8. Consult a physician to identify any causes related to medications or illness.
9. Don't take the behavior personally.
10. Share your experiences with others.

alz.org/care

The Alzheimer's and Dementia Caregiver Center provides information and resources, including:

- **Alzheimer's Navigator™** — create customized action plans.
- **Community Resource Finder** — find the local resources you need.
- **ALZConnected™** — connect with other caregivers who can relate to your situation.
- **Care Team Calendar** — invite friends, family members and neighbors to sign up for caregiving responsibilities.

800.272.3900

The Alzheimer's Association 24/7 Helpline

- Confidential consultation by master's-level clinicians.
- Referrals to local programs and services.

alzheimer's association®

The Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support and research. Our mission is to eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.

Our vision is a world without Alzheimer's®.

For information and support, contact the Alzheimer's Association:

800.272.3900
alz.org

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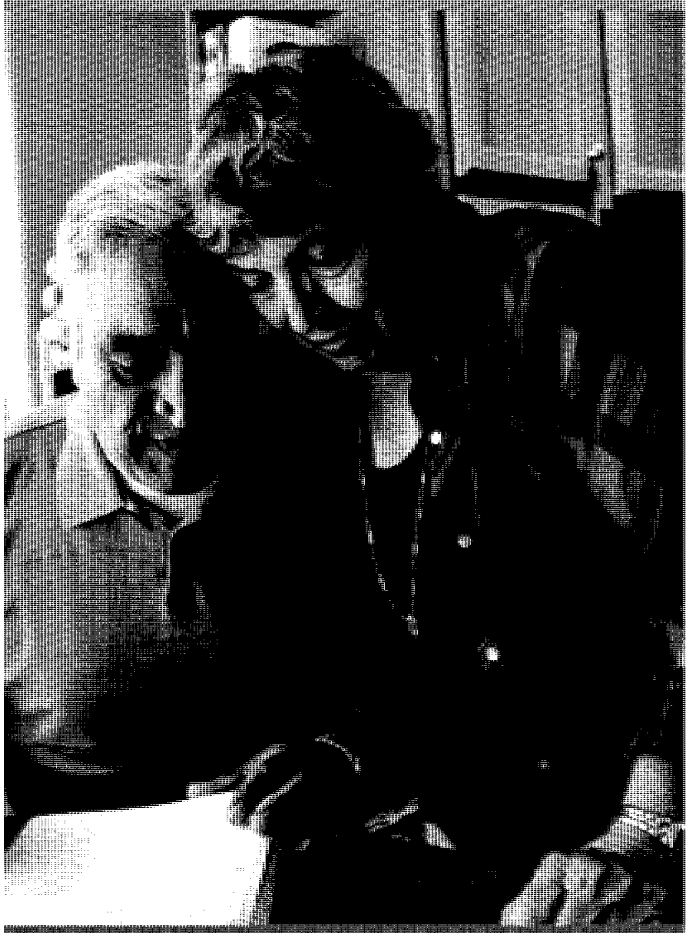
alzheimer's association

communication

Best ways to interact with a person with dementia



the compassion to care, the leadership to conquer

communication and dementia

Alzheimer's disease and related dementias can gradually diminish a person's ability to communicate. Not only do people with dementia have more difficulty expressing thoughts and emotions, they also have more trouble understanding others. The ability to exchange our ideas, wishes and feelings is a basic need.

Communication is:

- Sending and receiving messages.
- How we relate to each other.
- An important part of our relationships.
- A way to express who we are.
- More than talking and listening.
- About attitude, tone of voice, facial expressions and body language.

Changes in communication

Changes in the ability to communicate are unique to each person. A caregiver may recognize differences in the person with dementia such as:

- Difficulty finding the right words.
- Using familiar words repeatedly.
- Inventing new words to describe familiar things.
- Easily losing train of thought.
- Difficulty organizing words logically.
- Reverting to speaking in a native language.
- Using curse words.
- Speaking less often.
- Relying on gestures more than speaking.

A number of physical conditions and medications can affect a person's ability to communicate. Consult your doctor when you notice major changes.

The Alzheimer's Association recommends ways to better communicate with a person with dementia. Inside, you'll find tips for the following:

1. helping a person communicate

Communicating with a person with dementia requires patience and understanding. Above all, you must be a good listener.

To help a person communicate:

Be patient and supportive
Let the person know you're listening and trying to understand what is being said.

Show your interest
Keep good eye contact. Show the person that you care about what he or she is saying.

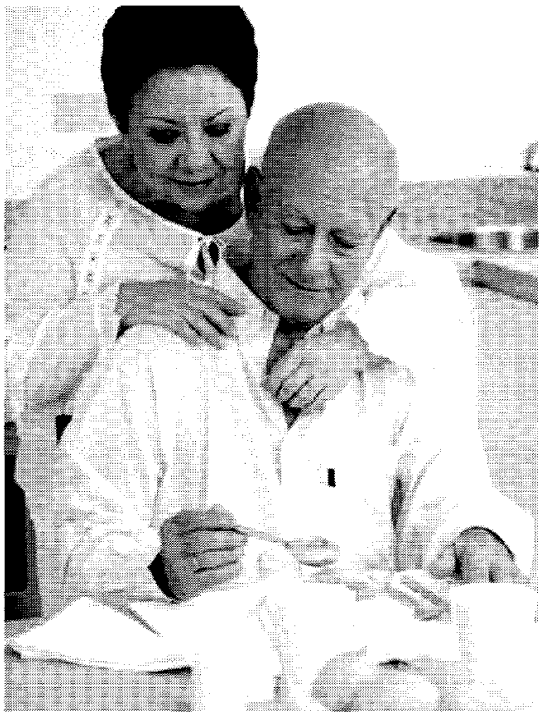
Offer comfort and reassurance
If he or she is having trouble communicating, let the person know that it's OK. Encourage the person to continue to explain his or her thoughts.

Give the person time
Let the person think about and describe whatever he or she wants. Be careful not to interrupt.

Avoid criticizing or correcting
Don't tell the person what he or she is saying is incorrect. Instead, listen and try to find the meaning in what is being said. Repeat what was said if it helps to clarify the thought.

Avoid arguing
If the person says something you don't agree with, let it be. Arguing usually only makes things worse.

Offer a guess
If the person uses the wrong word or cannot find a word, try guessing the right one. If you understand what the person means, you may not need to give the correct word. Be careful not to cause unnecessary frustration.



Encourage unspoken communication
If you don't understand what is being said, ask the person to point or gesture.

Limit distractions
Find a place that's quiet so you won't be interrupted. The surroundings should support the person's ability to focus on his or her thoughts.

Focus on feelings, not facts
Sometimes the emotions being expressed are more important than what is being said. Look for the feelings behind the words. At times, tone of voice and other actions may provide clues.

2. best ways for you to communicate

As dementia progresses, communication can become more and more challenging. Sensitive, ongoing communication is important, no matter how difficult it may become or how confused the person may be.

While a person with dementia may not always respond, he or she still requires and benefits from continued communication. When communicating with him or her, it's especially important to choose your words carefully.

To best communicate:

Identify yourself
Approach the person from the front. Tell the person who you are.

Call the person by name
This is not only courteous, it also helps orient the person and gets his or her attention.

Use short, simple words and sentences
Don't overwhelm the person with lengthy requests or stories. Speak in a concise manner. Keep to the point. In some cases, slang words may be helpful.

Speak slowly and clearly
Be aware of speed and clarity when speaking.

Give one-step directions
Break down tasks and instructions into clear, simple steps. Give one step at a time.

Ask one question at a time
Don't overwhelm or confuse the person with too many questions at once.

Patiently wait for a response
The person may need extra time to process what you said. Give the person the time and encouragement he or she needs to respond.

Repeat information or questions
If the person doesn't respond, wait a moment. Then ask again. Ask the question in the same way, using the same words as before.

Turn questions into answers
Try providing the solution rather than the question. For example, say "The bathroom is right here," instead of asking, "Do you need to use the bathroom?"

Avoid confusing expressions
If you tell the person to "Hop in!" he or she may take that as a literal instruction. Describe the action directly to prevent confusion. "Please come here. Your shower is ready."

Avoid vague statements
Instead of saying "Here it is!" try saying, "Here is your hat."

Emphasize key words
Stress the words in a sentence that you want to draw attention to, like "Here is *your coffee*."

Turn negatives into positives
Instead of saying, "Don't go there," say, "Let's go here."

Give visual cues
To help demonstrate the task, point or touch the item you want the individual to use. Or, begin the task for the person.

Avoid quizzing
Reminiscing may be healthy, but avoid asking, "Do you remember when ... ?" Refrain from saying things like, "You should know who that is."

Give simple explanations
Avoid using complex logic and reasoning. Instead give clear and concise responses.

Write things down
Try using written notes as reminders, if the person is able to understand them. A written response may also help when a spoken one seems too confusing.

Treat the person with dignity and respect
Avoid talking down to the person or talking as if he or she isn't there.

Be aware of your tone of voice

- Speak slowly and distinctly.
- Use a gentle and relaxed tone — a lower pitch is more calming.
- Convey an easygoing, non-demanding manner of speaking.
- Be aware of your feelings and attitude — you may be communicating through your tone of voice, even when you don't mean to.

Pay special attention to your body language

- Always approach the person from the front.
- Avoid sudden movements.
- Keep good eye contact; if the person is seated or reclining, get down to that level.
- Be aware of your stance to avoid sending a negative message.
- Use positive, friendly facial expressions.
- Use nonverbal communication like pointing, gesturing or touching.

3. people with hearing limitations

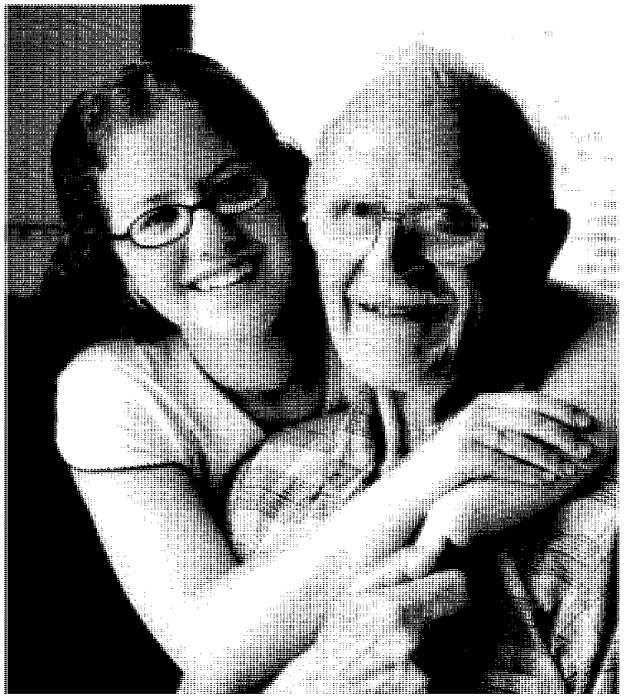
If the person has difficulty hearing:

- Approach the person from the front.
- Speak to him or her face to face.
- Get the person's attention by saying his or her name, and give a gentle touch.
- Speak slowly and clearly.
- Use a lower tone of voice.
- Use nonverbal communication like pointing, gesturing or touching.
- Write things down, if needed.
- If he or she has a hearing aid, encourage the person to wear it. Check the battery often.

4. people with vision limitations

If the person has difficulty seeing:

- Avoid startling the person with loud noises or sudden movements.
- Identify yourself as you approach the person.
- Tell the person of your intentions before you begin.
- Use large-print or audiotape materials, if available.
- If he or she has glasses, encourage the person to wear them. Keep them clean and have the prescription checked regularly.



10 quick tips

better communication

1. Be calm and supportive.
2. Move at person's pace and listen.
3. Pay attention to tone of voice.
4. Address the person by his or her name.
5. Speak slowly and use short, simple words.
6. Ask one question at a time.
7. Avoid vague words and negative statements.
8. Don't talk about the person as if he or she isn't there.
9. Use nonverbal communication like treating or smiling.
10. Be patient, flexible and understanding.

alzheimer's association

The Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support and research. Our mission is to eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.

Our vision: A world without Alzheimer's.

For information and support contact the Alzheimer's Association:

800.272.3900

alz.org

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Fact Sheet: Caregiver's Guide to Understanding Dementia Behaviors

Caring for a loved one with dementia poses many challenges for families and caregivers. People with dementia from conditions such as Alzheimer's and related diseases have a progressive *brain* disorder that makes it more and more difficult for them to remember things, think clearly, communicate with others, or take care of themselves. In addition, dementia can cause mood swings and even change a person's personality and behavior. This Fact Sheet provides some practical strategies for dealing with the troubling behavior problems and communication difficulties often encountered when caring for a person with dementia.

Ten Tips for Communicating with a Person with Dementia

We aren't born knowing how to communicate with a person with dementia—but we can learn. Improving your communication skills will help make caregiving less stressful and will likely improve the quality of your relationship with your loved one. Good communication skills will also enhance your ability to handle the difficult behavior you may encounter as you care for a person with a dementing illness.

1. **Set a positive mood for interaction.** Your attitude and body language communicate your feelings and thoughts stronger than your words. Set a positive mood by speaking to your loved one in a pleasant and respectful manner. Use facial expressions, tone of voice and physical touch to help convey your message and show your feelings of affection.

2. **Get the person's attention.** Limit distractions and noise—turn off the radio or TV, close the curtains or shut the door, or move to quieter surroundings. Before speaking, make sure you have her attention; address her by name, identify yourself by name and relation, and use nonverbal cues and touch to help keep her focused. If she is seated, get down to her level and maintain eye contact.

3. **State your message clearly.** Use simple words and sentences. Speak slowly, distinctly and in a reassuring tone. Refrain from raising your voice higher or louder; instead, pitch your voice lower. If she doesn't understand the first time, use the same wording to repeat your message or question. If she still doesn't understand, wait a few minutes and rephrase the question. Use the names of people and places instead of pronouns or abbreviations.

4. **Ask simple, answerable questions.** Ask one question at a time; those with yes or no answers work best. Refrain from asking open-ended questions or giving too many choices. For example, ask, *"Would you like to wear your white shirt or your blue shirt?"* Better still, show her the choices—visual prompts and cues also help clarify your question and can guide her response.

5. **Listen with your ears, eyes and heart.** Be patient in waiting for your loved one's reply. If she is struggling for an answer, it's okay to suggest words. Watch for nonverbal cues and body language, and respond appropriately. *Always strive to listen for the meaning and feelings that underlie the words.*

6. **Break down activities into a series of steps.** This makes many tasks much more manageable. You can encourage your loved one to do what he can, gently remind him of steps he tends to forget, and assist with steps he's no longer able to accomplish on his own. Using visual cues, such as showing him with your hand where to place the dinner plate, can be very helpful.

7. **When the going gets tough, distract and redirect.** When your loved one becomes upset, try changing the subject or the environment. For example, ask him for help or suggest going for a walk. *It is important to connect with the person on a feeling level, before you redirect.* You might say, *"I see you're feeling sad—I'm sorry you're upset. Let's go get something to eat."*

8. **Respond with affection and reassurance.** People with dementia often feel confused, anxious and unsure of themselves. Further, they often get reality confused and may recall things that never really occurred. *Avoid trying to convince them they are wrong.* Stay focused on the feelings they are demonstrating (which are real) and respond with verbal and physical expressions of comfort, support and reassurance. Sometimes holding hands, touching, hugging and praise will get the person to respond when all else fails.

9. **Remember the good old days.** Remembering the past is often a soothing and affirming activity. Many people with dementia may not remember what happened 45 minutes ago, but they can clearly recall their lives 45 years earlier. Therefore, *avoid asking questions that rely on short-term memory*, such as asking the person what they had for lunch. Instead, try asking general questions about the person's distant past—this information is more likely to be retained.

10. **Maintain your sense of humor.** *Use humor whenever possible, though not at the person's expense.* People with dementia tend to retain their social skills and are usually delighted to laugh along with you.

Handling Troubling Behavior

Some of the greatest challenges of caring for a loved one with dementia are the personality and behavior changes that often occur. You can best meet these challenges by using creativity, flexibility, patience and compassion. It also helps to not take things personally and maintain your sense of humor.

To start, consider these ground rules:

We cannot change the person. The person you are caring for has a brain disorder that shapes who he has become. When you try to control or change his behavior, you'll most likely be unsuccessful or be met with resistance. It's important to:

- *Try to accommodate the behavior, not control the behavior.* For example, if the person insists on sleeping on the floor, place a mattress on the floor to make him more comfortable.
- *Remember that we **can** change our behavior or the physical environment.* Changing our own behavior will often result in a change in our loved one's behavior.

Check with the doctor first. Behavioral problems may have an underlying medical reason: perhaps the person is in pain or experiencing an adverse side effect from medications. In some cases, like incontinence or hallucinations, there may be some medication or treatment that can assist in managing the problem.

Behavior has a purpose. People with dementia typically cannot tell us what they want or need. They might do something, like take all the clothes out of the closet on a daily basis, and we wonder why. It is very likely that the person is fulfilling a need to be busy and productive. *Always consider what need the person might be trying to meet with their behavior—and, when possible, try to accommodate them.*

Behavior is triggered. It is important to understand that all behavior is triggered—it doesn't occur out of the blue. It might be something a person did or said that triggered a behavior or it could be a change in the physical environment. *The root to changing behavior is disrupting the patterns that we create.* Try a different approach, or try a different consequence.

What works today, may not tomorrow. The multiple factors that influence troubling behaviors and the natural progression of the disease process means that solutions that are effective today may need to be modified tomorrow—or may no longer work at all. The key to managing difficult behaviors is being creative and flexible in your strategies to address a given issue.

Get support from others. You are not alone—there are many others caring for someone with dementia. Call your local Area Agency on Aging, the local chapter of the Alzheimer's Association, a Caregiver Resource Center or one of the groups listed below in *Resources* to find support groups, organizations and services that can help you. Expect that, like the loved one you are caring for, you will have good days and bad days. Develop strategies for coping with the bad days (see the FCA Fact Sheet, *Dementia, Caregiving and Controlling Frustration*).

The following is an overview of the most common dementia-associated behaviors with suggestions that may be useful in handling them. You'll find additional resources listed at the end of this Fact Sheet.

Wandering

People with dementia walk, seemingly aimlessly, for a variety of reasons, such as boredom, medication side effects or to look for "something" or someone. They also may be trying to fulfill a physical need—thirst, hunger, a need to use the toilet or exercise. Discovering the triggers for wandering are not always easy, but they can provide insights to dealing with the behavior.

- Make time for regular exercise to minimize restlessness.
- Consider installing new locks that require a key. Position locks high or low on the door; many people with dementia will not think to look beyond eye level. Keep in mind fire and safety concerns for all family members; the lock(s) must be accessible to others and not take more than a few seconds to open.
- Try a barrier like a curtain or colored streamer to mask the door. A "*stop*" sign or "*do not enter*" sign also may help.
- Place a black mat or paint a black space on your front porch; this may appear to be an impassable hole to the person with dementia.
- Add "child-safe" plastic covers to doorknobs.
- Consider installing a home security system or monitoring system designed to keep watch over someone with dementia. Also available are new digital devices that can be worn like a watch or clipped on a belt that use global positioning systems (GPS) or other technology to track a person's whereabouts or locate him if he wanders off..
- Put away essential items such as the confused person's coat, purse or glasses. Some individuals will not go out without certain articles.
- Have your relative wear an ID bracelet and sew ID labels in their clothes. Always have a current photo available should you need to report your loved one missing. Consider leaving a copy on file at the police department or registering the person with the Alzheimer's Association Safe Return program (see *Resources*).
- Tell neighbors about your relative's wandering behavior and make sure they have your phone number.

Incontinence

The loss of bladder or bowel control often occurs as dementia progresses. Sometimes accidents result from environmental factors; for example, someone can't remember where the bathroom is located or can't get to it in time. If an accident occurs, your understanding and reassurance will help the person maintain dignity and minimize embarrassment.

- Establish a routine for using the toilet. Try reminding the person or assisting her to the bathroom every two hours.
- Schedule fluid intake to ensure the confused person does not become dehydrated. However, avoid drinks with a diuretic effect like coffee, tea, cola, or beer. Limit fluid intake in the evening before bedtime.
- Use signs (with illustrations) to indicate which door leads to the bathroom.
- A commode, obtained at any medical supply store, can be left in the bedroom at night for easy access.
- Incontinence pads and products can be purchased at the pharmacy or supermarket. A urologist may be able to prescribe a special product or treatment.
- Use easy-to-remove clothing with elastic waistbands or Velcro® closures, and provide clothes that are easily washable.

Agitation

Agitation refers to a range of behaviors associated with dementia, including irritability, sleeplessness, and verbal or physical aggression. Often these types of behavior problems progress with the stages of dementia, from mild to more severe. Agitation may be triggered by a variety of things, including environmental factors, fear and fatigue. Most often, agitation is triggered when the person experiences "control" being taken from him.

- Reduce caffeine intake, sugar and junk food.
- Reduce noise, clutter or the number of persons in the room.
- Maintain structure by keeping the same routines. Keep household objects and furniture in the same places. Familiar objects and photographs offer a sense of security and can suggest pleasant memories.
- Try gentle touch, soothing music, reading or walks to quell agitation. Speak in a reassuring voice. Do not try to restrain the person during a period of agitation.
- Keep dangerous objects out of reach.
- Allow the person to do as much for himself as possible—support his independence and ability to care for himself.
- Acknowledge the confused person's anger over the loss of control in his life. Tell him you understand his frustration.

- Distract the person with a snack or an activity. Allow him to forget the troubling incident. Confronting a confused person may increase anxiety.

Repetitive speech or actions (perseveration)

People with dementia will often repeat a word, statement, question or activity over and over. While this type of behavior is usually harmless for the person with dementia, it can be annoying and stressful to caregivers. Sometimes the behavior is triggered by anxiety, boredom, fear or environmental factors.

- Provide plenty of reassurance and comfort, both in words and in touch.
- Try distracting with a snack or activity.
- Avoid reminding them that they just asked the same question. Try ignoring the behavior or question and distract the person into an activity.
- Don't discuss plans with a confused person until immediately prior to an event.
- You may want to try placing a sign on the kitchen table, such as, "*Dinner is at 6:30*" or "*Lois comes home at 5:00*" to remove anxiety and uncertainty about anticipated events.
- Learn to recognize certain behaviors. An agitated state or pulling at clothing, for example, could indicate a need to use the bathroom.

Paranoia

Seeing a loved one suddenly become suspicious, jealous or accusatory is unsettling. Remember, what the person is experiencing is very real to them. It is best not to argue or disagree. This, too, is part of the dementia—try not to take it personally.

- If the confused person suspects money is "missing," allow her to keep small amounts of money in a pocket or handbag for easy inspection.
- Help them look for the object and then distract them into another activity. Try to learn where the confused person's favorite hiding places are for storing objects, which are frequently assumed to be "lost." Avoid arguing.
- Take time to explain to other family members and home-helpers that suspicious accusations are a part of the dementing illness.
- Try nonverbal reassurances like a gentle touch or hug. Respond to the feeling behind the accusation and then reassure the person. You might try saying, "I see this frightens you; stay with me, I won't let anything happen to you."

Sleeplessness/Sundowning

Restlessness, agitation, disorientation and other troubling behavior in people with dementia often get worse at the end of the day and sometimes continue throughout the night. Experts believe this behavior, commonly called *sundowning,* is caused by a

combination of factors, such as exhaustion from the day's events and changes in the person's biological clock that confuse day and night.

- Increase daytime activities, particularly physical exercise. Discourage inactivity and napping during the day.
- Watch out for dietary culprits, such as sugar, caffeine and some types of junk food. Eliminate or restrict these types of foods and beverages to early in the day. Plan smaller meals throughout the day, including a light meal, such as half a sandwich, before bedtime.
- Plan for the afternoon and evening hours to be quiet and calm; however, *structured, quiet activity is important*. Perhaps take a stroll outdoors, play a simple card game or listen to soothing music together.
- Turning on lights well before sunset and closing the curtains at dusk will minimize shadows and may help diminish confusion. At minimum, keep a nightlight in the person's room, hallway and bathroom.
- Make sure the house is safe: block off stairs with gates, lock the kitchen door and/or put away dangerous items.
- As a last resort, consider talking to the doctor about medication to help the agitated person relax and sleep. Be aware that sleeping pills and tranquilizers may solve one problem and create another, such as sleeping at night but being more confused the next day.
- It's essential that you, the caregiver, get enough sleep. If your loved one's nighttime activity keeps you awake, consider asking a friend or relative, or hiring someone, to take a turn so that you can get a good night's sleep. Catnaps during the day also might help.

Eating/Nutrition

Ensuring that your loved one is eating enough nutritious foods and drinking enough fluids is a challenge. People with dementia literally begin to forget that they need to eat and drink. Complicating the issue may be dental problems or medications that decrease appetite or make food taste "funny." The consequences of poor nutrition are many, including weight loss, irritability, sleeplessness, bladder or bowel problems and disorientation.

- Make meal and snack times part of the daily routine and schedule them around the same time every day. Instead of three big meals, try five or six smaller ones.
- Make mealtimes a special time. Try flowers or soft music. Turn off loud radio programs and the TV.
- Eating independently should take precedence over eating neatly or with "proper" table manners. Finger foods support independence. Pre-cut and season the food. Try using a straw or a child's "sippy cup" if holding a glass has become

difficult. Provide assistance only when necessary and allow plenty of time for meals.

- Sit down and eat with your loved one. Often they will mimic your actions and it makes the meal more pleasant to share it with someone.
- Prepare foods with your loved one in mind. If they have dentures or trouble chewing or swallowing, use soft foods or cut food into bite-size pieces.
- If chewing and swallowing are an issue, try gently moving the person's chin in a chewing motion or lightly stroking their throat to encourage them to swallow.
- If loss of weight is a problem, offer nutritious high-calorie snacks between meals. Breakfast foods high in carbohydrates are often preferred. On the other hand, if the problem is weight gain, keep high-calorie foods out of sight. Instead, keep handy fresh fruits, veggie trays and other healthy low-calorie snacks.

Bathing

People with dementia often have difficulty remembering "good" hygiene, such as brushing teeth, toileting, bathing and regularly changing their clothes. From childhood we are taught these are highly private and personal activities; to be undressed and cleaned by another can feel frightening, humiliating and embarrassing. As a result, bathing often causes distress for both caregivers and their loved ones.

- Think historically of your loved one's hygiene routine – did she prefer baths or showers? Mornings or nights? Did she have her hair washed at the salon or do it herself? Was there a favorite scent, lotion or talcum powder she always used? Adopting—as much as possible—her past bathing routine may provide some comfort. Remember that it may not be necessary to bathe every day—sometimes twice a week is sufficient.
- If your loved one has always been modest, enhance that feeling by making sure doors and curtains are closed. Whether in the shower or the bath, keep a towel over her front, lifting to wash as needed. Have towels and a robe or her clothes ready when she gets out.
- Be mindful of the environment, such as the temperature of the room and water (older adults are more sensitive to heat and cold) and the adequacy of lighting. It's a good idea to use safety features such as non-slip floor bath mats, grab-bars, and bath or shower seats. A hand-held shower might also be a good feature to install. Remember—people are often afraid of falling. Help them feel secure in the shower or tub.
- Never leave a person with dementia unattended in the bath or shower. Have all the bath things you need laid out beforehand. If giving a bath, draw the bath water first. Reassure the person that the water is warm—perhaps pour a cup of water over her hands before she steps in.
- If hair washing is a struggle, make it a separate activity. Or, use a dry shampoo.

- If bathing in the tub or shower is consistently traumatic, a towel bath provides a soothing alter-native. A *bed* bath has traditionally been done with only the most frail and bed-ridden patients, soaping up a bit at a time in their beds, rinsing off with a basin of water and drying with towels. A growing number of nurses in and out of facilities, however, are beginning to recognize its value and a variation—the "*towel* bath"—for others as well, including people with dementia who find bathing in the tub or shower uncomfortable or unpleasant. The towel bath uses a large bath towel and washcloths dampened in a plastic bag of warm water and no-rinse soap. Large bath-blankets are used to keep the patient covered, dry and warm while the dampened towel and washcloths are massaged over the body. For more information, see the book *Bathing Without a Battle,* (details in the *Recommended Reading* section below), or visit www.bathingwithoutabattle.unc.edu/main_page.html.

Additional Problem Areas

- Dressing is difficult for most dementia patients. Choose loose-fitting, comfortable clothes with easy zippers or snaps and minimal buttons. Reduce the person's choices by removing seldom-worn clothes from the closet. To facilitate dressing and support independence, lay out one article of clothing at a time, in the order it is to be worn. Remove soiled clothes from the room. Don't argue if the person insists on wearing the same thing again.
- Hallucinations (seeing or hearing things that others don't) and delusions (false beliefs, such as someone is trying to hurt or kill another) may occur as the dementia progresses. State simply and calmly your perception of the situation, but avoid arguing or trying to convince the person their perceptions are wrong. Keep rooms well-lit to decrease shadows, and offer reassurance and a simple explanation if the curtains move from circulating air or a loud noise such as a plane or siren is heard. Distractions may help. Depending on the severity of symptoms, you might consider medication.
- Sexually inappropriate behavior, such as masturbating or undressing in public, lewd remarks, unreasonable sexual demands, even sexually aggressive or violent behavior, may occur during the course of the illness. Remember, this behavior is caused by the disease. Talk to the doctor about possible treatment plans. Develop an action plan to follow before the behavior occurs, i.e., what you will say and do if the behavior happens at home, around other adults or children. If you can, identify what triggers the behavior.
- Verbal outbursts such as cursing, arguing and threatening often are expressions of anger or stress. React by staying calm and reassuring. Validate your loved one's feelings and then try to distract or redirect his attention to something else.
- "Shadowing" is when a person with dementia imitates and follows the caregiver, or constantly talks, asks questions and interrupts. Like sundowning, this behavior often occurs late in the day and can be irritating for caregivers. Comfort the

person with verbal and physical reassurance. Distraction or redirection might also help. Giving your loved one a job such as folding laundry might help to make her feel needed and useful.

- People with dementia may become uncooperative and resistant to daily activities such as bathing, dressing and eating. Often this is a response to feeling out of control, rushed, afraid or confused by what you are asking of them. Break each task into steps and, in a reassuring voice, explain each step before you do it. Allow plenty of time. Find ways to have them assist to their ability in the process, or follow with an activity that they can perform.

Credits and Recommended Reading

Bathing Without a Battle, by Ann Louise Barrick, Joanne Rader, Beverly Hoeffer and Philip Sloane, (2002), Springer Publishing, (877) 687–7476.

Caring for a Person with Memory Loss and Confusion: An Easy Guide for Caregivers, (2002), Journeyworks Publishing, Santa Cruz, CA, (800) 775–1998.

Communicating Effectively with a Person Who Has Alzheimer's, (2002), Mayo Clinic Staff, *www.mayoclinic.com/invoke.cfm?id=AZ00004*

Steps to Enhancing Communication: Interacting with Persons with Alzheimer's Disease,(1996), Alzheimer's Association, Chicago, IL, (800) 272–3900.

Steps to Understanding Challenging Behaviors: Responding to Persons with Alzheimer's Disease, (1996), Alzheimer's Association, Chicago, IL, (800) 272–3900.

The Validation Breakthrough: Simple Techniques for Communicating with People with "Alzheimer's-Type Dementia," Naomi Feil , 2nd Edition 2002, Health Professions Press, Baltimore, MD, (410) 337–8539.

Understanding Difficult Behaviors: Some Practical Suggestions for Coping with Alzheimer's Disease and Related Illnesses, A. Robinson, B. Spencer, and L.White, (2001), Eastern Michigan University, Ypsilanti, MI, (734) 487–2335.

For More Information

Family Caregiver Alliance
180 Montgomery St., Suite 1100
San Francisco, CA 94104
(415) 434–3388
(800) 445–8106
www.caregiver.org
info@caregiver.org

Family Caregiver Alliance (FCA) seeks to improve the quality of life for caregivers through education, services, research and advocacy.

Through its National Center on Caregiving, FCA offers information on current social, public policy, and caregiving issues and provides assistance in the development of public and private programs for caregivers.

For residents of the greater San Francisco Bay Area, FCA provides direct support services for caregivers of those with Alzheimer's disease, stroke, traumatic brain injury, Parkinson's and other debilitating health conditions that strike adults.

FCA Publications

Practical Skills Training for Family Caregivers, Mary A. Corcoran, 2003, Family Caregiver Alliance, 180 Montgomery Street, Suite 1100, San Francisco, CA 94104, (800) 445–8106. *www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=954*

FCA Fact Sheets. All Family Caregiver Alliance Fact Sheets are available free online. Printed versions are $1.00 for each title—send your requests to FCA Publications, 180 Montgomery St., Suite 1100, San Francisco, CA 94104. For the full list, see: *www.caregiver.org/caregiver/jsp/publications.jsp?nodeid=345*

FCA Fact Sheet: *Dementia, Caregiving and Controlling Frustration*

FCA Fact Sheet: *Taking Care of YOU: Self-Care for Family Caregivers*

FCA Fact Sheet: *Hiring In-Home Help*

FCA Fact Sheet: *Community Care Options*

Other Web Sites

Alzheimer's Disease Education and Referral (ADEAR) Center
(800) 438-4380
www.alzheimers.org

This service of the National Institute on Aging offers information and publications on diagnosis, treatment, patient care, caregiver needs, long-term care, education and research related to Alzheimer's disease.

Eldercare Locator
(800) 677–1116
www.eldercare.gov

This service of the Administration on Aging offers information about and referrals to respite care and other home and community services offered by state and Area Agencies on Aging.

Alzheimer's Association Safe Return Program
(800) 272–3900
www.alz.org/SafeReturn

A nationwide program that identifies people with dementia who wander away and returns them to their homes. For a $40 registration fee, families can register their loved one in a national confidential computer database. They also receive an identification bracelet or necklace and other identification and educational materials.

This fact sheet was prepared by Family Caregiver Alliance in cooperation with California's statewide system of Caregiver Resource Centers. Reviewed by Beth Logan, M.S.W., Education and Training Consultant and Specialist in Dementia Care. Funded by the California Department of Mental Health. © *2004 Family Caregiver Alliance. All rights reserved. FS-CGTU20050610.*

THE WRONG AND THE BETTER WAY TO

DOCUMENT

When thinking about, "How do I document this case," always paint a solid picture of need so that others who review the case will be able to understand the need for services and hours authorized. This solid picture should always identify the consumer's functional impairments and the risk they pose to the consumer, and should spell out how In-Home Supportive Services will reduce the risk. In addition, remove all judgmental comments; instead, simply report observed behaviors and environmental conditions.

Here are a few examples that reflect two different ways to document FI ranking and/or hours authorized. The "better way" examples are often abbreviated versions of appropriate documentation. Documentation should always include information about the FI ranking and the hours authorized:

Wrong way: "The consumer needs Meal Preparation services."
Better way: "Consumer has congestive heart failure, which causes her to become short-of-breath, with minor exertion. As a result, she is only able to prepare a light breakfast (she states she has more energy in the morning), and needs meal preparation services for lunch and dinner."

[NOTES: Here the second example presents a description of functioning, but is missing information regarding types of meals and time required to prepare the meals and number of days a week needed.]

Wrong way: "Consumer's house is filthy."
Better way: "During the home visit, I observed animal feces on the floor in several places. Consumer's couch appeared stained, and had the odor of urine emanating from it. I noticed a pile of unwashed dishes in the kitchen sink, and a layer of black mold in the bathroom sink."

[NOTES: Here the "better way" presents facts and detailed observations; the statement, as originally written, could be an expression of the worker's judgment based on her own standards of cleanliness and does not provide information regarding how the social worker came to this conclusion.]

Wrong way: "Consumer needs one hour per week for Ambulation."
Better way: "During the home visit, I observed consumer attempting to ambulate. His gait appeared unsteady – he nearly fell twice during the visit – and he stated that he is afraid to walk unassisted. Consumer stated that he spends approximately 8-9 minutes per day, getting to and from the bedroom, bathroom and kitchen. This is equivalent to 1 hour per week for Ambulation."

[NOTES: MPP 30-757.14(k) defines Ambulation as, "consisting of assisting the recipient with walking or moving the consumer from place to place inside the home..." Based on the information, this consumer would also need assistance to and from the car for medical appointments. It should be evaluated and addressed here.]

Wrong way: "Consumer no longer needs Bathing services."
Better way: "Telephone call from consumer. She stated that her broken wrist is completely healed, and that her orthopedic surgeon removed her arm-cast today. She further stated that she is now bathing for herself, unassisted. Bathing services removed as of this date."

[NOTES: In this case, the consumer stated no further need for Bathing services, but the removal of a cast does not, per se, mean that the consumer can return to the former functioning level immediately. The worker would need additional information about the consumer's functioning now before eliminating Bathing. It is possible that the orthopedic surgeon will prescribe a regimen of physical therapy to regain functioning in the consumer's hand. If the fracture was in the consumer's dominant hand, then it is probable that the consumer will still need assistance with Bathing and Dressing until full functioning is regained.]

Wrong way: "Consumer needs total care. Maximum hours authorized."
Better way: "Consumer has Multiple Sclerosis, and she spends the entire day in bed. She requires assistance with all ADLs and IADLs because she lacks the physical strength and endurance to perform any Domestic and Related Services or Personal care."

[NOTES: Here the "better way" presents a description of functioning, and its connection to the specific types of services needed to address the impairment. Good documentation would also address hours of service needed. The social worker should not assume that all consumers who need care in most or all areas of IHSS would need maximum hours. Appropriate questions should be asked to determine specific tasks, amount of time, and frequency needed.]

Wrong way: "Consumer needs Protective Supervision."
Better way: "According to the physician's evaluation on a SOC 821, the consumer has a diagnosis of dementia from Alzheimer's disease and a history of wandering in the street, unable to recognize danger."

[NOTES: Here the physician's evaluation suggests elements of the consumer's behavior and cognitive limitations that could assist the SW in concluding that Protective Supervision is warranted. However, a full evaluation should be done by the SW, using the Protective Supervision criteria found in MPP 30-757.17 et seq. Additional information should be gathered about current behavior that consumer exhibits that places him/her at risk for injury, hazard or accident. Additionally, information should be solicited from others involved in the care of the consumer such as involved family members, the Regional Center, Mental Health, Day Care Centers, schools, etc.]

Wrong way: "Consumer was uncooperative."
Better way: "Three months ago, I suggested to consumer that the local Senior Center would be a resource for him, for both socialization and daily lunches. To date, he continues to state a feeling of isolation; however he has not contacted the Senior Center yet."

[NOTES: The "better way" describes the consumer's statements and actions and the social worker's efforts to resolve some of the issues identified during the home visit; the "wrong way" suggests uncooperativeness. Consumers have the right to refuse services, and not to follow the SW's suggestions. While, from the SW's perspective, going to the Senior Center could reduce social isolation, the social worker should determine if there are other issues that can be resolved such as of transportation.]

HEY, HEY, HEY, READ ALL ABOUT IT!

IHSS Social Workers are Documenting! Documenting! Documenting!

Documentation is important in each and every one of our IHSS cases; it allows the reader to have a visual picture of what took place while the social worker was in the home, and what has transpired since the home visit. This is important when, and if, the case is transferred to another worker or another county. It lays a foundation, which a consumer's history is built on. Case narrative is the readers visual picture of what has been going on with the consumer, his/her family dynamics, living environment, provider history and any changes in the consumer's health conditions.

Documentation / Narrative will be a valuable resource to you when you need to fall back on certain dates and times that a particular incident took place. It can be anything from a consumer being hospitalized, to a consumer alleging abuse by a caretaker. (Remember however, narrative alone is not enough if there is an allegation of abuse, you must also cross-report any abuse to APS/Law Enforcement on a SOC 341).

When documenting your case it is simple, just pretend that you work for the local news paper, no it is not the Daily Planet, it is the "IHSS" or the "Independent Helping Services Sentinel". Sentinel means "Look out, or Guard" which is the job of each social worker to look out for the best interest of their consumer, and guard them against possible fraud, or neglect. As a reporter for the Sentinel, it is your job to be accurate, grab the reader's attention and tell a story that will allow your reader to be there with you.

