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REASON FOR THIS TRANSMITTAL
[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[x] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

June 15, 2010

ALL-COUNTY LETTER NO. 10-33

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER ENROLLMENT REQUIREMENTS FOR SPECIFIED PROVIDERS IN PENDING STATUS ON JUNE 30, 2010

REFERENCE : ALL COUNTY LETTER (ACL) NO 09-52, DATED OCTOBER 1, 2009; ACLs NO. 09-54 AND 09-63, DATED OCTOBER 28, 2009; ACL NO. 09-66, DATED OCTOBER 29, 2009; AND ACL NO. 09-69 AND 09-70, DATED OCTOBER 31, 2009, AND, ACL 09-78 DATED NOVEMBER 25, 2009

Assembly Bill, Fourth Extraordinary Legislative Session (AB) X4 4 (Chapter 4, Statutes of 2009), and ABX4 19 (Chapter 17, Statutes of 2009) expanded IHSS provider enrollment requirements. These new requirements were implemented November 1, 2009 through instruction and information from the above-referenced ACLs. Providers who were enrolled prior to the effective date of these requirements were allowed until June 30, 2010 to complete the requirements. This ACL addresses circumstances under which these providers may continue as eligible providers and receive payment beyond June 30, 2010. This ACL and the policies detailed herein should be considered the most current and valid information.

BACKGROUND

The legislation referenced above mandated four requirements for IHSS provider enrollment with which new/ prospective and current providers must comply in order to be an eligible IHSS Provider:

Welfare and Institutions Code (W&IC) section 12305.81 (a) requires:

1. The person applying to provide supportive services complete and sign an IHSS Provider Enrollment Form (SOC 426). The prospective provider must submit the form to the county in person and also present original documentation verifying his/her identity, (e.g., current photo identification and social security card) for photocopying by the county.

W&IC section 12301.24 governs provider orientation and requires the following two elements:

2. Effective November 1, 2009, all prospective providers must complete a provider orientation at the time of enrollment. Between November 1, 2009 and June 30, 2010, all current providers are to receive the provider orientation material, or at his/her discretion attend the orientation.
3. The Provider Enrollment Agreement, SOC 846, must be signed and dated upon completion of the orientation for new/prospective providers and after receipt of the orientation materials by existing providers. The SOC 846 states that the provider understands and agrees to the rules of the IHSS program and the responsibilities of being an IHSS provider.

W&IC section 12301.6 (e) and 12305.86 requires:

4. Fingerprinting and Department of Justice criminal background checks for all prospective providers effective November 1, 2009 and all current providers by July 1, 2010.

EXTENSION OF TIME FOR CURRENT PROVIDERS TO COMPLETE PROVIDER ENROLLMENT REQUIREMENTS

Since November 1, 2009, the counties and Public Authorities/Non-Profit Consortia (PA/NPC) have made tremendous progress towards completing the enrollment of the active IHSS providers. As of June 9, 2010, approximately 225,000 have completed the provider enrollment requirements described above and another 104,000 have completed at least one of the four enrollment requirements and are in pending status in Case Management, Information and Payrolling System (CMIPS). This is a significant accomplishment given the short timeframes within which the provider enrollment requirements were implemented and the delays that were caused by court litigation.

Although the rate of enrollment completions has been rapidly increasing, the volume of provider enrollment forms, orientations, and criminal background checks are more than can be processed by June 30, 2010. Current providers who meet one of four specified conditions outlined above will be allowed until December 31, 2010, to complete the mandated enrollment requirements.

As a reminder to counties and for purposes of the four requirements above, a current provider is defined as a provider enrolled in the CMIPS system after January 1, 2001 and prior to November 1, 2009.

- Current providers who have completed at least one of the four required steps outlined above by June 30, 2010 will continue to be eligible and receive payment after June 30, 2010 for their current recipient relationships **only**, and will have until December 31, 2010 to complete all the enrollment requirements. "Current recipient relationship" is defined as any current provider who is actively providing services to that recipient prior to July 1, 2010. Current providers who do not complete all the enrollment requirements by December 31, 2010 will be terminated.

- Current providers hired to work by a recipient after June 30, 2010 must complete all of the four required steps outlined above and be determined an eligible IHSS provider before being enrolled and paid as a provider for the recipient. If they begin working for the recipient prior to completing the requirements, they may be enrolled and paid retroactively for recipient authorized hours they provided if they are determined eligible.

- **Current providers who have not completed at least one of the four required steps outlined above by June 30, 2010 will have all their recipient relationships terminated by CMIPS and no longer be eligible as an IHSS provider or to receive payment from the IHSS program.** If these providers wish to be reinstated as an IHSS provider, they will need to complete all four required steps and be determined an eligible IHSS provider. Current providers who continue working for the recipient after June 30, 2010 and who, at a later date, complete all four enrollment requirements and are determined an eligible provider may be paid retroactively to July 1, 2010, for recipient authorized hours they provided. However, if the provider is found ineligible, the recipient will be responsible for payment of any services provided.

During the first week of June 2010, the California Department of Social Services (CDSS) issued a reminder notice to providers who had not completed at least one of the above outlined requirements, and also to their associated recipients. The letter stated that as of June 30, 2010 if the provider had not completed one of the requirements the provider would be terminated and no longer be paid by the IHSS program. In addition, CDSS will be issuing a final notification to recipients whose provider has not completed one of the requirements by mid-June. This final notification will inform the recipient of the provider(s) that will be terminated as of June 30, 2010, if the provider(s) does not complete one of the new provider enrollment requirements prior to that date.

Provider completion of requirements will be determined by the indicators on the CMIPS provider enrollment screen. Therefore, **counties must ensure Provider Enrollment screens accurately reflect what each provider has completed by June 30, 2010**. After close of business on June 30, 2010, CMIPS will run an automated batch process to terminate all providers who have not completed one of the new provider enrollment requirements from every recipient case on which they are active.

The week of July 6, 2010 CDSS will issue a report to each county (with their monthly download) of all providers and their associated recipient(s) who were terminated by this process. Counties should have plans in place to assist recipients whose current provider(s) is terminated and is no longer eligible to be paid for providing services. Additionally, counties should anticipate that some providers will only respond and start the enrollment process after they are terminated.