Remember you are a star reporter, the Clark Kent of Social Services, you may not have a cape, and phone booths are really hard to find these days, but you have something more powerful, and that is you are a social worker. You are providing services to the elderly and dependent adult allowing them to remain in their own home as long as possible. So what you need to do to insure safety, and insure that your consumer is receiving the appropriate services, is simple, just follow the rules of journalism: Who, What, When, Where, How, and Why. So grab your mighty pen, which can write faster than a speeding bullet, okay maybe not faster, but pretty quickly, and practice the following:

Who is calling you?	The client, doctor, family member, Lois Lane, or a friend?
What are they calling you about?	Need a new provider, changes in their medical conditions, no longer in the home, hospitalized, can't find a phone booth or just needing information about other community resources that may be available to them.
When did the incident occur?	Was it today, yesterday, last week, last year or will it be sometime in the future.
Where was the client when it occurred?	In her own home, in the hospital or racing a locomotive.
How has this affected the client?	Emotionally, physically, financially? Did the provider quit, or has consumer hired a new provider.
Why did this happen?	Was it because of the consumer, the provider, a family member? Was it because of bills were not being paid, or because of theft?

*Remember the importance of documentation: "If it isn't documented it did not happen."

State Hearings:
When going to a State Hearing, it is important that you have completed an assessment tool, covering each area of service, and documented the home visit. The State Hearing Judge will rely on documented information from your case, and testimony from you, the consumer, and other witnesses. If you did not document certain events, and the consumer denies that you addressed these issues, it will be a case of "he said, she said" and the Judge usually will err on the side of the consumer. So for better results on those rare occasions when you have a case that is appealed by a consumer, you need to make sure that your documentation is accurate, filed appropriately in your case, and that it allows the reader reviewing your case to build a visual picture of what transpired during your home visit, and how you came up with your assessments, and the hours you granted or denied.

If you follow the simple rules of journalism, who knows-one day when a new social worker comes down the road and picks up one of your cases they may say "Wow who was that Super Social Worker?!!!!!!!"

NARRATIVE GUIDE

(Note: This is only a guide. Each case should be reviewed on a case-by-case basis and documented according to your specific findings and county procedures.)
Remember to always address: ***Who? What? When? Why? How?***

1. Reason for the interaction (annual reassessment, client request because of recent hospitalization, etc).

2. Age of consumer.

3. Current living arrangement (note who else is present during the interview).

4. Condition of the home (cleanliness, cluttered, odors, unkempt, lifestyle choice).

5. Consumer's general attitude and condition during the interview (ability to understand and answer questions).

6. Consumer's diagnosis (past and present).

7. Observations noted at the time of the home visit.

8. Consumer's current functional capabilities/limitations.

9. A summary supporting any changes to Functional Index Ranking.

Example:

Prior notes indicate the consumer was able to walk or move around inside the house without assistance. Due to a recent hip surgery and failure to show any significant improvement and the fact the consumer can no longer walk or move around the house without being at risk of falling and/or injury, the consumer currently requires assistance with ambulation.
Or
Prior notes indicate the recipient had hip surgery 6 months ago with significant medical improvement. It was observed that the consumer is now able to stand, walk, and move around inside the house without any limitations. The consumer does not require assistance walking or moving around inside the house.

10. Complete name of alternative resources and/or voluntary services and hours provided.

11. Description and justifications for Protective Supervision needs or changes.

12. Description and justifications for Paramedical needs or changes.

13. If it was established at the prior home visit that Paramedical services were temporary, a review and notation should be documented in the summary regarding the continuance or denial of the current Paramedical services.

DOCUMENTATION EXAMPLES

Meal Prep: *Rank 5* – Clt. post CVA – R (dominant) side paralysis – IP must cut meat in bite-sized pieces daily – 5 min. extra per day – 7.58 hrs./wk.

Reason for Assistance: Clt. is post CVA – R (dominant) side paralysis

Daily Needs:
Breakfast – 10 minutes – mostly eats oatmeal, toast, coffee or juice
Lunch – 20 minutes – eats soups or stew
Dinner – 35 minutes – mostly grilled meat, fish or poultry, some type of vegetables and potato

Shared Living Exceptions: Clt. lives alone for now but plans to move in with daughter.

Additional information to document exception: IP must cut meat, fish or poultry and vegetables into bite-sized pieces.

Meal Cleanup: *Rank 5* – Extra time needed b/c of clt.'s spasticity. IP has to clean up many spills following each meal. 10 min. breakfast; 15 min. lunch and dinner = 4.67 hrs./wk.

Reason for Assistance: Clt. has cerebral palsy.

Daily Needs:
Breakfast – 10 minutes
Lunch – 15 minutes
Dinner – 15 minutes

Shared Living Exceptions: Clt. lives with a live-in provider; Clt. and IP did not agree to have need for related services prorated.

Additional information to document exception: Due to clt.'s spasticity, there are many spills to clean up following each meal.

Bowel & Bladder: *Rank 3* – Clt. uses urinal and commode. Needs 9 min./daily = 1.05 hrs./wk.

Reason for Assistance: Shortness of breath

Daily Needs: 9 min./daily
2 min. X 3 daily to empty and rinse urinal = 6 min./daily
3 min. X 1 to empty and clean commode after bowel movement = 3 min./daily

Additional information to document exception: Clt. uses urinal for bladder care and commode for bm. Able to wipe self after bm.

Feeding: *Rank 2* – Clt. severely depressed and will not eat without constant encouragement – 6 meals/day b/c she can't eat much at a time. Needs 15 min./meal = 10.5 hrs./wk.

Reason for Assistance: Severe depression; will not eat without constant encouragement.

Daily Needs:
15 min. each meal, 6 meals

Additional information to document exception: 6 meals because clt. can't eat much at a time.

Bed Bath: *Rank 3* – Clt. sponge bathes b/c wheelchair won't fit into bathroom. Can bathe self once basin and supplies are brought to her and returned. Bathes 3x/wk. Needs 10 min./ daily = .5 hrs./wk.

Reason for Assistance: Wheelchair-bound.

Clt. needs 3 times per week @ 10 minutes each time.

Additional information to document exception: Can wash, rinse and dry body once basin and supplies are brought to her.

Bathing: *Rank 4* – Clt. can't reach feet from shower bench. Needs help w/ shampoo b/c arthritis of shoulders. Able to clean dentures. 3 showers/wk @ 15 min. ea. = .75 hrs./wk.

Reason for Assistance: Severe arthritis of shoulders and unable to reach feet from shower bench.

Clt. needs IP help in shampooing and applying conditioner, combing hair, soaping and rinsing from legs to feet while in the shower – 3 times per week @ 15 minutes each time.

Additional information to document exception: Able to clean dentures. Able to reach most of body parts. Nails done at the nearby nail salon.

Dressing: *Rank 2* – Clt. can dress self but needs wardrobe advice b/c of his developmental disability. Time needed = 0 hrs./wk.

Reason for Assistance: Can dress self but due to cognitive impairment, needs prompting on clothing selection. Clt. needs verbal assistance in selecting appropriate clothes.

Additional information to document exception: No need to document exception since Rank 2 and 0 hours are not an exception.

Repositioning and Rubbing Skin: *Rank N/A* – Clt. needs help on and off stationary bike in home 2x/day @ 1 min. ea. = .47 hrs./wk.

Reason for Assistance: Clt. is heavy and has poor balance. Bike ride is for circulation problems.

Client need to ride bike 2 times daily; 1 min. on and 1 min. off = 4 min./daily

Additional information to document exception: Once on the bike, Clt. able to pedal (very little resistance).

Transfer: *Rank 3* – Clt. needs boost to get up and elbow support to sit down. Transfers 8x/day @ 1 min. in each direction = 1.87 hrs./wk.

Reason for Assistance: 94 years old; history of falling and dizziness; diagnosed with osteoporosis.

Clt. needs boost to get up and elbow support to sit down 8 times per day @ 1 min. in each direction (4 times per day bed to wheelchair; 4 times per day wheelchair to couch).

Additional information to document exception: Clt. is 85 lbs., 5'5', very frail and scared of falling again.

Prosthetics: *Rank N/A* – Clt. can take meds if put into mediset. Needs 1x/wk. @ 10 min. = .40 hrs./wk. (Total Need) .17 hrs./wk. (Authorized Need)

Reason for Assistance: Poor eyesight and forgetful.

Clt. needs IP to prep meds in the mediset weekly @ 10 min./wk.

Additional information to document exception: Clt. takes meds 3 times a day. IP reminds clt. once a day while IP is at home providing other IHSS hours. (Insignificant amount of time so no extra would be authorized.) Daughter volunteers to call 2 times a day to remind clt. to take meds. (Phone calls = 1 min. each call; 14 min./wk. = .23 wk. SOC 450 form on file to show .23 min./wk. as Alternative Resources.)

Ambulation: *Rank 3* – Clt. able to walk with walker but needs elbow support down stairs in morning and up at night @ 12 min. ea. = 2.80 hrs./wk.

Reason for Assistance: Unsteady on feet; able to walk with walker but needs elbow support negotiating the stairs.

Clt. needs elbow support down stairs in the morning and going upstairs at night and once in the middle of the day when clt. naps and/or showers.

4 times/day @ 3 min. each time = 12 min./daily

Additional information to document exception: All bedrooms are on the second floor. (4 bed, 3 bath; full bath second floor and ½ bath first floor)

Assessment and Authorization: Day 2

When Authorizing Services

- IHSS operates under a "safety" standard, not a "comfort" standard.
- MPP 30-761.25 states: *"no services shall be determined to be needed which the consumer is able to perform in a safe manner without an unreasonable amount of physical or emotional stress."*

Authorizing Services

- Consider functional rankings first.
- Break service up into components.
- Ask about the frequency and duration of each task.
- Consult existing regulatory guidelines.
- Document exceptions.
- Think critically – "What is the need?"
- Consider "good days" and "bad days."
- Consider that at reassessment, functional rankings may change.

HTG Legislative Objectives

- HTG development is a key element of the Quality Assurance Initiative to:
  - Promote accurate and consistent service authorizations statewide
  - Facilitate equity in service authorizations

HTG Statutory Basis

- Collaborative effort:
  - CDSS, counties, advocates, consumers, providers and other interested stakeholders.
- Provide a tool for county workers:
  - Defines the scope of tasks.
  - Specifies a range of time *normally* required.
  - Provides criteria to assist in determining when an individual's service need falls outside the range.

Line	SERVICES
AA	Domestic Services
BB	Preparation of Meals
CC	Meal Clean Up
DD	Routine Laundry, Etc.
EE	Shopping for Food
FF	Other Shopping & Errands
GG	Heavy Cleaning
HH	Respiration
I I	Bowel & Bladder Care
JJ	Feeding
KK	Routine Bed Baths
LL	Dressing
MM	Menstrual Care
NN	Ambulation
OO	Moving in and out of Bed (Transfer)
PP	Bathing, Oral Hygiene, Grooming
QQ	Rubbing Skin, Repositioning, Etc.
RR	Care and Assistance with Prosthesis
SS	Accompaniment to Medical App't.
TT	Accompaniment to Alt. Resources
UU	Remove Grass, Weeds, Rubbish
VV	Remove Ice, Snow
WW	Protective Supervision
XX	Teaching & Demonstration
YY	Paramedical Services
ZZ	Meal Allowance

Services Not Affected by HTGs

Hourly Task Guidelines

The regulations were implemented for cases after September 1, 2006 for all assessments and reassessments.

Line	SERVICES
AA	Domestic Services
BB	Preparation of Meals
CC	Meal Clean Up
DD	Routine Laundry, Etc.
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FF	Other Shopping & Errands
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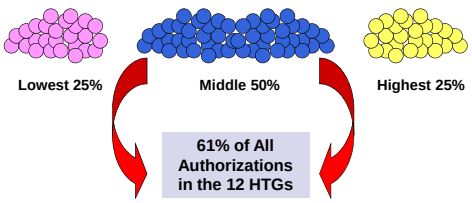
HTG Development Process

Time Ranges

- Range needed to reflect the norm
- Process
  - Standards reviewed from other states
  - Interviews with providers and consumers
- CMIPS data most reliable
  - Total Needs of all 360,000 active consumers
  - Interquartile statistical measurement used

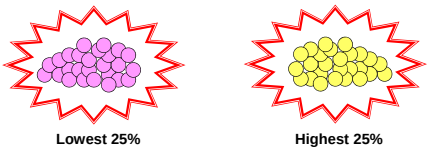
HTG Development – Time Ranges

The **Interquartile** is the central half of the values when arraying all values in order from the smallest to the largest.



HTG Development – Time Ranges

Those outside the range represent unusual or extra ordinary cases…



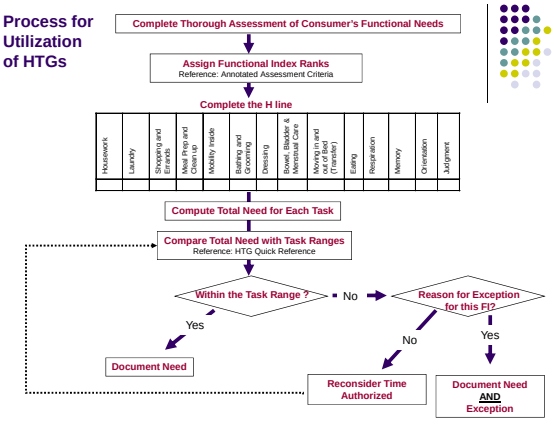
Lowest 25%

Highest 25%

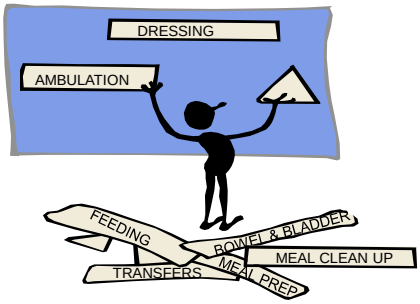
HTG Core Elements

- Do not replace the individualized assessment process.
- HTG ranges relate to the consumer's FI.
- No individual can have a range of time applied unless the time range meets his/her needs.
- When individual assessment indicates a need for time different than the HTG range, the different amount of time (exception) shall be authorized up to the allowable program limits (195/283 caps).
- The need for the authorized service level shall be documented in the case file.

Process for Utilization of HTGs



Exercise: Category Definitions



Bowel and Bladder Care

"Bowel and bladder" care does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program, or colostomy irrigation. These tasks are assessed as **"paramedical services"** specified at Section 30-757.19.

Meal Cleanup

Does not include **general** cleaning of the refrigerator, stove/oven, or counters and sinks. These services are assessed under **"domestic services"** in Section 30-757.11.

Meal Cleanup

- For meal cleanup, a recipient who has been determined able to wash breakfast/lunch dishes and utensils and only needs the provider to cleanup after dinner would require time based on the provider performing cleanup of the dinner meal only.
- A recipient who has less control of utensils and/or spills food frequently may require more time to cleanup.

Feeding

- "Feeding" tasks include assistance with reaching for, picking up, and grasping utensils and washing/drying hands before and after feeding.
- "Feeding" tasks do not include cutting food into bite-sized pieces or pureeing food, as these tasks are assessed in "preparation of meals" services specified at Section 30-757.131.

Bathing, Oral Hygiene, and Grooming

"Bathing, oral hygiene, and grooming" does not include getting to and from the bathroom. These tasks are assessed as mobility under **"ambulation"** services specified at Section 30-757.14(k).

Repositioning and Rubbing Skin *does not include:*

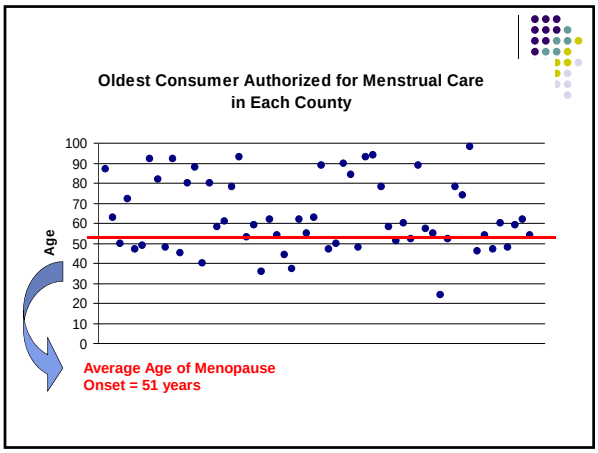
- Care of pressure sores (skin and wound care). This task is assessed as a part of "paramedical" services specified at Section 30-757.19.
- Ultra violet treatment (set up and monitor equipment) for pressure sores and/or application of medicated creams to the skin. These tasks are assessed as a part of "assistance with prosthetic devices" specified at Section 30-757.14(i).

Transfer *does not include:*

- Assistance on/off toilet. This task is assessed as a part of "bowel and bladder" care specified at Section 30-757.14(a).
- Changing the recipient's position to prevent skin breakdown and to promote circulation. This task is assessed as a part of "repositioning and rubbing skin" specified at Section 30-757.14(g).

Menstrual Care

- In assessing "menstrual" care, it may be necessary to assess additional time in other service categories specified in this section, such as "laundry," "dressing," "domestic," or "bathing, oral hygiene, and grooming."
- In assessing "menstrual" care, if the recipient wears diapers, time for menstrual care should not be necessary. This time would be assessed as a part of "bowel and bladder" care.



Use of Guidelines

- Functional Index ranking should be a key contributing factor, but not the only factor in determining amount of time per task.
- Services provided are subject to time guidelines unless the consumer's needs require an exception to the guideline.

HTG Exceptions

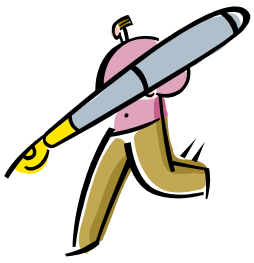
- Assessed needs for services are outside of the HTGs.
- Result – consumer receiving more or less time.
- Because assessed needs are individualized, exceptions are **expected**.

HTG Exceptions

- Exceptions cannot be made due to inefficiency or incompetence of the provider.
- All exceptions must be documented in the case file.

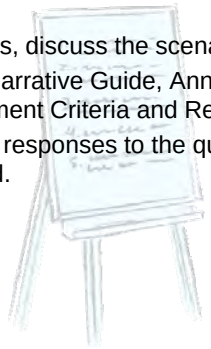
HTG Exceptions

- *Document in a way that clarifies the need*
- *State **why** more or less time is necessary for **both** safety **and** maintenance of independence*



Exercise: Documenting Needs

- In groups, discuss the scenarios.
- Utilize Narrative Guide, Annotated Assessment Criteria and Regulations.
- Prepare responses to the questions provided.



Variable Assessment Intervals

Variable Assessment Intervals: 18-Month Option

- Does not apply to IHSS Plus Option cases.
- County may extend the time for reassessment for up to 6 months beyond the 12-month period.
- This should be done only on a case-by-case basis.
- Reason for extension must be documented.

Variable Assessment Intervals: Less than 12 Months

- Need for supportive services is expected to decrease in less than 12 months.
- At intake, consumer has a condition that is likely to improve over time.
- Consumer has surgery or an acute medical condition.
- Anticipated changes in living situation.
- Unsure of stability of situation.

Universal Precautions

MPP 30-757-.(A)1

- Protective practices necessary to ensure safety and prevent the spread of infectious diseases.
- Should be used by anyone providing service which may include contact with blood or body fluids.
- Should include protective barriers such as gloves or facemask.

Infectious Diseases

- Blood-borne:
  - HIV
  - Hepatitis B, Hepatitis C
  - Other blood-borne pathogens (bacteria and viruses that can cause disease in humans)
- Skin / Wound
  - Staph and Methicillin-resistant *Staphylococcus Aureus* (MRSA)
- Fecal
  - Hepatitis A
  - Parasites
  - Bacterial Dysentery

How Germs or Pathogens Can Enter the Body

- Open sores
- Abrasions
- Acne
- Cuts and burns
- Damaged or broken skin such as sunburn or blisters
- Dry, chapped, cracked or peeling hands
- Cat scratches and scrapes
- Open or torn hangnails
- Mucus membranes
- Sexually transmitted

Barriers Should Be Used For Protection . . .

- Gloves
- Protective outer layer
- Mask
- Resuscitation bags
- Sharps disposal

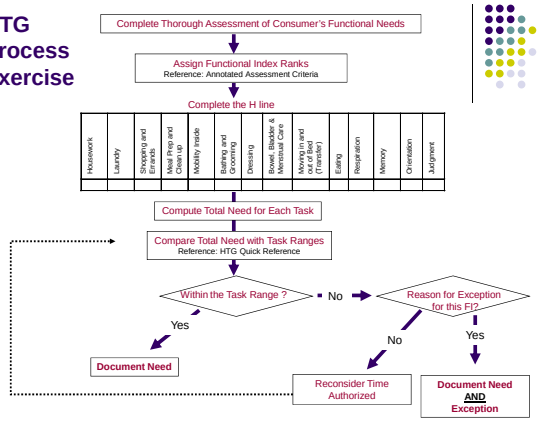
Universal Precautions and Clean Techniques

should be applied to…

all body fluids

of all consumers!

HTG Process Exercise



HTG Process Exercise

HTG Process Exercise

- Identify reasons for FI ranking given
- Identify service hours and exceptions
- Give clear indication of REASON for exception (↑ or ↓ HTG) for a consumer with this FI

Service Category FI	Hours	Exception? Y / N
1.		
2.		
3.		
4.		


Thanks For Your
Participation!

HTG DEVELOPMENT PROCESS

Statutory Basis

SB 1104 mandates CDSS to create Hourly Task Guidelines:

SEC. 43. Section 12301.2 is added to the Welfare and Institutions Code, to read:
12301.2. (a) (1) The department, in consultation and coordination with county welfare departments and in accordance with Section 12305.72, shall establish and implement statewide hourly task guidelines and instructions to provide counties with a standard tool for consistently and accurately assessing service needs and authorizing service hours to meet those needs.
(2) The guidelines shall specify a range of time normally required for each supportive service task necessary to ensure the health, safety, and independence of the recipient. The guidelines shall also provide criteria to assist county workers to determine when an individual's service need falls outside the range of time provided in the guidelines.
(3) In establishing the guidelines the department shall consider, among other factors, adherence to universal precautions, existing utilization patterns and outcomes associated with different levels of utilization, and the need to avoid cost shifting to other government program services. During the development of the guidelines the department may seek advice from health professionals such as public health nurses or physical or occupational therapists.
(b) A county shall use the statewide hourly task guidelines when conducting an individual assessment or reassessment of an individual's need for supportive services.
(c) Subject to the limits imposed by Section 12303.4, counties shall approve an amount of time different from the guideline amount whenever the individual assessment indicates that the recipient's needs require an amount of time that is outside the range provided for in the guidelines. Whenever task times outside the range provided in the guidelines are authorized, the county shall document the need for the authorized service level.
(d) The department shall adopt regulations to implement this section by June 30, 2006. The department shall seek input from the entities listed in Section 12305.72 when developing the regulations.

12305.72. The department shall convene periodic meetings in which supportive services recipients, providers, advocates, IHSS provider representatives, organizations representing recipients, counties, public authorities, nonprofit consortia, and other interested stakeholders may receive information and have the opportunity to provide input to the department regarding the quality assurance, program integrity, and program consistency efforts required by Sections 12305.7 and 12305.71. The program development activities that shall be covered in these meetings shall include, but are not limited to:
...
(b) Development and implementation of statewide hourly supportive services task guidelines as provided in Section 12301.2.

Tasks

CDSS met with County representatives, consumers, providers, advocates, public authority representatives, and other interested parties. The group evaluated the 25 IHSS tasks and ruled out the tasks that were not amenable to task guidelines. Specifically, the four tasks of *Domestic*, *Laundry*, *Shopping* and *Errands* were excluded from the implementation efforts because Time Task guidelines already exist for those tasks. *Heavy Cleaning* was excluded because it's a task that, when authorized, is only authorized for one month and because the need is more a function of the degree of dirt that needs to be cleaned and clutter that needs to be removed. *Respiration* was excluded because it covers many

functions and there is great variability of the need for this assistance, based on the kinds and frequency of assistance. The two tasks of *Medical Accompaniment* and *Accompaniment to Alternative Resources* were excluded because the needed time is a function of distance from consumers' homes to health care practitioners. More remote counties are likely to need to authorize more time. The two tasks of *Removal of Grass and Weeds* and *Snow Removal* are rarely authorized and, when appropriate, are reflective of the environment, so they are not good candidates for guidelines. Guidelines were not developed for *Teaching and Demonstration* because, if authorized, it covers one of many tasks. *Protective Supervision* was excluded because, by definition, the need is 168 hours per week (24 hours per day, 7 days a week). *Paramedical Services* were excluded because the authorization based on the time and frequency specified by the doctor who completes the SOC 321 Paramedical Authorization form.

Hourly Task Guidelines were developed for the remaining twelve tasks (the letters in front of the tasks are the letters of the fields on the SOC 293, Service Authorization grid where staff authorize services:

- BB Meal Preparation
- CC Meal Cleanup
- II Bowel and Bladder
- JJ Feeding
- KK Bed Baths
- LL Dressing
- MM Menstrual Care
- NN Ambulation
- OO Transfer
- PP Bathing
- QQ Rubbing Skin and Repositioning
- RR Care and Assistance with Prosthesis and Self Administration of Medications

Task Tool

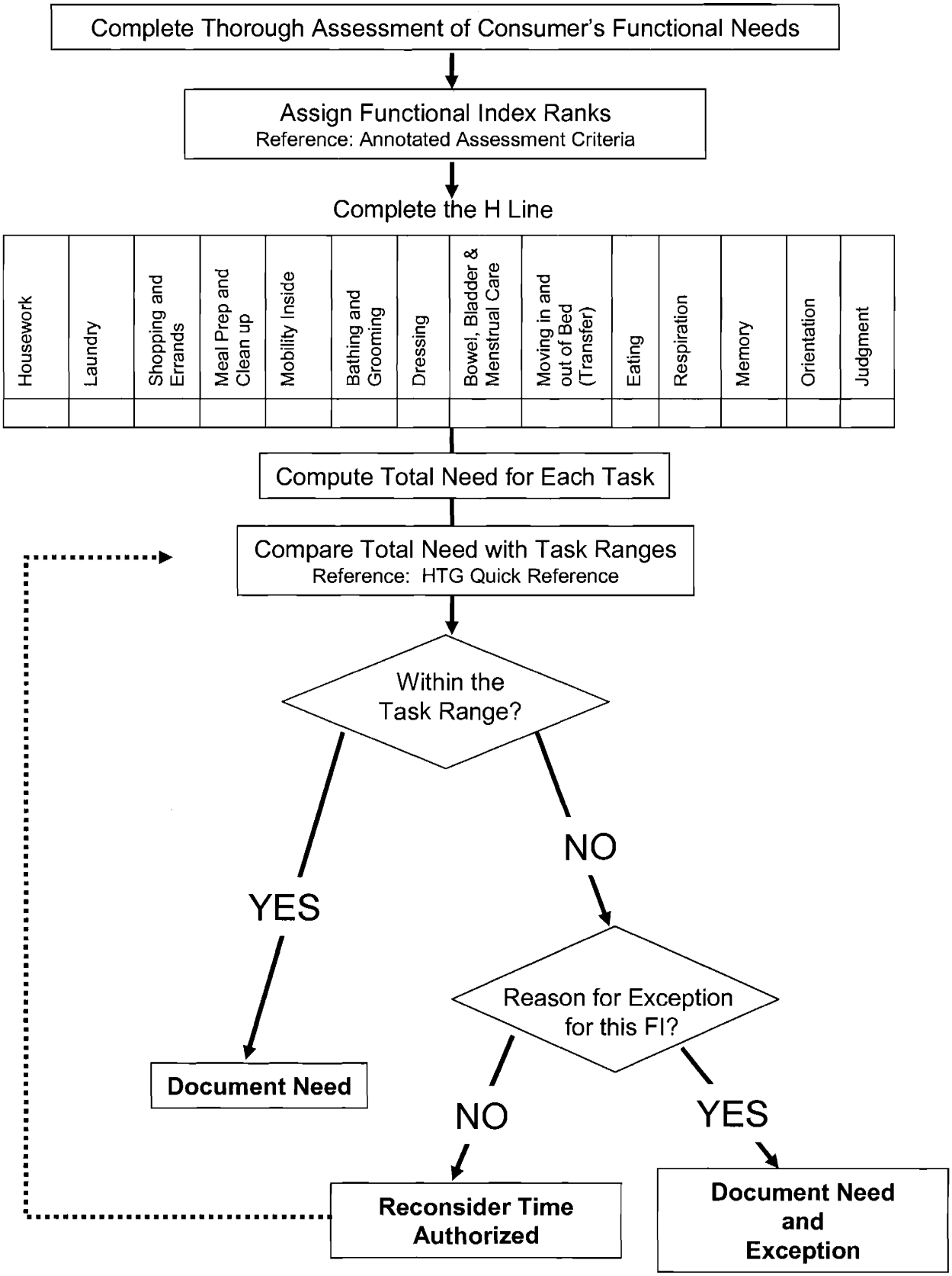
The County Welfare Directors Association coordinated efforts to develop the Task Tool. IHSS staff of many counties throughout the State participated in efforts to clarify task definitions and task components. The first step in assuring statewide uniformity is to assure that all workers throughout the State are defining tasks consistently. Current regulations contain overlap of tasks. For example, getting to and from the bathroom for the task of *Bowel and Bladder* is currently listed both within the task of *Bowel and Bladder* and *Ambulation*. It was moved to *Ambulation*. Wheelchair maintenance and battery charging is part of *Domestic* in the PCSP regulations, but is not mentioned in the IHSS regulations; many staff have been authorizing that assistance as part of *Care and Assistance with Prosthesis*. It is being moved into *Domestic*. *Bowel and Bladder* was revised to clarify the portions of the task that are Paramedical. The definition of *Bed Bath* was revised to include all sponge bathing because there is no reason to separate the task, assigning it to *Bathing* when done in a chair or other site, retaining *Bed Bath* for that function performed in a bed. *Rubbing Skin and Repositioning* was revised, moving getting on and off seats and wheelchairs to *Transferring.*

HTG Time Ranges

Statute required that the HTG be a range of time that reflects the normal amount of time to complete the tasks. Standards from all 50 states were reviewed; none were applicable to California's efforts because only 11 states had guidelines and none of those that did was as generous as California's. There were two series of intensive interviews with consumers and providers: one was conducted by Public Authorities and the other by CDSS and County staff. None of these efforts gave useful information for building

HTGs. The conclusion was that the only reliable information that in developing the HTGs was CMIPS data. The Total Needs of all 360,000 active consumers statewide were used. Many statistical tests were applied to CMIPS data. Many of the standard statistical tests could not be used in determining data trends because authorizations are not statistically "normal." By that we mean that if the authorization hours were graphed by frequency of authorization, it's not a bell-shaped curve. The best statistical measurement that reflects the most common values when data is skewed in the way CMIPS data is is the Interquartile. The Interquartile is the central half of the values when arraying all values in order from the smallest to the largest. Half of the values are below and half are above the central value. Because some values occur frequently, the Interquartile includes 61% of all authorizations in the 12 HTG tasks.

Utilization of HTGs – Process



2006 CHANGES TO CATEGORIES

ACTIVITY	CATEGORY	
	PREVIOUS	***CURRENT***
Moving to and from bathroom	Bowel and Bladder **AND** Ambulation	Ambulation
Wheelchair maintenance and battery charging	PCSP – Domestic *often* Care and Assistance with Prosthesis	Domestic
Getting on and off seats and wheelchairs	Rubbing Skin and Repositioning	Transfer
Getting in and out of vehicles	Rubbing Skin and Repositioning	Ambulation
Sponge bathing in chair	Bathing	Bed Baths

Other Changes:

- All Sponge Bathing is now under Bed Baths.
- Bowel and Bladder has been revised to clarify the portions of the task that are Paramedical.

VARIABLE ASSESSMENTS

Overview of Criteria for Extension of 6 Months

[MPP 30-761.215(a – h); MPP 30-761.216]

Recipient must meet the following criteria:

- ❑ At least 1 reassessment since the initial intake
- ❑ No change in living arrangements since last annual assessment
  - Must live with others *or* have regular meaningful contact with persons interested in his/her well being that are not the provider
- ❑ Able to satisfactorily direct his/her care
  - If minor this would be by his/her parent or legal guardian; or if incompetent, this would by his/her conservator
- ❑ No known change in supportive services needs in previous 24 months
- ❑ No reports to, or involvements of, an APS agency or other agencies responsible for addressing the health and safety of individuals documented in the case record since the last assessment
- ❑ No change in provider(s) in last 6 months
- ❑ No reported change in supportive services needs that require reassessment
- ❑ No hospitalization in previous 3 months

If some, but not all, are met:

- ❑ There is involvement of SW CM such as MSSP, regional center, county mental health.
- ❑ Health care professional states in writing that the recipient's medical condition is not likely to change.

In Home Supportive Services
VARIABLE ASSESSMENT CHECKLIST

Client Name:_____ Case #:_____

Original Assessment Date: _____ Assessment Extension Date:_____

Criteria	Initials
Client does **not** receive any of the following: *Advance Pay, Restaurant Meal Allowance, Parent Provider, Spouse Provider* *Source: Client file*	
Client has had at least one face-to-face reassessment since the initial program intake assessment. *Source: Client file*	
Client's living arrangement has not changed since the last annual reassessment **and** the client lives with others or has regular meaningful contact with other people other than the client's IHSS/PCSP provider. *Source: Client report/Client file*	
Client, parent or legal guardian (if minor), or conservator is able to satisfactorily direct the client's care. *Source: Social Worker determination*	
There has been no change in the client's supportive service needs within the previous 24 months. *Source: SOC 293*	
No reports have been made to and there has been no involvement of Adult Protective Services since the county last assessed the client. *Source: APS Database search*	
Client has had the same provider(s) for six months. *Source: CMIPS search/Client file*	
Client has not reported a change in his or her need for supportive services that requires a reassessment and did not indicate any opposition to extending the assessment interval for an additional 6 months. *Source: Client report*	
Client has not been hospitalized within the last three months. *Source: Client report*	
A phone call to the client has been documented in the comment sheet.	

If the client doesn't meet all of the above criteria but the social worker determines that an extended assessment interval is appropriate, please indicate the factors that justify extending the assessment:_____

_____

_____

If all of the above criteria are met and the social worker determines that it is appropriate to extend the reassessment from 12 months to 18 months, the case file and this checklist should be submitted to a supervisor for review.	
Social Worker Signature:	Date:
Supervisor Signature:	Date:

In Home Supportive Services
VARIABLE ASSESSMENT CHECKLIST
Procedure

Purpose

To identify the criteria used to assess those IHSS clients that are eligible to have their annual renewal visit extended from 12 months to 18 months.

Procedure

1. The Social Worker will review the renewals for a given month prior to the month they are due.

2. The Social Worker will identify those clients that appear to meet the Variable Assessment Criteria.

3. The Social Worker will complete a Variable Assessment Checklist on the clients that were identified.

4. For those clients that do not meet all of the criteria, the social worker will discard the Variable Assessment Checklist and proceed with scheduling the renewal. *(EXCEPTION: If the client doesn't meet all of the criteria, but the social worker determines that an assessment extension would be appropriate, the checklist may be submitted to the supervisor for further consideration.)*

5. If the client does meet all of the criteria, the social worker will submit the Variable Assessment Checklist with the client file for approval to extend the renewal date to 18 months. **(This must be approved by the supervisor no later than the 15th of the month for which the renewal is currently due.)**

6. If the supervisor approves the extension, the case file will be given back to the social worker. The original of the signed Variable Assessment Checklist will be filed in the case file.

7. The SW will modify the SOC 293 to reflect the new assessment end date. County Use only section will state "6 MO RENEW" to indicate this is a variable assessment. White copy of SOC 293 will be sent to payroll.

8. The assessment date in CMIPS will be modified by Payroll to reflect the new assessment date indicated on the SOC 293.

9. The completed Variable Assessment Checklist will be filed on the top left section of the chart during the extended assessment period. When the extended renewal date arrives, the Variable Assessment Checklist will be filed on the bottom right section of the chart.

HEPATITIS FACTS

Hepatitis A

Hepatitis A is one of the most common strains of Hepatitis, and is found in the feces of an infected person. It is spread as a result of poor personal hygiene and/or proper sanitation. One can become contract the Hepatitis A by eating food that has been prepared by one infected with the virus or by drinking Hepatitis A contaminated water. One can also contract Hepatitis A through close physical contact (i.e. sexual intercourse). Although some people do not experience symptoms, things to look out for are:

· A High Fever
· Nausea
· Fatigue
· Jaundice or Yellowing of Eyes and Skin
· Loss of Appetite
· Diarrhea
· Abdominal Pain
· Dark Urine

Symptoms usually last around six weeks, although there are those who remain ill for up to six months. A blood test should be taken to know for sure if one is infected. Hepatitis A has an average incubation period of 28 days.

A combination vaccine for prevention of both Hepatitis A and B is now available to the public for those aged 18 years or older (Twinrix). Otherwise, a Hepatitis A vaccine may be administered, or for short-term protection, an immune globulin injection may be given.

Hepatitis B

Hepatitis B is contracted through direct contact with infected blood or bodily fluids of an infected person. The routes of transmission are quite similar to those of Hepatitis C, EXCEPT for the fact that one can also contract Hepatitis B through sexual intercourse as well as by sharing needles, razors, and toothbrushes. Sadly, an infant can also contract the virus during childbirth from an infected mother. Hepatitis B is not spread through food, water, or casual contact. The symptoms of Hepatitis B Virus include:

· Loss of Appetite
· Jaundice or Yellowing of Eyes or Skin
· Nausea, Vomiting, Fever, Stomach and/or Joint Pain
· Extreme Fatigue

There are people with Hepatitis B who experience no symptoms at all. A blood test is the only concrete evidence of infection.

Once infected with Hepatitis B, there is no immediate cure. Treatment for Hepatitis B is used for chronic infection, and usually involves interferon injections combined with oral anti-viral medication; Lamivudine, Dipivoxil, and Adefovir are the names of some of the medications used. Treatment usually lasts anywhere from 16 to 48 weeks. Unfortunately, those with Hepatitis B virus will always be carriers of the virus.

Hepatitis C

Hepatitis C is a blood borne virus that attacks liver cells. The virus is contracted through contact with infected blood and has an incubation period of anywhere from 10 to 30 years. Routes of transmission include:

· Blood Transfusions
· IV Drug Use
· Sharing Razors or Toothbrushes
· Tattoos and body Piercings.

Hepatitis C was identified in 1989, and in 1990 a Hepatitis C antibody test became commercially available. Rarely do infected patients experience acute symptoms from Hepatitis C, but instead suffer from other ailments related to the disease such as:

· Extreme Fatigue,
· Mental Cloudiness,
· Digestive Problems and Loss of Appetite.

As the disease progresses, it can lead to various levels of fibrosis (scar tissue), then cirrhosis of the liver, and over time liver cancer. There is as of yet, no known vaccine nor cure. The treatments for Hepatitis C include injections of a synthetic form of interferon (a protein that helps the body's cells resist the virus), usually accompanied by Ribavirn, an anti-viral pill. Most experience debilitating side effects. Chinese medicine, including acupuncture and herbal remedies, is often used to treat Hepatitis C. Some patients even integrate both Eastern and Western therapies. Approximately 20% of patients with chronic Hepatitis C will die from liver failure due to advanced liver disease. Others will be forced to undergo a liver transplant. Still, many others, if they take proper care of themselves, can live out a normal life span.

http://www.silenceisdeadly.com/

HEPATITIS B FREQUENTLY ASKED QUESTIONS

What is hepatitis B?
Hepatitis B is caused by a virus that attacks the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

How do you know if you have hepatitis B?
Only a blood test can tell for sure.

How is HBV spread?
HBV is spread when blood from an infected person enters the body of a person who is not infected. For example, HBV is spread through having sex with an infected person without using a condom (the efficacy of latex condoms in preventing infection with HBV is unknown, but their proper use might reduce transmission), by sharing drugs, needles, or "works" when "shooting" drugs, through needlesticks or sharps exposures on the job, or from an infected mother to her baby during birth.

Hepatitis B is not spread through food or water, sharing eating utensils, breastfeeding, hugging, kissing, coughing, sneezing or by casual contact.

How long does it take for a blood test, such as HBsAg, to be positive after exposure to hepatitis B virus?
HBsAg will be detected in an infected person's blood on the average of 4 weeks (range 1-9 weeks) after exposure to the virus. About 1 out of 2 patients will no longer be infectious by 7 weeks after onset of symptoms and all patients, who do not remain chronically infected, will be HBsAg-negative by 15 weeks after onset of symptoms.

If a person has symptoms, how long does it take for symptoms to occur after exposure to hepatitis B virus?
If symptoms occur, they occur on the average of 12 weeks (range 9-21 weeks) after exposure to hepatitis B virus. Symptoms occur in about 70% of patients. Symptoms are more likely to occur in adults than in children.

What are the symptoms of hepatitis B?
Sometimes a person with HBV infection has no symptoms at all. The older you are, the more apt you are to have symptoms. You might be infected with HBV (and be spreading the virus) and not know it.

If you have symptoms, they might include:

- yellow skin or yellowing of the whites of your eyes (jaundice)
- tiredness
- loss of appetite
- nausea
- abdominal discomfort
- dark urine
- clay-colored bowel movements
- joint pain

What are the risk factors for hepatitis B?
You are at increased risk of HBV infection if you:

- have sex with someone infected with HBV
- have sex with more than one partner
- shoot drugs
- are a man and have sex with a man
- live in the same house with someone who has chronic (long-term) HBV infection
- have a job that involves contact with human blood
- are a client in a home for the developmentally disabled
- have hemophilia
- travel to areas where hepatitis B is common (country listing)

One out of 20 people in the United States will get infected with HBV some time during their lives. Your risk is higher if your parents were born in Southeast Asia, Africa, the Amazon Basin in South America, the Pacific Islands, or the Middle East.

Is there a cure for hepatitis B?
There are no medications available for recently acquired (acute) HBV infection. Hepatitis B vaccine is available for the prevention of HBV infection. There are antiviral drugs available for the treatment of chronic HBV infection.

How common is HBV infection in the U.S.?
In 2003, an estimated 73,000 people were infected with HBV. People of all ages get hepatitis B and about 5,000 die per year of sickness caused by HBV.

If you are pregnant, should you worry about hepatitis B?
Yes, you should get a blood test to check for HBV infection early in your pregnancy. This test is called hepatitis B surface antigen (HBsAg). If you test HBsAg-negative early in pregnancy, but continue behaviors that put you at risk for HBV infection (e.g., multiple sex partners, injection drug use), you should be retested for HBsAg close to delivery. If your HBsAg test is positive, this means you are infected with HBV and can give the virus to your baby. Babies who get HBV at birth might develop chronic HBV infection that can lead to cirrhosis of the liver or liver cancer.

If your blood test is positive, your baby should receive the first dose of hepatitis B vaccine, along with another shot, hepatitis B immune globulin (called HBIG), at birth. The second dose of vaccine should be given at aged 1-2 months and the third dose at aged 6 months (but not before aged 24 weeks).

Can I donate blood if I have had any type of viral hepatitis?
If you had any type of viral hepatitis since aged 11 years, you are not eligible to donate blood. In addition, if you ever tested positive for hepatitis B or hepatitis C, at any age, you are not eligible to donate, even if you were never sick or jaundiced from the infection.

How long can HBV survive outside the body?
HBV can survive outside the body at least 7 days and still be capable of causing infection.

What do you use to remove HBV from environmental surfaces?
You should clean up any blood spills - including dried blood, which can still be infectious - using 1:10 dilution of one part household bleach to 10 parts of water for disinfecting the area. Use gloves when cleaning up any blood spills.

http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm#general

HIV FACTS

HIV Facts is a comprehensive online resource for information about the Human Immunodeficiency Virus.

We offer information on dozens of topics including The immune system, Transmission and spread of HIV, HIV Testing, Books, Community Dicussions and much more.

Introduction

The human immunodeficiency virus (HIV) is a frequently mutating retrovirus that attacks the human immune system and which has been shown to cause acquired immune deficiency syndrome (AIDS).

HIV was discovered and identified as the agent for AIDS by Luc Montagnier of France.

A minority of scientists continue to question the connection between HIV and AIDS and even the very existence of HIV.

As of 27 November 2003, there were an estimated 54,862,417 worldwide HIV infections, 30% of which were in Southern Africa.

HIV causes disease by infecting the CD4+ T cells. These are a subset of leukocytes (white blood cells) that normally coordinate the immune response to infection. By using CD4+ T cells to replicate itself, HIV spreads throughout the body and at the same time depletes the very cells that the body needs to fight the virus.

Once an HIV-positive individual's CD4+ T cell count has decreased to a certain threshold, they are prone to a range of diseases that the body can normally control. These opportunistic infections are usually the cause of death.

There are several reasons why HIV is so hard to fight. First, the virus is an RNA virus, using the reverse transcriptase enzyme to convert its RNA into DNA.

During that process there is a large chance of mutation.

Therefore, the virus becomes quickly resistant to therapy. Second, the common notion that HIV is a killer feasting on T cells is not true.

If HIV were a killer virus, it would have died out soon because there would be too little time for new infections. Now, HIV stays in the body for years, infecting people through unsafe sex, blood transfusions and breastfeeding of infants while the patient sometimes doesn't know.

HIV can survive even when drugs eliminate all detectable virons in the blood. It integrates itself into the DNA of the host cell and can stay there for years, lying dormant, immune to all kinds of therapy because it is just DNA.

When the cell divides and the DNA is copied, the virus is copied too. After years, the virus can become active again, seize the cell's machinery and replicate.

In recent years, the notion that the CD4+ T cells decrease because of direct HIV infection has become doubted as well. The HIV coating protein readily detaches from virus particles.

The blood becomes filled with these proteins, which can stick to the CD4+ T cells, gluing them together. In addition, they are recognized by the immune system, causing the immune cells to attack their own CD4+ cells. In summary, HIV is a guerrilla terrorist, keeping low and seeking shelter when threatened, but always ready to hit where it hurts.

Transmission and Spread

HIV infection is spread through the exchange of infected blood, semen, vaginal fluid, and breast milk. Other fluids, such as cerebral spinal fluid, can also transmit the virus. But the average person does not come in contact with cerebral spinal fluid.

HIV is a blood-borne pathogen (something that causes disease), which means it needs blood to survive. HIV dies quickly on contact with air) The body fluids that can carry the virus all have blood in them. More specifically, they have white blood cells (CD4 cells) in them. Vaginal fluid may contain white blood cells from vaginal infections.

White blood cells are the cells that become infected with HIV, so the more white blood cells in the fluid, the more risky the fluid is for transmission. These fluids can be placed in risk order based on the amount of white blood cells they contain. From most risky to least risky, the order is blood, semen, vaginal fluid, and breast milk.

Intact skin is an excellent barrier to HIV infection. HIV infected blood, however, does have the potential of getting into an open cut or sore of another person. This has rarely occurred, but the potential is there.

For this reason, it is important to always follow universal precautions.

Other body fluids that do not have blood in them do not spread HIV You cannot get HIV from tears, sweat, urine, feces, saliva, mucus, vomit, or earwax.

Some of these fluids may carry other diseases, but not HIV If, however, these fluids do have visible blood in them, they can be infectious from unkilled HIV or other diseases.

The Centers for Disease Control and Prevention (CDC) have established a simple rule for urine, vomit, or other fluids: If you can see blood (red) in it, treat it as if it were blood, and infected. If you cannot see red, the amount of blood is too small to be of real concern for HIV But remember, you can get other diseases from these fluids.

Therefore always follow universal precautions. Use gloves for cleaning of blood, urine, or feces and disinfect floors or furniture with a 1 to 10 solution of bleach (or Lysol spray on fabric that would be stained by bleach). Never put dirty hands in your mouth or eyes. After you take off the gloves, wash your hands with warm water and soap.

How HIV Is Not Spread

You do not catch HIV the way you catch a cold or the flu. HIV is not spread from hugging, kissing, shaking hands, dancing, sharing food, drinking from a fountain, sitting on a toilet seat, or swimming in a pool or hot tub. You cannot get it in a restaurant, even if the waitress or cook is infected. You do not get HIV from someone coughing, sneezing, or spitting on you.

Touching

You do not get HIV from massage, tickling, or other contact with healthy skin. The skin is an excellent barrier for germs, including HIV. Any exposure to HIV on the skin is destroyed by exposure to air or mild disinfectants, such as soap and warm water, or other mild cleansers.

Kissing

As far as we know, no one has ever gotten HIV from kissing. Theoretically you could get HIV from French-kissing (open-mouth, deep, or tongue kissing) someone who is HIV infected. Here, both people would have to have open sores on their mouth, lips, or gums. Blood from the bleeding infected person would have to get into the mouth sores of the other person.

Regular kissing is not a risk, even if saliva is exchanged. Saliva is a poor transmitter of HIV It does not contain white blood cells, and it has a natural antibiotic substance that kills HIV Any HIV found in saliva is few in number and short lived.

Researchers agree that kissing poses a very small risk. Scientists from the National Institute of Dental Research (NIDR) have discovered the protein believed to be responsible for saliva's anti-HIV properties. It is called secretory leukocyte protease inhibitor, or SLPI (pronounced "slippy").

SLPI works by interacting with white blood cells, not HIV Although researchers aren't sure how, SLPI seems to keep HIV out. They hope this may help them find a way of protecting people exposed to HIV infected blood.

Giving Blood

You cannot get HIV from giving blood. When you donate blood, a brand new needle is used to take the blood. The needle is destroyed when you are finished giving blood. You are a blood donor, not a blood recipient, so you're not getting blood or any germs from another person. Don't be afraid to give blood. It is an important way to help others.

Mosquitoes

You cannot get HIV from mosquitoes. When you are bitten by a mosquito, you are a blood donor, not a blood recipient. What happens when a mosquito bites you? It lands on your skin and sticks its mouth into your skin. It regurgitates saliva into your skin to keep your blood from coagulating. This is what makes your skin itch after the bite. Then the mosquito sucks blood out.

This blood goes into its stomach, where it is digested. When the mosquito is hungry again, the process is repeated. No blood from the first person gets into you. You cannot get HIV from other biting or stinging insects such as fleas, lice, or flies.

How HIV Is Spread

HIV is spread in three ways: from the exchange of infected fluids during sexual intercourse, from an infected mother to her child, and from the sharing of infected needles.

Sexual Transmission

The primary way HIV is transmitted throughout the world is through sexual contact. Through June 1996, 59 percent of Americans who were diagnosed with AIDS contracted the disease from having sex with an infected person.

Among adolescents and young adults (13-24), through June 1996, 67 percent who were diagnosed with AIDS contracted the disease from having sex with an infected person. An addition al 11 percent of the cases had multiple risks, including sex.

There are three types of sexual intercourse: oral, vaginal, and anal. HIV can be transmitted during sexual intercourse if the virus in the blood, semen, or vaginal fluid of the infected person comes in contact with and gets into the body of the other person.

Blood includes menstrual blood, blood from cuts or sores, and bleeding from rough sex. Anal sex is particularly dangerous because it can easily cause rectal bleeding. Here, feces might be infected because of the infected blood they contain. Semen, a mixture of sperm and male sexual fluids, is released when a man ejaculates, or comes.

A drop of this fluid often comes out of the penis when a man is sexually aroused, or turned on. Even this pre-ejaculatory fluid can contain the virus in an infected male. Vaginal fluid is produced by glands inside the vagina and keeps the tissues moist and lubricated during sex. It can carry HIV in an infected woman.

Transmission takes place when these infected body fluids find an opening in the skin. If white blood cells carrying the virus from these fluids get into those openings, the person becomes infected.

Openings do not necessarily mean cuts or tears in the skin. Moist tissue in body openings, like the vaginal canal, the urinary opening at the tip of the penis, the rectum, or even the moist tissue inside the eye or at the back of the throat has microscopic openings for the virus to get in. Actually, the anus, urethra, vaginal canal, and back of the throat have columnar epithelial tissue, to which the virus binds. This is why mucous membranes are considered a problem for transmission.

When there are open sores or rashes on the penis or vagina, finding an entrance into the body is even easier for the virus.

For these reasons, all forms of sexual intercourse with an infected partner can place a person at risk for HIV infection.

The risks, however, are not equal. We can rank order the risk.

From high to low they are anal, vaginal, then oral intercourse. Anal intercourse is the riskiest form of intercourse.

It involves the male placing his penis in the rectum of his partner. Anal sex is practiced by both heterosexual (opposite sex) and homosexual (same sex) couples. Anal intercourse is risky for two reasons. First, the rectum was not designed for sexual intercourse. It does not stretch like the vaginal canal.

It is, therefore, susceptible to tearing and bleeding. These tears provide a natural opening for the virus to get in. In addition, the large intestine is a nonsterile environment. To prevent this nonsterile environment from infecting the body, the intestine contains a layer of white blood cells to fight off infection. These white blood cells are the very CD4 cells that pick up HIV These cells then transport the virus into the body. This can happen even if there is no tearing and bleeding during anal intercourse.

Vaginal intercourse with an infected person is a definite risk. This is the most common form of sexual intercourse. The man puts his penis inside the vagina of the woman. Semen coming out of the man's penis or vaginal fluid produced by the woman can carry HIV Even when there are no irritations or breaks in the vaginal wall, microscopic openings in the mucous membrane and the lining of epithelial cells can allow the virus into the body. The virus can also infect men through the urethra of the penis.

Oral intercourse is the least risky form of intercourse for HIV transmission. Also known as oral-genital sex, it involves using the mouth or tongue to stimulate the other person's sex organs. Both heterosexual and homosexual males and females practice this form of intercourse. The risk of HIV infection is low from oral sex for two reasons.

First there is a large amount of saliva in the mouth. The antibiotic action of the saliva helps kill or inactivate HIV before it can get into the body. Second, if infected fluids (semen or vaginal fluid) are swallowed, the strong stomach acid in an adult will kill the virus. It seems that the most vulnerable spots are the columnar epithelial cells of the mucous membrane at the back of the throat or open sores in the gums or mouth. There have not been any well-documented cases of HIV transmission via the mouth, but it is not risk free. More research needs to be done in this area.

It is important to remember that both men and women are at risk. During heterosexual sex, the woman is at greater risk. This is because there are more openings in the mucous membrane of the vaginal canal than in the urethra of the penis. What is more important, semen stays in the vaginal canal for many hours providing longer exposure.

The vaginal canal and the cervix can then have more time to act as a receptor for HIV In addition, infected semen usually contains more virus than infected vaginal fluid. During intercourse the semen is deposited in the vaginal canal and remains there long enough to cause infection. Infected vaginal fluid may not stay on the penis very long.

After intercourse, when the penis is withdrawn from the vagina, it is exposed to the air that will kill any virus on the outside. HIV can remain active as long as it is moist. When infected vaginal fluid, semen, or blood is thoroughly dry, exposed to the air, HIV is no longer active.

Some partners of infected individuals have been infected after having intercourse only once. Others, in spite of repeated exposure, have not become infected. The reason for this is somewhat of a mystery, but we do have some clues.

The higher the level of virus (high viral load) in the infected person's blood, the greater the risk of infection. As with other germs, some people are more resistant than others. Research has found that tobacco, alcohol, and other drugs weaken the immune system. Use of these substances seems to make a person more susceptible.

The more often a person has intercourse and the more sexual partners a person has, the greater the chances are of becoming infected. If one partner has another sexually transmitted disease (STD), the chances of HIV transmission go up. Other STDs, such as gonorrhea or syphilis, cause sores that provide openings for the virus to get in.

Several studies have shown that uncircumcised men have a higher risk of getting HIV and transmitting it to their partners. Circumcision is the removal of the foreskin of the penis. The operation is usually done during the first week after a baby boy is born. If the foreskin has not been removed, the chances are greater that dirt, bacteria, viruses, and infection will accumulate under the foreskin. Some men even have small sores under the foreskin that provide openings for the virus to get in or out.

Sexual intercourse during a woman's period may increase the chances of transmission. Increased blood in the vaginal area can make transmission to the male easier. Openings in the vaginal canal from menstrual bleeding leave the woman with more areas for the virus to enter her body. Studies have shown that women who have HIV positive partners and use oral contraceptives are less likely to become infected. Oral contraceptives tend to thicken the cervical mucus.

This may slow the passage of infected cells in semen once they encounter the cervix. Oral contraceptives, however, are not a substitute for the barrier methods of HIV prevention, such as using condoms. Use of an intrauterine device (IUD) has been associated with an increased risk of transmission. The IUD may cause inflammation of the uterine mucosa. The inflammation causes white blood cells to pool in that area. These cells are highly susceptible to HIV infection.

Women who have sex with women are at risk of HIV infection. The level of risk depends on their sexual practices. Use of sex toys, sexual activity around the menstrual cycle, and pre-existing STDs influences the risk.

New research has shown that some people-perhaps one in 100 whites-have a mutated gene that might protect them from HIV infection. This may explain why some people have repeated risky sex and still do not become infected.

The gene controls CCR5, which normally helps CD4 act as a docking station for HIV When the gene is defective, the docking between CD4 and HIV is slowed or prevented. Some people have one defective gene (getting it from one parent) and some have two (getting them from both parents).

The effects of having only one is still unclear, but researchers believe it may make people less likely to be infected. People with two of these genes seem to get no infection. How long this protection will last is still unknown. As this research continues, it may open possibilities for treatment and prevention.

Mother-to-Child Transmission

As of July 1996, 90 percent of the pediatric cases of AIDS in the United States were diagnosed in babies born to HIV-positive mothers. The remainder were infected by other means, such as infected needles, child abuse, or infected blood products.

The World Health Organization (WHO) estimates that 5 percent to 10 percent of the current global total HIV infections were transmitted from mother to infant during pregnancy, or about 1.5 million children. These transmissions seem to occur in about 25 percent of completed pregnancies in HIV infected women.

Several studies have tried to learn or predict what pregnancy risk factors might influence transmission. Whether the mother seroconverted before or during pregnancy; birth order of twins; proximity of a lower-lying twin to the cervix; fetal position; and natural vs. cesarean birth are risk factors that have been considered. No definite conclusions have resulted from the research.

HIV has been detected in breast milk of HIV infected women. Transmission after birth has been documented in breast-fed babies of infected mothers. There is much disagreement, however, whether transmission occurs from the milk. Some research has shown that the HIV level is higher in colostrum, the milky substance secreted from the breast before and just after birth, than in breast milk.

The frequency of transmission is also under question. There is also a question of whether transmission is more likely from mothers infected before delivery as opposed to those infected after delivery.

A mathematically predictive breast-feeding study was done using the numbers of infected mothers in New York City. It predicted that if all HIV-infected mothers did not breast-feed their infants, 5 fewer babies would die, but 58 more infants would die if all the uninfected mothers did not breast-feed. This is because breast-feeding helps prevent infection and disease in children. Because of this uncertainty, many countries still encourage women to breast feed.

Transmission in Drug Users

Worldwide, injecting drug use is the second largest cause of HIV transmission. In the United States, in 1995, it was responsible for 85 percent of the cases among heterosexual men.; Sixty-six percent of the cases among women in 1995 were transmitted either by sharing needles or through sexual contact with a drug user.

Sharing needles is a high-risk activity for blood-to-blood transmission. The risk of transmission increases with the frequency of injection, frequency of using shared needles, and injecting in shooting galleries (places people go to shoot drugs and where needles are often shared).

Drug users, especially crack users, tend to also be sexually active. A crack high often produces an enhanced sexual drive, and sex is a common way to get money to buy drugs.

Therefore, crack users and other drug users-even those who do not inject needles-are at greater risk of HIV. In addition, drug and alcohol use tends to impair judgment.

This puts them at greater risk of contracting HIV from sex or just wanting to try a new drug. People can also black out from alcohol or drug use, meaning that they do not remember what they did and with whom. They have no memory of their risks. For all these reasons, having sex with a person who has used drugs, especially needles, can be very risky.

Needle sharing for any reason is dangerous.

If a diabetic shared needles to take insulin, this is risky. Athletes who share needles when taking steroids are at risk of HIV. Never share needles for any reason.

The injected drug does not spread HIV, it is the sharing of the needles or works-syringes, eye droppers, needles, spoons or other items used to prepare the drug-that does. When a person injects or shoots drugs, blood is drawn back into the needle and syringe. Some blood from the first person may remain in the needle.

If the person is HIV-infected, the virus will be in the blood. The next person or persons who use the equipment can get HIV. Old needles that have not been used for a long time may still be infected because HIV can survive a long time inside needles. This is because blood remains in the hollow of the needle, where there is often no air.

Once people start using drugs, they can become addicted. This is especially true for injection drugs. Because you need a prescription in some states, needles are often expensive or hard to get. In some states and countries, needles are legal to possess without a prescription. Where they are available for purchase at pharmacies, there is a significantly lower rate of HIV infection among needle users, women, and children.

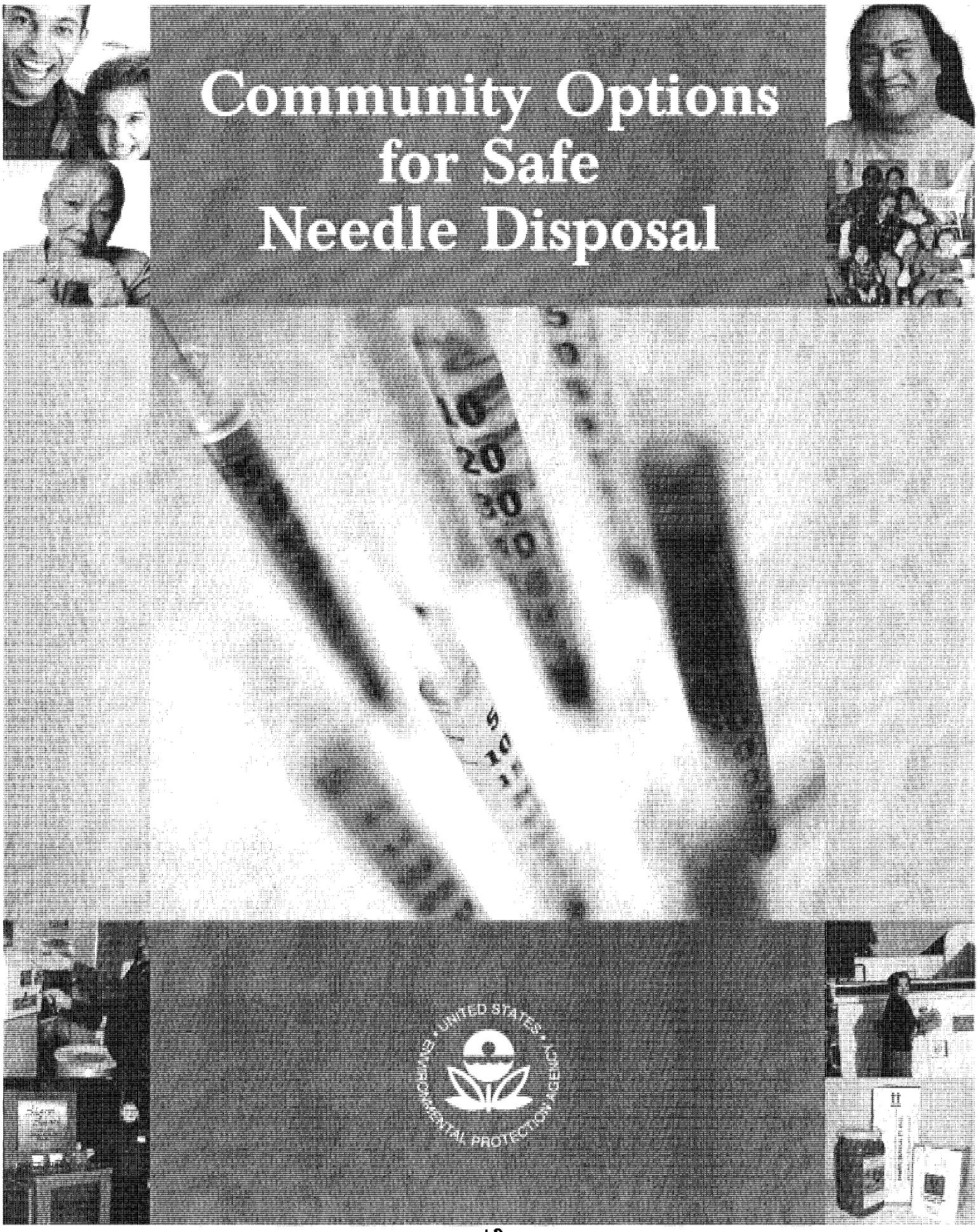
Some places have needle exchange programs, where addicts can bring in old needles and exchange them for new ones.' Addicts may start to feel sick if they go too long without the drug. When they finally get the drug, they often need a fix so badly that they do not take the time to sterilize the needle. They also may not have anything to sterilize it with.

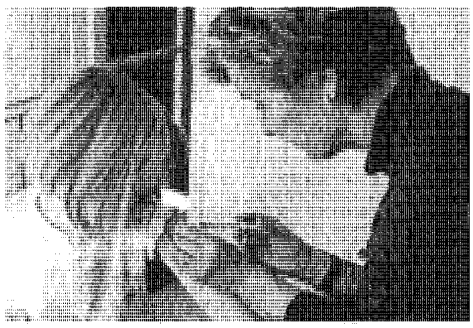
Drug users may not think clearly. Needle users often believe that only someone else will get HIV. They may not bother cleaning the needles or works. Users often shoot up with friends. It is a group activity. For some, cleaning needles is an insult. It implies that the friend is not clean or is infected.

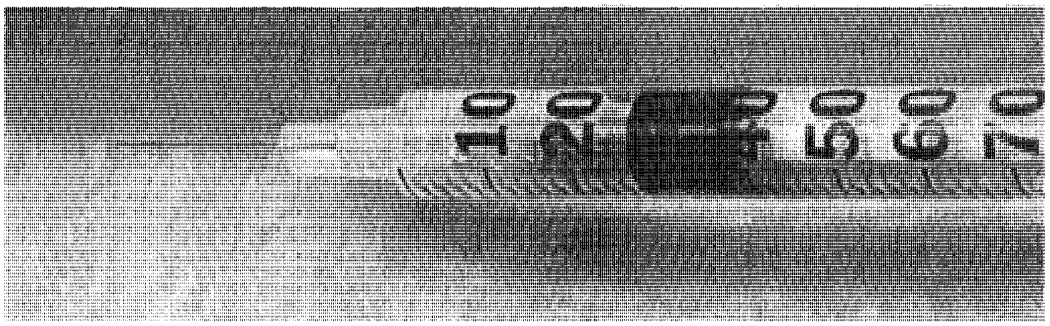
Many drug users go to shooting galleries to get drugs. These are often in abandoned buildings or unclean locations. Equipment or supplies for sterilizing works are often not available there. At shooting galleries, people often rent out or share works. They may be used by many people each day. The HIV infection rate is very high among those who frequent shooting galleries.

A common practice in many cities is for addicts to sell repackaged needles. These are sold as clean needles but are really not clean. Addicts are selling their old needles to make money to buy more drugs. Never trust a needle bought on the street.

http://www.hiv-facts.com/


Community Options
for Safe
Needle Disposal





Each year, 8 million people across the country use more than 3 billion needles, syringes, and lancets—also called sharps—to manage medical conditions at home.

Sharps disposal by self-injectors is not typically regulated, and self-injectors do not always know the safest disposal methods. This situation could lead to haphazard disposal habits and increased community exposure to sharps. People at the greatest risk of being stuck by used sharps include sanitation and sewage treatment workers, janitors and housekeepers, and children.

Due to the hazards that unsafe disposal practices present, many states and municipalities are choosing to offer safe, convenient disposal options to sharps users.

What are the dangers of used sharps?

Some sharps users throw their used needles in the trash or flush them down the toilet. Used sharps left loose among other waste can hurt sanitation workers during collection rounds, at sorting and recycling facilities, and at landfills, or become lodged in equipment, forcing workers to remove them by hand. Children, adults, and even pets are also at risk for needle-stick injuries when sharps are disposed improperly at home or in public settings.

Loose needles at a municipal solid waste location.

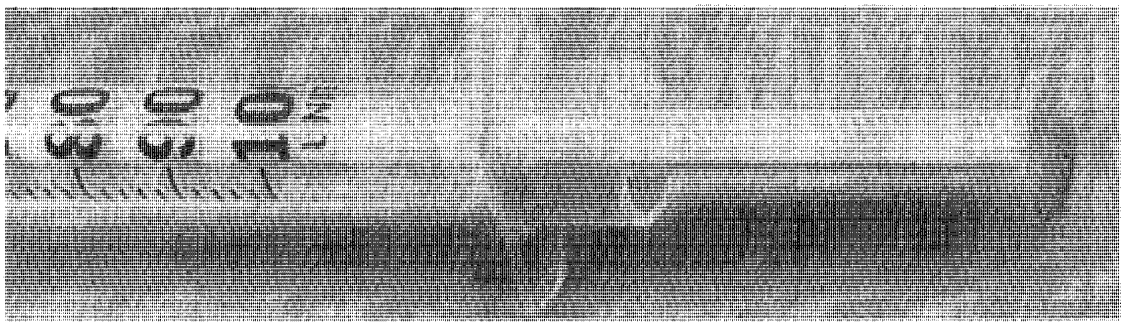
What Are Sharps Used For?

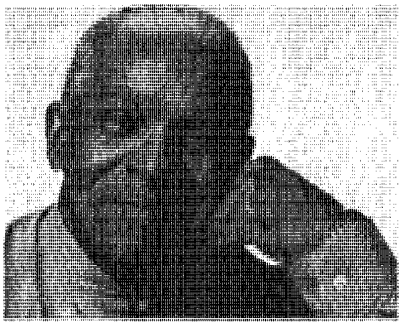
People use sharps to treat all sorts of medical conditions in the home, and the number of conditions treated at home with injectable medicines continues to rise. Sharps users may use lancets and/or needles and syringes to deliver medicine for conditions such as:

- Allergies
- Arthritis
- Cancer
- Diabetes
- Hepatitis
- HIV/AIDS
- Infertility
- Migraines
- Multiple Sclerosis
- Osteoporosis
- Psoriasis

People exposed to sharps face not only the risk of a painful stick, but also the risk of contracting a life-altering disease such as HIV/AIDS or Hepatitis B or C. All needle-stick injuries are treated as if the needle were infected with a disease. Victims of sharps-related injuries face the cost of post-injury testing, disease prevention measures, and counseling, even if no infection or disease was spread. Some diseases can take a long time to appear on test results, leading to months of testing and apprehension.

Needle-stick injuries are a preventable health risk, and states and municipalities can take specific actions to protect their residents from this risk.

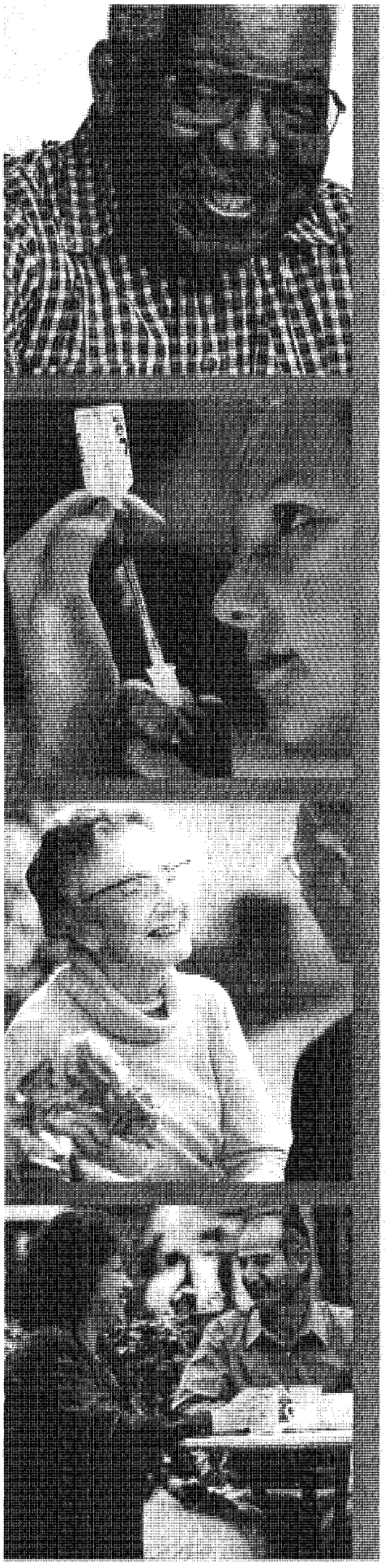




Safe Disposal Options

- **Drop-off collection sites:** Sharps users can take their filled sharps container to appropriate collection sites, which may include doctors' offices, hospitals, health clinics, pharmacies, health departments, community organizations, police and fire stations, and medical waste facilities. These programs often give self-injectors the option of continuing to use empty household containers to collect sharps, but prevent the sharps from entering the household waste stream.
- **Household hazardous waste collection sites:** Self-injectors can place their used sharps in a special sharps container or, in some cases, an approved household container, take them to municipal household hazardous waste collection sites, and place them in the sharps collection bins. These sites also commonly accept hazardous materials such as household cleaners, paints, and motor oil.
- **Residential special waste pickup services:** Self-injectors can place their used sharps in a special container, similar to a recycling container, and put it outside their home for collection by trained special waste handlers. Some programs require customers to call for pickup, while others offer regular pickup schedules.
- **Mail-back programs:** Used sharps are placed in special containers, which are mailed (in accordance with U.S. Postal Service requirements) to a collection site for proper disposal. Mail-back programs are available for individual use by sharps users, and can also serve as a disposal method for community collection sites. These programs work especially well for rural communities, communities that don't already have a medical waste pickup service (e.g., school systems, retail outlets, sporting arenas, casinos), and individuals who wish to protect their privacy.
- **Syringe exchange programs:** Sharps users can exchange their used needles for new needles. Exchange programs are usually operated by community organizations, which properly dispose of the used needles collected at exchange sites.
- **Home needle destruction devices:** A variety of products are available that clip, melt, or burn the needle and allow the sharps user to throw the syringe or plunger in the garbage. These devices can reduce or eliminate the danger of sharps entering the waste stream.

A household hazardous waste disposal center in San Bernardino, California.



Where can I find more inform

A variety of resources are available for states and municipalities that want to improve the safe options for sharps disposal available to their residents.

Program Assistance Information

You can contact the Coalition for Safe Community Needle Disposal by phone at (800) 643-1643 or online at <www.safeneedledisposal.org>. The coalition can assist in implementing a safe sharps disposal program in your area.

If your state or municipality wishes to establish a syringe exchange program, contact the North American Syringe Exchange Network at (253) 272-4857 or <www.nasen.org>.

Government Resources

The Internet is a valuable resource for researching the steps other states and municipalities have taken to inform their citizens and ensure safe sharps disposal.

The Centers for Disease Control (CDC) Web site, located at <www.cdc.gov/needledisposal>, provides state-by-state information on sharps-related laws and regulations, safe community disposal programs, published guidance, and contact information.

Some states that use the Internet to publicize their sharps disposal programs and regulations include:

- **California**

  www.ciwmb.ca.gov/wpie/healthcare/ppcp.htm

- **Florida**

  www.doh.state.fl.us/environment/facility/biomed/hmesharp.htm

- **New Hampshire**

  www.des.nh.gov/factsheets/sw/sw-31.htm

- **New Jersey**

  www.state.nj.us/health/eoh/phss/syringe.pdf

nation about sharps disposal?

- **New York**

  www.health.state.ny.us/nysdoh/hivaids/esap/housesharps.htm

  www.health.state.ny.us/nysdoh/hivaids/esap/regover.htm#emergency

- **Rhode Island**

  www.health.ri.gov/environment/risk/medwaste.htm

- **Washington (Seattle/King County)**

  www.metrokc.gov/health/apu/resources/disposal.htm

- **Wisconsin**

  www.dnr.wi.gov/org/aw/wm/medinf

Mail-back Program Providers

Mail-back programs, which allow home sharps users to mail their used sharps to a licensed disposal facility, present a safe, viable sharps disposal option for every community. For a list of providers, visit the Coalition for Safe Community Needle Disposal Web site at <www.safeneedledisposal.org>.

Home Needle Destruction Devices

These devices sever, melt, or burn the needle, allowing sharps users to throw the syringe or plunger in the garbage. For a list of vendors, visit the Coalition for Safe Community Needle Disposal Web site at <www.safeneedledisposal.org>.

Other Relevant Information

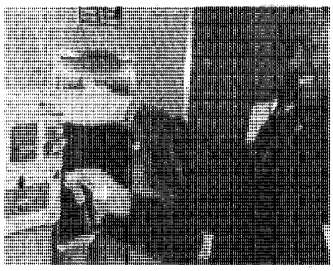
To learn more about regulations concerning medical waste disposal, consult EPA's Medical Waste Web site at <www.epa.gov/epaoswer/other/medical>.

The Household Hazardous Waste section of the Earth 911 Web site, <www.earth911.org>, allows users to enter their ZIP code and view a list of sharps disposal programs available in their area.

As home use of injectable medicines continues to rise, communities throughout the United States are implementing safe disposal programs to reduce the public health hazards that used sharps present when improperly disposed. Currently, hundreds of collection or disposal programs exist across the country. Active states include: California, Florida, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, Washington, and Wisconsin.

Drop-Off Collection:

Low-cost Solution Protects Employees
Houston, Texas

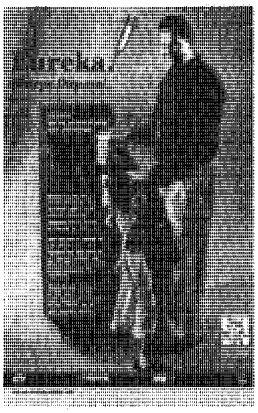


To better serve sharps users while guarding against needle-stick injuries, the Houston Airport System (HAS) installed wall-mounted sharps disposal units in all 69 of its public and employee restrooms at a cost of $300 per year and a startup cost of $2,000. HAS financed the disposal program. **For more information on the program, contact Bush Intercontinental Airport at (281) 230-3017.**

Drop-Off Collection:

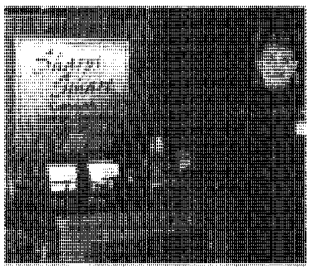
Statewide Partnership Reduces Needle Sticks
Rhode Island

Rhode Island formed a state coalition, headed by the Diabetes Foundation of Rhode Island, to address an increase in needle-stick injuries at the state's landfill and materials recovery facility. The program placed sharps disposal kiosks at 42 locations statewide, including pharmacies, doctors' offices, and fire and police stations. Home sharps users bring their filled sharps containers for disposal and receive a new sharps container in return, all free of charge. The annual average cost to maintain a kiosk is $1,500, which includes the cost of the sharps containers provided to users, literature, kiosk maintenance, and proper waste disposal. In addition, the program now assists other states in designing similar programs and identifying potential funding sources. **For more information, contact the Diabetes Foundation of Rhode Island at (401) 725-7800.**



Drop-Off Collection:

24-Hour Low-cost Community Solution
Wisconsin Rapids, Wisconsin

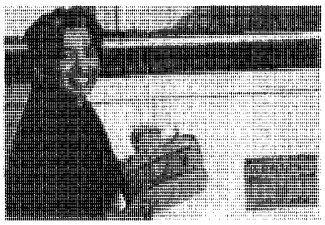


Riverview Hospital in Wisconsin Rapids, Wisconsin, began its own sharps disposal program. *Sharps Smart* was implemented to help sharps users follow the state law that keeps used sharps out of the waste stream. The program allows self-injectors to bring their filled commercial sharps containers or sealed household containers to the hospital, where users mark the container with an orange biohazard label and drop it into the *Sharps Smart* cart for free disposal. Maintaining the program costs about $2,500 per year. The collection cart, located in the entryway of the hospital, is always available to residents. **For more information, contact Riverview Hospital Environmental Services at (715) 421-7443.**

The mention of any company, product, or process in this publication does not constitute or imply endorsement by the U.S. Environmental Protection Agency.

Household Hazardous Waste Collection:

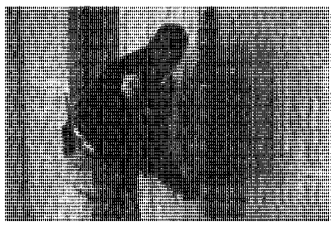
State-funded Collection Program
San Bernardino, California



When the city of San Bernardino's hospital stopped accepting used sharps from community members, sanitation workers began to notice an increase in needle sightings—despite a city ordinance that prohibits disposing of used sharps in household trash. The city implemented a sharps disposal program that allows sharps users to drop off sharps containers at the city's existing household hazardous waste collection facilities. The program is successful largely due to the fact that it is convenient and free. The California Integrated Waste Management Board funded the program for the first two years at an annual cost of $5,900. The city of San Bernardino now funds it at an annual cost of $6,000. To publicize the program, the city offers a point-of-sale display to pharmacies and includes information about the program in the city newsletter. **To learn more, contact the city of San Bernardino at (909) 384-5549.**

Residential Special Waste Pickup:

Door-to-Door Disposal Service
Columbus, Georgia

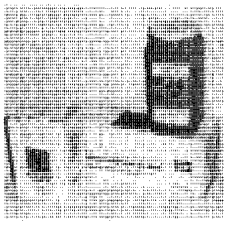


The city of Columbus, Georgia, took a personal approach to its sharps disposal program after sanitation workers suffered needle-stick injuries from sharps discarded in household garbage. Residents now collect their sharps in their own hard plastic container and call the city's waste management agency when their sharps container is full. A waste supervisor is then dispatched to their home to take the container for safe disposal.