If a provider is terminated erroneously due to inaccurate information on the Provider Enrollment screen a process for correction has been developed. This process will be issued to counties by Program Manager Letter.

Questions or requests for clarification on policies included in this ACL should be directed to the appropriate Bureau within the Adult Programs Branch, as follows:

Criminal Background Check,
Provider Enrollment Requirements ..... Policy Bureau at (916) 229-4000

Provider Orientation,
Inter-County Transfers ..... Operations & Quality Assurance Bureau at (916) 229-3494

CMIPS Issues ..... Fiscal, Administrative & Systems Bureau at (916) 229-4002

Provider Appeals ..... Litigation & Appeals Bureau at (916) 229-4003

Sincerely,

Original Document Signed By:
Eileen Carroll

EVA L. LOPEZ
Deputy Director
Adult Programs Division

c: CWDA
CAPA

CDSS
STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
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July 16, 2010

REASON FOR THIS TRANSMITTAL
[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[✓] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

ALL-COUNTY LETTER (ACL) NO.: 10-35

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: QUESTIONS AND ANSWERS REGARDING THE EXPANDED IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER ENROLLMENT REQUIREMENTS

REFERENCES: ACL NO. 09-52, DATED OCTOBER 1, 2009; ACLs NO. 09-54 AND 09-63, DATED OCTOBER 28, 2009; ACL NO. 09-66, DATED OCTOBER 29, 2009; ACLs NO. 09-69 AND 09-70, DATED OCTOBER 31, 2009; ACL 09-78 DATED NOVEMBER 25, 2009; AND ACL 10-05, DATED FEBRUARY 17, 2010

The above-referenced ACLs provided information and instructions to counties on the implementation of expanded IHSS provider enrollment requirements. These expanded requirements became effective November 1, 2009, as mandated by Assembly Bill (AB), Fourth Extraordinary Legislative Session (ABX4) 4 (Chapter 4, Statutes of 2009), and ABX4 19 (Chapter 17, Statutes of 2009). This ACL clarifies and updates several issues related to the implementation of those requirements. This ACL and the policies detailed herein should be considered the most current and valid information.

CRIMINAL BACKGROUND CHECKS

1. **Does Welfare and Institutions Code (W&IC) section 12305.81, which "prohibits any individual who in the last 10 years has been convicted of, or incarcerated following a conviction for, a crime involving fraud against a government health care or supportive services program, or a violation of subdivision (a) of Section 273a of the Penal Code (PC) (abuse of a child under circumstances/conditions likely to produce great bodily harm or death), or Section 368 of the PC (abuse of an elder or dependent adult), or similar violations in another jurisdiction," apply only to felony offenses?**

   No. W&IC section 12305.81 applies to both felony and misdemeanor offenses. Hence, an individual who in the last 10 years has been convicted for or incarcerated following a conviction for a crime specified in W&IC section 12305.81 – regardless

of whether the crime was a felony or a misdemeanor – would not be eligible to be enrolled as a provider or to receive payment for providing supportive services in the IHSS program.

2. Who pays for background checks?

W&IC section 12305.86(b) states that criminal background checks are to be conducted at the provider/applicant's expense. This statute, which was added by ABX4 19, supersedes earlier statute (W&IC section 15660(d)(2)) in regard to the fees charged for the criminal background checks. The statute does not address whether another entity (e.g., community based organization) would be prohibited from paying for the background check; however, the intent of the law is that state funds would not be used. Counties are advised to carefully research the statutes governing other programs to determine whether the funding could be used for these purposes.

The fee waiver for an indigent individual to obtain a copy of his/her criminal history record referred to in W&IC section 12305.86(c)(3) applies only to those individuals found ineligible to be providers based on the results of information found through an initial criminal background check. An individual cannot use the fee waiver process to avoid the costs of the initial criminal background check. The response to Question #8 in ACL 10-05 provides information about the fee waiver.

3. Does the fingerprinting/criminal background review process place the county, Public Authority (PA) or Non-Profit Consortium (NPC) in the position of the employer of record?

No. W&IC section 12305.86 requires that the counties perform background checks of current and potential providers. If a county/PA/NPC chooses not to perform background checks, they do so in violation of statute.

There is no statute that expressly or implicitly states that the county/PA/NPC becomes the "employer of record" either because they perform a provider background check or for any other reason. There are many instances in which a public agency performs a background check and this does not create an employment relationship between the subject and the agency (e.g. community care licensing, nursing/physician, state bar license).

The IHSS recipient is the employer for all purposes except where, by statute, another entity is specifically deemed the "employer." Notably, W&IC section 15660 (which grants DOJ the authority to perform the background checks at issue) specifically references the recipient as the employer. ("For purposes of this paragraph, 'employer' includes, but is not limited to, an in-home supportive services

recipient.") W&IC section 12302.2, which obligates the state to make deductions from provider pay for income tax, disability benefits, and unemployment compensation, specifically refers to the recipient as the employer.

4. **Would a conviction for, or incarceration following a conviction, under W&IC section 10980, within the past 10 years, disqualify an individual from being a provider?**

   County District Attorneys (DAs) have discretion under which code section(s) to prosecute crimes involving fraud against government programs. Whether an individual would be disqualified for a conviction under W&IC section 10980 depends upon which government program was involved. If the Criminal Offender Record Information (CORI) showing a conviction under W&IC section 10980 does not specify which program the individual committed fraud against, it will be necessary for the county/PA to obtain additional information from either the court or law enforcement to determine whether the fraud involved a health care or supportive services program. The California Department of Social Services (CDSS) is consulting with county DAs to obtain additional information about the prosecution of crimes involving fraud against government programs so that guidance can be provided to counties/PAs at a later date.

   Fraud against a public social services program, such as California Work Opportunity and Responsibility to Kids (CalWORKs), would not disqualify an individual from being an IHSS provider. This is because CalWORKs is not considered "a government health care or supportive services program" per W&IC section 12305.81 and, it is funded under Title IV, rather than Titles V, XX or XXI, of the Social Security Act. Other non-disqualifying programs would include the Foster Care Program, the Food Stamps Program, the Supplemental Nutrition Program for Women, Infants and Children (WIC), etc.

5. **W&IC section 12305.81 states that, "a person shall not be eligible to provide or receive payment for providing supportive services for 10 years following a conviction for, or incarceration following a conviction for, fraud against a government health care or supportive services program, including Medicare, Medicaid, or services provided under Title V, Title XX, or Title XXI of the federal Social Security Act..." Which specific health or supportive services programs would be included in this description?**

   Prior fraud against the IHSS program would disqualify an individual from being an IHSS provider. In addition, fraud against one of the programs listed below which are fully or partially funded under Titles V, XX and XXI of the Social Security Act, would make an individual ineligible. (Note: This list of programs is <u>not</u> exhaustive.)

- Title V. (Maternal and Child Health Services Block Grant): Sudden Infant Death Syndrome Program, Oral Health Program, Breastfeeding Program, California Birth Defects Monitoring Program, California Diabetes and Pregnancy Program, Childhood Injury Prevention Program, Fetal and Infant Mortality Review Program, Local Health Department Maternal, Child and Adolescent Health Program, Maternal, Child and Adolescent Health in Schools Program, and Regional Perinatal Programs of California.

- Title XX. (Block Grants to States for Social Services): There are currently no identified government health care or supportive services programs funded under Title XX in California.

- Title XXI. (State Children's Health Insurance Program): Healthy Families Program, and the Access for Infants and Mothers (AIM) Program.

PROVIDER ENROLLMENT REQUIREMENTS

6. What are the rules for "existing" vs. "new" providers?

A new provider is any provider who was not enrolled prior to November 1, 2009 and who did not exist in Legacy CMIPS prior to that date. New providers must complete the new provider enrollment process and be determined eligible before their timesheets can be processed and a warrant issued.

An existing provider is any provider who exists in the legacy Case Management, Information, and Payrolling System (CMIPS), in any status, from January 1, 2001, to October 31, 2009. These "existing providers" may continue to work and be paid for authorized hours they work for a recipient if they were enrolled as an active provider for that recipient prior to July 1, 2010 and he/she completed at least one of the provider enrollment requirements by June 30, 2010. Providers who meet the above condition will have until December 31, 2010 to complete any remaining provider enrollment requirements. Additionally, after June 30, 2010, an existing provider cannot receive payment for providing services to another (new) recipient, until he/she completes all of the enrollment requirements and is determined eligible.

If an existing provider did not complete at least one of the enrollment requirements prior to July 1, 2010, he/she has been terminated. In order to be re-employed as an IHSS provider and be paid by the IHSS program, he/she must complete all the enrollment requirements and be determined eligible.

Please refer to ACL 10-33 dated June 15, 2010, for additional information regarding the above provider requirements.

7. Are recipients required to submit the Recipient Designation of Provider form (SOC 426A) even if there has been no change in the provider?

Yes. All recipients, regardless of whether their providers are new or existing, eventually will be required to have on file a completed SOC 426A for each provider. However, if there has been no change in a recipient's provider and there is currently on file a copy of the 9/02 version of the Provider Enrollment Form (SOC 426) with the client certification (Part II) completed, a recipient need not complete the SOC 426A at the present time. Because all providers will be required to complete the revised SOC 426 (currently under development), and because the revised SOC 426 will not include a client certification, all recipients will need to complete the SOC 426A when their provider completes the revised SOC 426. Once the revised SOC 426 is released, counties will be required to obtain the revised SOC 426 from providers and the SOC 426A from recipients. This may be done at the time of a recipient's reassessment, or at some other time at the discretion of the county. For recipients who select a new provider or who make a change in their existing provider, the SOC 426A must be completed at the time the recipient makes his/her selection/change.

8. Are new providers eligible to receive retroactive pay for services they provide for recipients once they have completed all of the provider enrollment requirements?

Yes. If an individual seeking to be a provider begins providing services for an eligible recipient prior to completing all of the provider enrollment requirements, and he/she is ultimately determined to be eligible to be a provider, he/she would be eligible to receive retroactive payment to the start date of employment for the services he/she provided.

However, if the individual is ultimately found ineligible to be a provider for any reason, he/she cannot receive payment from the IHSS program. The recipient will have to pay for services provided from his/her own pocket. For this reason, CDSS strongly encourages counties/PAs/NPC to ensure that recipients fully understand the potential financial responsibility they accept by allowing individuals to provide services prior to completing all of the provider enrollment requirements. CDSS suggests that counties provide this clarification at the same time that they provide direction to recipients on their responsibilities as employers, i.e., when recipients complete the Application for Social Services (SOC 295) and the Recipient/Employer Responsibility Checklist (SOC 332).

9. Why is there no start date field on the SOC 426A?

CDSS is revising the SOC 426A to include a start date field and will release the revised form shortly. Both the SOC 426 and SOC 426A are mandated forms. Counties are not permitted to substitute county-developed forms or to revise these forms in any way.

10. Are the counties required to retain copies of the Provider Enrollment Agreement (SOC 846) indefinitely?

Yes. W&IC section 12301.24(d) states that counties shall indefinitely retain the SOC 846 in the provider's file. Retaining the provider enrollment agreement form can serve as verification of a provider's eligibility and his/her understanding of the IHSS program rules and procedures which benefits both the provider and recipient. Counties may consider archiving these documents electronically or by other means. Government Code section 12168.7 requires that storing such documents be done in a manner that would not substantially alter their original form.

11. What identification must an individual present when submitting the SOC 426?

A provider/applicant must present one piece of current and valid U.S. government-issued (federal or state) picture ID along with an original Social Security card or original official correspondence from the Social Security Administration (SSA) verifying his/her Social Security number (SSN). Refer to ACL 09-52 for acceptable forms of identification. If the spelling, order, or other details of the provider's/applicant's name as it appears on the SOC 426 and other ID does not match the Social Security card, the SSA may not verify the SSN. See Question #25 for information on the SSN verification process.