By having waste collection supervisors—who are already in the field on their regular rounds—pick up sharps from residents, Columbus has provided a safe disposal option that costs the city virtually nothing. **For more information, contact the city of Columbus at (706) 653-4161.**

Mail-back Program:

Flexibility and Accessibility by Mail
Alameda County, California



Some municipalities are recognizing the flexible benefits of mail-back programs and are beginning to offer them to their residents. Restaurant chains, department stores, stadiums, and school districts are also beginning to use mail-back programs as a viable disposal option for their collected sharps. Mailback programs complement existing needle collection programs by offering disposal solutions for rural or homebound residents.

Alameda County, California, is conducting a pilot program by distributing mail-back containers free of charge to medically under-served populations. The county's large size and diverse demographics have presented problems in adopting more traditional methods of safe sharps disposal, such as drop-off sites or residential collection. By contracting with a vendor for mail-back service, Alameda hopes to reach a greater percentage of its self-injecting population—if residents have a mailbox, they have access to the service. **For more information, contact the Alameda County Sharps Coalition at (510) 532-1930.**

United States
Environmental Protection Agency
5305W
Washington, DC 20460

EPA530-K-04-001
October 2004
www.epa.gov/osw

MRSA INFECTION

Introduction

Methicilllin-resistant Staphylococcus aureus (MRSA) infection may be one of the most frightening illnesses you've never heard of. Unlike more galvanizing diseases such as smallpox and bird flu, MRSA infection has quietly been killing and maiming hundreds of thousands of vulnerable people, including children, without grabbing a single headline.

One reason may be that staphylococcus aureus bacteria, often simply called staph, are common — they're found on the skin or in the nose of about one-third of the population. The bacteria are generally harmless unless they enter the body through a cut or other wound, and even then they often cause only minor skin problems in healthy people. But in older adults and people who are ill or have weakened immune systems, ordinary staph infections can be deadly.

Decades ago, a strain of staph emerged in hospitals that was resistant to the broad-spectrum antibiotics commonly used to treat it. Dubbed methicillin-resistant Staphylococcus aureus (MRSA), it was one of the first germs to outwit all but the most powerful drugs. Since then, MRSA infection has flourished in hospitals and care facilities worldwide, where it can cause massive infections in bones, joints, the bloodstream and surgical wounds. When not treated properly, MRSA infection is fatal.

In the 1990s, a type of MRSA began showing up in the wider community. Today, that form of staph, known as community-associated MRSA, or CA-MRSA, is responsible for most serious skin and soft tissue infections and for a lethal form of pneumonia.

Vancomycin is one of the few antibiotics still effective against hospital strains of MRSA infection, although the drug is no longer effective in every case. Several drugs continue to work against CA-MRSA, but CA-MRSA is a dangerous and rapidly evolving bacterium, and it may simply be a matter of time before it, too, becomes resistant to most antibiotics.

Signs and Symptoms

Staph infections, including MRSA, generally start as small red bumps that resemble pimples, boils or spider bites. These can quickly turn into deep, painful abscesses that require surgical draining. Sometimes the bacteria remain confined to the skin. But they can also burrow deep into the body, causing potentially life-threatening infections in bones, joints, surgical wounds, the bloodstream, heart valves and lungs.

Unlike hospital-associated MRSA, CA-MRSA produces a deadly toxin (Panton-Valentine leukocidin) that destroys white blood cells and living tissue. The toxin can cause severe, often fatal skin infections (necrotizing, or "flesh-eating," fasciitis) and pneumonia.

Causes

Although the survival tactics of bacteria contribute to antibiotic resistance, humans bear most of the responsibility for the problem. Leading causes of antibiotic resistance include:

- **Unnecessary antibiotic use in humans.** Like other superbugs, MRSA is the result of decades of excessive and unnecessary antibiotic use. For years, antibiotics have been prescribed for colds, flu and other viral infections that don't respond to these drugs, as well as for simple bacterial infections that normally clear on their own.

- **Antibiotics in food and water.** Prescription drugs aren't the only source of antibiotics. In the United States, about 70 percent of all antibiotics wind up not in people but in beef cattle, pigs and chickens. For the most part, these drugs aren't used to treat disease but to fatten the animals quickly and to prevent illnesses that are common in the unhygienic conditions in which animals are raised. The same antibiotics then find their way into municipal water systems when the runoff from feedlots contaminates streams and groundwater. Routine feeding of antibiotics to animals has become such a threat to public health that the practice is banned in the European Union and many other industrialized countries. Antibiotics given in the proper doses to animals who are actually sick don't seem to produce resistant bacteria.
- **Germ mutation.** Even when antibiotics are used appropriately, they contribute to the rise of drug-resistant bacteria because they don't destroy every germ they target. Bacteria live on an evolutionary fast track, so germs that survive treatment with one antibiotic soon learn to resist others. And because bacteria mutate much more quickly than new drugs can be produced, some germs end up resistant to just about everything. That's why only a handful of drugs are now effective against most forms of staph.

Hospitals: Germ incubators

MRSA first emerged in hospitals in the 1960s and since then has been nearly unstoppable. It travels from person to person on clothing, cart handles, bedrails and catheters, and even breeds in the water in floral arrangements, leading hospitals in the United Kingdom to ban flowers in critical care units. Evading every effort to control it, MRSA accounts for half of the major complications in hospitalized people and for tens of thousands of deaths every year.

Scientists think hospital-acquired MRSA is particularly virulent and tenacious because it hides and replicates in a common type of amoeba — a single-celled organism that's present on most surfaces. Amoebas can spread in the air, which means that MRSA may be transmitted without human contact. What's more, germs that breed in amoebas are stronger and more drug-resistant than other pathogens are.

CA-MRSA: Right under your nose

MRSA was confined to healthcare settings until the late 1990s, when four previously healthy children in the Midwest died suddenly of massive MRSA infections. Around the same time, athletes began showing up with hard-to-treat boils, and inmates in some U.S. prisons developed deep abscesses that didn't respond to antibiotic treatment. MRSA also turned up among military recruits and some gay men.

It's likely that what is now called community-associated MRSA (CA-MRSA) entered the wider world in the nostrils of people who picked up the bacteria in hospitals. The Centers for Disease Control and Prevention estimates that at least 1 percent of the population, or 2 million people, now carry CA-MSRA in their noses. Carriers may not be sick, but they can spread the infection and run the risk of becoming ill themselves.

The bacteria spread mainly through skin-to-skin contact and through small cuts and abrasions. Overcrowding and poor hygiene also encourage the spread of staph. Once CA-MRSA enters the body, it causes boils and abscesses and, like hospital strains, sometimes sparks massive infections in the bone, blood or lungs.

Risk Factors

Because hospital and community strains of MRSA generally occur in different settings, the risk factors for the two strains differ.

Risk factors for hospital-acquired MRSA include:

- **A current or recent hospitalization.** Despite attempts to eradicate it, MRSA remains the scourge of hospitals, where it attacks the most vulnerable — older adults and people with weakened immune systems, burns, surgical wounds or serious underlying health problems.
- **Residing in a long-term care facility.** MRSA is far more prevalent in these facilities than it is in hospitals. Most people admitted to a care facility are likely to carry MRSA and have the ability to spread it, even if they're not sick themselves.
- **Invasive devices.** People who are on dialysis, are catheterized, or have feeding tubes or other invasive devices are at especially high risk.

These are the main risk factors for CA-MRSA:

- **Young age.** CA-MRSA can be particularly deadly in children, sometimes ravaging their bodies in a matter of hours. The bacteria usually enter through a cut or scrape but can quickly cause a massive systemic infection. Children and young adults are also much more likely to develop necrotizing pneumonia than older people are. Children may be susceptible because their immune systems aren't fully developed or they don't yet have antibodies to common germs.
- **Participating in contact sports.** CA-MRSA has crept into both amateur and professional sports teams. The bacteria spread easily through cuts and abrasions and skin-to-skin contact.
- **Sharing towels or athletic equipment.** Although few outbreaks have been reported in public gyms, CA-MRSA has spread among athletes sharing razors, towels, uniforms or equipment.
- **Having a weakened immune system.** People with weakened immune systems, including those living with HIV/AIDS, are more likely to have severe CA-MRSA infections.
- **Living in crowded or unsanitary conditions.** Outbreaks of CA-MRSA have occurred in military training camps and in dozens of American and European prisons, killing some inmates and infecting guards and other staff.
- **Recent hospitalization or antibiotic use.** A recent hospital stay or treatment with fluoroquinolones (ciprofloxacin, ofloxacin or levofloxacin) or cephalosporin antibiotics can increase the risk of CA-MRSA.
- **Association with health care workers.** People who are in close contact with health care workers are at increased risk of serious staph infections. MRSA can travel through families, passing between parents and children on shared clothing, towels and other personal items.

When to Seek Medical Advice

Keep an eye on minor skin problems — pimples, insect bites, cuts and scrapes — especially in children. If wounds become infected, see your doctor. Ask to have any skin infection tested for MRSA before starting antibiotic therapy. Drugs that treat ordinary staph aren't effective against MRSA, and their use could lead to serious illness and more resistant bacteria.

Screening and Diagnosis

Most often, doctors diagnose MRSA by checking a tissue sample or nasal secretions for signs of drug-resistant bacteria. The sample is sent to a lab where it's placed in a dish of nutrients that encourage bacterial growth (culture). But because it takes about 48 hours for the bacteria to grow, infected people may continue to spread MRSA while awaiting test results, and those who are already ill can become worse or, in the most serious cases, die. Newer tests that can detect staph DNA in a matter of hours are available, but they're more expensive than culture tests, and most hospitals don't yet use them.

Treatment

Although resistant to many common antibiotics, both hospital and community strains of MRSA still respond to certain medications. In hospitals and care facilities, doctors generally rely on the last-ditch antibiotic vancomycin to treat resistant germs. CA-MRSA may be treated with vancomycin or other antibiotics that have proved effective against particular strains. Although vancomycin saves lives, its constant use makes it more likely that germs will soon grow resistant to it as well; some hospitals are already seeing outbreaks of vancomycin-resistant MRSA. To help reduce that threat, doctors often drain abscesses caused by MRSA rather than treat the infection with drugs.

Prevention

Every year, about 2 million Americans develop hospital-acquired infections and 90,000 die of them. Many of these are the result of MRSA, one of the most virulent and tenacious of the antibiotic-resistant germs. Hospitals are fighting back by instituting surveillance systems that track bacterial outbreaks and by investing in products such as antibiotic-coated catheters and gloves that release disinfectants. Still, the best way to prevent the spread of germs is for health care workers to wash their hands frequently, to properly disinfect hospital surfaces and to take other precautions such as wearing a mask when working with people with weakened immune systems.

Here's what you can do to protect yourself, family members or friends from hospital-acquired infections.

- Ask all hospital staff to wash their hands before touching you — every time.
- Wash your own hands frequently.
- Make sure that stethoscopes and other instruments are wiped with alcohol before use.
- Ask to be bathed with disposable cloths treated with a disinfectant rather than with soap and water.
- Make sure that intravenous tubes and catheters are inserted and removed under sterile conditions; some hospitals have dramatically reduced MRSA blood infections simply by sterilizing patients' skin before using catheters. Better yet, avoid having a urinary tract catheter whenever possible.

Preventing CA-MRSA

Protecting yourself from CA-MRSA — which might be just about anywhere — may seem daunting, but these common-sense precautions can help reduce your risk:

- **Keep personal items personal.** Avoid sharing personal items such as towels, sheets, razors, clothing and athletic equipment. MRSA spreads on contaminated objects as well as through direct contact.
- **Keep wounds covered.** Keep cuts and abrasions clean and covered with sterile, dry bandages until they heal. The pus from infected sores often contains MRSA, and keeping wounds covered will help keep the bacteria from spreading.

- **Sanitize linens.** If you have a cut or sore, wash towels and bed linens in hot water with added bleach and dry them in a hot dryer. Wash gym and athletic clothes after each wearing.
- **Wash your hands.** In or out of the hospital, careful hand washing remains your best defense against germs. Scrub hands briskly for at least 15 seconds, then dry them with a disposable towel and use another towel to turn off the faucet. Carry a small bottle of hand sanitizer containing at least 62 percent alcohol for times when you don't have access to soap and water.
- **Get tested.** If you have a skin infection that requires treatment, ask your doctor to test for MRSA. Many doctors prescribe drugs that aren't effective against antibiotic-resistant staph, which delays treatment and creates more resistant germs. If you're having surgery, ask to be tested for MRSA one week before you enter the hospital.

By Mayo Clinic Staff
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Case Scenario – Jason
Consumer with DME

Jason is a 20-year-old male who is a paraplegic as a result of an automobile accident two years earlier. He lives with his parents and has a bedroom and bathroom that have been adapted to meet his needs. He has a roll-in shower in the bathroom and a lightweight wheelchair that he uses to move around the house and participate in wheelchair sports such as basketball and track events. Jason's mother and father are employed and up to this point have had insurance which has covered all of the medical expenses and home care. The insurance has paid for someone to come in during the day and help Jason with his personal care (bathing and grooming and dressing), clean his room, and cook meals while his parents are out of the home. As the policy dollar limits have been reached, private insurance is not available and Jason's parents have applied for IHSS for their son and have indicated that they would like to have a provider come in and provide the same services that the private insurance covered.

At the time of the home visit, Jason is at home with his mother. Jason is observed to be a well-nourished, young adult who is able to move around the house with agility. He has one portion of his room set up for weight lifting which he states that he does for approximately two hours per day to maintain his upper extremity strength. Jason indicates that he is able to perform most ADLs and IADLs without help from another person. He indicates that he does not have time to clean his own room because he is busy with other activities. He states he has never had to clean his own room, even before the accident. Jason's mother indicates that he needs to have someone cook his meals during the day because he will just eat junk food all day if no one cooks for him and will not clean up the kitchen after he cooks. She also states he needs to have range of motion exercises performed two times per day. Jason's mother states that he is able to dress himself, but does not always dress appropriately for the occasion, so he needs reminding regarding clothing selection. She states as an example he wears t-shirts and shorts to church. You observe him to be neatly and appropriately dressed.

Group Tasks:

How would you assess the Functional Index rankings for:

- Domestic
- Meal Preparation and Cleanup
- Bathing, Oral Hygiene and Grooming
- Dressing

Case Scenario – Kimberly
Assessing FI Score for Consumers with Variable Functioning

Kimberly is a 39-year-old female who has a diagnosis of Fibromyalgia. She receives SSI and has applied for IHSS. During the initial interview, Kimberly states that she needs help with most ADLs and IADLs on a daily basis due to her intense back pain. Kimberly has lived with her mother off and on for the last ten years, and she states that when she lived at home, her mother helped her. Kimberly has recently moved into a one-bedroom duplex with her boyfriend, Jeff, who is a tow truck driver. Jeff is willing to help Kimberly when he is home, but since he is on call 24 hours a day, he is gone for a large portion of the day and night. This is the second time that you have scheduled an interview with Kimberly. No one answered the door when you arrived for the first visit.

At the time of the 3:00 p.m. interview, Kimberly greets you at the door. She is able to walk back to the living room and seat herself in a recliner without any apparent stress or pain, although she ambulates slowly. Kimberly is dressed in sweats and appears somewhat disheveled. Kimberly states that she just got up a half hour earlier because she didn't sleep well the night before. The house is cluttered and looks like it has not been cleaned in a long period of time. There are many dirty dishes in the sink, dirty pots on the stove and piles of clothes everywhere. Kimberly begins by apologizing for not answering the door when the first interview was scheduled. She said she was experiencing so much pain that day that she could not get out of bed.

Kimberly states that she wants IHSS because she primarily needs someone to clean her house and cook her meals, but she also needs help with some personal care when Jeff is not at home. She states that on average he is gone about 16 hours per day. She states that in her Fibromyalgia support group, there are several people who get IHSS and she learned about the program from them.

During the interview, Kimberly states that on bad days, Jeff helps her get in and out of bed, getting to and from the bathroom, and on and off the toilet when he is home. When asked about what type of help he gives her, she said that he gives her a boost and steadies her because she must move very slowly. He must be careful when getting her out of bed to prevent her back from twisting. She states that he will come by and check on her and help her with personal care or fixing a snack if needed during the day when he is between calls, but cannot do this when he has a really busy day. She states that this is why she needs someone else who she can call to help with her personal care on bad days. She states that when Jeff is not there, she tries to limit the trips to the bathroom because getting in and out of bed and on and off the toilet causes her intense pain. She states that on bad days, because her pain is so severe, she limits her intake of liquids to minimize the frequency that she must go to the bathroom so she can wait until she can get help. She

states that the lady who lives next door helps her occasionally, but she doesn't like to bother her. She says that if the lady were paid by IHSS for helping her, she would not be so hesitant about calling her.

Kimberly states that she takes multiple medications and lives on Vicodin and sleep medications prescribed by her doctor.

When asked about good days and bad days, Kimberly states that a good day is one in which she can sit in the living room and watch TV all day. She states that on good days, she probably could do a little around the house or cook a meal or wash the dishes. On a bad day, she is not able to get out of bed without assistance and she must wait until Jeff or the neighbor comes in to help her with all activities. Kimberly says that she has on average three or four good days per week. She states that she is having a good day on the day of the interview even though she did not sleep well the night before.

Kimberly requests that someone cook meals, do the entire meal cleanup, clean the house, and help her with personal care when Jeff is not at home.

Group Tasks:

How would you assess the Functional Index rankings for:

- Domestic
- Meal Preparation and Cleanup
- Transfer
- Bowel and Bladder

Case Scenario – Alice
Consumers that Understate Need

Alice is a 94-year-old lady who lives independently in a three-room apartment in a senior apartment complex. She had been performing all ADLs and IADLs without assistance until recently when she was hospitalized following a fall. Her diagnoses include hypertension and congestive heart failure. She is quite thin. She says she was 5'6" before she started losing height. When she was admitted to the hospital, she weighed 97 lbs. She also has mild tremors in her hands from early stages of Parkinson's disease. The hospital discharge planner has made an IHSS referral indicating she needs assistance with Domestic and Related services, Bathing and Grooming, and Dressing. During the initial IHSS evaluation, Alice reports that she has lived for 94 years without any help and does not need any help now. Alice indicates that she feels that her main problem is dizziness which contributed to the recent fall. She stated that when she feels dizzy, she holds onto the walls when she ambulates around the home.

At the time of the visit, the apartment is neat and tidy. Alice reports that although she feels tired all of the time and it often takes her all day, she does manage to do all of the housework herself. She states that her daughter vacuums once per week. She states that she does all of her personal laundry by hand and hangs it on a clothes rack to dry inside. Her daughter comes over once a week and takes the other laundry to her house. Alice indicates that her daughter or neighbor shop for her. She states that she eats toast and coffee for breakfast if she is hungry, makes a sandwich for lunch, and can prepare a light dinner herself. She states that if she is feeling dizzy, she will use the walls for support to go into the kitchen and heat up a can of soup for dinner. Her daughter brings dinner to her three times per week. She denies that she needs any assistance with personal care.

Group Tasks:

How would you assess the Functional Index rankings for:

- Domestic
- Meal Preparation
- Ambulation
- Bathing, Oral Hygiene and Grooming

Case Scenario – Emily
Assessing Need

Emily

Emily is a 38-year-old consumer who lives with her husband Bobby and their two children (13-year-old Jill and 8-year-old Jordan). Emily was diagnosed with Multiple Sclerosis approximately two years ago, and her disease has progressed rapidly. Bobby works during the day and provides some of Emily's care during the evenings and weekends, but he chooses not to be paid. Her 18-year-old daughter Amy, who does not live in the home, provides the rest of her care. In addition to Multiple Sclerosis, Emily has high blood pressure and Type I diabetes, which requires two daily insulin injections and periodic blood sugar testing. She takes multiple pills for her blood pressure and MS twice daily. Emily has an electric wheelchair which she is able to use independently to get around the home. When she goes out for her medical appointments, she requires assistance getting from the house to the car and from the car into the doctor's office. She also requires assistance transferring from the wheelchair to the car and from the car to the wheelchair. The home is equipped with a Hoyer lift, which is used to move her in and out of bed. Emily requires assistance with all Domestic and Related services, and with personal care including bowel and bladder care. Emily is completely unable to bathe herself. Her daughter Amy states that it is difficult to hold her mother up in the shower, requiring a longer time than usual to perform this task. Emily is also at risk of choking because she is unable to chew solid food. For this reason, Amy must puree her mother's food. Emily has no strength in her hands and is unable to grasp utensils. Every Saturday, Emily's mother, Bertha, comes over to dress and bathe her and to make a day's worth of meals for Emily and her family. Emily's husband, Bob, is afraid to leave his wife unattended at any time. He states that Emily requires 24-hour care and supervision. He is afraid that, if left unattended, she could be harmed by an intruder or could choke on something. He is requesting Protective Supervision.

Bob

Bob is 40 years old and has been married to Emily for 19 years. She is his one and only true love, but her illness has been hard on him over the last two years, and at times, he just does not know if he can take it anymore. Bob wants the maximum of 283 hours of care for Emily. Bob does not understand that service hours are based on assessed needs. He believes that someone needs to be with his wife at least 8 hours per day, 7 days per week, which is why he is requesting Protective Supervision. Bob can get pretty upset when speaking with the social worker because he believes no one understands the situation and that IHSS is not providing his wife with the hours she needs.

Doctor

Emily has numerous doctors, including a neurologist who is optimistic about Emily's health status. On the medical evaluation form he states: "not at risk of placement … does require assistance with housekeeping, meals, dishes, laundry, shopping … all personal care ... Diagnosis: MS, HTN, and Diabetes." He also completed the SOC 321, stating: "needs assistance with insulin injections and blood sugar checks … length of time: 99 months."

Amy

Amy is Emily's 18-year-old daughter, who recently graduated from high school. She had been accepted at Stanford University, but decided to give up school to take care of her mother. Amy feels guilty that she resents her mother at times, but knows that one day she will be able to go off to school. Amy knows that the situation is hard on the whole family, but she wants to be able to move on with her life. Amy made the comment, "I want to be my mom's little princess again." Amy lives in a small studio apartment a few doors from her parents' home. Amy claims that it was nice that her father fixed up the apartment for her, but that she does not have any freedom. She is out of the main house, but she spends all day taking care of her mother, and then she runs her younger brother and sister around. By the time Saturday arrives, she is so tired physically and mentally that all she does is sleep. Amy speaks about the dreams she had of becoming a teacher, and about traveling to Europe this summer with her friends, which she will not be able to do. Amy talks about the many nights she and her mother spent talking about those dreams, but that was before her mother became sick. For Amy, life is not about dreams anymore, but making it through one more day.

Group Tasks

Identify the functional rankings on the H line provided.

Housework	*Laundry*	*Shopping & errands*	*Meal prep and clean up*	*Mobility Inside*	*Bathing and grooming*	*Dressing*	*Bowel, bladder & menstrual care*	*Moving in and out of bed (Transfer)*	*Eating*	*Respiration*	*Memory*	*Orientation*	*Judgment*

Case Scenario – Mary
Documenting Need

Initial Assessment

Mary is a 72-year-old female who lives with her daughter, Rebecca, in a two-bedroom, one-bath apartment. Rebecca indicates during the assessment that she quit her job when her mother moved in with her to receive IHSS. Rebecca indicates that Mary was living independently until approximately one year ago when she had a stroke which left her paralyzed on her right (dominant) side and unable to speak. Rebecca indicates that her mother had been fiercely independent before the stroke and that she has seen a marked decrease in her overall condition since the stroke. Rebecca believes that her mother has "given up" and further indicates that on most days, her mother does not want to get out of bed. Rebecca states that she must do "everything" for her mother and that she is exhausted from what she indicates is 24-hour care. She states that since her mother will not get up to use the bathroom, she must continuously monitor her skin condition. She indicates that although her mother wears diapers and has pads on the bed, she must change the bedding every day because it still gets soiled and wet. Rebecca indicates that a neighbor does all of the food shopping and errands for her and her mother and does not wish to be compensated.

Rebecca's sister comes over and stays with her mother when she goes out once a week to do the laundry. She states that she does her mother's laundry separately from hers because of incontinence issues and must take the laundry to a laundry facility about three miles from her home. Rebecca explains that the laundry machines in the apartment complex are frequently broken, and people steal things when laundry is left unattended. Rebecca states that she appreciates her sister staying with her mother while she does the laundry, and recognizes that her sister is limited in her ability to care for her mother due to her own family obligations. However, she states that she still feels some resentment because she has given up her career to care for her mother.

Group Tasks:

Based on the information above and utilizing the Task Tool, Annotated Assessment Criteria, and IHSS Regulations, the group should discuss their answers to the following questions:

1. What factors would you take into consideration in assessing the need for Housework, Laundry, and Food Shopping?
2. Please indicate your reasons and what you would need to document in the case file.
3. What other actions would you take?

Critique the following *Narrative Summary* for Mary's Reassessment:

1. What do you like about this documentation sample?
2. What is missing or should not be included?

(You may want to reference the Narrative Guide in Tab 8.)

2-1-06 – Home visit with Mary and daughter/provider, Rebecca, for reassessment. Rebecca provided all responses to questions as Mary has been unable to speak since a stroke about one year previously. Mary moved in with Rebecca to receive care following the stroke. Rebecca indicates that she believes her mother's condition has continued to deteriorate since the stroke and feels her mother has "given up." She states that her mother usually does not want to get out of bed and that she must do everything for her. The apartment was neat and clean at the time of the HV. Mary appeared to be sleeping in her bed at the time of the HV, although she seemed to open her eyes and recognize me when I spoke her name. There was a large pile of laundry in Mary's bedroom. There continues to be alternative resources available as the neighbor does all of the food shopping and errands. A SOC 450 was obtained from the neighbor at the initial visit and is in the case file. Mary's laundry is done separately by Rebecca at a facility about three miles away. One of Mary's other daughter's comes over and stays with her while Rebecca does the laundry. I asked Rebecca if her sister provided services to her mother when she comes over and she stated that her sister just sits there like a bump on a log and does not lift a finger. Rebecca seemed overwhelmed during the HV and appeared exhausted. During the HV, I discussed with Rebecca her feelings regarding her sister's inability to help with her mother's care. Rebecca indicated that although she sometimes resented the fact that she gave up her career and at times feels like her sister could do more, she is generally able to cope with the situation. She indicated that although her sister does not provide much physical help, she is always willing to talk to her and provide emotional support. I provided Rebecca with information on how to hire another provider and how to access the PA Registry. I also provided her with information regarding community resources which may assist her, including MSSP and ADHC. I reviewed the current FI Rankings and determined that the rankings for Bathing and Grooming and Bowel and Bladder Care should be changed based on the increased amount of assistance needed in these areas. I also increased the amount of time assessed for these services to reflect the current need. The hours for Domestic include only the room used exclusively by Mary which I assessed at 1.00 hour per month, which was increased to 2.00 hours to reflect extra bed linen changes. Out of home laundry authorization assessed at 1.50 hours as laundry facilities on premises cannot be utilized. No proration of laundry as it is done separately due to incontinence.

Case Scenario – Albert
Documenting Need

Initial Assessment

Albert is a 78-year-old man who lives independently in a one-bedroom apartment. Albert uses a walker to move around within his house and indicates that he has been disabled for 20 years due to an accident he had while working. He states that he had lung surgery due to cancer but continues to smoke. When you walk into the apartment, you note a heavy smoke odor. Albert indicates that he uses oxygen at night, but does not need it during the day. He keeps the oxygen set up in his bedroom and is able to hook it up without assistance. The oxygen supplier services the equipment.

Albert's provider comes in four days per week to help him. When questioned regarding his need for Meal Preparation, Albert indicates that he has had toast and coffee for breakfast everyday for the last 20 years and would not want to eat anything else. He indicates that he gets lunch from Meals on Wheels (MOW) five days per week, which he eats for his main meal. On the days that he does not receive MOW, his provider prepares the main meal for him. Albert says that he cannot prepare the main meals because he cannot stand for longer than five minutes at a time. Albert states that the type of meal his provider prepares varies, but it usually takes about one half hour to prepare each meal. Albert is able to make a sandwich or soup for himself which he has for lunch or his evening meal. Albert indicates that the provider cleans up after preparing the main meal, which usually takes her about 15 minutes. She also washes any accumulated dishes when she gets there each day and that it usually takes her about 10 minutes. Albert admits that he could probably wash the few dishes that accumulate from his breakfast, lunch, and dinner, but he leaves them for his provider because he thinks she enjoys washing them.

Albert indicates that he is unable to get into the bathroom at night so he uses a bedside commode which the provider empties and cleans. Albert indicates that he does not need any help with toileting at any other time, but you note a strong urine smell in the apartment.

Group Tasks:

Based on the information above and utilizing the Task Tool, Annotated Assessment Criteria, and IHSS Regulations, the group should discuss their answers to the following questions:

1. What factors would you take into consideration in assessing the need for Meal Preparation, Meal Cleanup, and Bowel and Bladder Care?
2. Indicate how you would address the issue of the urine odor with Albert.
3. Indicate any other issues you feel need to be addressed.

Critique the following *Narrative Summary* for Albert's Reassessment:

1. What do you like about this documentation sample?
2. What is missing or should not be included?

(You may want to reference the Narrative Guide in Tab 8.)

2-1-06 – Home visit with Albert for reassessment. Albert has been diagnosed with lung cancer and has had lung surgery. It was noted during the prior assessment that Albert uses oxygen, but continues to smoke. A heavy smoke odor was present in the apartment. When Albert opened the door, I observed him ambulating with the use of a walker. This appeared to be safe for him. Albert indicated that he uses oxygen only at night and that he has it set up in his bedroom. Albert indicated he could do some minor housework but that his provider did most of it for him. He indicates his provider comes four days per week. Albert indicated that the services he needs assistance with are meal prep and cleanup, laundry, shopping, and emptying the commode which he uses at night. I noted that there was a urine odor in the entire apartment. I reviewed Albert's need for services with him and obtained the following information: He has only toast and coffee for breakfast which he prefers and has been his habit for 20 years. He gets MOW five days per week for lunch. His provider prepares his main meal on the four days that she is there which he reheats in the microwave. When she is not there, he prepares a sandwich or soup for his evening meal. Although Albert states he can do any breakfast, lunch or other cleanup, he states that he leaves them for his provider because she likes to do them. I am changing the assessment for Meal Prep from 7.00 hours per week to reflect availability of MOW and provider preparing main meal 2 x per week. I am also changing assessed need for Meal Cleanup to reflect Meal Cleanup for main meal on days provider prepares, as Albert is capable of doing small amount of dishes from meals. I explained this to Albert and he said he understood. Albert states he cannot get to the bathroom at night due to oxygen use so he uses a bedside commode which his provider empties and cleans. Albert states that he showers once per week and sits on a bath bench. He has appropriate rails in his bathroom. I discussed the urine odor with Albert and he said he didn't understand why there would be an odor. He thinks that maybe his provider hadn't cleaned the commode correctly the last time she was there. I told him that he should make sure that if he did require additional assistance with B/B care or other personal care, he should be sure to call me so that we can make sure that needed services are authorized. He said he would do this. Authorization for B/B care will continue as indicated in prior assessment.

Case Scenario – George
HTG

George is a 68-year-old male whose diagnoses include hypertension and renal failure. He goes to dialysis three times per week. George was recently diagnosed with emphysema. He moved in with his daughter, Marie, two months prior to the home visit. His daughter has applied for IHSS on his behalf. Prior to moving in with his daughter, he lived alone in an upstairs apartment. During the home visit, George's daughter states that she wanted him to move in with her because of her concern over his increasing shortness of breath and the fear that he would not be able to negotiate the stairs by himself, in the near future. The current residence is a small three-bedroom, one-bathroom, ranch-style house. The residents are George, Marie and her husband, and their three children – ages 4, 10, and 16. George sleeps on the couch in the living room.

At the time of the home visit, George is lying on the couch. Marie states that her father returned from dialysis shortly before your arrival. George appears to be alert, although you occasionally have to repeat questions and note that he appears to doze off a couple of times during the interview. George states that, in his view, Marie exaggerates his condition and that he is generally able to take care of all of his own needs. He states that he misses the independence and privacy he had in his own apartment. He does admit that on dialysis days, he requires some assistance from Marie, including assistance off of the couch, ambulation to and from the bathroom, and assistance to and from the kitchen for meals.

During the interview, Marie frequently interrupts and contradicts what her father says. She states that he needs help on all days. She says that after dialysis he cannot do anything for himself. She states that she must help him to put on his pajamas and to manage his clothing when he uses the bathroom. She states that she always assists him with bathing also because she is afraid he will fall. She indicates that even when George goes for a short walk outside, she always accompanies him because she is afraid that he will fall: he is unsteady when walking outside the house.

Marie states that she must frequently encourage her father to eat because he does not have any appetite. She states that she left him alone on a couple of occasions on non-dialysis days, and that he did not eat dinner on those days. She says she prepares George's meals separately because he is on a high-protein, restricted salt, phosphorous and potassium diet. She states that he usually eats a poached egg and a piece of toast for breakfast. She indicates that he probably could fix his own breakfast on non-dialysis days, but it would take him too long. She also agrees that he could make his own breakfast on dialysis days because he doesn't leave the house until 9:00 a.m. She says it takes her a half hour to make his breakfast and serve it, and that she prepares his lunch

(usually cottage cheese and canned fruit or yogurt) because that is what daughters do for their fathers. She says that this meal takes about 10 minutes to make. She says that a typical dinner for George is meat, a small amount of starch, and some vegetables, which takes her about a half hour to prepare.

You ask Marie if you can speak to her father without her present as you have some personal questions you need to ask him, and that you believe he will be more comfortable if you can ask those questions in private. Marie reluctantly agrees.

After Marie leaves, George states that he is unhappy with his current living arrangement and misses his friends from the apartment complex. He states that he spent much of his time playing cards with his friends prior to moving in with Marie. He states that his grandchildren are in and out of the living room at all hours of the day and night and that the TV is constantly on with kids shows. He states that there is not much to do even when he is feeling well and that Marie will not let him do anything. When you ask him about other activities he enjoys, he states that when he had his own house he enjoyed working in the garden. He says Marie will not let him help with the garden because she thinks he will fall. George states he currently feels useless.

George states that on his non-dialysis days he can ambulate without assistance and sometimes goes for short walks to get out of the house. He does, however, need a boost from the chair or couch, even on non-dialysis days. He states that on non-dialysis days he would be able to fix meals for himself, but Marie does not want him to do this. He states that at his apartment he did all meal preparation and cleanup, but admits that on his dialysis days, he frequently did not eat dinner because it was too much work for him. He states that when he lived at his apartment, he would bathe about once or twice a week and that he continues this habit. He states that he bathes on non-dialysis days and that Marie does not assist or monitor him. He admits that he requires assistance off of the couch on dialysis days and that his daughter helps him walk to and from the bathroom, and to and from the kitchen for meals, because he is unsteady on his feet. He also states that Marie helps him put on his pajamas when he gets home on dialysis days and that she also manages his clothes after he uses the bathroom. When you ask George about the time Marie spends helping him with these activities, he replies that you will have to ask Marie because he does not have any idea. He states that Marie drives him to and from the dialysis clinic. When he lived in his apartment a van would pick him up and bring him home. The van personnel would assist him from his apartment to the van, then from the van to the clinic and back again after dialysis. George states that he would still be able to use the van, but Marie prefers to drive him.

When Marie returns to the room, she states that she thinks she spends about 15 minutes per day helping George to and from the bathroom for a bowel movement. While conducting the interview you observe her helping George up from the couch and steadying him while he ambulates the short distance to the bathroom. You note that George is slow getting up from the couch and returning to a seated position and that it takes approximately 1 minute for Marie to help him get up, another minute gaining balance before walking, and another minute for him to return to a seated position. You note that Marie provides elbow support when George walks and that it takes approximately five minutes from the time that he starts to get up from the couch until he is seated again. Marie states that on non-dialysis days she assists him with transfers about ten times per day and that it takes 5 minutes to get him to a standing position and 5 minutes to return to a seated position. You observe that it is about the same distance from the couch to the bathroom as the couch to the kitchen. You ask her to think of how much help he needs on dialysis days. She says that she needs to do just about everything for him on those days; it is hard because she is worried about how frail he has gotten and she also has her own kids and husband to take care of. Luckily – Marie tells you – her youngest is in preschool, it is not so bad, and she is glad to be able to help her father. When he was living alone, she was so worried about him.

You ask her to be specific about the help she provides him. She states that on dialysis days she helps him up 3 times a day to go to the kitchen table and back to the couch for meals, and once a day to go to the bathroom and back to the couch for his bowel movement. He does not urinate because of the dialysis. When she takes him to the dialysis clinic she has to do the following:

- assistance getting him up from the couch;
- elbow support while he walks from the couch to the car;
- assistance into the car for the trip to the dialysis center;
- assistance out of the car, once they arrive at the dialysis center;
- elbow support while he walks from the car to the dialysis clinic;
- all of the above steps (in reverse order) after his dialysis treatment is finished.

Marie states that George has two different doctors – his primary physician and his nephrologist. He sees each of them every other month, alternating between the two, for an average of one trip per month. Marie states that the dialysis clinic and his two doctors are located in the same medical complex and that it takes her 10 minutes to help George from the front door of the house to the car and about 12 minutes to help him from the car to the clinic.

Marie states that – one or two times a week on non-dialysis days – she sets up the shower bench, helps her father in and out of the shower, and gives him the hand-held shower head. She says that, once seated, he can manage his own shower, but she has to be within ear-shot to hear him in case he needs her while he showers. According to Marie, if George bends over to dry his legs and feet, he gets dizzy when he sits up again. For this reason, she helps him to dry his legs and feet when he has finished showering. This whole process takes about a half hour each time.

Group Tasks:

1. Using the Annotated Assessment Criteria/Task Tools document, discuss why the following FI rankings are appropriate for George.

   Mobility Inside – 4
   Meal Preparation – 4
   Transfer – 3
   Eating – 2
   Bathing – 3

2. Use the available information to determine the assessed need for Transfer, Ambulation, Meal Preparation and Bathing. Complete the Documentation Worksheet to show how you calculated the need.

3. Use the HTG documents to determine if the assessed need for Transfer, Ambulation, Meal Preparation and Bathing is within the HTG. If it is not within the guidelines, indicate how you would document the exception(s) on the Documentation Worksheet.

George – Documentation Worksheet

Meal Preparation

Needs help with ☐ Breakfast ☐ Lunch ☐ Dinner

FI Rank (Enter)		
	Low	High
Rank 2	3.02	7.00
Rank 3	3.50	7.00
Rank 4	5.25	7.00
Rank 5	7.00	7.00

Note: Compare Total Need with above range.

Meal	Example of Typical Meal	Need Per Meal	# of Days Per Week	Total Need
Breakfast				
Lunch				
Dinner				
Snacks				

Reason for assistance:

Shared living exceptions (required when services not prorated):

Additional information to document exceptions to guidelines and identification of Alt. Resources such as MOW:

Ambulation

FI Rank (Enter)		
	Low	High
Rank 2	0.58	1.75
Rank 3	1.00	2.10
Rank 4	1.75	3.50
Rank 5	1.75	3.50

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Walking inside home				
Retrieving assistive devices				
Assistance from house to car & in/out of car for medical appt. and to Alt. Resource				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Transfer

FI Rank (Enter)		
	Low	High
Rank 2	0.50	1.17
Rank 3	0.58	1.40
Rank 4	1.10	2.33
Rank 5	1.17	3.50

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance from standing, sitting, or prone position to another, or transfer from one piece of equipment or furniture to another				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Bathing, Oral Hygiene, and Grooming

FI Rank (Enter)		
	Low	High
Rank 2	0.50	1.92
Rank 3	1.27	3.15
Rank 4	2.35	4.08
Rank 5	3.00	5.10

Note: Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with getting in/out of tub/shower				
Oral hygiene				
Grooming				

Reason for assistance:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

Fibromyalgia

Definition

Fibromyalgia is a chronic syndrome (constellation of signs and symptoms) characterized by diffuse or specific muscle, joint, or bone pain, fatigue, and a wide range of other symptoms.