12. Can the Medi-Cal Eligibility Data System (MEDS) be used to obtain an individual's SSN if they do not have an original Social Security card or original official correspondence from the SSA?

No. Providers/applicants must present documentation in the form of an original Social Security card or original official correspondence from the SSA.

13. Would an individual be required to present a Social Security card when he/she presents a United States (U.S.) passport as the primary identification?

Yes. A U.S. passport is acceptable as identification; however, it does not allow for the verification of the SSN. Therefore, the county must also view an original Social Security card or original official documentation from the SSA so that the SSN provided on the SOC 426 can be confirmed.

TRANSLATED MATERIALS

14. When will the translated provider enrollment forms and orientation materials be made available?

The languages that currently meet the five percent statewide IHSS recipient population threshold are: Armenian, Chinese and Spanish. Pending further court action in the Beckwith, et al. v. Wagner litigation, revisions may be necessary to the SOC 426. When the revision of the SOC 426 is completed, the form will be translated into all three threshold languages and camera-ready copies will be posted on the below-referenced web page.

A camera-ready copy of the version of SOC 426 currently in use (dated 9/02) is available in Spanish on the CDSS Translated Forms and Publications web page at: http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

Translations of the Provider Orientation Guide and handouts in the threshold languages are now available on the new IHSS Provider Orientation page of the CDSS Adult Programs web site at: http://www.cdss.ca.gov/agedblinddisabled/PG2082.htm.

Pursuant to the Dymally-Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and state regulation (Manual of Policies and Procedures Division 21, Civil Rights Nondiscrimination, section 115), counties are responsible for providing translation/interpretation services for non-English speaking or limited English proficient populations.

Questions relating to these translated materials should be directed to the CDSS Language Services Unit, at (916) 651-8876 or LTS@dss.ca.gov.

PROVIDER ORIENTATION

15. When will written provider orientation materials be available?

All provider orientation materials have been made available. The CD-ROM and the required handouts were distributed to counties on October 20, 2009. The written Provider Guide and required handouts were mailed on November 23, 2009.

Translations of the orientation materials in Spanish, Armenian and Chinese have been completed. See Question #14 above for information on where the translated documents can be accessed online. These materials were mailed to counties in mid-December 2009. Translation of the Provider Orientation CD-ROM was completed and the translations were mailed to counties in mid-January 2010.

16. Are existing providers required to attend an on-site orientation session?

No. Existing providers are not required to attend an on-site orientation session. They also have the option of reviewing the Provider Orientation Guide or CD-ROM, whichever they prefer and find most accessible.

Existing providers are required, however, to submit the SOC 426 in person and present their original government-issued ID and Social Security card. Existing providers must also return a signed SOC 846. It is not necessary for the either form to be signed in the presence of county/PA staff.

17. When will the orientation materials include the final list of crimes that would disqualify a provider?

Pending further court action, at this time the ruling of the Alameda County Superior Court in the Beckwith, et al. v. Wagner court case provides the crimes that would make an individual ineligible to be a provider in the IHSS program. These are limited to a conviction (or incarceration following a conviction) within the last 10 years for those crimes specified in W&IC section 12305.81:

1) Fraud against a governmental health care or supportive services program;
2) Violation of subdivision (a) of Section 273a of the PC (abuse of a child under circumstances/conditions likely to produce great bodily harm or death); or
3) Violation of Section 368 of the PC (abuse of an elder or dependent adult).

This change will be incorporated into the provider orientation training curriculum at the next revision of the materials.

18. Will the provider orientation be made available in DVD format?

The provider orientation training covers detailed information and instructions. It was determined that it was best suited to a power-point presentation format and, as a result, the format dictated use of the CD-ROM. However, the training materials will be revised in the next fiscal year and other formats will be considered at that time.

19. Can counties present other information that new providers would need to know about the IHSS program during the orientation?

Yes. As stated in ACL 09-54, counties are required to use the materials developed by CDSS, but they may supplement the orientation with county-specific information and/or directions.

PROVIDER APPEALS

20. Is there a new form counties will be required to use for appeals?

CDSS developed a Fact Sheet Supporting Denial form that Provider Enrollment Appeals Unit (PEAU) staff forward to counties or PAs each time an appeal has been filed. The form requests the criminal conviction code(s) and conviction date(s) used by counties/PAs as the basis for declining to enroll a prospective provider or to find a provider ineligible. Counties should also provide any additional documentation not obtained from the Department of Justice (DOJ) that was used as part of the eligibility determination as an attachment to this form. If a county/PA has concerns or questions regarding transferring/sharing relevant conviction data obtained from the DOJ with CDSS via the form, they are urged to contact the Record Access & Security Program, DOJ, at (916) 227-3460 or RecordSecurity@doj.ca.gov for guidance. Although the form is intended to simplify the transmission of this information from the county to the state, counties are not mandated to use this form; a locally-developed form may be used as long as it contains all of the required information.

CMIPS ISSUES

21. Does the input of a termination reason code on the CMIPS Provider Enrollment screen pose any county liability in terms of violation of confidentiality of CORI received from DOJ?

No. The reason codes in CMIPS were updated to identify ineligibility reasons in a general way. According to DOJ, the county can input the reason for ineligibility/termination into CMIPS and it would not violate the confidentiality of the CORI. Further, DOJ indicated that it is acceptable for CMIPS to be updated with information that indicates that an individual is not eligible as a result of information from the criminal background check.

22. CMIPS is a point-in-time system. It does not track provider enrollment process. Will the new provider enrollment screens only be completed when the provider has completed the enrollment process and is either eligible or ineligible for payment?

No. The ENRL screen can be accessed at any time using the provider's SSN. Since it is unlikely that most providers will complete the entire enrollment process at one time, the screen was designed to allow counties to check off the necessary items as they are completed. Providers who have not completed the entire process are in pending "P" status. Once all of the steps have been completed, county staff must change the provider to "E" (eligible) status on the PELG screen. However, be aware that the system will not allow a change in the provider's status to "E" on the PELG screen until the enrollment process has been completed.