Characteristics

The defining symptoms of Fibromyalgia are chronic, widespread pain and tenderness to light touch, and usually moderate to severe fatigue.

In addition to pain and fatigue, people who have Fibromyalgia may experience:

- sleep disturbances,
- morning stiffness,
- headaches,
- irritable bowel syndrome,
- painful menstrual periods,
- numbness or tingling of the extremities,
- restless legs syndrome,
- temperature sensitivity,
- cognitive and memory problems (sometimes referred to as "fibro fog"), or
- a variety of other symptoms.

Fibromyalgia is often referred to as an **"invisible" illness** or disability due to the fact that generally there are no outward indications of the illness or its resulting disabilities.

Functional Considerations

- Fibromyalgia can affect every aspect of a person's life due to pervasive and persistent chronic pain.
- Expect that the consumer may have cycles of good days and bad days.
- Individuals suffering from invisible illnesses in general often face disbelief or accusations of malingering or laziness from others that are unfamiliar with the syndrome and therefore may be defensive during the assessment.
- Fibromyalgia is a chronic condition, but is not progressive.

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CHAPTER 30-700 SERVICE PROGRAM NO. 7: IN-HOME SUPPORTIVE SERVICES

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30-700 PROGRAM DEFINITION 30-700

.1 The In-Home Supportive Services (IHSS) Program provides assistance to those eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without this assistance. IHSS is an alternative to out-of-home care. Eligibility and services are limited by the availability of funds.

.2 The Personal Care Services Program (PCSP) provides personal care services to eligible Medi-Cal beneficiaries pursuant to Welfare and Institutions Code Section 14132.95 and Title 22, California Code of Regulations, Division 3 and is subject to all other provisions of Medi-Cal statutes and regulations. The program is operated pursuant to Division 30.

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

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

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

.33 The IHSS Plus Waiver Program is a "Section 1115 Demonstation Project" as defined in 42 USC, Section 1315. This demonstration project has been approved for 5 years, beginning August 1, 2004. Eligibility and services are limited to the availability of funds and potential extensions to the demonstration.

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

.5 All civil rights laws, rules, and regulations of Division 21 shall be complied with in administering IHSS program regulations.

NOTE: Authority cited: Sections 10553, 10554, 12300, 14142.95, and 14132.951, Welfare and Institutions Code; Chapter 939, Statutes of 1992; and 42 USC, Section 1315(a) of the Social Security Act. Reference: Sections 12300, 14132.95, and 14132.91, Welfare and Institutions Code.

30-701 SPECIAL DEFINITIONS 30-701

(a) (1) Administrative costs are those costs necessary for the proper and efficient administration of the county IHSS program as defined below. Activities considered administrative in nature include, but are not limited to:

(A) Determine eligibility;

(B) Conduct needs assessments;

(C) Give information and referrals;

(D) Establish case files;

(E) Process Notices of Action;

(F) Arrange for services;

(G) Compute shares of cost;

(H) Monitor and evaluate contractor performance;

(I) Respond to inquiries;

(J) Audit recipient and individual provider timesheets;

(K) Enter case and payroll information into the CMIPS;

(L) Screen potential providers and maintain a registry or list.

(2) Administrative activities for PCSP are those activities necessary for the proper and efficient administration of the county PCSP. In addition to all activities listed in Section 30-753(a)(1) as administrative activities for IHSS except Section 30-753(a)(1)(G), the following activities are considered administrative in nature, subject to PCSP funding:

(A) Nursing supervision;

(B) Clerical staff directly supporting nursing supervision of PCSP cases;

(C) Physician certification of medical necessity when such certification is completed by a licensed health care professional who is a county employee;

(D) Provider enrollment certification.

30-701 SPECIAL DEFINITIONS **30-701**
(Continued)

(3) Allocation means federal, state, and county monies which are identified for a county by the Department for the purchase of services in the IHSS Program.

(b) (1) Base Allocation means all federal, state and county monies identified for counties by the Department for the purchase of services in the IHSS Program, exclusive of any provider COLA allocation, but including recipient COLA.

(2) Base Rate means the amount of payment per unit of work before any premium is applied for overtime or related extraordinary payments.

(c) (1) Certified Long-Term Care Insurance Policy or Certificate or certified policy or certificate means any long-term care insurance policy or certificate, or any health care service plan contract covering long-term care services, which is certified by the California Department of Health Services as meeting the requirements of Welfare and Institutions Code Section 22005.

(2) Compensable services are only those services for which a provider could legally be paid under the statutes.

(3) Consumer means an individual who is a current or past user of personal care services, as defined by Section 30-757.14, paid for through public or private funds or a recipient of IHSS or PCSP.

(4) County Plan means the annual plan submitted to the California Department of Social Services specifying how the county will provide IHSS and PCSP.

(5) CRT or Cathode Ray Tube means a device commonly referred to as a terminal which is used to enter data into the IHSS payrolling system.

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30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(6) CRT County means a county in which one or more CRTs have been located allowing the county to enter its data directly into the payrolling system.

(d) (1) Deeming means procedures by which the income and resources of certain relatives, living in the same household as the recipient, are determined to be available to the recipient for the purposes of establishing eligibility and share of cost.

(2) Designated county department means the department designated by the county board of supervisors to administer the IHSS program.

(3) Direct advance payment means a payment to be used for the purchase of authorized IHSS which is sent directly to the recipient in advance of the service actually being provided.

(e) (1) Employee means the provider of IHSS under the individual delivery method as defined in Section 30-767.13.

(2) Employer means the recipient of IHSS when such services are purchased under the individual delivery method as defined in Section 30-767.13.

(3) Equity Value means a resource's current market value after subtracting the value of any liens or encumbrances against the resources which are held by someone other than the recipient or his/her spouse.

(f) (Reserved)

(g) Gatekeeper Client means a person eligible for, but not placed in a skilled or intermediate care facility as a result of preadmission screening.

(h) (1) Hours Worked means the time during which the provider is subject to the control of the recipient, and includes all the time the provider is required or permitted to work, exclusive of time spent by the provider traveling to and from work.

(2) Housemate means a person who shares a living unit with a recipient. An able and available spouse or a live-in provider is not considered a housemate.

(i) (1) "Intercounty Transfer" means a transfer of responsibility for the provision of IHSS services from one county to another when the recipient moves to a new county and continues to be eligible for IHSS:

(A) "Transferring County" means the county currently authorizing IHSS services.

(B) "Receiving County" means the county to which the recipient moves to make his/her home.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(C) "Transfer Period" means the period during which the transferring county remains responsible for payment of IHSS services, after which the receiving county will be responsible for payment. The transfer period starts when the transferring county sends *the* documentation, including the notice of transfer form, and records to the receiving county.

(D) "Expiration of Transfer Period" means the end of the transfer period. The transfer period shall end as soon as administratively possible but no later than the first day of the month following 30 calendar days after the notification of transfer form is sent to the receiving county or as allowed in Section 30-759.96.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

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(E) Example: The transferring county sends a notification of transfer form along with documents to the receiving county on January 20th.

The receiving county has 30 calendar days to return the transfer form. The receiving county returns the transfer form on February 19th, stating that they will assume responsibility effective March 1st.

- The transfer period begins January 20th.

- The transfer period ends on March 1st. IHSS payment is terminated by the transferring county.

- The receiving county begins IHSS payment effective March 1st and the transfer is complete.

HANDBOOK ENDS HERE

(j) (Reserved)

(k) (Reserved)

(l) (1) Landlord/Tenant Living Arrangement means a shared living arrangement considered to exist when one housemate, the landlord, allows another, the tenant, to share housing facilities in return for a monetary or in-kind payment for the purpose of augmenting the landlord's income. A landlord/tenant arrangement is not considered to exist between a recipient and his/her live-in provider. Where housemates share living quarters for the purpose of sharing mortgage, rental, and other expenses, a landlord tenant relationship does not exist, though one housemate may customarily collect the payment(s) of the other housemate(s) in order to pay mortgage/rental payments in a lump sum.

(2) Licensed Health Care Professional means a person who is a physician as defined and authorized to practice in this state in accordance with the California Business and Professions Code.

(3) Live-In Provider means a provider who is not related to the recipient and who lives in the recipient's home expressly for the purpose of providing IHSS-funded services.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(4) A list means any informal or formal listing or registry of written name(s) of prospective In-Home Support Services providers maintained by the county agency, county social services staff, a contractor as defined under Welfare and Institutions Code Section 12302.1, or any public or private agency for purposes of referring the prospective providers for employment.

(m) Minor means any person under the age of eighteen who is not emancipated by marriage or other legal action.

(n) (1) Net Nonexempt Income means income remaining after allowing all applicable income disregards and exemptions.

(2) Nonprofit consortium means an association that has a tax-exempt status and produces a tax exempt status certificate and meets the definition of a nonprofit organization as contained in OMB Circular A-122 found at Federal Register, Vol. 45, No. 132, dated July 8, 1980.

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(A) OMB Circular A-122 found at Federal Register, Vol. 45, No. 132, dated July 8, 1980, defines a nonprofit organization as one which:

(1) Operates in the public interest for scientific, educational, service or charitable purposes;

(2) Is not organized for profit making purposes;

(3) Is not controlled by or affiliated with an entity organized or operated for profit making purposes; and

(4) Uses its net proceeds to maintain, improve or expand its operations.

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(o) (1) Out-of-Home Care Facility means a housing unit other than the recipient's own home, as defined in (o) (2) below. Medical out-of-home care facilities include acute care hospitals, skilled nursing facilities, and intermediate care facilities. Nonmedical out-of-home care facilities include community care facilities and homes of relatives which are exempt from licensure, as specified in Section 46-325.5, where recipients are certified to receive board and care payment level from SSP.

(2) Own Home means the place in which an individual chooses to reside. An individual's "own home" does not include an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or a board and care facility. A person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement is not considered to be living in his/her home.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(p) (1) Paper County means a county which sends its data in paper document form for entry into the payrolling system to the IHSS payrolling contractor.

(2) Payment Period means the time period for which wages are paid. There are two payment periods per month corresponding to the first of the month through the fifteenth of the month and the sixteenth of the month through the end of the month.

(3) Payrolling System means a service contracted for by the state with a vendor to calculate paychecks to individual providers of IHSS; to withhold the appropriate employee taxes from the provider's wages; to calculate the employer's taxes; and to prepare and file the appropriate tax return.

(4) Personal Attendant means a provider who is employed by the recipient and, as defined by 29 CFR 552.6, who spends at least eighty percent of his/her time in the recipient's employ performing the following services:

(A) Preparation of meals, as provided in Section 30-757.131.

(B) Meal clean-up, as provided in Section 30-757.132.

(C) Planning of menus, as provided in Section 30-757.133.

(D) Consumption of food, as provided in Section 30-757.14(c).

(E) Routine bed baths, as provided in Section 30-757.14(d).

(F) Bathing, oral hygiene and grooming, as provided in Section 30-757.14(e).

(G) Dressing, as provided in Section 30-757.14(f).

(H) Protective supervision, as provided in Section 30-757.17.

(5) Preadmission Screening means personal assessment of an applicant for placement in a skilled or intermediate care facility, prior to admission to determine the individual's ability to remain in the community with the support of community-based services.

(6) Provider Cost-of-Living Adjustment (COLA) means all federal, state and county monies identified for counties by SDSS for the payment of wage and/or benefit increases for service providers in the IHSS program.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(7) Public Authority means:

(A) An entity established by the board of supervisors by ordinance, separate from the county, which has filed the statement required by Section 53051 of the Government Code, and

(B) A corporate public body, exercising public and essential governmental functions and that has all powers necessary and convenient to carry out the delivery of in-home supportive services, including the power to contract for services and make or provide for direct payment to a provider chosen by a recipient for the purchase of services.

(q) (Reserved)

(r) (1) Recipient means a person receiving IHSS, including applicants for IHSS when clearly implied by the context of the regulations.

(2) Reduced payment means any payment less than full payment that may be due.

(s) (1) Severely Impaired Individual means a recipient with a total assessed need, as specified in Section 30-763.5, for 20 hours or more per week of service in one or more of the following areas:

(A) Any personal care service listed in Section 30-757.14.

(B) Preparation of meals.

(C) Meal cleanup when preparation of meals and consumption of food (feeding) are required.

(D) Paramedical services.

(2) Shared Living Arrangement means a situation in which one or more recipients reside in the same living unit with one or more persons. A shared living arrangement does not exist if a recipient is residing only with his/her able and available spouse.

(3) Share of cost means an individual's net non-exempt income in excess of the applicable SSI/SSP benefit level which must be paid toward the cost of IHSS authorized by the county.

(4) Spouse means a member of a married couple or a person considered to be a member of a married couple for SSI/SSP purposes. For purposes of Section 30-756.11 for determining PCSP eligibility, spouse means legally married under the laws of the state of the couple's permanent home at the time they lived together.

30-701 SPECIAL DEFINITIONS (Continued) **30-701**

(5) SSI/SSP means the Supplemental Security Income and State Supplementary Program administered by the Social Security Administration of the United States Department of Health and Human Services in California.

(6) State Allocation Plan means that process whereby individual county IHSS program allocations are developed in a manner consistent with a) Welfare and Institutions Code Sections 10102 and 12300 et seq., and b) funding levels appropriated and any control provision contained in the Annual Budget Act.

(7) State-mandated program cost means those county costs incurred for the provision of IHSS to recipients, as specified in Section 30-757, in compliance with a state approved county plan. Costs caused by factors beyond county control such as caseload growth and increased hours of service based on individually assessed need, shall also be considered state-mandated.

(8) Substantial Gainful Activity means work activity that is considered to be substantial gainful activity under the applicable regulations of the Social Security Administration, 20 CFR 416.932 through 416.934. Substantial work activity involves the performance of significant physical or mental duties, or a combination of both, productive in nature. Gainful work activity is activity for remuneration of profit, or intended for profit, whether or not profit is realized, to the individual performing it or to the persons, if any, for whom it is performed, or of a nature generally performed for remuneration or profit.

(9) Substitute Payee means an individual who acts as an agent for the recipient.

(t) Turnaround Timesheet means a three-part document issued by the state consisting of the paycheck, the statement of earnings, and the timesheet to be submitted for the next pay period.

(u) (Reserved)

(v) (1) Voluntary Services Certification is the form numbered SOC 450 (10/98) which is incorporated by reference and which is to be used statewide by person(s) providing voluntary services without compensation.

(w) (Reserved)

(x) (Reserved)

(y) (Reserved)

(z) (Reserved)

NOTE: Authority cited: Sections 10553, 10554, 12301.1, and 22009(b), Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 11102, 12300(c), 12301, 12301.6, 12304, 12306, 12308, 13302, 14132.95, 14132.95(e), 14132.95(f), and 22004, Welfare and Institutions Code.

30-702 COUNTY QUALITY ASSURANCE AND QUALITY IMPROVEMENT 30-702

.1 Each county shall establish a Quality Assurance (QA) unit or function which, at a minimum, will be required to perform the following tasks:

.11 Develop and regularly review policies and procedures, implementation timelines, and instructions under which county QA and Quality Improvement (QI) programs will function.

.12 Perform routine, scheduled reviews of supportive services cases which include reviewing a sample of case files and other documents.

.121 The county shall define routine, scheduled reviews in their QA procedures.

.122 The county's QA case sample shall:

(a) Include cases from all district offices and all workers involved in the assessment process.

(b) Include a minimum number of cases determined by CDSS based on the county's caseload and QA staffing allocation.

.123 If the county is unable to meet the requirements of Section 30-702.122, the county shall submit a written alternative proposal to CDSS outlining the reason as well as an alternative sample method. CDSS shall review the proposal and determine if it is acceptable for compliance with Section 30-702.122.

.124 The county's routine, scheduled reviews shall consist of desk reviews and home visits.

.125 The review process shall be a standardized process, including standard forms for completing desk reviews of cases and for completing home visits.

(a) The desk reviews must include:

(1) A sample of denied cases.

(2) Validation of case file information by recipient contact using a sub-sample of cases.

(3) A process to verify:

30-702 COUNTY QUALITY ASSURANCE AND QUALITY IMPROVEMENT 30-702
(Continued)

(A) Required forms are present, completed, and contain appropriate signatures.

(B) There is a dated Notice of Action in the case file for the current assessment period.

(C) The need for each service and hours authorized is documented.

(b) The county shall conduct home visits using a sub-sample of their desk reviews to confirm that the assessment is consistent with the recipient's needs for services and the applicable federal and state laws and policies have been followed in the assessment process. When conducting home visits the county shall:

(1) Notify the recipient prior to the home visit.

(2) Verify the recipient's identity.

(3) Verify the need for any IHSS service tasks, not just the task currently authorized.

(4) Verify all data on the G-Line of the SOC 293 (1/91), which includes specific information that may impact the assessment of need.

(5) Verify the recipient understands which services have been authorized and the amount of time authorized for each.

(6) Discuss with the recipient, the recipient's health issues and physical limitations to assist in identifying the recipient's functional limitations.

(7) Discuss any changes in the recipient's condition or functional limitations since the last assessment.

(8) Discuss the quality of services provided by the county with the recipient, including addressing the recipient's awareness of, and the ability to, contact and communicate with his/her worker.

(9) Verify that the recipient understands his/her ability to request a fair hearing.

(10) Ensure a completed back-up plan, that indicates the steps the recipient must take in the event of an emergency, is in the recipient's file and a copy has been provided to the recipient to use as a future resource.

30-702 COUNTY QUALITY ASSURANCE AND QUALITY IMPROVEMENT 30-702
(Continued)

.126 The county's QA review process shall also identify any optional county special requirements.

.127 When the county QA staff is prevented from completing a review on a specific case, this information shall be conveyed to the appropriate staff and an alternative case shall be selected.

.13 Develop procedures to report QA findings to county and State management and to ensure that deficiencies identified are appropriately reported and corrected.

.131 The county's reporting procedures shall identify a standardized process for communicating results of routine, scheduled reviews to management, line staff, and the immediate supervisors of line staff. The process shall include:

(a) A specified time frame for response to QA findings and a follow-up process.

(b) Protocols for identifying and responding to a need for immediate action.

(c) Measures to ensure that corrective actions address problems that are systematic in nature.

.14 Review and respond to information provided as a result of data matches conducted by the State with other agencies that provide services to program recipients or State control agencies.

.141 In performing data match activities, counties shall ensure that confidentiality requirements are adhered to.

.15 Develop procedures to detect and prevent potential fraud by providers, recipients, and others, which include informing providers, recipients, and others that suspected fraud of supportive services can be reported by using the toll-free Medi-Cal fraud telephone hotline and/or internet web site.

.16 Conduct appropriate follow-up of suspected fraud and seek recovery of any overpayments, as appropriate.

.17 Identify potential sources of third-party liability and make appropriate referrals. Potential sources of third-party liability include but are not limited to:

30-702 COUNTY QUALITY ASSURANCE AND QUALITY IMPROVEMENT 30-702
(Continued)

.171 Long-Term Care Insurance.

.172 Worker's Compensation Insurance.

.173 Victim Compensation Program Payments.

.174 Civil Judgment/Pending Litigations.

.18 Conduct joint case review activities with State QA staff.

.19 Develop a plan for and perform targeted QA/QI studies based on:

.191 Analysis of data acquired through the county's quality assurance program; or

.192 Analysis of data available through Case Management Information Payrolling System (CMIPS), county systems; or

.193 Other information, including but not limited to:

(a) Data from QA case review findings; or

(b) Input from Public Authorities and other consumer groups.

.194 The county shall submit a quarterly report of their QA/QI activities to CDSS on the SOC 824 (3/06) form fifteen days after the report quarter ends. (Quarters end on March 31, June 30th, September 30th, and December 31st).

.2 Each county shall develop and submit an annual QA/QI Plan to CDSS no later than June 1 of each year.

.21 The QA/QI Plan shall identify how the county will use the information gathered through QA activities to improve the quality of the IHSS program at the local level.

NOTE: Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code. Reference: Section 12305.71, Welfare and Institutions Code.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM 30-755

.1 Eligibility

.11 A person is eligible for IHSS who is a California resident living in his/her own home, and who meets one of the following conditions:

.111 Currently receives SSI/SSP benefits.

.112 Meets all SSI/SSP eligibility criteria including income, but does not receive SSI/SSP benefits.

.113 Meets all SSI/SSP eligibility criteria, except for income in excess of SSI/SSP eligibility standards or immigration criteria, and meets applicable share of cost obligations.

(a) A person must meet immigration status criteria as provided in 20 CFR Part 416, subpart P, or must meet the state program noncitizen status criteria as provided in MPP Section 30-770.51.

.114 Was once eligible for SSI/SSP benefits, but became ineligible because of engaging in substantial gainful activity, and meets all of the following conditions:

(a) The individual was once determined to be disabled in accordance with Title XVI of the Social Security Act (SSI/SSP).

(b) The individual continues to have the physical or mental impairments which were the basis of the disability determination.

(c) The individual requires assistance in one or more of the areas specified under the definition of "severely impaired individual" in Section 30-753.

(d) The individual meets applicable share of cost obligations.

.12 Otherwise eligible applicants, currently institutionalized, who wish to live in their own homes and who are capable of safely doing so if IHSS is provided, shall upon application receive IHSS based upon a needs assessment.

.121 Service delivery shall commence upon the applicant's return home, except that authorized services as specified in Section 30-757.12 may be used to prepare for the applicant's return home.

.2 Eligibility Determination

.21 Eligibility shall be determined by county social service staff at the time of application, at subsequent 12-month intervals, and when required based on information received about changes in the individual's situation.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

.22 Eligibility for current recipients of SSI/SSP shall be determined by verifying receipt of SSI/SSP. This can be done in any of the following ways:

.221 Seeing the current SSI/SSP Notice of Determination.

.222 Seeing the current SSI/SSP benefit check.

.223 Contacting the Social Security District Office.

.224 Checking the Medi-Cal Eligibility Data System (MEDS) or the State Data Exchange (SDX) screens.

.23 Eligibility for those persons described in Sections 30-755.112, .113, and .114 above shall be determined as follows:

.231 Age, blindness, and disability shall be determined by social service staff using the eligibility standards specified in Sections 30-770 through 30-775.

(a) Age, blindness or disability may be established by looking at the third and fourth digits of the Medi-Cal number. If the number is 10, the recipient is aged; if 20, the recipient is blind; and if 60, the recipient is disabled. However, if the third and fourth digits of the number are not 20 or 60, a new determination of blindness or disability may be required.

.232 Residence, property, and net nonexempt income shall be determined by social service staff using the eligibility standards specified in Sections 30-770 through 30-775.

.233 Net nonexempt income in excess of the applicable SSI/SSP benefit level shall be applied to the cost of IHSS.

(a) Payment of the entire obligated share of cost is a condition of eligibility for IHSS.

(b) Providers shall have the primary responsibility for collecting any share of cost owed to them.

(1) The county may collect the share of cost.

(2) Counties shall have the responsibility for collection of any share of cost which must be paid against the provider's tax liability.

(c) If a recipient fails to pay his/her entire obligated share of cost within the month for which it is obligated, IHSS shall be terminated.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

(1) Termination will be effective the last day of the month following the month of discovery of the recipient's failure to pay his/her entire obligated share of cost.

(d) If an applicant/recipient states verbally or in writing that he/she will not pay his/her share of cost, the applicant/recipient shall not be eligible for IHSS services.

.24 Notwithstanding Section 30-755.232 above, net nonexempt income for persons specified in Section 30-755.113 above shall be determined, depending on the aid category to which the individual was linked in December, 1973, according to the Old Age Security (OAS), Aid to the Blind (AB) and Aid to the Totally Disabled (ATD) income regulations which would have been applicable in the individual's case in June, 1973, if it is to the person's advantage and either of the following conditions is met:

.241 In December 1973 the person was receiving only homemaker/chore services or was receiving an OAS, AB or ATD cash grant solely for attendant care, and has received IHSS services continuously since that date.

.242 In December 1973 the person had applied for attendant care of homemaker/chore service, met all eligibility requirements in that month, and has received IHSS services continuously since that date.

.25 The case record for persons specified in .111 above shall indicate the information used to determine receipt of SSI/SSP benefits.

.26 The case record for persons specified in Sections 30-755.112, .113, and .114 above shall include:

.261 The information used by the county to determine age, blindness or disability.

.262 The information regarding the recipient's property, income, and living situation used by the county in determining eligibility. Such information shall be recorded on a statement of facts form which shall be signed by the recipient or his/her authorized representative under penalty of perjury, and shall be dated. The county shall verify income. The county may verify other information if necessary to insure a correct eligibility determination.

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM (Continued) **30-755**

.263 For persons eligible under .114 above, the information used to decide that the recipient was once determined to be eligible for SSI/SSP, was once determined to be disabled as provided in .114(a) above, and was discontinued from SSI/SSP because of engaging in substantial gainful activity.

.264 The computation of the amount the recipient must pay toward the cost of in-home supportive services.

.3 Medi-Cal

.31 Recipients of services under .112, .113, and .114 above are eligible for Medi-Cal, provided that any net nonexempt income in excess of the SSI/SSP benefit level shall be applied to the cost of in-home supportive services.

NOTE: Authority cited: Sections 10553, 10554, and 12150, Welfare and Institutions Code; Chapter 939, Statutes of 1992; and Senate Bill 1569 (Chapter 672, Statutes of 2006). Reference: Sections 10554, 12304.5, 12305, 12305.6, 13283, 14132.95, and 18945 Welfare and Institutions Code.

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30-756 NEED **30-756**

.1 Staff of the designated county department shall determine the recipient's level of ability and dependence upon verbal or physical assistance by another for each of the functions listed in Section 30-756.2. This assessment shall evaluate the effect of the recipient's physical, cognitive and emotional impairment on functioning. Staff shall quantify the recipient's level of functioning using the following hierarchical five-point scale:

.11 Rank 1: Independent: able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

.12 Rank 2: Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement.

.13 Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.

.14 Rank 4: Can perform a function but only with substantial human assistance.

.15 Rank 5: Cannot perform the function, with or without human assistance.

.2 Staff of the designated county department shall rank the recipient's functioning in each of the following functions.

(a) Housework;

(b) Laundry;

(c) Shopping and errands;

(d) Meal preparation and cleanup;

(e) Mobility inside;

30-756 NEED (Continued) **30-756**

(f) Bathing and grooming;

(g) Dressing;

(h) Bowel, bladder and menstrual;

(i) Repositioning;

(j) Eating;

(k) Respiration;

(l) Memory;

(m) Orientation; and

(n) Judgment.

.3 Staff of the designated county department shall use the following criteria to support the determination of functional impairment:

.31 The recipient's diagnosis may provide information to substantiate demonstrated functional impairments, but the recipient's functioning is an evaluation of the recipient's capacity to perform self-care and daily chores.

.32 Need may be distinct from current practice. The assessment of need shall identify the recipient's capacity to perform functions safely. The assessment of need shall identify the recipient's capacity rather than level of dependence.

.33 The recipient's needs shall be assessed within his/her environment, considering the mechanical aids or durable medical appliances the recipient uses.

.34 The scales are hierarchical. The higher the score, the more dependent the recipient is upon another person to perform IHSS services activities.

.35 Most functions are evaluated on a five-point scale. However, the functions of memory, orientation and judgment contain only three ranks. The function of respiration contains only ranks 1 and 5. These inconsistencies in the ranking patterns exist because differing functional ability in these areas does not result in significantly different need for human assistance.

30-756 NEED (Continued) **30-756**

.36 The order in which the physical functions are listed in Sections 30-756.2(a) through (k) is hierarchical.

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.361 In 95 percent of any impaired population, people tend to lose functioning in the inverse order of normal infant development. Therefore, it would be unlikely for a recipient to score higher ranks in the functions listed at the bottom of the list than those at the top. This listing should assist in the assessment process.

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.37 Mental functioning shall be evaluated as follows:

.371 The extent to which the recipient's cognitive and emotional impairment (if any) impacts his/her functioning in the 11 physical functions listed in Sections 30-756.2(a) through (k) is ranked in each of those functions. The level and type of human intervention needed shall be reflected in the rank for each function.

.372 The recipient's mental function shall be evaluated on a three-point scale (Ranks 1, 2, and 5) in the functions of memory, orientation and judgment. This scale is used to determine the need for protective supervision.

.4 Notwithstanding Section 30-756.11, staff shall rank a recipient the rank of "1" if the recipient's needs for a particular function are met entirely with paramedical services as described in Section 30-757.19 in lieu of the correlated task.

.41 If all of the recipient's ingestion of nutrients occurs with tube feeding, the recipient shall be ranked "1" in both meal preparation and eating because tube feeding is a paramedical service.

.42 If all the recipient's needs for human assistance in respiration are met with the paramedical services of tracheostomy care and suctioning, the recipient should be ranked a "1" because this care is paramedical service rather than respiration.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 12309, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

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30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757

.1 Only those services specified in Sections 30-757.11 through .19 shall be authorized through IHSS. A person who is eligible for a personal care service provided pursuant to the PCSP shall not be eligible for that personal care service through IHSS. A service provided by IHSS shall be equal to the level of the same service provided by PCSP.

(a) For services in this section where time guidelines are specified, the services shall be subject to the specified time guideline unless the recipient's needs require an exception to the guideline. When assessing time for services (both within and outside the time guidelines), the time authorized shall be based on the recipient's individual level of need necessary to ensure his/her health, safety, and independence based on the scope of tasks identified for service. In accordance with Welfare and Institutions Code Section 12301.2, the dual purpose of the guidelines is to provide counties with a tool for both consistently and accurately assessing service needs and authorizing time.

(1) In determining the amount of time per task, the recipient's ability to perform the tasks based on his/her functional index ranking shall be a contributing factor, but not the sole factor. Other factors could include the recipient's living environment, and/or the recipient's fluctuation in needs due to daily variances in the recipient's functional capacity (e.g., "good days" and " bad days").

(A) In determining the amount of time per task, universal precautions should be considered.

1. Universal precautions are protective practices necessary to ensure safety and prevent the spread of the infectious diseases. Universal precautions should be followed by anyone providing a service, which may include contact with blood or body fluids such as saliva, mucus, vaginal secretions, semen, or other internal body fluids such as urine or feces. Universal precautions include the use of protective barriers such as gloves or facemask depending on the type and amount of exposure expected, and always washing hands before and after performing tasks. More information regarding universal precautions can be obtained by contacting the National Center for Disease Control.

(2) An exception to the time guideline may result in receiving more or less time based on the recipient's need for each supportive service and the amount of time needed to complete the task.

(3) Exceptions to the hourly task guidelines identified in this section shall be made when necessary to enable the recipient to establish and maintain an independent living arrangement and/or remain safely in his/her home or abode of his/her own choosing and shall be considered a normal part of the authorization process.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(4) No exception shall result in the recipient's hours exceeding the maximum limits of 195 hours per month as specified at Section 30-765.121 for nonseverely impaired cases or 283 hours per month for severely impaired cases as specified in Section 30-765.111. No exception shall result in the recipient's hours exceeding the maximum limit for PCSP cases as specified at Section 30-780.2(b).

(5) No exceptions to hourly task guidelines shall be made due to inefficiency or incompetence of the provider.

(6) When an exception to an hourly task guideline is made in a recipient's case, the reason for the exception shall be documented in the case file.

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(A) Documentation of the reason for the exception will provide necessary data to audit the effectiveness of each guideline in terms of:
1. Achieving equity in service authorizations; and
2. Evaluating program costs.

(B) In documenting an exception, the county worker can record the circumstances requiring more or less time than the range recommends. Examples of written documentation may include:

1. Writing a few words, phrases, or sentences (e.g., more time needed due to frequent urination, etc.); or

2. Citing the regulation that identifies the exception reason when the reason is listed as one of the exception criteria provided in regulation for that particular service (e.g., under "bowel and bladder" care, frequent urination per Section 30-757.14(a)(4)(A)).

(C) The worker's supervisor should review the documentation of the worker in accordance with current county procedures and current program regulations. The purpose of supervisory case review is to assure that service hours authorized by workers accurately reflect the individual's care needs and that these needs have been appropriately documented in the case file by the worker.

(D) Consistent with current practice, if the supervisor determines that the worker's documentation is not sufficient, the supervisor should discuss the case with the worker and identify any additional items needed to see if the worker can substantiate the exception prior to the supervisor making any changes.

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30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES **30-757**
(Continued)

.11 Domestic services which are limited to the following:

(a) Sweeping, vacuuming, washing and waxing of floor surfaces.

(b) Washing kitchen counters and sinks.

(c) Cleaning the bathroom.

(d) Storing food and supplies.

(e) Taking out garbage.

(f) Dusting and picking up.

(g) Cleaning oven and stove.

(h) Cleaning and defrosting refrigerator.

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

(j) Changing bed linen.

(k) Miscellaneous domestic services (e.g., changing light bulbs, wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the caseworker as necessary for the recipient to remain safely in his/her home.

(1) The time guideline for "domestic services" shall not exceed 6.0 hours total per month per household unless the recipient's needs require an exception.

.12 Heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

.121 The county shall have the authority to authorize this service only at the time IHSS is initially granted, to enable the provider to perform continuous maintenance; or if a lapse in eligibility occurs, eligibility is reestablished, and IHSS has not been provided within the previous 12 months. The county shall also have the authority to authorize this service should the recipient's living conditions result in a threat to his/her safety and such service may be authorized where a recipient is at risk of eviction for failure to prepare his/her home or abode for fumigation as required by statute or ordinance. The caseworker shall document the circumstances, justifying any such allowance.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.13 Related services which are limited to the following:

.131 Preparation of meals, which includes planning menus; removing food from the refrigerator or pantry; washing/drying hands before and after meal preparation; washing, peeling, and slicing vegetables; opening packages, cans and bags; measuring and mixing ingredients; lifting pots and pans; trimming meat; reheating food; cooking and safely operating the stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-size pieces.

(a) The time guidelines range for " preparation of meals" shall be as follows unless the recipient's needs require an exception:

Preparation of Meals Hours per Week Time Guidelines		
	Low	High
Rank 2	3.02	7.00
Rank 3	3.50	7.00
Rank 4	5.25	7.00
Rank 5	7.00	7.00

Note: Rank represents the recipient's level of functioning (functional index as provided in Section 30-756.1.

(b) Factors for the consideration of time include, but are not limited to:

(1) The extent to which the recipient can assist or perform tasks safely.

(2) The types of food the recipient usually eats for breakfast, lunch, dinner, and snacks and the amount of time needed to prepare the food (e.g., more cooked meals versus meals that do not require cooking).

(3) Whether the recipient is able to reheat meals prepared in advance and the types of food the recipient eats on days the provider does not work.

(4) The frequency the recipient eats.

(5) Time for universal precautions, as appropriate.

(c) Exception criteria to the time guideline range include, but are not limited to:

(1) If the recipient must have meals pureed or cut into bite-sized pieces.

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(Continued)

(2) If the recipient has special dietary requirements that require longer preparation times or preparation of more frequent meals.

(3) If the recipient eats meals that require less preparation time (e.g., toast and coffee for breakfast).

.132 Meal clean-up, which includes loading and unloading dishwasher; washing, rinsing, and drying dishes, pots, pans, utensils, and culinary appliances, and putting them away; storing/putting away leftover foods/liquids; wiping up tables, counters, stoves/ovens, and sinks; and washing/drying hands.

(a) Meal clean up does not include general cleaning of the refrigerator, stove/oven, or counters and sinks. These services are assessed under "domestic services" in Section 30-757.11.

(b) The time guideline range for "meal cleanup" shall be as follows unless the recipient's needs require an exception:

Meal Cleanup Hours per Week Time Guideline		
	Low	High
Rank 2	1.17	3.50
Rank 3	1.75	3.50
Rank 4	1.75	3.50
Rank 5	2.33	3.50

(c) Factors for consideration of time include, but are not limited to:

(1) The extent to which the recipient can assist or perform tasks safely.

(A) A recipient with a Rank 3 in "meal cleanup" who has been determined able to wash breakfast/lunch dishes and utensils and only needs the provider to cleanup after dinner would require time based on the provider performing cleanup of the dinner meal only.

(B) A recipient who has less control of utensils and/or spills food frequently may require more time for cleanup.

(2) The types of meals requiring the cleanup.

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(Continued)

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(A) A recipient who chooses to eat eggs and bacon for breakfast would require more time for cleanup than a recipient who chooses to eat toast and coffee.

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(3) If the recipient can rinse the dishes and leave them in the sink until the provider can wash them.

(4) The frequency that meal cleanup is necessary.

(5) If there is a dishwasher appliance available.

(6) Time for universal precautions, as appropriate.

(d) Exceptions criteria to the time guideline range may include, but are not limited to:

(1) If the recipient must eat frequent meals which require additional time for cleanup.

(2) If the recipient eats light meals that require less time for cleanup.

.133 Restaurant meal allowance.

(a) An aged or disabled client who has adequate cooking facilities at home but whose disabilities prevent their use shall be advised of his/her option to receive a restaurant meal allowance in lieu of the services specified in .131 through .133, above, and shopping for food which the recipient would otherwise receive.

(1) The amount of the restaurant meal allowance shall be that specified in Welfare and Institutions Code Section 12303.7 or as otherwise provided by law.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(A) IHSS restaurant meal allowances established in accordance with Welfare and Institutions Code Section 12303.7 shall be as follows:

Allowance for an Individual	Allowance for a Couple
$62.00 per month	$124.00 per month

(2) A recipient who receives a restaurant meal allowance as part of his/her SSP grant shall not receive a restaurant meal allowance from IHSS.

(3) An aged or disabled recipient who is an SSP recipient, who requests a restaurant meal allowance, and who does not have adequate cooking facilities at home shall be referred to SSP.

.134 Laundry services which includes the tasks of washing and drying laundry, mending, ironing, folding, and storing clothes on shelves or in drawers.

(a) Laundry facilities are considered available in the home if, at a minimum, there exists a washing machine and a capability to dry clothes on the premises.

(b) The need for out-of-home laundry services exists when laundry facilities are not available on the premises and it is therefore necessary to go outside the premises to accomplish this service. Included in out-of-home laundry is the time needed to travel to/from a locally available laundromat or other laundry facility.

(c) The time guideline for laundry service where laundry facilities are available in the home shall not exceed 1.0 hours total per week per household unless the recipient's need requires an exception to exceed this limit.

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(1) In assessing time for in-home laundry services, it is expected that the provider will accomplish other tasks while clothes are washing and drying.

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(d) The time guideline for laundry services where laundry facilities are not available in the home shall not exceed 1.5 hours total per week per household unless the recipient's need requires an exception to exceed this limit.

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(Continued)

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(1) It is expected that the typical provider will use a local laundromat as necessary for efficient time utilization.

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(e) An exception to grant more time than the time guidelines specified in Sections 30-757.134(c) and (d) may be necessary for recipients who have incontinence.

.135 Food shopping which includes reasonable food shopping and other shopping/errands limited to the nearest available stores or other facilities consistent with the recipient's economy and needs.

(a) The county shall not authorize additional time for the recipient to accompany the provider.

(b) Food shopping includes the tasks of making a grocery list, travel to/from the store, shopping, loading, unloading, and storing food.

(1) The time guideline for " food shopping" shall not exceed 1.0 hour total per week per household unless the recipient's need requires an exception to exceed this limit.

(c) Other shopping/errands includes the tasks of making a shopping list, travel to/from the store, shopping, loading, unloading, and storing supplies purchased, and/or performing reasonable errands such as delivering a delinquent payment to avert an imminent utility shut-off or picking up a prescription, etc.

(1) The time guideline for "other shopping/errands" shall not exceed 0.5 hour total per week per household unless the recipient's need requires an exception to exceed this limit.

.14 Personal care services, limited to:

(a) "Bowel and bladder" care, which includes assistance with using, emptying, and cleaning bed pans/bedside commodes, urinals, ostomy, enema and/or catheter receptacles;, application of diapers; positioning for diaper changes; managing clothing; changing disposable barrier pads; putting on/taking off disposable rubber gloves; wiping and cleaning recipient; assistance with getting on/off commode or toilet; and washing/drying recipient's and providers hands.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(1) "Bowel and bladder" care does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program, or colostomy irrigation. These tasks are assessed as "paramedical services" specified at Section 30-757.19.

(2) The time guideline range for "bowel and bladder" care shall be as follows unless the recipient's needs require an exception:

Bowel and Bladder Care Hours per Week Time Guideline		
	Low	High
Rank 2	0.58	2.00
Rank 3	1.17	3.33
Rank 4	2.91	5.83
Rank 5	4.08	8.00

(3) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The frequency of the recipient's urination and/or bowel movements.