Additionally, the system requires both the ENRL enrollment process to be completed AND the SSNV field on the PELG screen to be verified in "V" before the PELG status can be changed to "E."

23. Will the Informing Notices to providers link to the new provider enrollment screen so that notices/letters to providers can be generated automatically as they are currently when counties make changes to client eligibility and NOAs are generated?

No. As stated in ACL 09-66, page three, counties will be responsible for generating and mailing provider enrollment eligibility notification letters.

24. How will county staff record provider ineligibility based on a conviction received as a result of the background check?

The county staff will enter the ENRL screen in either "A" (add) or "C" (change) mode. In the Fingerprint/BI field on the ENRL screen they will enter a "Y" to show the background check has been completed. In the Enrollment Status field they will enter "I" (ineligible) and enter Termination Reason Code 11.

25. What is the SSN verification process and how often are the results posted on provider records?

The SSN verification process is a batch process that is performed twice a week by the CMIPS vendor. The new provider records are sent to the SSA for verification. The results of each batch will be posted to each provider record within 3 business days of when the batch was run. The batch is customarily run on Tuesdays and Fridays, but holidays may change this schedule. If the SSN is correct and has been verified it will be followed by a "V" on the H3 line of the PELG screen. If the SSN does not match the SSA records the provider will be included on the CMIPS Online SSN Verification Report to be resolved by county staff. A new provider is not eligible to be paid until their SSN is in "V" status.

26. Why are the forced manual edit and extra steps necessary when entering a P.O. Box on the provider screen?

At this time, system functionality necessitates that the forced edit be used to meet the new residential address and mailing requirements. This programming ensures that a county worker examines this requirement while still allowing counties the option of overriding the restriction on mailing checks to P.O. Boxes, if the county has approved an exemption. Information and instructions regarding the use of a P.O. Box as a mailing address will be transmitted in an upcoming ACL.

SOC 295

27. Why has CDSS included additional language on the revised SOC 295 that seems to go beyond what is required by ABX4 4?

In addition to revisions to meet the requirements of ABX4 4, the revised SOC 295 includes language that informs IHSS applicants of some key program aspects and recipient responsibilities, including:

- The basic responsibilities of IHSS recipients as the employer of their provider of IHSS service;
- The new requirements individuals must meet to be paid as IHSS providers; and
- New program integrity and fraud detection and prevention activities.

28. ACL 09-63 indicates that the application form SOC 295 will be further updated and an ACL "issued with new requirements as they are implemented." Does this mean that these instructions are not final?

ACL 09-63 was released with the new form and instructions to use the revised SOC 295. The new form is posted on CDSS' Forms and Publications website (http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm). The statement regarding the application being further updated was included simply to inform counties that this form will be revised again as other requirements, such as recipient fingerprinting and timecard fingerprinting, are implemented at a later date.

29. The application states, "To promote program integrity, I may be subject to unannounced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns" from DHCS, CDSS, and/or the county. This statement does not specify why such visits might occur. Aren't these visits and letters to be in a more targeted fashion and per protocols that are still to be developed per ABX4 19?

This reference conveys that recipients/providers may be subject to an unannounced home visit. The protocols are being developed with input from stakeholders. County staff may provide clarification to recipients and providers as needed. The SOC 295 will be further updated as new program requirements become effective.

PROVIDER I-9 POLICIES

30. Are counties/PAs/NPC required to obtain and retain a copy of Form I-9? If so, how should the signed form be maintained?

No. Counties/PAs/NPCs are not required to obtain and retain a copy of Form I-9. Completing the Form I-9 is a requirement of the U. S. Citizenship and Immigration Services (USCIS). The Form I-9 instructions state that the form is not filed with the

USCIS; it must be retained by the employer, which in the case of IHSS would be the recipient.

As stated in ACL 09-69, some counties/PAs/NPCs have made it a practice to retain these forms to assist their recipients. Counties/PAs/NPC may continue to do so provided that these forms are filed in a secure and confidential manner, such as in the IHSS provider's file or in a specific Form I-9 file. Additionally, counties/PAs/NPC may consider archiving the documents electronically or by other means. State law specifies that storing such documents shall be accomplished in a manner that would not substantially alter its original form (Government Code section 12168.7) and federal regulations permit that Form I-9 may be signed and retained electronically (8 Code of Federal Regulations, section 274a.2).

31. How should the county/PA/NPC proceed with provider enrollment when an individual presents a Social Security card imprinted with "Valid for Work Only with DHS Authorization"?

For the purpose of verifying an individual's SSN in order to complete the provider enrollment process, the county/PA/NPC may accept a Social Security card imprinted with "Valid for Work Only with DHS Authorization."

However, when an individual who possesses a Social Security card with this notation is hired by a recipient as a provider and he/she completes the Form I-9, additional steps would need to be taken to verify whether the individual is authorized to work in the U.S. For more information on the steps needed to verify this employment eligibility, refer to the USCIS's website (http://www.uscis.gov/portal/site/uscis) and click on the link to the E-Verify Homepage.

INTER-COUNTY TRANSFERS

32. When a recipient moves from one county to another and begins receiving services from a new provider, how long does the transferring county continue to pay the case?

Consistent with regulations for the inter-county transfer process, upon acknowledgement from the receiving county that the new provider is an eligible provider, the transferring county has the responsibility for authorizing services and continuing payment to the new provider until the transfer period ends, at which time the receiving county becomes responsible. The receiving county has the responsibility for assisting the recipient in obtaining an existing enrolled provider or ensuring the recipient's new provider has completed the provider enrollment requirements.

33. When a recipient moves from one county to another along with his/her existing provider, must the provider undergo a criminal background check in the new county?

Yes. The provider must submit fingerprints and undergo a criminal background check in the new county even if the individual has completed one in the originating county. However, an existing provider who has completed at least one of the provider enrollment requirements by June 30, 2010, has until December 31, 2010 to complete the remaining provider enrollment requirements, including the criminal background check.

Questions or requests for clarification on policies included in this ACL should be directed to appropriate Bureau within the Adult Programs Branch, as follows:

- Criminal Background Check,
  Provider Enrollment Requirements,
  Application for Social Services, or
  Provider I-9 Policies ..... Policy Bureau, at (916) 229-4000

- Provider Orientation, or
  Inter-County Transfers .... Operations & Quality Assurance Bureau, at (916) 229-3494

- CMIPS Issues ..... Fiscal, Administrative & Systems Bureau, at (916) 229-4002

- Provider Appeals ..... Litigation & Appeals Bureau, at (916) 229-4003

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
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EDMUND G. BROWN JR.
GOVERNOR

REASON FOR THIS TRANSMITTAL

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

January 24, 2012

ALL-COUNTY INFORMATION NOTICE NO.: I-04-12

TO: ALL COUNTY WELFARE DIRECTORS
IHSS PROGRAM MANAGERS

SUBJECT: QUESTIONS AND ANSWERS REGARDING CRIMINAL BACKGROUND CHECKS FOR IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDERS

REFERENCE: All-County Letter NO. 11-12, DATED JANUARY 26, 2011

The above referenced All-County Letter (ACL) provided information and instructions for implementing sections of Assembly Bill (AB) 1612 (Chapter 725, Statutes of 2010) relating to criminal background checks for individuals seeking to become service providers in the In-Home Supportive Services (IHSS) Program. AB 1612 added Welfare & Institutions Code (W&IC) section 12305.87, which expanded the list of crimes for which a conviction or incarceration following a conviction, within the last 10 years would exclude an individual from being enrolled as an IHSS provider. The attachment to this All-County Information Notice (ACIN) provides answers to questions raised by counties and Public Authorities (PAs) regarding the criminal background check process. The questions and answers reference the applicable statutes and should be considered the most current and valid guidelines.

Additionally, this ACIN transmits a new notice, the Notice to Provider of Provider Eligibility Acknowledgement of Receipt of Waiver (SOC 870), which responds to an issue raised within this ACIN.

Any additional questions or requests for clarification should be directed to the Policy and Operations Bureau at (916) 651-5350.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Attachments

c: CWDA

Questions and Answers
Regarding Criminal Background Checks for
In-Home Supportive Services (IHSS) Providers

Tier 1 & Tier 2 Crimes/Criminal Offender Record Information (CORI)

1. The listing of Tier 2 exclusionary crimes contains a number of Penal Code (PC) sections which do not include a specific subsection/subdivision. Would a subsection/subdivision of a crime that is on the listing also be exclusionary? For example, the listing includes PC section 261. Would a conviction for PC 261(a) be considered exclusionary?

Response: Yes. When a full section is included on the list, any subsection is also exclusionary. If only the subsection is exclusionary, it is listed specifically.

2. Misdemeanor convictions are NOT Tier 2 crimes, even if they are misdemeanor convictions for a sexual crime such as PC sections 288.2(a) (sends or causes to be sent harmful matter to a minor with the intent to arouse...) and 647.6(a)(1) (annoy or molest any child under 18 years of age). Based on my understanding, only certain FELONY crimes are considered Tier 2 crimes, NOT misdemeanor crimes.

Response: Tier 2 crimes are only felonies; there are no misdemeanor Tier 2 crimes.

3. Does a felony conviction for PC section 245(a) (1) (Any person who commits an assault upon the person of another with a deadly weapon or instrument other than a firearm...) meet the criteria on the last page of the list of Tier 2 crimes, which states "Any felony in which the defendant personally used a dangerous or deadly weapon?"

Response: Yes, a felony conviction for PC 245(a) (1) is a Tier 2 crime and would qualify as a disqualifying crime.

4. Welfare & Institutions Code (W&IC) sections 12305.81 and 12305.87 include the phrase, "or incarceration following a conviction." If an individual was convicted of a disqualifying crime more than 10 years ago but his/her incarceration for that conviction ended within the last 10 years, is that individual ineligible based on the above referenced code sections? Are there other more complex interpretations of this language? For example, if an individual has been on probation within the last 10 years, is that considered incarceration? What if the individual on probation for the disqualifying crime violated the terms of his/her probation and was re-incarcerated within the last 10 years?

Response: The 10 year time frame begins at the end of the "incarceration following a conviction." Therefore, even if an individual's conviction was more than 10 years ago, if he or she was released from incarceration within the last 10 years, he or she is not eligible to serve as an IHSS provider under either W&IC section 12305.81 or 12305.87. "Incarceration" is defined by statute as time served in a correctional facility; it does not include probation or parole. If the individual violates the terms of his or her parole and is returned to incarceration to serve out the remainder of his or her original sentence that would count as incarceration for the original conviction. Therefore, the 10 year timeframe would not begin until after the individual was released from incarceration the second time.

5. PC section 487 (Grand Theft) is not included on the list of Tier 2 exclusionary crimes (that is, unless the PC section 487 is combined with the use of a firearm, as part of a conspiracy or as part of a street gang.). However, we are aware that in some counties, including ours, the district attorney prosecutes IHSS fraud under PC section 487. In our county, we have the ability to contact the DA's office to determine if a PC section 487 conviction is for IHSS fraud; however, there are no practical means to determine this when the conviction occurred in another jurisdiction. How should a county proceed when a CORI shows a PC section 487 which occurred in another jurisdiction and it is not possible to confirm the nature of the theft?

Response: When a CORI includes a conviction for PC section 487 and the county is unable to positively determine that the conviction is for IHSS fraud, either because the conviction occurred in another jurisdiction (county) or otherwise, the county shall not exclude the individual. The county may exclude an individual for a Tier 1 crime when his/her CORI includes either a misdemeanor or felony conviction for PC 487 when it can be positively determined, through court records, information from a law enforcement agency, or some other official means/source, that the crime for which the individual was convicted involved fraud against IHSS (or other governmental health care or supportive services program). Additionally, a felony conviction for PC 487, in conjunction with a conviction for PC 664, would be considered a Tier 2 exclusionary crime.

6. On page 10 of the list of Tier 2 exclusionary crimes, it says "Any felony in which the defendant personally inflicts great bodily injury (GBI) on another person other than an accomplice or any felony in which the defendant personally uses a firearm". Would the felony crimes listed below meet the criteria?