(C) If there are assistive devices available which result in decreased or increased need for assistance.

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1. Situation where elevated toilet seats and/or Hoyer lifts are available may result in less time needed for "bowel and bladder" care if the use of these devices results in a decreased need for assistance by the recipient.

2. Situations where a bathroom door is not wide enough to allow for easy wheelchair access may result in more time needed if its use results in an increased need.

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(Continued)

(D) Time for universal precautions, as appropriate.

(4) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient has frequent urination or bowel movements.

(B) If the recipient has frequent bowel or bladder accidents.

(C) If the recipient has occasional bowel or bladder accidents that require assistance from another person.

(D) If the recipient's morbid obesity requires more time.

(E) If the recipient has spasticity or locked limbs.

(F) If the recipient is combative.

(b) Respiration limited to nonmedical services such as assistance with self-administration of oxygen and cleaning IPPB machines.

(c) "Feeding," which includes assistance with consumption of food and assurance of adequate fluid intake consisting of feeding or related assistance to recipients who cannot feed themselves or who require other assistance with special devices in order to feed themselves or to drink adequate liquids.

(1) "Feeding" tasks include assistance with reaching for, picking up, and grasping utensils and cup; cleaning recipient's face and hands; and washing/drying hands; and washing/drying hands before and after feeding.

(2) "Feeding" tasks do not include cutting food into bite-sized pieces or pureeing food, as these tasks are assessed in "preparation of meals" services specified at Section 30-757.131.

(3) The time guideline range for "feeding" shall be as follows unless the reciepient's needs require an exception:

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

Feeding Hours per Week Time Guideline		
	Low	High
Rank 2	0.70	2.30
Rank 3	1.17	3.50
Rank 4	3.50	7.00
Rank 5	5.25	9.33

(4) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The amount of time it takes the recipient to eat meals.

(C) The type of food that will be consumed.

(D) The frequency of meals/liquids.

(E) Time for universal precautions, as appropriate.

(5) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the constant presence of the provider is required due to the danger of choking or other medical issues.

(B) If the recipient is mentally impaired and only requires prompting for feeding him/herself.

(C) If the recipient requires frequent meals.

(D) If the recipient prefers to eat foods that he/she can manage without assistance.

(E) If the recipient must eat in bed.

(F) If food must be placed in the recipient's mouth in a special way due to difficulty swallowing or other reasons.

(G) If the recipient is combative.

(d) Routine bed baths, which includes cleaning basin or other materials used for bed sponge baths and putting them away; obtaining water and supplies; washing, rinsing, and drying body; applying lotion, powder and deodorant; and washing/drying hands before and after bathing.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(1) The time guideline range for "bed baths" shall be as follows unless the recipient's needs require an exception:

Bed Baths Hours per Week Time Guideline		
	Low	High
Rank 2	0.50	1.75
Rank 3	1.00	2.33
Rank 4	1.17	3.50
Rank 5	1.75	3.50

(2) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) If the recipient is prevented from bathing in the tub/shower.

(C) If bed baths are needed in addition to baths in the tub/shower.

(D) Time for universal precautions, as appropriate.

(3) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient is confined to bed and sweats profusely requiring frequent bed baths.

(B) If the weight of the recipient requires more or less time.

(C) If the recipient is combative.

(e) Bathing, oral hygiene and grooming:

(1) Bathing includes cleaning the body in a tub or shower; obtaining water/supplies and putting them away; turning on/off faucets and adjusting water temperature; assistance with getting in/out of tub or shower; assistance with reaching all parts of the body for washing, rinsing, drying and applying lotion, powder, deodorant; and washing/drying hands.

(2) Oral hygiene includes applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(3) Grooming includes hair combing/brushing; hair trimming when the recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care when these services are not assessed as "paramedical" services for the recipient; and washing/drying hands.

(4) "Bathing, oral hygiene, and grooming," does not include getting to/from the bathroom. These tasks are assessed as mobility under "ambulation" services specified at Section 30-757.14(k).

(5) The time guideline range for "bathing, oral hygiene, and grooming," shall be as follows unless the recipient's needs require an exception:

Bathing, Oral Hygiene, and Grooming Hours per Week Time Guideline		
	Low	High
Rank 2	0.50	1.92
Rank 3	1.27	3.15
Rank 4	2.35	4.08
Rank 5	3.00	5.10

(6) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The number of times the recipient may need to bathe.

(C) If the recipient requires assistance in/out of tub/shower.

(D) If the recipient needs assistance with supplies.

(E) If the recipient requires assistance washing his/her body.

(F) If the provider must be present while the recipient bathes.

(G) If the recipient requires assistance drying his/her body and/or putting on lotion/powder after bathing.

(H) If the recipient showers in a wheelchair.

(I) Universal precautions, as appropriate.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(7) Exceptions to the time guideline range may include, but are not limited to:

(A) If the provider's constant presence is required.

(B) If the weight of the recipient requires more or less time.

(C) If the recipient has spasticity or locked limbs.

(D) If a roll-in shower is available.

(E) If the recipient is combative.

(f) Dressing, which includes washing/drying of hands; putting on/taking off, fastening/unfastening, buttoning/unbuttoning, zipping/unzipping, and tying/untying of garments, undergarments, corsets, elastic stockings and braces; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.

(1) The time guideline range for "dressing" shall be as follows unless the recipient's needs require an exception.

Dressing Hours per Week Time Guideline		
	Low	High
Rank 2	0.56	1.20
Rank 3	1.00	1.86
Rank 4	1.50	2.33
Rank 5	1.90	3.50

(2) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The type of clothing/garments the recipient wears.

(C) If the recipient prefers other types of clothing/garments.

(D) The weather conditions.

(E) Universal precautions, as appropriate.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(3) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient frequently leaves his/her home, requiring additional dressing/undressing.

(B) If the recipient frequently bathes and requires additional dressing or soils clothing, requiring frequent changes of clothing.

(C) If the recipient has spasticity or locked limbs.

(D) If the recipient is immobile.

(E) If the recipient is combative.

(g) Repositioning and rubbing skin, which includes rubbing skin to promote circulation and/or prevent skin breakdown; turning in bed and other types of repositioning; and range of motion exercises which shall be limited to the following:

(1) General supervision of exercises which have been taught to the recipient by a licensed therapist or other health care professional to restore mobility restricted because of injury, disuse or disease.

(2) Maintenance therapy when the specialized knowledge and judgment of a qualified therapist is not required and the exercises are consistent with the patient's capacity and tolerance.

(A) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(3) "Repositioning and rubbing skin" does not include:

(A) Care of pressure sores (skin and wound care). This task is assessed as a part of "paramedical" services specified at Section 30-757.19.

(B) Ultraviolet treatment (set up and monitor equipment) for pressure sores and/or application of medicated creams to the skin. These tasks are assessed as part of "assistance with prosthetic devices" at Section 30-757.14(i).

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(4) The time guideline range for "repositioning and rubbing skin" shall be as follows unless the recipient's needs require an exception:

Repositioning and Rubbing Skin Hours per Week Time Guideline		
	Low	High
* Functional ranking does not apply	0.75	2.80

(5) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) If the recipient's movement is limited while in the seating position and/or in bed, and the amount of time the recipient spends in the seating position and/or in bed.

(C) If the recipient has circulatory problems.

(D) Universal precautions, as appropriate.

(6) Exceptions criteria to the time guideline range may include, but are not limited to:

(A) If the recipient has a condition that makes him/her confined to the bed.

(B) If the recipient has spasticity or locked limbs.

(C) If the recipient has or is at risk of having decubitus ulcers which require the need to turn the recipient frequently.

(D) If the recipient is combative.

(h) "Transfer," which includes assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, couch, wheelchair, walker, or other assistive device generally occurring within the same room.

(1) "Transfer" does not include:

(A) Assistance on/off toilet. This task is assessed as part of "bowel and bladder" care specified at Section 30-757.14(a).

30-757 **PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES** 30-757
(Continued)

(B) Changing the recipient's position to prevent skin breakdown and to promote circulation. This task is assessed as part of "repositioning and rubbing skin" specified at Section 30-757.14(g).

(2) The time guideline range for "transfer" shall be as follows unless the recipient's needs require an exception:

Transfer Hours per Week Time Guideline		
	Low	High
Rank 2	0.50	1.17
Rank 3	0.58	1.40
Rank 4	1.10	2.33
Rank 5	1.17	3.50

(3) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The amount of assistance required.

(C) The availability of equipment, such as a Hoyer lift.
(D) Universal precautions, as appropriate.

(4) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient gets in and out of bed frequently during the day or night due to naps or use of the bathroom.

(B) If the weight of the recipient and/or condition of his/her bones requires more careful, slow transfers.

(C) If the recipient has spasticity or locked limbs.

(D) If the recipient is combative.

(i) Care of and assistance with prosthetic devices and assistance with self-administration of medications, which includes assistance with taking off/putting on and maintaining and cleaning prosthetic devices, vision/hearing aids and washing/drying hands before and after performing these tasks.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(1) Assistance with self-administration of medications consists of reminding the recipient to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(2) The time guideline range for "care and assistance with prosthetic devices" shall be as follows unless the recipient's needs require an exception:

Care and Assistance with Prosthetic Devices Hours per Week Time Guideline		
	Low	High
*Functional ranking does not apply	0.47	1.12

(3) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient is able to manage medications and/or prosthesis independently and safely.

(B) The amount of medications prescribed for the recipient.

(C) If the recipient requires special preparation to distribute medications (e.g., cutting tablets, putting medications into Medi-sets, etc.).

(D) If the recipient has cognitive difficulties that contribute to the need for assistance with medictions and/or prosthetic devices.

(E) Universal precautions, as appropriate.

(4) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient takes medications several times a day.

(B) If the pharmacy sets up medications in bubble wraps or Medi-sets for the recipient.

(C) If the recipient has multiple prosthetic devices.

(D) If the recipient is combative.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(j) Routine menstrual care which is limited to external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes, using and/or disposing of barrier pads, managing clothing, wiping and cleaning, and washing/drying hands before and after performing these tasks.

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(1) In assessing "menstrual" care, it may be necessary to assess additional time in other service categories specified in this section, such as "laundry," "dressing," "domestic," "bathing, oral hygiene, and grooming."

(2) In assessing "menstrual" care, if the recipient wears diapers, time for menstrual care should not be necessary. This time would be assessed as a part of "bowel and bladder" care.

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(3) The time guideline range for "menstrual care" shall be as follows unless the recipient's needs require an exception:

Menstrual Care Hours per Week Time Guideline		
	Low	High
*Functional rank does not apply	0.28	0.80

(4) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) If the recipient has a menstrual cycle.

(C) The duration of the recipient's menstrual cycle.

(D) If there are medical issues that necessitate additional time.

(E) Universal precautions, as appropriate.

(5) Exception criteria to the time guideline range may include, but are not limited to:

(A) If the recipient has spasticity or locked limbs.

(B) If the recipient is combative.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(k) Ambulation, which includes assisting the recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving and retrieving assistive devices, such as a cane, walker, or wheelchair, etc. and washing/drying hands before and after performing these tasks. "Ambulation" also includes assistance to/from the front door to the car (including getting in and out of the car) for medical accompaniment and/or alternative resource travel.

(1) The time guideline range for "ambulation" shall be as follows unless the recipient's needs require an exception:

Ambulation Hours per Week Time Guideline		
	Low	High
Rank 2	0.58	1.75
Rank 3	1.00	2.10
Rank 4	1.75	3.50
Rank 5	1.75	3.50

(2) Factors for consideration of time include, but are not limited to:

(A) The extent to which the recipient can assist or perform tasks safely.

(B) The distance the recipient must move inside the home.

(C) The speed of the recipient's ambulation.

(D) Any barriers that impede the recipient's ambulation.

(E) Universal precautions, as appropriate.

(3) Exceptions to the time guideline range may include, but are not limited to:

(A) If the recipient's home is large or small.

(B) If the recipient requires frequent help getting to/from the bathroom.

(C) If the recipient has a mobility device, such as a wheelchair that results in a decreased need.

(D) If the recipient has spasticity or locked limbs.

(E) If the recipient is combative.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.15 Assistance by the provider is available for transportation when the recipient's presence is required at the destination and such assistance is necessary to accomplish the travel, limited to:

.151 Transportation to and from appointments with physicians, dentists and other health practitioners.

.152 Transportation necessary for fitting health related appliances/devices and special clothing.

.153 Transportation under .151 and .152 above shall be authorized only after social service staff have determined that Medi-Cal will not provide transportation in the specific case.

.154 Transportation to the site where alternative resources provide in-home supportive services to the recipient in lieu of IHSS.

.16 Yard hazard abatement is light work in the yard which may be authorized for:

.161 Removal of high grass or weeds, and rubbish when this constitutes a fire hazard.

.162 Removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

.163 Such services are limited by Sections 30.763.235(b) and .24.

.17 Protective Supervision consists of observing recipient behavior and intervening as appropriate in order to safeguard the recipient against injury, hazard, or accident.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.171 Protective Supervision is available for observing the behavior of nonself-directing, confused, mentally impaired, or mentally ill persons only.

(a) Protective Supervision may be provided through the following, or combination of the following arrangements.

(1) In-Home Supportive Services program;

(2) Alternative resources such as adult or child day care centers, community resource centers, Senior Centers; respite centers;

(3) Voluntary resources;

(4) Repealed by Manual Letter No. SS-07-01

.172 Protective Supervision shall not be authorized:

(a) For friendly visiting or other social activities;

(b) When the need is caused by a medical condition and the form of the supervision required is medical.

(c) In anticipation of a medical emergency;

(d) To prevent or control anti-social or aggressive recipient behavior.

(e) To guard against deliberate self-destructive behavior, such as suicide, or when an individual knowingly intends to harm himself/herself.

.173 Protective Supervision is only available under the following conditions as determined by social service staff:

(a) At the time of the initial assessment or reassessment, a need exists for twenty-four-hours-a-day of supervision in order for the recipient to remain at home safely.

(1) For a person identified by county staff to potentially need Protective Supervision, the county social services staff shall request that the form SOC 821 (3/06), "Assessment of Need for Protective Supervision for In-Home Supportive Services Program," which is incorporated by reference, be completed by a physician or or other appropriate medical professional to certify the need for Protective Supervision and returned to the county.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(A) For purposes of this regulation, appropriate medical professional shall be limited to those with a medical specialty or scope of practice in the areas of memory, orientation, and/or judgment.

(2) The form SOC 821 (3/06) shall be used in conjunction with other pertinent information, such as an interview or report by the social service staff or a Public Health Nurse, to assess the person's need for Protective Supervision.

(3) The completed form SOC 821 (3/06) shall not be determinative, but considered as one indicator of the need for Protective Supervision.

(4) In the event that the form SOC 821 (3/06) is not returned to the county, or is returned incomplete, the county social services staff shall make its determination of need based upon other available information.

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(5) Other available information can include, but is not limited to, the following:

(A) A Public Health Nurse interview;

(B) A licensed health care professional reports;

(C) Police reports;

(D) Collaboration with Adult Protective Services, Linkages, and/or other social service agencies;

(E) The social service staff's own observations.

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(b) At the time of reassessment of a person receiving authorized Protective Supervision, the county social service staff shall determine the need to renew the form SOC 821 (3/06).

(1) A newly completed form SOC 821 (3/06) shall be requested if determined necessary, and the basis for the determination shall be documented in the recipient's case file by the county social service staff.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

(c) Recipients may request protective supervision. Recipients may obtain documentation (such as the SOC 821) from their physicians or other appropriate medical professionals for submission to the county social service staff to substantiate the need for protective supervision.

.174 Social Services staff shall explain the availability of protective supervision and discuss the need for twenty-four-hours-a-day supervision with the recipient, or the recipient's parent(s), or the recipient's guardian or conservator, the appropriateness of out-of-home care as an alternative to Protective Supervision.

.175 (Reserved.)

.176 County Social Services staff shall obtain a signed statement from the provider(s) of record or any other person(s) who agrees to provide any In-Home Supportive Services (IHSS) or PCSP compensable service voluntarily. The statement [Form SOC 450 (10/98)] shall indicate that the provider knows of the right to compensated services, but voluntarily chooses not to accept any payment, or reduced payment, for the provision of services.

(a) The voluntary services certification for IHSS shall contain the following information:

(1) Services to be performed;

(2) Recipient(s) name;

(3) Case number;

(4) Day(s) and/or hours per month service(s) will be performed;

(5) Provider of services;

(6) Provider's address and telephone number;

(7) Provider's signature and date signed;

(8) Name and signature of Social Service Worker;

(9) County; and

(10) Social Security Number (Optional, for identification purposes only [Authority: Welfare and Institutions Code Section 12302.2]).

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.18 Teaching and demonstration services provided by IHSS providers to enable recipients to perform for themselves services which they currently receive from IHSS. Teaching and demonstration services are limited to instruction in those tasks specified in .11, .13, .14, and .16 above.

.181 This service shall be provided by persons who ordinarily provide IHSS. The hourly rate of provider compensation shall be the same as that paid to other IHSS providers in the county for the delivery method used.

.182 This service shall only be provided when the provider has the necessary skills to do so effectively and safely.

.183 Services shall be authorized for no more than three months.

.184 Services shall be authorized only when there is a reasonable expectation that there will be a reduction in the need for a specified IHSS funded service as a result of the service authorized under this category which is at least equivalent to the cost of the services provided under this category.

(a) The reduction in cost is equivalent if the full cost of service authorized under this part is recovered within six months after the conclusion of the training period.

.185 Within seven months after completion of teaching and demonstration in a specific case, social service staff shall report in to the Department on the results of the service. The report shall include:

(a) The tasks taught.

(b) The instructional method used.

(c) The delivery method used.

(d) The frequency and duration of the instruction.

(e) The total need for each service to be affected both before and six months after the instruction.

(f) The results of instruction including the number of hours of each authorized IHSS funded service to be affected by the instruction both before and six months after the end of the instruction in hours per month.

(g) The hourly rate paid the provider.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.19 Paramedical services, under the following conditions:

.191 The services shall have the following characteristics:

(a) are activities which persons would normally perform for themselves but for their functional limitations,

(b) are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health.

(c) are activities which include the administration of medications, puncturing the skin, or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

.192 The services shall be provided when ordered by a licensed health care professional who is lawfully authorized to do so. The licensed health care professional shall be selected by the recipient. The recipient may select a licensed health care professional who is not a Medi-Cal provider, but in that event shall be responsible for any fee payments required by the professional.

.193 The services shall be provided under the direction of the licensed health care professional.

.194 The licensed health care professional shall indicate to social services staff the time necessary to perform the ordered services.

.195 This service shall be provided by persons who ordinarily provide IHSS. The hourly rate of provider compensation shall be the same as that paid to other IHSS providers in the county for the delivery method used.

.196 The county shall have received a signed and dated order for the paramedical services from a licensed health care professional. The order shall include a statement of informed consent saying that the recipient has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the recipient, or his/her guardian or conservator. The order and consent shall be on a form developed or approved by the department.

.197 In the event that social services staff are unable to complete the above procedures necessary to authorize paramedical services during the same time period as that necessary to authorize the services described in .11 through .18, social services staff shall issue a notice of action and authorize those needed services which are described in .11 through .18 in a timely manner as provided in Section 30-759. Paramedical services shall be authorized at the earliest possible subsequent date.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.198 In no event shall paramedical services be authorized prior to receipt by social services staff of the order for such services by the licensed health care professional. However, the cost of paramedical services received may be reimbursed retroactively provided that they are consistent with the subsequent authorization and were received on or after the date of application for the paramedical services.

NOTE: Authority cited: Sections 10553, 10554, 12300, 12301.1 and 12301.21, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Peremptory Writ of Mandate, Disabled Rights Union v. Woods, Superior Court, Los Angeles County, Case #C 380047; Miller v. Woods/Community Services for the Disabled v. Woods, Superior Court, San Diego County, Case Numbers 468192 and 472068; and Sections 12300, 12300(c)(7), 12300(f), 12300(g), 12300.1, and 12301.2, Welfare and Institutions Code.

30-758 TIME PER TASK AND FREQUENCY GUIDELINES 30-758

Repealed by Manual letter No. SS-06-02, effective 9/1/06

NOTE: Authority cited: Sections 10553, 10554, 12300, and 12301.2, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Peremptory Writ of Mandate, Disabled Rights Union v. Woods, Superior Court, Los Angeles County, Case #C 380047; and Sections 12300, and 12301.2, Welfare and Institutions Code.

30-759 APPLICATION PROCESS 30-759

.1 Each request or application for services shall have been made in accordance with Section 30-009.22.

.11 Recipient information including ethnicity and primary language (including sign language) shall be collected and recorded in the case file.

.2 Applications shall be processed, including eligibility determination and needs assessment, and notice of action mailed no later than 30 days following the date the written application is completed. An exception may be made for this requirement when a disability determination in accordance with Section 30-771 has not been received in the 30-day period. Services shall be provided, or arrangements for their provision shall have been made, within 15 days after an approval notice of action is mailed.

.3 Pending final determination, a person may be considered blind or disabled for purposes of non-PCSP IHSS eligibility under the following conditions:

.31 For a disabled applicant, eligibility may be presumed if the applicant is not employed and has no expectation of employment within the next 45 days, and if in the county's judgment the person appears to have a mental or physical impairment that will last for at least one year or end in death.

.32 For a blind applicant, eligibility may be presumed if in the county's judgment the person appears to meet the requirements of Section 30-771.2.

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30-759 APPLICATION PROCESS (Continued) **30-759**

.4 In-Home Supportive Services payment shall be made for authorizable services, as specified in Section 30-761.28, received on or after the date of application or of the request for services as provided in Section 30-009.224, if either the recipient or the provider does not qualify for PCSP. If the ineligible recipient/provider becomes eligible for payment under PCSP, payment shall be made from PCSP as soon as administratively feasible in lieu of IHSS.

.5 Once services have been authorized, the authorization shall continue until there is a change in eligibility or assessed level of need.

.6 The availability or continuity of services to a recipient shall not be limited or reduced because the county fails to comply with administrative processing standards in this section and in Section 30-761.2, unless the recipient has substantially contributed to the county's failure to comply.

.7 A written notice of action containing information on the disposition of the request for service shall be sent to the applicant in accordance with MPP Sections 10-116 and 30-763.8.

.8 Emergency services may be authorized to aged, blind, or disabled persons prior to the completion of a needs assessment if the recipient meets the eligibility criteria specified in .3 above or in Section 30-755 and the recipient's needs warrant immediate provision of service. The county shall subsequently perform a complete needs assessment within 30 days after the date of application as specified in .4 above, and comply with the standards for application processing.

.9 An intercounty transfer shall be initiated by the transferring county after receiving notification from the recipient or person as described in Section 30-760.1 of his/her move to a new county. This transfer shall be accomplished in accordance with the following procedures:

.91 The transferring county shall, within ten calendar days from the original date of notification, send (by mail or FAX) a notification of transfer form which includes a place for the names and numbers and telephones numbers of the social service workers from both the sending and receiving counties, the statement "Please sign and return a copy of this document which will verify that your county will accept responsibility for the case effective (date to be filled in)," a space for additional comments, and other documents pertaining to the transfer of responsibility and provision of IHSS to the receiving county. If faxed, mailed copy(ies) shall follow in a timely manner for auditing purposes.

.911 The documents required in Section 30-759.91 include, but are not limited to, an application for In-Home Supportive Services (SOC 295, 10/90); the most recent IHSS assessment, an IHSS provider eligibility update, a personal care services program provider enrollment form (SOC 428, 5/90), if applicable; a paramedical authorization form (SOC 321, 10/88), if applicable; current NOAs, and any information pertaining to overpayments and fraud investigations, if applicable.

.92 There shall be no interruption or overlapping of services as the result of a recipient moving from one county to another.

30-759 APPLICATION PROCESS (Continued) **30-759**

.921 The transferring county is responsible for authorizing and funding services until the transfer period expires, at which time the receiving county becomes responsible.

.922 If the recipient moves from the receiving county to a third county during the transfer period, the transferring county is responsible for canceling the transfer to the original receiving county and initiating the transfer to the new receiving county.

.93 The receiving county shall complete and return a notification of transfer form to the transferring county within 30 days of receipt of the form.

.931 If the notification of transfer form has not been returned within 30 calendar days by the receiving county, the transferring county shall contact the receiving county to assure that the new county has received the notification of transfer and is taking action.

.94 As part of the transfer process, the receiving county shall complete a face-to-face assessment with the recipient during the transfer period.

.941 There shall be no change in the recipient's level of authorized hours/benefits taken or initiated by the transferring county during the transfer period unless there is a substantive change in living arrangements or other eligibility factors as verified by the receiving county.

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(a) Some examples of what is considered a "substantive change in living arrangements" follow:

1. A change in the number of persons living in the household;
2. A change in the age(s) of persons living in the household;
3. A change in the layout or location of living areas;
4. A change in the number of rooms in the living space;
5. A change in the availability of cooking facilities;
6. A change in the availability of alternate resources.

(b) The receiving county should be notified immediately once appropriate action, including a notice of action (NOA) is taken.

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30-759 APPLICATION PROCESS (Continued) **30-759**

.95 When services are discontinued by the transferring county during the transfer period, and the recipient does not appeal the discontinuance through the state hearing process, any reapplication shall be treated as a new application with the county in which the recipient currently resides (receiving county).

.96 When an IHSS recipient appeals a discontinuance, decrease of hours, or any adverse action against him/her by the transferring county during the transferring process, the transferring county shall maintain full responsibility for the case. The transferring county is accountable for the hearing and aid paid pending (if applicable), until a hearing decision is made, after which the transfer of the case to the receiving county can be completed.

.97 If a person has an IHSS application pending at the time he/she moves to a new county, the responsibility for completion of the application shall remain with the transferring county in accordance with the following:

.971 If the person is eligible at the time the county of residence changes, a transfer process can be initiated.

.972 If a Determination of Disability is pending, responsibility shall be retained by the transferring county until the disability determination is received. The transferring county shall forward the disability determination, along with a notification of transfer form (see Section 30-759.91), within 10 calendar days of the date the determination was received.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10950, 11102, 12301, 12305.71, and 14132.95, Welfare and Institutions Code.

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30-760 RESPONSIBILITIES 30-760

.1 Applicant/Recipient Responsibilities

The applicant/recipient, his/her conservator, or in the case of a minor, his/her parents or guardian shall be responsible for:

.11 Completing or participating in completion of all documents required in the determination of eligibility and need for services.

.12 Making available to the county all documents that are in his/her possession or available to him/her which are needed to determine eligibility and need for service.

.13 Cooperating with county fraud detection and prevention and quality assurance activities including case reviews and home visits.

.14 Reporting all known facts which are material to his/her eligibility and level of need.

.15 Reporting within ten calendar days of the occurrence, any change in any of these facts.

.16 Reporting all information necessary to assure timely and accurate payment to providers of service.

.17 Reporting within 10 calendar days when a change of residence places the recipient within the jurisdiction of another county.

.2 County Responsibilities

.21 Informing recipients of their rights and responsibilities in relation to eligibility and need for services.

.22 Evaluating the capacity of applicants or recipients to discharge their responsibilities as set forth in .1 above.

.23 Assisting recipients as needed in establishing their eligibility and need for service.

.24 Correctly determining eligibility and need.

.25 Complying with administrative standards to ensure timely processing of recipient requests for service.

NOTE: Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 11102, 12301, and 14132.95, Welfare and Institutions Code.

30-761 NEEDS ASSESSMENT STANDARDS 30-761

.1 Services shall be authorized only in cases which meet the following condition:

.11 The recipient is eligible as specified in Sections 30-755 or 30-780, except that services may be authorized on an interim basis as provided in Section 30-759.3.

.12 A needs assessment establishes a need for the services identified in Section 30-757 consistent with the purposes of the IHSS program, as specified in Section 30-700.1, except as provided in Section 30-759.8.

.13 Social services staff of the designated county department has had a face-to-face contact with the recipient in the recipient's home at least once within the past 12 months, except as provided in Sections 30-761.215 through .217, and has determined that the recipient would not be able to remain safely in his/her own home without IHSS. If the face-to-face contact is due but the recipient is absent from the state but still eligible to receive IHSS pursuant to the requirements stated in Section 30-770.4, Residency, the face- to-face requirement is suspended until such time as the recipient returns to the state.

.14 Performance of the service by the recipient would constitute such a threat to his/her health/safety that he/she would be unable to remain in his/her own home.

.2 Needs Assessments

.21 Needs assessments are performed:

.211 Prior to the authorization of IHSS services when an applicant is determined to be eligible, except in emergencies as provided in Section 30-759.8.

.212 Prior to the end of the twelfth calendar month from the last face-to-face assessment except as provided in Sections 30-761.215 through .217.

(a) If a reassessment is completed before the twelfth calendar month, the month for the next reassessment shall be adjusted to the 12-month requirement except as provided in Section 30-761.215 through .217.

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

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.213 Example: If a recipient's initial face-to-face assessment for IHSS was completed on December 12th, the county may complete the next reassessment anytime prior to December 31st of the following year.

.214 Example: If a reassessment is completed on September 15th, prior to the actual twelfth calendar month because of a change in the recipient's condition, the next reassessment shall occur anytime prior to September 30th of the following year.

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.215 Except for IHSS Plus Waiver cases, prior to the end of the eighteenth calendar month from the last reassessment if the county opted to extend the assessment in accordance with these regulations. A county may opt to extend the time for a reassessment for up to six months beyond the regular 12-month period on a case-by-case basis if the county can document that all the following conditions exist, except as provided in Section 30-761.216:

(a) The recipient had at least one reassessment since the initial program intake assessment: and

(b) The recipient's living arrangement has not changed since the last annual assessment; and:

(1) The recipient lives with others (i.e., spouse, parent, live-in provider, housemate, children, a relative or non-relative); or

(2) Has regular meaningful contact with persons interested in the recipient's well being other then his/her provider; and

(c) The recipient is able to satisfactorily direct his/her care; or:

(1) If the recipient is a minor, his/her parent or legal guardian is able to satisfactorily direct the recipient's care; or

(2) If the recipient is incompetent, his/her conservator is able to satisfactorily direct the recipient's care; and

(d) There has not been any known change in the recipient's supportive services needs in the previous 24 months; and

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

(e) There have not been any reports to, or involvements of, an adult protective services agency or other agencies responsible for addressing the health and safety of individuals documented in the case record since the last assessment; and

(f) The recipient has not had a change in provider(s) in the previous six months; and

(g) The recipient has not reported a change in his/her supportive services needs that requires a reassessment; and

(h) The recipient has not been hospitalized in the previous three months.

.216 If some, but not all, conditions specified in Section 30-761.215(a) through (h) are met, the county may consider other factors in determining if the extended assessment period is appropriate. The factors include, but are not limited to:

(a) Involvement in the recipient's care from a social worker case manager or similar representative of a human services agency, such as Multi Services Seniors Program (MSSP), Linkages, a regional center, or county mental health program; or

(b) Prior to the end of the twelfth calendar month following the last assessment, the county receives a medical report from a physician or other licensed health care professional that states the recipient's medical condition is not likely to change.

(1) For purposes of this regulation, a licensed health care professional means a medical professional licensed in California by the appropriate California Regulatory Agency, acting within the scope of his or her license or certificate as defined in the California Business and Professions Code, and who has knowledge of the recipient's medical history.

.217 If the county opts to extend the reassessment period as provided in Section 30-761.215 through .216, the county shall document the basis of the decision in the case file.

.218 When the county has information indicating that the recipient's need for supportive services is expected to decrease in less than 12 months, the county may reassess the recipient's needs in less than 12 months since the last assessment.

.219 The county shall reassess the recipient's need for services:

(a) Any time the recipient notifies the county of a need to adjust the service hours authorized due to a change in circumstances; or

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

(b) When there is other pertinent information which indicates a change in circumstances affecting the recipient's need for supportive services.

.22 Repealed by Manual Letter No. 82-67 (10/1/82).

.23 The designated county department shall not delegate the responsibility to do needs assessments to any other agency or organization.

.24 The needs assessment shall identify the types and hours of services needed and the services which will be paid for by the IHSS program.

.25 No services shall be determined to be needed which the recipient is able to perform in a safe manner without an unreasonable amount of physical or emotional stress.

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

.26 Social service staff shall determine the need for services based on all of the following:

.261 The recipient's physical/mental condition, or living/social situation.

(a) These conditions and situations shall be determined following a face-to-face contact with the recipient, if necessary.

.262 The recipient's statement of need.

.263 The available medical information.

.264 Other information social service staff consider necessary and appropriate to assess the recipient's needs.

.27 A needs assessment and authorization form shall be completed for each case and filed in the case record. The county shall use the needs assessment form developed or approved by the Department. The needs assessment form shall itemize the need for services and shall include the following:

.271 Recipient information including age, sex, living situation, the nature, and extent of the recipient's functional limitations, and whether the recipient is severely impaired.

.272 The types of services to be provided through the IHSS program, the service delivery method and the number of hours per service per week.

.273 Types of IHSS provided without cost or through other resources, including sources and amounts of those services.

.274 Unmet need for IHSS.

.275 Beginning date of service authorization.

30-761 NEEDS ASSESSMENT STANDARDS (Continued) **30-761**

.28 Services authorized shall be justified by and consistent with the most recent needs assessment, but shall be limited by the provisions of Section 30-765.

.3 IHSS staff shall be staff of a designated county department.

.31 Classification of IHSS assessment workers shall be at the discretion of the county.

.32 IHSS assessment workers shall be trained in the uniformity assessment system.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code. Reference: Sections 12301.1 and 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

30-763 SERVICE AUTHORIZATION **30-763**

.1 Services staff shall determine the need for only those tasks in which the recipient has functional impairments. In the functions specified in Section 30-756.2, a functional impairment shall be a rank of at least 2.

.11 The applicant/recipient shall be required to cooperate to the best of his/her ability in the securing of medical verification which evaluates the following:

.111 His/her present condition.

.112 His/her ability to remain safely in his/her own home without IHSS services.

.113 His/her need for either medical or nonmedical out-of-home care placement if IHSS were not provided.

.114 The level of out-of-home care necessary if IHSS were not provided.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.12 Applicant/recipient failure to cooperate as required in Section 30-763.11 shall result in denial or termination of IHSS.

.2 Using the needs assessment form, services staff shall calculate the number of hours per week needed for each of the services determined to be needed by the procedure described in Section 30-763.1.

.3 Shared Living Arrangements: The following steps apply to assessing need for clients who live with another person(s). With certain exceptions specified in Section 30-763.4, the need for IHSS shall be determined in the following manner.

.31 Domestic Services and Heavy Cleaning

.311 The living area in the house shall be divided into areas used solely by the recipient, areas used in common with others, and areas not used by the recipient.

.312 No need shall be assessed for areas not used by the recipient.

.313 The need for services in common living areas shall be prorated to all the housemates, the recipient's need being his/her prorated share.

.314 For areas used solely by the recipient, the assessment shall be based on the recipient's individual need.

.32 Related Services need shall be assessed as follows:

.321 When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the recipient's need is his/her prorated share.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.322 When the service is not being provided by a housemate, and is being provided separately to the recipient, the assessment shall be based on the recipient's individual need.

.33 The need for protective supervision shall be assessed based on the recipient's individual need provided that:

.331 When two (or more) IHSS recipients are living together and both require protective supervision, the need shall be treated as a common need and prorated accordingly. In the event that proration results in one recipient's assessed need exceeding the payment and hourly maximums provided in Section 30-765, the apportionment of need shall be adjusted between the recipients so that all, or as much as possible of the total common need for protective supervision may be met within the payment and hourly maximums.

.332 For service authorization purposes, no need for protective supervision exists during periods when a provider is in the home to provide other services.

.34 The need for teaching and demonstration services shall be assessed based on the recipient's individual need, except when recipients live together and have a common need, the need shall be met in common when feasible.

.35 Other IHSS Services:

.351 The recipient's need for transportation services, paramedical services and personal care services shall be assessed based on the recipient's individual need.

.352 The need for yard hazard abatement shall not be assessed in shared living arrangements, except when all housemates fall into one or more of the following categories:

(a) Other IHSS recipients unable to provide such services.

(b) Other persons physically or mentally unable to provide such services.

(c) Children under the age of fourteen years.

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30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.4 Exceptions when assessing needs in shared living arrangements:

.41 Able and Available Spouse

.411 When an IHSS recipient has a spouse who does not receive IHSS, the spouse shall be presumed able to perform certain specified tasks unless he/she provides medical verification of his/her inability to do so.

.412 An able spouse of an IHSS recipient shall be presumed available to perform certain specified tasks except during those times he/she is out of the home for employment, health or for other unavoidable reasons and the service must be provided during his/her absence.

.413 When the recipient has an able and available spouse there shall be no payment to the spouse or any other provider for the following services as described in 30-757:

(a) Domestic

(b) Related Services

(c) Yard Hazard Abatement

(d) Teaching and Demonstration

(e) Heavy Cleaning

.414 When an able spouse is not available because of employment, health, or other unavoidable reasons, a provider may be paid for the following services only if they must be provided during the spouse's absence:

(a) Meal Preparation

(b) Transportation

(c) Protective Supervision

.415 An able and available spouse or other provider may be paid for providing:

(a) Personal care services

(b) Paramedical service

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.416 In addition to those services listed in Section 30-763.445, a spouse may be paid to provide the following services when he/she leaves full-time employment or wishes to seek employment but is prevented from doing so because no other suitable provider is available:

(a) Transportation

(b) Protective Supervision

.42 Landlord/Tenant Arrangements

.421 When the recipient is the tenant, the need for domestic and heavy cleaning services shall be based on the living area used solely by the recipient. No need for yard hazard abatement shall be assessed. The needs assessment shall take into account any services the landlord is obligated to perform under the rental agreement.

.422 When the recipient is the landlord, the need for domestic and heavy cleaning services shall be assessed for all living areas not used solely by the tenant. The needs assessments shall take into account any services the tenant is obligated to perform under the rental agreement.

.43 If the recipient has moved into a relative's home primarily for the purpose of receiving services, the need for domestic and heavy cleaning services shall be assessed only for living areas used solely by the recipient. Yard hazard abatement services shall not be provided.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.44 When the recipient is under eighteen years of age and is living with the recipient's parent(s), IHSS may be purchased from a provider other than the parent(s) when no parent is able to provide the services for any of the following reasons:

.441 when the parent(s) is absent because of employment or education or training for vocational purposes.

.442 if the parent(s) is physically or mentally unable to perform the needed services.

.443 when the parent is absent because of on-going medical, dental or other health-related treatment.

.444 up to eight hours per week may be authorized for periods when the parent(s) must be absent from the home in order to perform shopping and errands essential to the family, or for essential purposes related to the care of the recipient's siblings who are minors.

.45 When the recipient is under eighteen years of age and is living with the recipient's parent(s), IHSS may be purchased from a parent under the following conditions:

.451 All of the following conditions shall be met:

(a) The parent has left full-time employment or is prevented from obtaining full-time employment because of the need to provide IHSS to the child;

(b) There is no other suitable provider available;

(c) If the child does not receive the listed services the child may inappropriately require out-of-home placement or may receive inadequate care.

.452 For the purposes of Section 30-763.451(b), a suitable provider is any person, other than the recipient's parent(s), who is willing, available, and qualified to provide the needed IHSS.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.453 When both parents are in the home, a parent may receive a payment as an IHSS provider only under the following conditions:

(a) The conditions specified in Sections 30-763.451(a) through (c) shall be met.

(b) The nonprovider parent shall be unable to provide the services because he/she is absent because of employment or in order to secure education as specified in Section 30-763.441, or is physically or mentally unable to provide the services, as specified in Section 30-763.442.

(c) If the nonprovider parent is unable to provide services because he/she is absent for employment or educational purposes, payment shall be made to the provider parent only for services which are normally provided during the periods of the nonprovider parent's absence as indicated above.

.454 The IHSS provided shall be limited to:

(a) Related services, as specified in Section 30-757.13.

(b) Personal care services, as specified in Section 30- 757.14.

(c) Assistance with travel, as specified in Section 30-757.15.

(d) Paramedical services, as specified in Section 30-757.19.

(e) Protective supervision, as specified in Section 30-757.17, limited to that needed because of the functional limitations of the recipient. This service shall not include routine child care or supervision.

.46 When the recipient is a parent living with his/her child(ren) who is under fourteen years of age and who is not eligible or does not need IHSS.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.461 The recipient's need for domestic and heavy cleaning services in common living areas, and for related services shall be assessed as if the child(ren) did not live in the home.