23152(B) VC – DUI ALCOHOL/0.08% W/PRIORS WITH PRIOR
DISPO: CONVICTED – PROB/JAIL
CONV STATUS: FELONY
487(A) PC – GRAND THEFT: MONEY/LABOR/PROP $400+
DISPO: CONVICTED – PROB/JAIL
CONV STATUS: FELONY

Response: Felony crimes in which GBI was inflicted, or a firearm or dangerous or deadly weapon was used, or where the crimes are punishable by death or life imprisonment, meet the criteria for an exclusionary crime. There is no restriction on the type of felony that qualifies. So, both of the above examples would be potentially excludable. However, a felony on its own would not satisfy these criteria. There must be a finding of one of the listed criteria, such as use of a firearm/dangerous or deadly weapon or type of potential punishment.

In the example of a felony conviction for violation of Vehicle Code section 23152 (b), it would be reasonable for a county to consider driving (an automobile) under the influence (DUI) of alcohol or drugs to be use of a dangerous or deadly weapon, in which case, this could be considered a Tier 2 disqualifying crime. Furthermore, if a CORI includes a felony conviction for DUI and it also includes a reference to "bodily injury," the county would be within reason to consider the conviction to be a Tier 2 crime.

In the example of a felony conviction for grand theft, unless the CORI also included some indication that a firearm or other dangerous or deadly weapon was used, or this can be positively determined through court records, information from a law enforcement agency, or some other official means/source, the county should not disqualify the individual.

7. On the list of Tier 2 exclusionary crimes (Attachment A of All County Letter No. 11-12) under the "Code Section" column, when a PC is listed in conjunction with another PC, e.g., PC 487 with PC 664, what does it mean? In this example, if a CORI shows a conviction for PC 487 but it does not also show a conviction for PC 664, would the individual be disqualified?

Response: No. The individual would not be disqualified. For those Tier 2 crimes which list a PC section conviction in conjunction with another PC section conviction, a conviction for only one of the PC sections would not be disqualifying. The CORI must show convictions for both PC sections in order for the individual to be disqualified.

8. With regards to Tier 1 convictions, there are the 3 crimes that are exclusionary: child abuse, elder abuse and fraud against Medicare or MediCal. But I thought I had read someplace, that a person could be excluded if they were convicted of similar crimes in another jurisdiction (meaning state). Is this correct? I've reviewed the ACL's that have been issued and I can't find it on any of them.

Response: If the county receives documentation (such as an FBI criminal background check or court documents from another state) showing that an applicant provider has been convicted of child or elder abuse or fraud against a government healthcare or supportive services program in a jurisdiction outside California (such as another state), that applicant provider would be disqualified to serve as an IHSS provider, per W&IC section 12305.81(a) (2). This section also specifies that child and elder abuse convictions are Tier 1 crimes. The section states:

> (2) An individual who, in the last 10 years, has been convicted for or incarcerated following conviction for, a violation of subdivision (a) of section 273a of the Penal Code or section 368 of the Penal Code, or similar violations in another jurisdiction, is not eligible to be enrolled as a provider or to receive payment for providing supportive services.

9. Is it necessary to pursue the exact nature of a W&IC section 10980 misdemeanor to ensure it is not a Tier 1 crime?

Response: Yes, it is important to determine the exact nature of the crime regarding misdemeanor W&IC section 10980 to ensure it is not a Tier 1 crime. If an applicant provider has been convicted of a W&IC section 10980 misdemeanor for fraud against a healthcare or supportive services program, the applicant provider is ineligible to provide services, due to his/her conviction of a Tier 1 crime.

10. PAs feel they have a responsibility for assisting the recipient with screening potential providers by providing the recipient with a list of registry providers who meet the recipient's needs and do not pose a potential danger. Because of this responsibility, is it permissible for a PA to deny eligibility to applicant providers for crimes not listed as disqualifying under W&IC sections 12305.81 and 12305.87? The PAs are reluctant to send notification of Tier 2 criminal convictions to recipients who may wish to submit waiver requests for providers with criminal convictions due to potential liability issues.

Response: The only crimes for which applicant providers can be denied eligibility are those specifically set forth in W&IC sections 12305.81 and 12305.87. These crimes are the same for both registry and non-registry providers. Individual counties and Public Authorities (PAs) cannot create their own lists of disqualifying crimes and deny eligibility for any of those crimes if they do not fall under the scope of either of the code sections listed. Denying eligibility in this way would erroneously disqualify an applicant provider who is otherwise eligible to work as a provider. W&IC section 12305.87(d)(1) requires that the counties and PAs allow those recipients, who wish to hire a provider with a criminal conviction which would disqualify that person under W&IC section 12305.87, to sign and submit an individual waiver to allow that person to work for him or her.

The Department is aware of the concerns PAs have with the current statute (W&IC section 12305.87(d) (7)) under which PAs do not share the same immunity from liability for filing waivers as the state and counties currently have. An amendment to the current statute would be necessary to extend this immunity to PAs.

11. Through January 31, 2011, we were denying applicant providers with W&IC 10980(c) (2) convictions and having them appeal through the PEAU (Provider Enrollment Appeals Unit). Under the new ACL (ACL 11-12, dated January 26, 2011), the Tier 1 type of fraud is still NOT defined. However, the Tier 2 list includes W&IC 10980(c) (2) as a conviction. If that conviction was for food stamps or welfare fraud, the applicant provider could work for a recipient if approved through the individual waiver process. As you know, the CORI does not state the type of fraud involved in that conviction. I may need to send out a denial to an applicant provider; however, under ACL 11-12, I need to state if this is a Tier 1 or a 2 conviction. Do we make these Tier 1 convictions and send them to the PEAU, knowing this can take six months?