.462 The child(ren)'s needs shall not be considered when assessing the need for services, including domestic or heavy cleaning in areas used solely by the child(ren).

.47 Live-in Providers:

.471 Domestic and heavy cleaning services shall not be provided in areas used solely by the provider. The need for related services may be prorated between the provider and the recipient, if the provider and the recipient agree. All other services shall be assessed based on the recipient's individual need, except as provided in Sections 30-763.33 and .34.

.5 Having estimated the need according to Sections 30-763.1 and .2, and after making the adjustments identified in Sections 30-763.3 and .4 as appropriate, the remaining list of services and hours per service is the total need for IHSS services.

.6 Identification of Available Alternative Resources

.61 Social services staff shall explore alternative in-home services supportive services which may be available from other agencies or programs to meet the needs of the recipient as assessed in accordance with Section 30-761.26.

.611 Social services staff shall arrange for the delivery of such alternative resources as necessary in lieu of IHSS program-funded services when they are available and result in no cost to the IHSS program or the recipient except as provided in Section 30-763.613.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.612 The IHSS program shall not deliver services which have been made available to the recipient through such alternative resources, except as provided in Section 30-763.613.

.613 In no event shall an alternative resource be used at the financial expense of the recipient, except:

(a) At the recipient's option; or

(b) When the recipient has a share of cost obligation which shall be reduced by the amount necessary for the purchase of the alternative resource.

.62 Social services staff shall explore with the recipient the willingness of relatives, housemates, friends or other appropriate persons to provide voluntarily some or all of the services required by the recipient.

.621 Social services staff shall obtain from the recipient a signed statement authorizing discussion of the case with any persons specified in Section 30-763.62.

.622 Social services staff shall not compel any such volunteer to provide services.

.63 Social services staff shall document on the needs assessment form the total need for a specific service, which shall then be reduced by any service available from an alternative resource. The remaining need for IHSS is the adjusted need.

.64 Social Services staff shall obtain a signed statement from the provider(s) of record or any other person(s) who agrees to provide any IHSS/PCSP compensable service voluntarily. The statement [Form SOC 450 (10/98)] shall indicate that the provider(s) knows of the right to compensated services, but voluntarily chooses not to accept any payment, or reduced payment, for the provision of services. (See MPP Section 30-757.176 for information regarding the voluntary services certification form).

.7 The Determination of Services Which Shall be Purchased by IHSS

.71 Services shall be authorized to meet all of the adjusted need for IHSS up to the appropriate service maximum identified in Section 30- 765.

.72 These services shall not be authorized concurrently with the SSI/SSP nonmedical out-of-home care living arrangement.

.8 Notice of Action

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.81 Whenever an IHSS needs assessment is completed the recipient shall be sent a notice of action in accordance with the requirements of MPP 10-116 and 30-759.7. In addition to the information required in 10- 116, the notice shall include:

.811 a description of each task for which need is assessed.

.812 the number of hours authorized for the completion of the task.

.813 identification of hours for tasks increased or decreased and the difference from previous hours authorized.

.9 Miller vs. Woods and Community Service Center for the Disabled vs. Woods.

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.91 Background

On October 21, 1983 the Court of Appeal, Fourth Appellate District, issued a decision in the consolidated case of Miller vs. Woods and Community Service Center for the Disabled vs. Woods. The court declared invalid MPP 30-463.233c (now 30-763.233c) which provided that no need for protective supervision may be assessed when a housemate is in the home.

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.92 Case Review Procedures

.921 The county shall identify no later than June 30, 1984 all open IHSS cases with recipients living with a housemate where a need for protective supervision as defined in 30-757.17 may exist.

.922 The county shall determine through recipient contact whether a need for protective supervision exists unless the case record provides conclusive evidence which indicates that no need exists.

.93 Authorization and Notification

.931 The county shall complete a new Needs Assessment form to authorize protective supervision. The authorization shall be effective as of May 1, 1984.

30-763 SERVICE AUTHORIZATION (Continued) **30-763**

.932 The county shall send a Notice of Action to all affected recipients which shall state: "Hours for protective supervision are authorized based on the Miller vs. Woods and Community Service Center for the Disabled vs. Woods court action."

.94 Recordkeeping

.941 The county shall maintain a listing of those recipients who were previously not authorized to receive protective supervision because of the presence of a housemate.

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.942 DSS will provide each county with a computer generated listing which identifies any recipient whose address matches the address of an Individual Provider. The listing should be used as an aid and cross-check in the case review process; the listing is not a substitute for the case review.

.943 For those recipients with an Individual Provider, the listing in Section 30-763.941 will be generated through use of a special reason code indicating increased hours due to the Miller vs. Woods court decision.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12300, 12309, and 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code; and Miller v. Woods/Community Services for the Disabled v. Woods, Superior Court, San Diego County, Case Numbers 468192 and 472068.

30-764 INDIVIDUAL PROVIDER COMPENSATION 30-764

.1 Computation of Payment

.11 Social service staff shall determine the amount of the IHSS payment required to purchase services to meet the IHSS adjusted need as specified in 763.41 above.

.12 The IHSS payment shall be determined by multiplying the monthly adjusted need for IHSS hours by the base payment rate used by the county, except as provided in .14 below.

.13 The hours and amount of compensation available for personal attendant providers shall be determined by county social services staff. The payment shall be the minimum necessary to obtain adequate service to meet the authorized service needs of the recipient.

.2 Rate of Compensation

.21 The base rate of compensation used by the county shall not be less than the legal minimum wage in effect at the time the work is performed, except when personal attendants are employed.

.22 In advance pay cases, the base rate paid by the recipient to the provider shall not be less than the base rate used by the county for the authorized IHSS payment.

.23 The recipient shall develop a work schedule which is consistent with the authorized service hours at the county's base rate. If the recipient finds that a work schedule cannot be established without requiring payment in excess of the county's base rate, the recipient shall bring such information to the county's attention. The county will determine if payment in excess of the base rate is necessary. Any additional costs resulting from the recipient's actions in work scheduling or increasing the rate paid per work unit shall be borne by the recipient unless prior county approval has been obtained.

.24 No adjustments in the IHSS payment shall be made for meals and lodging provided to the provider by the recipient except as specified in Section 30-763. However, any income received by the recipient through this means is countable income for eligibility purposes as specified in Section 30-775 and shall be reported as such by the recipient.

30-764 INDIVIDUAL PROVIDER COMPENSATION 30-764

.3 Employer Responsibilities

.31 As employers recipients have certain responsibilities for standards of compensation, work scheduling and working conditions as they apply to IHSS individual providers. The county will assure that all recipients understand their basic responsibilities as employers.

.32 Non live-in employees shall be compensated at the base rate for the first forty hours worked during a work week. Each hour, or fraction thereof, worked in excess of forty hours during a work week shall be compensated at one and one-half times the base rate.

30-765 COST LIMITATIONS 30-765

.1 The following limitations shall apply to all payments made for in-home supportive services:

.11 The maximum services authorized per month except as provided in Section 30-765.3, under IHSS to any recipient determined to be severely impaired, as defined in Section 30-753(s)(1) shall be that specified in Welfare and Institutions Code Section 12303.4(b) or as otherwise provided by law.

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.111 The IHSS service hours for a severely impaired recipient receiving services through the individual provider mode of delivery shall not exceed 283 hours per month effective July 8, 1988. (Welfare and Institutions Code Section 12303.4(b)(1)).

.112 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.

.113 Welfare and Institutions Code Section 12300(g)(2) states:

"Any recipient receiving services under both Section 14132.95 and this article shall receive no more than 283 hours of service per month, combined, and any recipient of services under this article shall receive no more than the applicable maximum specified in Section 12303.4." (See Section 30-765.11.)

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.12 The maximum services authorized per month except as provided in Section 30-765.3, under non-PCSP to any recipient determined not to be severely impaired shall be that specified in Welfare and Institutions Code Section 12303.4(a) or as otherwise provided by law.

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.121 The IHSS service hours for a recipient who is not determined to be severely impaired and receives services through the individual provider mode of service delivery shall not exceed 195 hours per month effective July 8, 1988 (Welfare and Institutions Code Section 12303.4(a)(1)).

.122 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.

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30-765 COST LIMITATIONS (Continued) **30-765**

.13 The statutory maximum service hours per month shall be inclusive of any payment by IHSS for a restaurant meal allowance established in accordance with the Welfare and Institutions Code Section 12303.7.

.131 The statutory maximum for individuals receiving services through the individual provider mode of service delivery and eligible for the restaurant meal allowance shall be determined by multiplying the statutory maximum hours of service by the county wage rate, subtracting the restaurant meal allowance (see Section 30-757.134(a)(1)(A)) from this product and dividing the remainder by the county hourly wage rate.

.132 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.

.14 The county shall not make monthly payments of IHSS monies to recipients in excess of the computed maximums in Sections 30-765.11, .12 and .13. The sum of the IHSS monthly payment and the recipient's share of cost, if any, shall not exceed the appropriate maximum.

.2 The statewide wage rate for individual providers shall be determined by the Department. Effective July 8, 1988, the statewide wage rate is $4.25.

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.21 DHS regulation Section 51535.2 reads:

Reimbursement Rates for Personal Care Services Program.

(a) For the individual provider mode for providing personal care services, the reimbursement rate shall be a maximum of $5.50 per hour of service: provided, however, that the reimbursement rate in each county shall not exceed the rate in each county for the individual provider mode of service in the IHSS program pursuant to Article 7 (commencing with Section 12300) of Part 3 of Division 9 of the Welfare and Institutions Code, as it existed on September 28, 1992.

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30-765 COST LIMITATIONS (Continued) **30-765**

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(b) For the contract mode for providing personal care services pursuant to Welfare and Institutions Code Sections 12302 and 12302.1, the reimbursement rates shall be those specified in the contract between the county and the agency contractor not to exceed the following maximum rates for services provided through State fiscal year 1993-1994 as follows:

(1)	Butte	$ 9.65
(2)	Nevada	$10.34
(3)	Riverside	$12.29
(4)	San Diego	$10.49
(5)	San Francisco	$12.28
(6)	San Joaquin	$ 9.50
(7)	San Mateo	$12.65
(8)	Santa Barbara	$11.76
(9)	Santa Clara	$11.11
(10)	Santa Cruz	$13.61
(11)	Stanislaus	$10.51
(12)	Tehama	$11.30
(13)	Ventura	$11.04

(c) Nothing in this section is intended to be a limitation on the rights of providers and beneficiaries or on the duties of the Department of Social Services, pursuant to Welfare and Institutions Code Section 12302.2 subdivision (a). Contributions, premiums and taxes paid pursuant to Welfare and Institutions Code Section 12302.2, subdivision (a) shall be in addition to the hourly rates specified in subdivision (a) of this section.

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30-765 COST LIMITATIONS (Continued) **30-765**

.3 IHSS recipients receiving services through the individual provider mode of delivery shall not receive less service hours per month than he/she received during June 1988, without a reassessment of need. The reassessment shall not result in an automatic reduction in authorized hours, unless the recipient no longer needs the hours.

.4 These regulations shall remain in effect until July 1, 1990, unless a later enacted regulation extends or repeals that date.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12300, 12303.4, and 14132.95, Welfare and Institutions Code.

30-766 COUNTY PLANS 30-766

.1 Each county welfare department shall develop and submit a county plan to CDSS no later than 30 days following receipt of its allocation, which specifies the means by which IHSS will be provided in order to meet the objectives and conditions of the program within its allocation.

.11 The plan shall be submitted to CDSS and shall be based upon relevant information, as specified in Welfare and Institutions Code Sections 12301 and 14132.95, including, but not limited to the information specified below:

.111 Projected caseload, hours paid, and costs per month/quarter by mode;

.112 Modes of IHSS and PCSP service delivery the county intends to use;

.113 Estimated program costs for both the IHSS and PCSP programs;

.114 Methods the county will utilize to control non-PCSP program costs to comply with required fiscal limitations; and

.115 Program design intended to meet PCSP requirements.

.12 County plans and amendments shall be effective upon submission.

.13 CDSS shall review each county plan for compliance with Welfare and Institutions Code Sections 12300, et seq. and 14132.95, regulations of CDSS and DHS, and when appropriate, issue departmental approval.

.131 CDSS, when appropriate, shall adjust funding levels contained in the plan, as a condition of approval.

.132 A county plan which includes IHSS administrative costs shall not be issued departmental approval.

.133 If, after review, CDSS determines that a county plan is not in compliance, the Department shall require the county to amend its plan.

.134 CDSS shall develop a county plan for counties which have not submitted plans within the required time frame, based on CDSS' estimate for those counties. Such plans shall be effective upon written notification to the county.

30-766 COUNTY PLANS (Continued) **30-766**

.14 In the event that funds are available for reallocation, special consideration shall be given to those counties which submit their county plans by the due date.

.141 CDSS shall be permitted to reallocate funds from counties which are late based on CDSS's estimate for those counties.

.15 Each county shall monitor its expenditures monthly. Upon discovery by either CDSS or the county that anticipated expenditures will exceed the amount of the county's base allocation, the county shall immediately submit to CDSS for approval an amended plan.

.151 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.

.152 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.

.16 Counties shall not reduce authorized services or hours of service to recipients in order to remain within their allocation.

.17 All state-mandated program costs, after the required county contribution, shall be eligible for reimbursement from state social service funds. If appropriated funds are insufficient to reimburse counties for all state-mandated costs, the state shall fully reimburse the counties for all state-mandated program costs, less the required county contribution.

.18 The portion of county expenditures which, after the county contribution, exceeds the allocation, shall not be eligible for reimbursement from state social service funds if such deficit is caused by:

.181 Noncompliance with the requirements of the state-approved county plan or State allocation plan; or

.182 Non-state-mandated costs; or

.183 IHSS administrative costs.

30-766 COUNTY PLANS (Continued) **30-766**

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(a) Some examples of situations where reimbursement would not be made are:

(1) A county chooses to give a wage/benefit increase to IHSS providers which is higher than that provided in the Budget Act; or

(2) A county chooses to expand its use of a more expensive service delivery mode beyond the level of caseload and hours growth for each mode that is built into the Budget Act; or

(3) A county chooses to enter into a third party contract at an hourly rate higher than the maximum established for that county; or

(4) A county chooses to shift to a more expensive mode without providing for noncomitant offsetting savings in other areas, and causing a cost overrun.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; Chapter 939, Statutes of 1992. Reference: Sections 10102, 12301, 12302, 12306, 12308, 13002, and 14132.95, Welfare and Institutions Code; and Chapter 93, Statutes of 1989 (Budget Act of 1989).

30-767 SERVICE DELIVERY METHODS **30-767**

.1 The county shall arrange for the provision of IHSS through one or more of the methods specified below in accordance with an approved county plan:

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Counties may choose modes of delivery that best meet the needs of their recipient population in their county demographic situation (WIC 12302). However, state reimbursement can be available only within the constraints imposed by the annual budget act (WIC 12300) and state allocation plan (WIC 10102), all of which must be reflected in state-approved individual county plans. Counties which exceed the constraints run the risk of not receiving full reimbursement if the cost overrun was due to non-state mandated costs, i.e., costs within county control, or more expensive modes used beyond amounts approved in an individual county plan.

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30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.11 County Employment.

.111 The county shall be permitted to hire service providers in accordance with established county civil service requirements or merit system requirements. The county shall be permitted to consider such providers as temporary employees if approved by the appropriate civil service system.

.112 The county shall insure that each service provider is capable of and is providing the services authorized.

.12 Purchase of Service from an Agency.

.121 The county may contract with an agency to provide service in accordance with the requirements of Division 10 and 23. The contract shall include a provision requiring the contractor to maintain a listing of contract recipients, their authorized hours, service hours provided and the amount paid for those services to the contract agency.

.122 The county shall insure that the contractor guarantees the continuity and reliability of service to recipients, supervision of service providers, that each service provider is capable of and is providing the service authorized and complies with the requirements of Division 21 (Civil Rights).

.123 The county shall insure that preference is given to the selection of providers who are recipients of public assistance or other low-income persons who would qualify for public assistance in the absence of such employment, except in regard to persons recruited by the recipient.

.13 Purchase of Service From An Individual.

.131 The county shall make payment under this delivery method through the payrolling system as described in Section 30-769.

.132 The county shall make a reasonable effort to assist the recipient to obtain a service provider when the recipient is unable to obtain one individually.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.133 The county shall have the right to change from one to another of the three delivery methods outlined above or from payment in advance to payment in arrears when any of the following apply:

(a) It has been determined that a recipient is using his/her payment for other than the purchase of authorized services.

(b) The recipient has failed to submit time sheets, as specified in Section 30-769.737 within 90 days from the date of payment.

(c) The recipient has not provided timely payment to his/her providers.

.2 Counties may elect to contract with a nonprofit consortium or may create a public authority to provide for the delivery of IHSS.

.21 The board of supervisors shall establish a public authority by ordinance.

.211 The public authority shall be separate from the county. Employees of the public authority shall not be considered to be employees of the county for any purpose.

.212 The ordinance shall designate the governing body of the public authority and specify the qualifications of the individual members, the procedures for nomination, selection, appointment, tenure and removal of members, and such other matters as the board of supervisors deems necessary for the operation of the public authority.

(a) The board of supervisors may designate itself as the governing body of the public authority.

(1) If the board of supervisors is the governing body, the ordinance shall require the appointment of an advisory committee of no more than 11 members.

(2) No fewer than 50 percent of the advisory committee shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).

(b) If the board of supervisors does not designate itself the governing body of the public authority, it shall specify by ordinance the membership of the governing body of the public authority.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

(1) No fewer than 50 percent of the members of the governing body shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).

.213 Before appointing members to the governing body or advisory committee, the board of supervisors shall solicit recommendations from the general public and interested persons and organizations through a fair and open process which includes reasonable written notice and a reasonable time to respond.

(a) The provisions at Section 30-767.213 shall be met by satisfying the requirements governing legislative bodies outlined in Government Code and other state and federal law, including, but not limited to, the Ralph M. Brown Act (Government Code Section 54950 et seq.) and the Americans with Disabilities Act.

.214 Prior to initiating delivery of IHSS through a public authority, the county shall enter an agreement with the public authority specifying the purposes, scope or nature of the agreement, the roles and responsibilities of each party including provisions which ensure compliance with all applicable state and federal labor laws, and compliance with all statutory and regulatory provisions applicable to the delivery of IHSS. This agreement shall also specify the fiscal provisions under which the public authority shall be reimbursed for its performance under the agreement. The county, in exercising its option to establish a public authority, shall not be subject to competitive bidding requirements.

.215 Prior to initiating the delivery of IHSS through a public authority, the county shall submit to the California Department of Social Services a copy of the agreement as specified in Section 30-767.214 along with the following information concerning the public authority:

(a) Organization chart of the public authority.

(b) Funding provision for public authority costs, including how the proposed rate was developed.

(1) The rate development process and the public authority hourly rate must be approved by Department of Health Services prior to initiating the delivery of services.

(c) Public authority staffing classifications and duties.

(d) A description of how the functional requirements of Welfare and Institutions Code Section 12301.6(e) will be met.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

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(e) The requirements of Welfare and Institutions Code Section 12301.6(e) are listed in Section 30-767.23.

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.216 If the public authority contracts with another entity to provide the delivery of IHSS, the agreement shall satisfy the requirements of Manual of Policies and Procedures Chapter 23-600 relating to contracting.

.217 All costs claimed for the delivery of services under an agreement as specified in Section 30-767.214 shall be claimed in compliance with criteria for rate setting found at Section F, attachment 4.19-B of the California Medicaid State Plan.

(a) A county shall use county-only funds to fund both the county share and the state share of any increase in the cost of the program, including employment taxes, due to any increase in provider wages or benefits negotiated or agreed to by a public authority or nonprofit consortium unless otherwise provided for in the annual budget act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect until the Department has obtained the approval of the State Department of Health Services.

.22 A county may contract with a consortium for delivery of services.

.221 A consortium entering a contract under Section 30-767.22 shall have a governing body composed as described in Section 30-767.212(b)(1), or shall have established an advisory committee composed as described in Sections 30-767.212(a)(1) and (2).

.222 Such contracts shall be subject to the provisions of Manual of Policies and Procedures Chapter 23-600.

.223 A consortium entering a contract under Section 30-767.22 shall be deemed to be the employer of IHSS personnel referred to recipients as described in Section 30-767.23 for the purposes of collective bargaining over wages, hours and other terms and conditions of employment.

.23 Any public authority or consortium shall provide the following minimum services:

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

.231 Provide registry services to recipients receiving services pursuant to Section 30-767.23.

(a) Assistance in finding providers through the establishment of a registry.

(b) Investigation of the qualifications and background of potential providers listed on the registry.

(c) Establishment of a referral system under which potential providers are made known to recipients.

.232 Provide access to training for providers and recipients.

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(a) Access to training for providers and recipients does not mean that the county or the Public Authority is under any obligation:

(1) to provide the training directly, to pay for training provided in the community, to pay for the provider's time to attend or to accompany the recipient to training, to pay for transportation to the training, or to pay for any materials required by the training; or

(2) to screen or be responsible for the content of any training it tells providers and/or recipients is available in the community; or

(3) to ensure that any provider or recipient attended/completed any training.

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.233 Perform any other function related to the delivery of IHSS.

.234 Ensure that the requirements of the Personal Care Services Program pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are met.

.24 Any public authority may adopt reasonable rules and regulations for the administration of employer-employee relations.

30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

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.241 The Employer-Employee Relations Policy for Public Authorities Delivering In-Home Supportive Services is available from the California Department of Social Services as a model for public authorities. Public authorities may adopt, reject, or modify the policy in part or in its entirety.

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.25 Public authorities and consortia must submit cost reports and such other data as required for the Case Management, Information and Payrolling System (CMIPS).

.26 Any county that elects to provide for in-home supportive services pursuant to this section shall be responsible for any increased costs to the CMIPS attributable to such election. The Department shall collaborate with any county that elects to provide in-home supportive services pursuant to this section prior to implementing the amount of financial obligation for which the county shall be responsible.

.3 No recipient of any services specified in Section 30-757.14 or .19 shall be compelled to accept services from any specific individual, except for individuals recruited by the recipient's guardian, conservator, or, in the case of recipients who are minors, by their parents.

.31 For those recipients who are receiving services through the delivery methods described in .11 and .12 above, hiring preference shall be given to qualified persons recruited by the recipient to deliver services. For the purpose of this section a qualified person is one who meets the minimum requirements established by the contract agency or the County Civil Service or Merit Systems.

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.4 Personal Care Services Program Providers

DHS regulation Section 51181 reads:

Personal Care Services Provider.

A personal care services provider is that individual, county employee, or county contracted agency authorized by the Department of Health Services to provide personal care services to eligible beneficiaries. An individual provider shall not be a family member, which for purposes of this section means the parent of a minor child or a spouse.

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30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

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.5 Personal Care Services Program Provider Enrollment

DHS regulation Section 51204 reads:

Personal Care Services Provider.

All providers of personal care program services must be approved by Department of Health Services and shall sign the "Personal Care Program Provider/Enrollment Agreement" form [SOC 426 1/93)] designated by the Department agreeing to comply with all applicable laws and regulations governing Medi-Cal and the providing of personal care service. Beneficiaries shall be given a choice of service providers.

(a) Individual providers will be selected by the beneficiary, by the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian. The beneficiary or the beneficiary's personal representative, or in the case of a minor, the legal parent or guardian shall certify on the provider enrollment document that the provider, in the opinion of the beneficiary, is qualified to provide personal care so long as the person signing is not the provider.

(b) Contract agency personal care providers shall be selected in accordance with Welfare and Institutions Code Section 12302.1. The contract agency shall certify to the designated county department that the workers it employs are qualified to provide the personal care services authorized.

.6 Provider Audit Appeals

DHS regulation Section 51015.2 reads:

Providers of Personal Care Services Grievance and Complaints.

Notwithstanding Section 51015, when a provider of personal care services has a grievance or complaint concerning the processing or payment of money for services rendered, the following procedures must be met:

(a) The provider shall initiate an appeal, by submitting a grievance or complaint in writing, within 90 days of the action precipitating the grievance or complaint, to the designated county department identifying the claims involved and specifically describing the disputed action or inaction regarding such claims.

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30-767 SERVICE DELIVERY METHODS (Continued) **30-767**

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(b) The designated county department shall acknowledge the written grievance or complaint within 15 days of its receipt.

(c) The designated county department shall review the merits of the grievance or complaint and send a written decision of its conclusion and reasons to the provider within 30 days of the acknowledgment of the receipt of the grievance or complaint.

(d) After following this procedure, a provider who is not satisfied with the decision by the designated county department may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later than one year after receiving notice of the decision.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12301.6, 12302, 12302.1, and 14132.95, Welfare and Institutions Code and Section 54950 et seq., Government Code.

30-768 OVERPAYMENTS/UNDERPAYMENTS **30-768**

.1 Definition of Overpayment for Non-PCSP Payments

.11 Overpayment means that cash payment was made for the purchase of IHSS or services were delivered in an amount to which the recipient was not entitled.

.111 Services payments paid pending a state hearing decision as required by MPP 22-022.5 are not overpayments and cannot be recovered.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.2 Amount of Overpayment for Non-PCSP Payments

When the county has determined that an overpayment has occurred, the county shall calculate the amount of overpayment as follows:

.21 Overpayment due to the recipient's failure to use total direct advance payment for the purchase of authorized hours.

.211 Authorization based on an hourly rate

a. Determine the number of service hours for which the recipient received a direct advance payment in excess of those service hours actually paid for.

b. Multiply this amount by the hourly wage rate used in computing the recipient's authorized payment.

.212 Authorization for a personal attendant

When services are delivered by a personal attendant, the amount of the overpayment is the difference between the amount that should have been paid and the amount which was actually paid.

.213 When the recipient receives a direct advance payment to purchase services in a given month, but fails to submit a reconciling time sheet within 45 days from the date of payment, there is a rebuttable presumption that the unreconciled amount is an overpayment.

.22 Overpayment due to excess service authorization

.221 Authorization based on an hourly rate

a. Determine the number of service hours for which payment was made in excess of the correct service authorization.

b. Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.222 Authorization for a personal attendant

When services are delivered by a personal attendant, the amount of overpayment is the difference between the amount paid and the amount which would have been paid if the service authorization was correct.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.23 Overpayment due to incorrect share of cost

Where the correct share of cost was more than the recipient paid, the resulting overpayment is determined by subtracting the amount paid from the correct amount.

.24 Overpayment due to nonpayment of share of cost

Where the service hours were provided to the recipient, but he/she did not pay his/her obligated share of cost, the county should initiate overpayment recovery for the entire amount of the IHSS payment for the month in which the recipient was ineligible.

.25 Overpayment due to nonexpenditure of restaurant meal allowance

Where the recipient received an allowance for the purchase of restaurant meals, and used none of the allowance for that purpose, or if the recipient was ineligible for a restaurant meal allowance he/she received, the entire amount is an overpayment.

.3 Recovery of Overpayments for Non-PCSP Payments

.31 Limitations on amount of Recovery

.311 The repayment liability of the recipient shall be limited to the amount of liquid resources and income excluded or disregarded by the SSI/SSP Program. Liquid resources are cash or financial instruments that can be converted to cash, except funds set aside for burial.

.312 When an overpayment results from the recipient's failure to spend the entire amount of an advance direct payment for the purchase of authorized services, the difference in value between the hours purchased and the hours authorized shall be considered an available resource in determining repayment liability.

.32 Methods of Recovery

.321 The county may recover overpayments using any one or a combination of the methods listed below.

(a) Balancing

(1) Balancing means recovery of all or a portion of an overpayment by applying a repayable underpayment against it.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

(2) An underpayment shall not be balanced against an overpayment if the underpayment is discovered and payable prior to the time an overpayment is discovered and adjustable.

(b) Payment Adjustment

(1) Payment adjustment means that the county reduces payment for future authorized services to offset an overpayment.

(2) If the service payment is reduced to adjust for previous overpayments, the recipient shall be responsible for paying the current month's adjustment amount to the service provider in addition to any share of cost.

(c) Voluntary Cash Recovery

(1) Voluntary cash recovery means repayment voluntarily made to the county by a recipient who has incurred an overpayment.

(2) The recipient shall be given the option of voluntary cash repayment of all or a part of the amount to be adjusted in lieu of payment adjustment.

(d) Civil Judgment

The county shall have the authority to demand repayment and file suit for restitution for any unadjusted portion of an overpayment.

.33 Notice of Action

If the county determines that an overpayment has occurred as defined in .11 above and proposes to recover the overpayment, the county shall notify the recipient of the following:

.341 The period of time during which the overpayment occurred.

.342 The reason for the overpayment.

.343 The amount of overpayment and a description of how the amount was calculated.

.344 The method by which the county proposes to recover the overpayment.

.4 Definition of Underpayment for Non-PCSP Payments

.41 Underpayment means the recipient was entitled to more service than was authorized or that the share of cost paid by the recipient was greater than the correct amount.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.411 An underpayment has occurred when the county has failed to determine the correct share of cost or authorize the correct amount of service when all essential information was available to the county.

.412 An underpayment has not occurred when there is a disagreement in the county's exercise of discretion or opinion, where discretion or opinion is allowed in the determination of the need for service.

.42 Amount of Underpayment

When the county has determined that an underpayment has occurred, the county shall calculate the underpayment as follows:

.421 Incorrect Service Authorization

(a) Subtract the number of hours actually authorized from the number of hours to which the recipient was entitled.

(b) Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.422 Share of Cost

When the correct share of cost was less than the recipient paid, the resulting underpayment is determined by subtracting the correct amount from the amount paid.

.423 Restaurant Meals

When the amount paid was less than the amount to which there was entitlement, subtract the amount paid from the correct amount.

.43 Method of Payment

.431 Underpayments shall be adjusted by an increase in the service authorization when the unauthorized service for which there was entitlement was yard hazard abatement or heavy cleaning, and the service was not previously provided through another source at no cost to the recipient.

.432 All other underpayments shall be corrected by a retroactive payment issued to the recipient in an amount equal to that of the calculated underpayment.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

.44 Notice of Action

If the county determines that an underpayment has occurred as defined in .4 above, the county shall notify the recipient of the following:

.441 The time period during which the underpayment occurred.

.442 The reason for the underpayment.

.443 The amount of the underpayment, and a description of how the amount was calculated.

.444 The method by which the county proposes to adjust the underpayment.

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.5 DHS regulation Section 50781 reads:

Potential Overpayments

(a) A potential overpayment occurs when any of the following conditions exist, as limited by (c).

(1) A beneficiary has property in excess of the property limits for an entire calendar month.

(2) A beneficiary or the person acting on the beneficiary's behalf willfully fails to report facts and those facts, when considered in conjunction with the other information available on the beneficiary's circumstances, would result in ineligibility or an increased share of cost.

(3) A beneficiary has other health coverage of a type designated by the Department [of Health Services] as not subject to post-service reimbursement, and the beneficiary or the person acting on the beneficiary's behalf willfully fails to report such coverage.

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30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

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(b) A beneficiary of the person acting on the beneficiary's behalf willfully fails to report facts if he/she has completed and signed a Medi-Cal Responsibilities Checklist, form MC 217, and a Statement of Facts and has, within his/her competence, done any of the following:

(1) Provided incorrect oral or written information.

(2) Failed to provide information which would affect the eligibility or share of cost determination.

(3) Failed to report changes in circumstances which would affect eligibility or share of cost within 10 days of the change.

(c) If a change occurred in a person's circumstances and that change could not have been reflected in the person's eligibility determination for the month in which the change occurred or the month following because of the 10 day notice requirements specified in Section 50179, no potential overpayment exists in that month or in the following month if appropriate.

.6 DHS regulation Section 50786 reads:

Action on Overpayment -- Department of Health Services or County Unit Contracted to Collect Overpayments

(a) Upon receipt of a potential overpayment referral, the Department's Recovery Section or the county unit contracted to collect overpayments shall:

(1) Determine the amount of Medi-Cal benefits received by the beneficiary for the period in which there was a potential overpayment.

(2) Compute the actual overpayment in accordance with the following:

(A) When the potential overpayment was due to excess property, the actual overpayment shall be the lesser of the:

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30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

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1. Actual cost of services paid by the Department during that period of consecutive months in which there was excess property throughout each month.

2. Amount of property in excess of the property limit during that period of consecutive months in which there was excess property throughout each month. This excess amount shall be determined as follows:

   a. Compute the excess property at the lowest point in the month for each month.

   b. The highest amount determined in a. shall be the amount of the excess property for the entire period of consecutive months.

(B) When the potential overpayment was due to increased share of cost, the actual overpayment shall be the lesser of the:

1. Actual cost of services received in the share of cost period which were paid by the Department.

2. Amount of the increased share of cost for the share of cost period(s).

(C) When the overpayment was due to excess property and increased share of cost, the actual overpayment shall be a combination of (A) and (B).

(D) When the potential overpayment was due to other factors which result in ineligibility the overpayment shall be the actual cost of services paid by the Department.

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30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued) **30-768**

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(E) Potential overpayments, due to beneficiary possession of other health coverage that is not subject to post-service reimbursement, shall be processed by the Department to determine and recover actual overpayments in all cases. The actual overpayment in such cases shall be the actual cost of services paid by the Department which would have been covered by a private health insurance or other health coverage, had the coverage been known to the Department. The actual overpayment shall not include any costs which can be recovered directly by the Department from the health insurance carrier or other source.

(3) Refer those cases where there appears there may be fraud to the Investigations Branch of the Department.

(4) Take appropriate action to collect overpayments in accordance with Section 50787.

.7 DHS regulation Section 50787 reads:

Demand for repayment

(a) The Department or the county unit contracted to collect overpayments shall demand repayment or actual overpayments in accordance with procedures established by the Department.

(b) The Department or the county unit contracted to collect overpayments may take other collection actions as permitted under state law.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 12304.5 and 14132.95, Welfare and Institutions Code.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS 30-769

.1 This section governs the procedures that shall be followed by counties making payments under the delivery method specified in Section 30-767.13. Counties shall not enter into any agreements or contracts to make payment to individual providers.

.2 County Responsibility

.21 The CRT counties shall directly input required data and initiate transactions into the system via terminals located in the county.

.22 The Paper counties shall input required data and initiate transactions on prescribed forms and submit those forms to the payrolling contractor.

.221 Exception: Special preauthorized transactions may be initiated by phone to the payrolling contractor. The prescribed document shall subsequently be sent from the payrolling contractor to the county confirming the transaction.

.23 For purposes of the payrolling system, the initial authorization period begins in the calendar month in which the first day of authorization occurs and continues until changed.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.24 General Process

.241 The counties shall:

(a) Enter prescribed data on all recipients and providers, as defined in Section 30-767.13, into the payrolling system.

(b) Change data as necessary to ensure correct payment to the correct individual.

(c) Authorize the disbursement of all funds paid by the payrolling contractor by:

(1) Reviewing all time sheets prior to entry of time sheet data into the system to ensure consistency between hours reported and hours authorized.

(2) Reviewing any significant discrepancies between hours reported and hours authorized to determine the reason and take corrective action as indicated.

(3) Initiating special transactions as described in .25 below.

(d) Retain completed time sheets as required by Section 23-353 in such a manner that they are easily accessible for review.

(e) Respond to and resolve payment inquiries from recipients and providers. The payrolling contractor will provide all necessary information.

.25 Special Transaction

.251 Special transactions are used to handle situations which fall outside the normal payroll process. Counties shall be held responsible for closely monitoring and controlling the use of the following transactions.

.252 The county shall initiate emergency/supplemental checks for:

(a) Payments resulting from retroactive state hearing decisions.

(b) Payments resulting from prior underpayments.

(c) Payments in excess of the base rate as provided in Section 30-764.

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30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

(d) Payments for severely impaired recipients in advance pay status who become eligible for payment between a pay cycle.

(e) Payments where the county finds that an emergency situation exists.

(f) Payments to counties for reimbursements of emergency checks as described in .26 below.

(g) Payments for other unusual situations not provided for by the regular payrolling process and where the county deems appropriate.

(h) Payments for time sheets submitted three or more months beyond the current payroll cycle.

.253 A request for a replacement check shall be made expeditiously by the county but no sooner than five (5) days from the date the original check should have been received.

.254 A void transaction shall be used:

(a) When a payroll check is returned to the payrolling contractor or county.

(b) When a payroll check is mutilated.

(c) When a payroll check is not in the possession of the county or the payrolling contractor.

.255 Adjustment transactions shall be used to make adjustments to tax records when any of the following occur:

(a) An overpayment.

(b) An underpayment.

(c) An incorrect deduction.

.26 County issued payments shall only be issued in cases of extreme emergency when the county finds that the emergency check procedure provided in .252 is not adequate.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.261 The county shall issue checks for an amount not to exceed ninety (90%) percent of the amount the recipient/provider should receive.

.262 The county shall be reimbursed for payments made under .261 above by the payrolling contractor using the emergency/supplemental check transaction.

.263 The county shall not receive reimbursement until an emergency/ supplemental transaction has been initiated to pay the recipient/ provider the remaining balance.

.264 The county shall receive a time sheet before the transaction in .261 or .263 above shall occur. Exception: The county may issue a check prior to receipt of a time sheet for a severely impaired recipient who opted for advance pay.

.27 The counties shall be responsible for verifying eligibility of recipients for IHSS between January 1, 1978 and December 31, 1979 as needed for retroactive tax payments.

.28 The county shall ensure that all providers are informed of the requirements they must meet in order to be paid.

.3 The County Has The Sole Responsibility For Determining And Investigating Fraud And Forgery for Non-PCSP

.31 The county shall, with no effect on current county procedures:

.311 Identify suspected fraud cases;

.312 Determine if actual fraud exists;

.313 Take appropriate action as necessary.

.32 The county will be notified by the payrolling contractor if an original check has already been cashed when a replacement check is requested. The county shall then follow the applicable procedure in the user's manual.

.4 PCSP Fraud or Forgery

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

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.41 DHS regulation Section 50782 reads:

Fraud occurs if an overpayment occurs and the beneficiary or the person acting on the beneficiary's behalf willfully failed to report facts as specified in Section 50781(b) with the intention of deceiving the Department, the county department or the Social Security Administration for the purpose of obtaining Medi-Cal benefits to which the beneficiary was not entitled.

.42 If PCSP fraud or forgery occurs, DHS will follow the procedures cited in DHS regulation Section 50793.

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.5 Return Check Procedures

.51 Counties which receive a returned check from a provider or recipient shall follow the applicable procedures in the user's manual.

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30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.6 Refunds/Recoupment

.61 Counties which receive refunds or recoupments shall:

.611 Deposit the money received in a county account; and

.612 Send a monthly check to the payrolling contractor for the amount of refund/recoupment received during the previous month in accordance with applicable procedures in the User's Manual.

.7 Recipient Responsibility

.71 It is the responsibility of the recipient to report to social services staff accurately and completely all information necessary to complete the SOC 311.

.72 The recipient, within his/her physical, emotional, educational or other limitations, shall:

.721 Designate the authorized hours per provider within the total of the recipient's authorized hours.

.722 Designate each provider(s) portion of the share of cost.

.723 Sign and date the prescribed time sheet to:

(a) Verify payment of the share of cost to the appropriate provider(s).

(b) Verify that services authorized where rendered by the appropriate provider.

.724 Inform social services staff of any changes affecting the payrolling process.

.73 Payments for authorized services rendered shall be sent to the recipient's appropriate provider. The recipient shall not receive payment for services except as provided in .731 through .734 below.

.731 Severely impaired recipients as defined under Section 30-753, shall have the option of choosing to directly receive their payment at the beginning of each authorized month. Such payment shall be the net amount exclusive of the appropriate withholdings.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.732 In direct payment cases, where a recipient is incapable of handling his/her financial and legal affairs and has a legal guardian or conservator, direct payment shall be made to the recipient's legal guardian or conservator at such person's request.

.733 Payment may be made to a recipient's guardian, conservator, substitute payee, or person designated by the recipient.

.734 When payment is made as a result of a state hearing decision.

.735 If the recipient is severely impaired he/she shall be notified in writing of the right to hire and pay his/her own provider, and to receive his/her monthly cash payment in advance.

.736 When direct payment is made to a recipient, guardian, conservator, or substitute payee, the provider shall be hired, supervised, and paid by such payee. In such cases, the recipient or the person authorized to act in the recipient's behalf shall insure that the services provider is capable of and is providing the services authorized.

.737 It shall be the responsibility of the severely impaired recipient, legal guardian or conservator who receives payment in advance to submit their provider's time sheets at the end of each authorized service month to the appropriate county social services office.

.8 Provider Benefits

.81 The department has elected to provide the worker's compensation coverage required by Welfare and Institutions Code Section 12302.2 through a single statewide insurance policy. Additional insurance coverage will not be reimbursed as an IHSS program cost.

.82 The department has elected to handle the payment of the unemployment insurance tax, unemployment disability insurance tax, and social security tax required by Welfare and Institutions Code Section 12302.2 through the payrolling system.

.83 The department has elected to require the payrolling contractor to deduct the employee's share of the following taxes from the payment to the provider or the recipient:

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) **30-769**

.831 Social security.

.832 State disability insurance.

.84 The department has elected to deduct and transmit the state and federal income tax withholdings due on the provider's earnings for those providers who voluntarily request this service.

.9 Excessive Compensation

(See Section 30-769.91 (Handbook) for examples of excessive compensation)

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.91 Excess compensation to an individual provider but is not necessarily limited to the following circumstances:

.911 The provider was paid for more hours than authorized or more hours than worked.

.912 The provider was paid at a higher hourly rate than appropriate.

.913 The share of cost withheld from provider's payment was less than the recipient affirms was paid to the provider.

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.92 All excess provider compensation is recoverable. The county shall demand repayment from the provider. The county shall be permitted to seek recovery of excess compensation by civil suit.

.93 Provider Fraud or Forgery

If the county suspects that excess provider payment occurred because of fraudulent devices of the provider, forgery, or collusion between the provider and the recipient, the county shall investigate the suspected fraud, forgery, or collusion. If the facts warrant prosecution and the county does not have an investigative unit, the county shall refer the matter directly to the county district attorney's office for investigation and possible prosecution.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code.

30-770 ELIGIBILITY STANDARDS 30-770

.1 Persons applying for IHSS under Sections 30-755.112, .113 and .114 shall meet the SSI/SSP eligibility standards except as modified by Section 30-755.1.

.2 Detailed eligibility standards shall be those located in 20 CFR Part 416, except as modified by IHSS regulations beginning with Section 30-750.

.3 Definitions.

.31 For the purposes of eligibility for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18, or under the age of 22 and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him/her for gainful employment.

.311 For the purposes of deeming for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18.

.312 Regularly attending school means being enrolled in eight semester or quarterly hours weekly in a college or university, or 12 hours weekly in a secondary school. In a course of vocational or technical training, 15 clock hours weekly are required; without shop practice, at least 12 hours weekly are required.

.313 Eligible spouse means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual who has not been living apart from such other aged, blind, or disabled individual for more than six months.

.4 Residency

.41 Residency in State Required

To be eligible for IHSS, an individual shall be a U.S. citizen, or an eligible alien pursuant to Welfare and Institutions Code Section 11104. The individual shall also be a California resident, physically residing in the state except for temporary absence as noted below in Sections 30-770.42 through .45, with the intention to continue residing here.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

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Welfare and Institutions Code Section 11104 states:

"Aliens shall be eligible for aid only to the extent permitted by federal law.

"An alien shall only be eligible for aid if the alien has been lawfully admitted for permanent residence, or is otherwise permanently residing in the United States under color of law. No aid shall be paid unless evidence as to eligible alien status is presented."

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.42 Physical Absence from the State

Physical absence from the state indicates a possible change of state residence. The county shall make inquiry of a recipient who has been continuously absent from the state for 30 days or longer in order to ascertain the recipient's intent to maintain California residency. If the inquiry establishes that the recipient is no longer a California resident, authorization for IHSS shall be discontinued.

.421 The county inquiry to the recipient will require the recipient to submit a written statement that:

(a) Declares his/her anticipated date of return to the state, or his/her intent not to return to the state;

(b) Declares his/her reason for continued absence from the state; and

(c) Provides needed information on his/her location and status of household arrangements.

.422 The county will include in the inquiry to the recipient a statement that his/her failure to respond to the inquiry by a specified date will result in his/her ineligibility and the discontinuation of IHSS.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.43 Evidence of Residence Intention

.431 The written statement of the recipient is acceptable to establish his/her intention and action on establishing residence unless the statement is inconsistent with the conduct of the person or with other information known to the county.

.432 If the recipient does not respond by the specified date to the inquiry of residence, it shall be presumed that he/she does not intend to maintain California residency, and authorization for IHSS shall be discontinued when the absence exceeds 60 days in accordance with regulations (Sections 30-759.7 and 10-116).

.433 If the recipient responds to the inquiry and advises the county that he/she does not intend to return to California, authorization for IHSS shall be discontinued in accordance with regulations.

.44 Absence from State for More than 60 Days

.441 If the recipient responds to the inquiry and advises the county that he/she intends to maintain his/her California residence, but he/she remains or has remained out of state for 60 days or longer, his/her continued absence is prima facie evidence of the recipient's intent to have changed his/her place of residence to a place outside of California, unless he/she is prevented by illness or other good cause from returning to the state at the end of 60 days. Such absence in itself is sufficient evidence to support a determination that the recipient has established residence outside of California. Therefore, his/her intent to return must be supported by one or a combination of the following:

(a) Family members with whom the recipient lived, currently live in California;

(b) The recipient has continued maintenance of his/her California housing arrangements (owned, leased, or rented);

(c) The recipient has employment or business interest in California;

(d) Any other act or combination of acts by the recipient which establishes his/her intent to reside in California.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.442 Even if the recipient's intent to reside in California is supported by .441 above, the following evidence shall be utilized to determine the recipient's intent to reside in California:

(a) The recipient has purchased or leased a place of residence out of state since leaving California;

(b) The recipient has been employed out-of-state since leaving California;

(c) The recipient has obtained an out-of-state motor vehicle driver's license after leaving California;

(d) The recipient has taken any other action which indicates his/her intent to establish residence outside of California.

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.443 Welfare and Institutions Code Section 1110 states that if a recipient is prevented by illness or other good cause from returning to California at the end of 60 days, and has not by act or intent established residence elsewhere, he shall not be deemed to have lost his residence in this state. The following is added by Welfare and Institutions Code Section 11100.1(a):

For purposes of the In-Home Supportive Services Program ..."good cause," as defined in Section 11100, shall include, but is not limited to, the following:

(1) Outpatient medical treatment necessary to maintain the recipient's health where the medical treatment is not available in California.

(2) Short-term schooling or training necessary for the recipient to obtain self-sufficiency where training which would achieve that objective is not available or accessible in California.

(3) Court-issued subpoena or summons.

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30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

(a) For outpatient medical treatment out of state, good cause for continuing to receive benefits while absent from the state for more than 60 days shall also include the situation where the medical treatment is not accessible in California.

(b) Accessible in these regulations means attainable for the recipient in California, given the dysfunctioning and needs of the recipient.

(c) Other good cause reasons for continuing to receive IHSS benefits while absent from the state for over 60 days shall be consistent with the good cause reasons contained in Welfare and Institutions Code Section 11100.1.

(1) The situation shall be of an urgent or emergency nature:

(2) The service required shall be necessary to maintain the physical or psychological health of the recipient:

(3) The services required or like services shall be either not available or not accessible in California.

.444 A recipient absent from California for more than 60 days and who is not prevented from returning to this state because of illness or other good cause shall have his/her authorization for IHSS discontinued in accordance with regulations.

.45 Absence from the State Exceeding Six Months

.451 Authorization for IHSS shall be suspended for any recipient who leaves the state and who remains absent from the state for a period which exceeds six months, notwithstanding the fact that the recipient has continued to receive IHSS benefits beyond 60 days because he/she was prevented from returning to the state due to illness or other good cause, as specified in Sections 30-770.43 and .44. Suspension of benefits will be in accordance with notice of Action regulations contained in Sections 30-759.7 and 10-116.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.452 In-Home Supportive Services shall not be resumed until the recipient, upon returning to the state, requests a reassessment of need from the county, and the reassessment has been completed in accordance with regulations (Section 30-763).

.46 Outside the United States While Absent from the State

.461 In-Home Supportive Services shall be discontinued for any recipient who is outside the United States for all of any month, or for 30 days in a row, as such an individual is no longer eligible to receive SSI/SSP. Discontinuation of benefits will be in accordance with notice of action regulations.

(a) Upon the individual's return to the United States, and upon his/her reestablishment as an SSI/SSP recipient, an SSI/SSP eligible recipient, or an individual who would be eligible for SSI/SSP except for excess income, he/she may again apply for IHSS benefits. The county shall redetermine IHSS eligibility and perform a needs assessment based on current circumstances.

(b) "United States" includes the 50 states, the District of Columbia, and the Northern Mariana Islands.

.47 Continuation of IHSS While Absent from the State

.471 When the county has determined that the recipient is entitled to the continuation of IHSS benefits while absent from the state (the recipient is absent from the state for 60 or more days and is prevented from returning due to illness or other good cause, as determined in Sections 30-770.42, .43, and .44), the following apply:

(a) The recipient shall continue to receive the same number of hours of IHSS that were authorized prior to his/her temporary absence. This level of authorization will continue until a reassessment is required.

(b) The recipient's out-of-state individual provider (IP) shall be reimbursed at the county's lowest current IP base rate.

(c) The recipient must continue to mail time sheets to the county as required by regulations.

30-770 ELIGIBILITY STANDARDS (Continued) **30-770**

.5 State Program Noncitizen Status

.51 A noncitizen victims of human trafficking, domestic violence, or other serious crimes as defined under the Trafficking and Crime Victims Assistance Program (TCVAP), MPP Chapter 70-100, shall be eligible for IHSS if all other eligibility criteria are met.

.511 A victim of human trafficking must meet the same eligibility criteria as those used for the TCVAP found in MPP Sections 70-102 and 70-103.1. For examples of documentation requirements, please see Sections 70-103.2 through .4.

.512 A victim of domestic violence or other serious crimes must meet the same eligibility criteria as those used for the TCVAP found in MPP Section 70-104.1. For examples of the definition of a noncitizen victim of serious crime, please see Handbook Section 70-104.11. For examples of documentation requirements, please see Section 70-104.12.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Senate Bill 1569 (Chapter 672, Statutes of 2006). Reference: Sections 13283 and 18945, Welfare and Institutions Code.

30-771 LINKAGE 30-771

.1 Aged - An aged individual shall be considered to be one who is 65 years of age or older.

.2 Blindness - An individual shall be considered to be blind for purposes of IHSS if:

.21 He/she has central visual acuity of 20/200 or less in the better eye with use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less.

.22 He/she is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.

.3 Disability - An individual shall be considered to be disabled for the purposes of IHSS if one of the following applies:

.31 He/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of not less than 12 months.

.32 In the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity.

.33 He/she is permanently and totally disabled as defined under a state plan approved under Title XIV as in effect for October 1972 and received aid under such plan on the basis of disability for at least one month prior to July 1973 and for December 1973, provided that he/she is continuously disabled as so defined.

.4 Additional criteria regarding aged, blindness and disabled eligibility shall be applied as outlined in 20 CFR 416, Subpart 1.

30-773 RESOURCES 30-773

.1 All resources, both liquid and non-liquid, shall be evaluated based upon their equity value with the exception of automobiles, which shall be evaluated as specified in .6(c) below.

.2 Each aged, blind, or disabled individual whose eligibility for aid commenced on or after January 1, 1974 may have countable resources not in excess of $1,500 in value and be eligible.

.3 An individual who is living with either an eligible or ineligible spouse may have countable resources not in excess of $2,250 in value and remain eligible.

.31 The $2,250 limitation includes the resources of such spouse.

.4 The resources of a recipient child who is living with his/her parent, parents, or parent and spouse of parent, shall be deemed to include that portion of the countable resources of his/her parent(s) and spouse of parent which exceeds $1,500 in value in the case of one parent, or $2,250 in value in the case of two parents or parents or parent and spouse.

.41 For the purposes of this section, a recipient child is an unmarried person under the age of 18.

.5 Individuals receiving AB, ATD, or OAS in December 1973, including individuals who applied for aid in December 1973 and met all the conditions of eligibility for payment in that month, shall continue to be subject to the property limitations in effect in December 1973 unless the recipient would be advantaged by the regulations regarding resource limitations currently in effect.

.6 In determining the countable resources of an individual, and spouse if any, the following items shall be excluded:

(a) The home.

(b) Household goods and personal effects to the extent that the combined equity value does not exceed $2,000. Where the equity value exceeds $2,000, the excess shall be counted toward the resources limitation.

30-773 RESOURCES (Continued) **30-773**

(c) Automobiles, as defined in 20 CFR 416, Subpart L.

(1) One automobile shall be totally excluded regardless of its value if, for the individual or a member of the individual's household, one of the following applies:

(A) It is necessary for employment.

(B) It is necessary for transportation to a site for medical treatment of a specific ongoing medical problem.

(C) It is modified for operation by or transportation of a handicapped person.

(2) If no automobile is excluded under (1) above, one automobile shall be excluded from counting as a resource to the extent its current market value does not exceed $4,500.

(A) If the market value exceeds $4,500, the excess shall be counted against the resources limitation.

(3) When the recipient or spouse has more than one automobile, such additional automobile(s) shall be treated as non-liquid resources and shall be counted to the extent of their equity value unless they are the property of a trade or business, or are nonbusiness properties which are essential to the means of self-support, as provided in (d) and (e) below.

(d) Property of a trade or business which is essential to the means of self-support, as provided in federal guidelines.

(e) Nonbusiness property which is essential to the means of self-support, as provided in federal guidelines.

(f) Resources of a blind or disabled individual which are necessary to fulfill a plan for achieving self-support as described in Section 30-775.436.

(g) Life insurance if the face value does not exceed $1,500. If the face value exceeds $1,500, the entire cash surrender value of the insurance shall be counted toward the resources limitation. Term insurance and burial insurance shall be totally excluded.

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30-773 RESOURCES (Continued) **30-773**

(h) Any other resources deemed excludable by the Secretary of Health and Human Services under the provisions of Title XVI of the Social Security Act.

(i) Restricted allotted land owned by an enrolled member of an Indian tribe.

(j) Per capita payments distributed pursuant to any judgment of the Indian Claims Commission or the Court of Claims in favor of any Indian tribe as specified in Public Law 93-134.

(k) Shares of stock and money payments made to Alaskan Natives under the Alaskan Native Claims Settlement Act provided that the payments or stock remain separately identifiable and are not commingled with nonexempt resources. Any property obtained from stock investments under the Act shall not be exempt.

(l) Tax rebates, credits or similar temporary tax relief measures which state or federal laws specifically exclude from consideration as a personal property resource. The specific rebates and credits listed in Section 30-775.42(a) shall also be exempt as property provided that the monies retained are not commingled and are separately identifiable as a proportionate share of the recipient's property.

(m) Otherwise countable resources shall be exempt up to the amount of benefits paid on behalf of the applicant/recipient for long-term care services under a State certified long-term care insurance policy or certificate, certified by the State to provide such exemption.

(1) Any income generated by such exempt property is countable as income in the month received. See Section 30-775.

30-773 RESOURCES (Continued) **30-773**

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(A) An example of income generated by such exempt property would be rental income generated by an exempt resource.

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(2) The burden shall be rebuttably presumed to have been met if the applicant/recipient presents a "SERVICE SUMMARY" signed by a representative of the insurance company verifying that the applicant/recipient is a holder of an insurance policy or certificate certified by the State to provide the exemption, and specifying the total amount of qualifying benefits paid out under the policy to date.

(3) The amount of the qualifying benefits stated to have been paid in the "SERVICE SUMMARY" referred to in Section 30-773.6(m)(2) shall be the amount of the exemption to which the applicant/recipient is entitled.

(4) If the statement by the insurance company is found to be erroneous, the county shall promptly notify the California Department of Health Services.

(5) If the statement by the insurance company is such that the county cannot determine whether the applicant/recipient is covered by a qualifying policy or the amount of the benefits paid out on behalf of the beneficiary, the county shall deny the exemption. When an exemption is denied, the county shall refer the recipient to the California Department of Health Services for assistance and shall notify the California Department of Health Services of the reasons for this determination.

30-773 RESOURCES (Continued) **30-773**

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(6) This is a sample of a SERVICE SUMMARY as referred to in Section 30-773.6(m)(2). The service summary is a form required by the California Department of Health Services. (See Title 22, Sections 58032 and 58080.)

(Company letterhead with company seal)

Name of Insured _____ Date of Birth _____

Social Security Number _____

Address of Insured _____

Policy Number _____ Issue Date _____

Insurance Company _____

SERVICE SUMMARY:	The Total Amount of Benefits Paid for Long-Term Care Services Countable toward the Medi-Cal Property Exemption	$91,000

To the Insured: This summary provides you with the total amount of insurance payments that count towards the Medi-Cal Property Exemption to be applied in determining eligibility for the State of California's Medicaid (Medi-Cal) Program. Please examine this summary and carefully compare your current asset total with the amount. If the amount of your Medi-Cal Property exemption is close to the amount of the assets you currently have, you may be eligible for the Medi-Cal Program. It is your responsibility to make application to the county (usually the Department of Social Services) for such eligibility. At the time of your application, a determination will be made whether and when you are eligible. (Please note: You may have assets, in addition to the Property Exemption listed above, that are exempted from the determination of Medi-Cal eligibility.)

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30-773 RESOURCES (Continued) **30-773**

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To the County: This summary verifies that the amount indicated with the label "SERVICE SUMMARY" was paid by (company name) for long-term care services as defined in California Code of Regulations, Title 22, Section 58023 on behalf of the person whose name appears as the "Name of Insured" above. This amount is exempt from the determination of Medi-Cal eligibility pursuant to California Code of Regulations, Title 22, Section 50453.7. If such person is found eligible for Medi-Cal by applying the Medi-Cal Property Exemption amount reported in this summary and after receiving Medi-Cal services is found to be ineligible solely by reason of errors in this summary, the Department of Health Services may recover from (company name) the amount of service payments as provided in California Code of Regulations, Title 22, Section 58082(e).

(Name and Title) _____ (date) _____

(Company Name) _____

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.7 Disposition of Resources.

.71 Although an individual's resources, including those of his/her spouse, exceed the limits imposed in .2 through .4 above, he/she shall be eligible for IHSS during the period of disposition of such excess resources provided that he/she meets other eligibility criteria, including those specified in this section.

.711 In no event shall total countable resources exceed $3,000 in value for an individual, or $4,500 in value for an individual and spouse. Total countable liquid resources shall not exceed $714 for an individual or $1,071 for an individual and spouse.

.72 The applicant or recipient shall agree in writing to dispose of the excess resources within the time limit specified in .74 below and to repay any overpayments with the proceeds of the disposition.

30-773 RESOURCES (Continued) **30-773**

.73 During the period that the excess property is held and is under disposition, in accordance with the individual's agreement to dispose of the property, any IHSS payments made shall be considered to be overpayments.

.731 The net proceeds from the disposition of the excess property shall be considered to be available for liquidation of overpayments occurring during the disposition period in accordance with Section 30-768.3.

.74 The disposition of the excess property shall be accomplished within a six-month period in the case of real property and within three months in the case of personal property.

.741 The time period shall begin on the date the agreement is signed by the individual.

(a) In the case of a disabled individual, the time period shall begin on the date of the disability determination.

.742 The time limits may be extended another three months where it is found that the individual had "good cause" for failing to dispose of the property within the original time period.

(a) "Good cause" shall exist if, despite reasonable and diligent effort on his/her part, he/she was prevented by circumstances beyond his/her control from disposing of the property.

NOTE: Authority cited: Section 22009(b), Welfare and Institutions Code. Reference: Section 22004, Welfare and Institutions Code.

30-775 INCOME **30-775**

.1 Income means the money or other gain periodically received by an individual for labor or service, or from property, investment, operations, etc. Income may be in the form of cash, including checks and money orders; in-kind items; real property; or personal services.

.11 When the item of receipt is not in the form of cash, the cash equivalent shall be determined.

.12 An individual's or individual and eligible spouse's income shall include all of his/her or their income in cash or in-kind, both earned and unearned.

30-775 INCOME (Continued) **30-775**

.13 An individual's income shall also include those amounts of income of his/her eligible spouse, or, if the individual is a child as defined in Section 30-770.3, of his/her parent and parent's spouse residing in the same household.

.14 If income after applying the allowable disregards or exclusions exceeds the appropriate SSI/SSP benefit level, the excess shall be applied to the cost of IHSS.

.2 Earned Income

.21 Earned income means:

.211 Gross wages.

.212 Net earnings from self-employment.

(a) Net earnings shall be determined by deducting from gross earnings from self-employment all ordinary and necessary business expenses. Principal payments on encumbrances and personal income taxes shall not be considered expenses. Schedules attached to Form 1040 of the IRS for various types of self-employment may be used to verify allowable expenses.

.213 Those amounts of countable earned income deemed to be available to the individual from the income of his/her ineligible spouse, or parent(s) in the case of a recipient child.

(a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.

(b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.

.3 Unearned Income.

.31 Unearned income means all other available income.

.32 In evaluating the amount of unearned income which is available to the individual, consideration shall be given to any necessary costs involved in obtaining or securing the income.

30-775 INCOME 30-775

.33 Unearned income includes, but is not limited to, the following:

.331 Support and maintenance furnished in cash or in-kind.

(a) A person who meets the criteria in Section 46-325.51 shall have the household of another SSI/SSP benefit level used to compute share of cost in lieu of counting the support and maintenance as unearned income.

(1) A person subject to the above procedure may still be eligible for IHSS if living in his/her own home as defined in Section 30-753.

.332 Any payments received as an annuity, pension, retirement, disability, OASDI, unemployment, veteran's or workmen's compensation benefit.

.333 Prizes and awards.

.334 Gifts, support and alimony payments, and inheritances.

.335 Rents, dividends, interests, and royalties.

.336 The proceeds of any life insurance policy to the extent that they exceed the amount expended by the beneficiary for purposes of the insured individual's last illness and burial expenses or $1,500, whichever is less.

.337 Those amounts of countable unearned income deemed to be available to the individual from the income of his/her ineligible spouse or parent(s) in the case of a recipient child.

(a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.

(b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.

30-775 INCOME (Continued) **30-775**

.4 Payments Excluded or Disregarded in Considering Income.

.41 In determining the eligibility for and amount of IHSS, certain payments received or portions thereof shall not be counted as income to the individual and eligible spouse. These exclusions shall also apply in deeming from an ineligible spouse or, in the case of a recipient child, the ineligible parent(s).

.42 The following items shall be excluded from consideration as income:

(a) Refunds, credits and rebates of taxes.

(1) Refunds of taxes paid on real property or purchased food received from any public agency, or renter's credit payments, or special tax credit payments for renters 62 years and older.

(2) Tax rebates, credits or similar temporary tax relief measures which state or federal law specifically exclude from consideration as income.

(b) Assistance based on need.

(1) Payments which are composed entirely of state or local government funds, when made under a program using income level as a criteria for determining the amount of such payment.

(A) When federal or nonpublic monies are included in the assistance payment, such payments shall be countable, including AFDC payments to federally eligible persons, which are countable on a dollar-for-dollar basis related to the recipient's pro rata share.

(c) Grants, scholarships, and fellowships.

(1) Any portion of any grant, scholarship, or fellowship received, used or to be used in paying tuition and fees at any educational institution, including technical or vocational.

30-775 INCOME (Continued) **30-775**

(d) Home produce.

(1) The value of agricultural products which are not raised in connection with a trade or business and are utilized for consumption by the household.

(A) If the produce is sold, the net earnings shall be countable as earned income.

(e) Foster care payments.

(1) Payments for the foster care of a child who is not an eligible individual but who resides in the same home as such individual and was placed there by a public or nonprofit agency.

(f) Support payment from an absent parent.

(1) One-third of any payment received from an absent parent for an eligible individual who is a child as defined in Section 30-770.3.

(A) The remainder shall be countable as unearned income.

(g) Readers and educational scholarships for the blind.

(1) Funds, not available to meet basic needs, awarded for readers and educational scholarships by a high school, institution of higher learning, or a vocational or technical training institution to a recipient due to his/her blindness while he/she is regularly attending any public school or any institution of higher learning in this state.

(h) Vendor payments.

(1) Payments made from any source to a vendor in order to meet the needs of the recipient for medical or social services, as determined by the county welfare department. When the vendor is the recipient's spouse, the provisions of .213 above shall apply.

30-775 INCOME (Continued) **30-775**

(i) CETA incentive payments.

(1) Up to $30 per week of the incentive allowances made to trainees under Title I of the Comprehensive Employment and Training Act (CETA).

(A) This exemption shall apply to any CETA trainee whose needs or income are taken into account in determining the amount of public assistance payments to himself/herself or others.

(B) This exemption shall not apply to wages or other training allowances under the Act.

(j) Payments to Indians.

(1) Per capita payments distributed pursuant to any judgment of the Indian Claims Commission or the Court of Claims in favor of any Indian tribe as specified in Public Law 93-134.

(A) This exemption shall apply to anyone whose income is taken into account to determine the eligibility or grant of a recipient.

(k) Payments made to Alaskan Natives.

(1) Shares of stock and money payments made to Alaskan Natives under the Alaskan Native Claims Settlement Act.

(A) Income resulting directly from stock investments under the Act shall not be exempt.

(l) Supportive services payments.

(1) Payments for supportive services or reimbursement of out-of-pocket expenses made to persons serving in the Service Corps of Retired Executives (SCORE) and the Active Corps of Executives (ACE) pursuant to Section 418 of Public Law 93-113.

(A) This exemption shall apply to all persons whose income is taken into account in determining the amount of the IHSS payment.

30-775 INCOME (Continued) **30-775**

(m) Domestic Volunteer payments.

(1) Payments made under the Domestic Volunteer Services Act of 1973 to welfare recipients who are VISTA volunteers.

(n) Supplemental food assistance.

(1) The value of supplemental food assistance received under the Child Nutrition Act (WIC) and the National School Lunch Act, as specified in Public Laws 92-433 and 93-150.

(o) Energy assistance allowances.

(1) Payments or allowances made under any federal, state or local laws for the purpose of energy assistance, e.g., Low Income Energy Assistance Program (EAP), Energy Crisis Assistance Program (ECAP), and Crisis Intervention Programs (CIP) payments.

(A) Such payments or allowances shall be clearly identified as energy assistance by the legislative body authorizing the program or providing the funds.

.43 The following disregards shall be applied in the order listed below:

.431 Infrequent or irregular income.

(a) Unearned income.

(1) Unearned income which does not exceed $60 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.

(b) Earned income.

(1) Earned income which does not exceed $30 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.

.432 Student exemption.

(a) Up to $1,200 per calendar quarter of the earned income of the recipient who is a child and a student, but in no instance more than $1,620 per calendar year.

30-775 INCOME (Continued) **30-775**

.433 The first $20 per month.

(a) The first $20 of earned or unearned income per month not disregarded above. If the eligible individual or individual and eligible spouse has:

(1) Only earned income, the disregard shall be applied to that income.

(2) Only unearned income, the disregard shall be applied to that income.

(3) Both types of income, the disregard shall first be applied toward the unearned income, and any amount of the disregard remaining shall be applied to the earned income.

.434 Earned income.

(a) The first $65 per month of earned income not disregarded above plus one-half of the remainder.

.435 Work expenses of the blind.

(a) Earned income not disregarded above of a blind individual in the amount of ordinary and necessary expenses related to work activity, and only to the extent that they are paid or to be paid. Broad categories of expenses shall include but not be limited to the following:

(1) Transportation to and from work.

(2) Job performance.

(3) Qualification for promotion.

.436 Income necessary to achieve self-support.

(a) Earned or unearned income not disregarded above and received by an individual who is blind or disabled as defined in Sections 30-771.2 and .3 to the extent that such income is needed to implement a plan of self-support.

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30-775 INCOME (Continued) **30-775**

(1) Such plan shall be in writing and shall be approved by the United States Social Security Administration (SSA) unless a state-approved plan is still in effect when the blind or disabled individual becomes eligible for IHSS.

(2) The plan shall contain the following elements:

(A) Specific savings and/or disbursement goals for a designated occupational objective.

(B) Identification and segregation of such money and other resources as are being accumulated and conserved toward this goal.

.437 Income exclusions for certain blind individuals.

(a) For an individual who is blind as determined under the state plan approved until Title X as in effect in October 1972, and who received assistance under such plan in December 1973, an amount equal to the greater of the following:

(1) The maximum amount of any earned or unearned income which could have been disregarded under the state plan as in effect in October 1972; or

(2) The amount which would be required to be disregarded under .4 above without application of this subsection.

30-776 PROVIDER IDENTIFICATION **30-776**

.1 Proof of provider identification shall be required pursuant to Welfare and Institutions Code Section 12306.5.

30-776 PROVIDER IDENTIFICATION (Continued) **30-776**

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Welfare and Institutions Code Section 12306.5 states that any public or private agency, including a contractor as defined in Welfare and Institutions Code Section 12302.1, who maintains a list or registry of prospective In-Home Supportive Services providers shall require proof of identification from a prospective provider prior to placing the prospective provider on a list or registry or supplying a name from the list or registry to an applicant for, or recipient of, In-Home Supportive Services.

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.11 Proof of identification shall not be required for prospective providers to remain on a list or registry that existed before April 1, 1988. However, proof of identification shall be required prior to providing those prospective providers' names to an applicant or recipient of In-Home Supportive Services, or prior to providing the names of any prospective providers where proof of identification has not been established.

.12 Proof of identification shall include, but is not limited to, one of the following:

.121 A positive photograph identification from a government source, such as:

(a) a valid California driver's license;

(b) a valid identification card issued by a government agency; or

(c) a valid military identification card.

.122 A valid student identification card issued by an accredited college or university.

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780

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.1 Scope of Services

DHS regulation Section 51183 reads:

Personal Care Services.

Personal care services include (a) personal care services and (b) ancillary services prescribed in accordance with a plan of treatment.

(a) Personal care services include:

(1) Assisting with ambulation, including walking or moving around (i.e. wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.

(2) Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub, or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

(3) Dressing includes putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(4) Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

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

(A) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, or sofa, and the like, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

(B) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(6) Feeding, hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, manipulating food on plate. Cleaning face and hands as necessary following meal.

(7) Assistance with self-administration of medications. Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(8) Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.

(9) Paramedical services are defined in Welfare and Institutions Code Section 12300.1 as follows:

(A) Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(B) Paramedical services are activities which persons could perform for themselves but for their functional limitations.

(C) Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health.

(b) Ancillary services are subject to time per task guidelines when established in Sections 30-757 of the Department of Social Services' Manual of Policies and Procedures and are limited to the following:

(1) Domestic services are limited to the following:

(A) Sweeping, vacuuming, washing and waxing of floor surfaces.

(B) Washing kitchen counters and sinks.

(C) Cleaning the bathroom

(D) Storing food and supplies.

(E) Taking out the garbage.

(F) Dusting and picking up.

(G) Cleaning oven and stove.

(H) Cleaning and defrosting refrigerator.

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

(J) Changing bed linen.

(K) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(2) Laundry services include washing and drying laundry, and is limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending, or ironing, folding, and storing clothing on shelves, in closets or in drawers.

(3) Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs; compiling a list, bending, reaching, and lifting, managing cart or basket, identifying items needed, putting items away, phoning in and picking up prescriptions, and buying clothing.

(4) Meal preparation and cleanup including planning menus; e.g., washing, peeling and slicing vegetables; opening packages, cans and bags, mixing ingredients; lifting pots and pans; reheating food, cooking and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.

(5) Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance is necessary to accomplish the travel limited to:

(A) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after staff of the designated county department has determined that no other Medi-Cal service will provide transportation in the specific case.

(B) Accompaniment to the site where alternative resources provide in-home supportive services to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

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

(7) Yard hazard abatement which is light work in the yard which may be authorized for:

(A) removal of high grass or weeds and rubbish when this constitutes a fire hazard.

(B) removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

(c) Ancillary services may not be provided separately from personal care services listed in subsection (a) above.

.2 Personal Care Services Program Tasks

DHS regulation Section 51350 reads:

Personal Care Services.

(a) Personal care services as specified in Section 51183 are provided when authorized by the staff of a designated county department based on the state approved Uniformity Assessment tool. To the extent not inconsistent with statutes and regulations governing the Medi-Cal program, the needs assessment process shall be governed by the Department of Social Services' Manual of Policies and Procedures Sections 30-760, 30-761, and 30-763.

(b) Personal care services may be provided only to a categorically needy beneficiary as defined in Welfare and Institutions Code, Section 14050.1, who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. The services shall be provided in the beneficiary's home or other locations as may be authorized by the Director subject to federal approval. Personal care services authorized shall not exceed 283 hours in a calendar month.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(c) Personal care services will be prescribed by a physician. The beneficiary's medical necessity for personal care shall be certified by a licensed physician. Physician certification shall be done annually.

(d) Registered nurse supervision consists of review of the service plan and provision of supportive intervention. The nurse shall review each case record at least every twelve months. The nurse shall make home visits to evaluate the beneficiary's condition and the effectiveness of personal care services based on review of the case record or whenever determined as necessary by staff of a designated county department. If appropriate, the nurse shall arrange for medical follow-up. All nurse supervision activities shall be documented and signed in the case record of the beneficiary.

(e) Paramedical services when included in the personal care plan of treatment must be ordered by a licensed health professional lawfully authorized by the State. The order shall include a statement of informed consent saying that the beneficiary has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the beneficiary, the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian.

(f) Grooming shall exclude cutting with scissors or clipping toenails.

(g) Menstrual care is limited to external application of sanitary napkin and cleaning. Catheter insertion, ostomy irrigation and bowel program are not bowel or bladder care but paramedical.

(h) Repositioning, transfer skin care, and range of motion exercises have the following limitations:

(1) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

HANDBOOK CONTINUES

(2) Range of motion exercises shall be limited to the general supervision of exercises which have been taught to the beneficiary by a licensed therapist or other health care professional to restore mobility restricted because of the injury, disuse or disease. Range of motion exercises shall be limited to maintenance therapy when the specialized knowledge or judgment of a qualified therapist is not required and the exercises are consistent with the beneficiary's capacity and tolerance. Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

.3 Personal Care Services Program Required Documentation

DHS regulation Section 51476.2 reads:

Personal Care Services Records.

Each county shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of personal care services provided to a Medi-Cal beneficiary. Records shall be made at or near the time the service is rendered or the assessment or other activity is performed. Such records shall include, but not be limited to the following:

(a) Time sheets

(b) Assessment forms and notes

(c) All service records, care plans, and orders/prescriptions ordering personal care.

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30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

.4 Eligibility for PCSP shall be limited to those IHSS recipients who do not receive IHSS advance payment as specified in Section 30-769.731.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan amendment, Approved pursuant to Sections 12301.2 and 14132.95(b), Welfare and Institutions Code.

30-785 IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS WAIVER PROGRAM 30-785

(a) Program and Special Definitions

(1) The IHSS Plus Waiver program will follow the IHSS, Program Definitions and Special Definitions, specified in MPP Section 30-700 and 30-701, unless otherwise specified.

(b) Eligibility

(1) A person is eligible for the IHSS Plus Waiver who is a California resident, living in his/her own home and is aged, blind or disabled according to Medi-Cal based definitions, and;

(2) Has been found eligible for full-scope federally funded Medi-Cal based upon either;

(A) receipt of cash assistance through SSI/SSP, CalWORKs cash aid or Foster Care, or

(B) an eligibility determination completed by a Medi-Cal Eligibility Worker for full-scope federally funded Medi-Cal, in accordance with Medi-Cal regulations located at Title 22, California Code of Regulations (CCR), Division 3, Subdivision 1, Chapters 1 and 2, and;

(3) Has an assessed need, based upon a needs assessment as described im MPP Section 30-761, and;

(4) Receives at least one of the following;

(A) Restaurant Meal Allowance as specified in MPP Section 30-757.134;

(B) Advance Pay as specified in MPP Section 30-769.73;

(C) Service(s) provided by his/her spouse as allowed in MPP Section 30-763.41; or

(D) Service(s) as a minor child provided by his/her parent as allowed in MPP Section 30-763.45, and;

30-785 IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS WAIVER PROGRAM 30-785
(Continued)

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

(A) In determining the applicable share of cost the following shall apply;

1. Medi-Cal rules regarding share of cost will be followed for purposes of determining Medi-Cal eligibility in accordance with Title 22, CCR, Division 3, Chapter 2, Articles 10, 11 and 12.

2. To the extent a recipient comes within the terms of the supplemental payment program described in Welfare and Institutions Code Section 12305.1, a share-of-cost compensation as described in that section shall be performed. The applicable share of cost for such recipients shall include the supplementary payment authorized in that section.

(c) Process for Determination of Eligibility for IHSS Plus Waiver Services

(1) The process for determining eligibility for the IHSS Plus Waiver program shall be in accordance with MPP Section 30-755.2.

(d) Need

(1) Designated county staff shall determine the recipient's level of ability, dependence, physical assistance and need in accordance with MPP Section 30-756.

(e) Program Content

(1) IHSS Plus Waiver program content shall be the same as the program content expressed in MPP Section 30-757.

(A) A person who is eligible for a service provided pursuant to the IHSS Plus Waiver shall not be eligible for any service through the IHSS program.

(B) A person who is eligible for all of their services pursuant to the PCSP shall not be eligible for any service through the IHSS Plus Waiver or IHSS programs.

(f) Time Per Task and Frequency Guidelines

(1) When assessing the need for services the assessed time shall be in accordance with MPP Section 30-758.

30-785 IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS WAIVER PROGRAM 30-785
(Continued)

(g) Application Process

(1) The IHSS Plus Waiver application process shall follow the MPP Section 30-759, except for 30-759.3.

(2) Presumptive disability is determined in accordance with Medi-Cal regulations located at Title 22, CCR, Division 3, Section 50167(a)(1)(C).

(3) Additionally, for those not already determined eligible for full-scope federally funded Medi-Cal, a determination for Medi-Cal eligibility must be completed before final eligibility for the IHSS Plus Waiver can be established.

(4) Intercounty transfers of the IHSS Plus Waiver service case must be coordinated with the intercounty transfer of the Medi-Cal eligibility case.

(h) Responsibilities

(1) IHSS Plus Waiver applicant/recipient and county responsibilities shall be the same as the responsibilities specified in MPP Section 30-760(b).

(i) Needs Assessment Standards

(1) Services shall be authorized only in cases which meet the conditions established in MPP Section 30-761.1 and eligibility as specified in MPP Section 30-785(b).

(2) Needs Assessments are performed in accordance with MPP Section 30-761.2, except;

(A) A reassessment must be completed prior to the end of the twelfth calendar month from the last assessment.

(3) IHSS staff shall be staff of a designated county department as specified in MPP Section 30-761.3.

(j) Service Authorization

(1) Authorization for services shall be determined in accordance with MPP Section 30-763.

(k) Individual Provider's Compensation

(1) The computation of payment, rate of compensation and employer responsibilities for the IHSS Plus Waiver program shall follow the guidelines specified in MPP Section 30-764.

30-785 IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS WAIVER PROGRAM 30-785
(Continued)

(l) Cost Limitations

(1) The cost limitations that apply to all payments made for IHSS Plus Waiver Services shall follow the guidelines specified in MPP Section 30-765.

(m) County Plans

(1) Each county welfare department shall develop and submit a county plan to CDSS no later than 30 days following receipt of its allocation, which specifies the means by which the IHSS Plus Waiver program will be provided in order to meet the objectives and conditions within its allocation as specified in MPP Section 30-766.

(n) Service Delivery Methods

(1) The county shall arrange for the provision of IHSS Plus Waiver through one or more of the Service Delivery Methods as specified in MPP Sections 30-767.11, .12 and .13.

(o) Overpayment/Underpayments

(1) For purposes of determining overpayments, action on overpayments and demand for repayment for an IHSS Plus Waiver recipient. DHS regulation Sections 50781, 50786 and 50787 (MPP Handbook Sections 30-768.5, .6 and .7) shall apply.

(p) Payrolling for Individual Providers

(1) Counties shall follow the payrolling-for-individual-providers procedures, specified in MPP Section 30-769, for individual providers who provide services to IHSS Plus Waiver recipients.

(q) Provider Identification

(1) Proof of provider identification shall follow the guidelines specified in IHSS, Provider Identification, MPP Section 30-776.

NOTE: Authority cited: Sections 10553, 10554, 12300, 14132.95, and 14132.951, Welfare and Institutions Code; and 42 USC, Section 1315(a) of the Social Security Act. Reference: Sections 12300, 12305.1, 14132.95, and 14132.951, Welfare and Institutions Code, and Special Terms and Conditions (STC) for the California IHSS Plus Waiver, granted under Section 1115 Demonstration Project.

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