Response: Applicants should not automatically be denied because not all fraud convictions under W&IC section 10980(c) (2) are Tier 1 criminal convictions. Counties must determine by examining court records or any other available resources, to determine which program was defrauded because a conviction for a crime involving fraud against a healthcare or supportive services program, such as IHSS, whether it be a misdemeanor or a felony, would be a Tier 1 crime. A felony conviction for fraud against a public social services program, such as CalWORKs or CalFresh, would be a Tier 2 crime; however, a misdemeanor conviction for fraud against a public social services program is not exclusionary under Tier 2. A "felony" conviction for W&IC section 10980 would be a Tier 2 crime unless the county/PA has documentation indicating the conviction is for fraud "against a government health care or supportive services program . . .", which would then be a Tier 1 crime.

12. Are we to understand from page 1 of the list of Tier 2 exclusionary crimes, that if an individual is convicted of PC section 182 alone, they are not excluded from working as an IHSS provider? But, if the individual was convicted of that crime in addition to any of those listed in the "Title" column (apparently, not only PC section 290(c) crimes), then the individual would be excluded?

Response: PC section 182 is for conspiracies, but not all conspiracies are excludable crimes. A provider can be denied for a conspiracy felony only if the conspiracy was to commit one of the crimes listed in PC sections 290(c) or 1192.7(c). There does not necessarily need to be an additional conviction for one of the PC section 290(c) or PC section 1192.7(c) crimes. However, there must be a conspiracy conviction as well as evidence that the conspiracy was to commit one of those crimes. If a CORI includes a conviction for PC 182, but

does not include a conviction for PC 290(c) or 1192.7(c) crime, and the CORI also does not include a reference to which crime the individual conspired to commit (e.g., the charge), the county shall not disqualify the individual.

13. Why are the following crimes not included on the Tier 2 crimes list individually when these crimes are specifically referenced under "PC 182 with any PC 290(c) crime." PC 261(a)(1), PC 261(a)(2), PC 261(a)(3), PC 261(a)(4), PC 261(a)(6), PC 262(a)(1) and PC 272?

Response: PC 261(a)(1), PC 261(a)(2), PC 261(a)(3), PC 261(a)(4), PC 261(a)(6) are not included individually because they are subsections of PC 261 which is listed. Similarly, PC 262(a)(1) is a subsection of PC 262 which is included on the list. Refer to the response to Question #1.

PC 272 would be a Tier 2 exclusionary crime only when it involves lewd or lascivious conduct. If the CORI includes a conviction for PC 272 and it also includes a specific reference (e.g., a charge) to lewd or lascivious conduct, or the county can positively determine, through court records, information from a law enforcement agency, or some other official means/source, that the crime involved lewd or lascivious conduct, the county may disqualify the individual. However, if the CORI includes a conviction for PC 272 and it does not include a specific reference to lewd or lascivious conduct, and the county cannot positively determine that the crime involved lewd or lascivious conduct, the county shall not disqualify the individual.

14. Why are PC 288a(c) (2), PC 289(a)(1), PC 461, and PC 487(d)(2) not included on the Tier 2 crimes list individually when these crimes are specifically referenced under "PC 182 with any PC 1192.7(c) crime"?

Response: PC 288a(c)(2) and PC 289(a)(1) are not included individually because they are subsections of PC 288a and PC 289 which are included on the list. Refer to the response to Question #1. Similarly, PC 487(d) (2) is a subsection of PC 487 which is included on the list (when in conjunction with PC 664). Refer to the response to Question #5 regarding circumstances in which a conviction for PC 487 alone may be considered a Tier 1 exclusionary crime.

PC 461 pertains to the punishment for burglary: PC 461(a) specifies the punishment for first degree (felony) burglary; PC 461(b) specifies the punishment for second degree (misdemeanor) burglary. PC 461(a) would be a Tier 2 crime.

15. On pages 7 and 8 of the list of Tier 2 exclusionary crimes, the "Title" column for "PC 664 with any PC 290(c) crime" and "PC 664 with any PC 1192.7(c) crime" includes references to crimes not included on the Tier 2 crimes list. Why?

Response: Refer to the response to Question #13.

16. If an individual is convicted of PC section 182, does it have to be with one of the listed PC section 1192.7(c) crimes, or does a PC section 182 conviction as a standalone crime preclude someone from being a provider? For example, if a CORI shows a conviction for PC section 182(a)(1) (Conspiracy to commit a crime), as well as convictions for PC section 459 (Burglary) and PC section 470(a) (Forgery), neither of which are included on the Tier 2 crimes list nor are they PC section 1192.7 listed crimes, would the individual be disqualified?

Response: Refer to the response to Question #13. PC sections 459 and 470(a) should not be considered exclusionary crimes. Therefore, the individual would be eligible to be a provider.

17. The top of page 8 of ACL 11-12 lists specific Tier 2 crimes for which expungement pursuant to PC section 1203.4 does not apply. Several of the crimes listed are NOT included on the list of Tier 2 exclusionary crimes. Specifically, PC section 288a(c) is not included on the Tier 2 list but PC section 288a is included; PC section 289(j) is not included but PC section 289 is; and, PC section 261.5(d) is not included but PC section 261 is.

Are the crime codes listed on page 8 correct?

If the page 8 crimes are Tier 2 crimes, why are they not included in the Tier 2 list? Are we to assume all subsections of a crime included on the list are also Tier 2 crimes?

If the crimes on page 8 are valid Tier 2 crimes, does that mean that any crime included on the Tier 2 list includes all subsections of that code? For example, does the fact that PC section 289 is in the list mean that PC section 289(j) (and all other possible subsections) is also a Tier 2 crime? If so, that would be inconsistent because PC section 288 and PC section 288.5 are specifically listed on page 8. What about PC section 288.2, PC section 288.3, and other PC section 288 subsections that are included in the Tier 2 list?

Response: PC section 288(a)(c) would be an exclusionary crime because PC section 288(a) includes all subsections. The same would apply to PC section 289 (j), which is a subsection of PC section 289. Refer to the response to Question #1.

Although the crimes on page 8 are correct in that they are crimes that cannot be expunged pursuant to PC section 1203.4, some of them should not have been included in the ACL because they are not Tier 2 crimes. Specifically, PC section PC 261.5(d) is a crime that would be ineligible for expungement; however, it is not a Tier 2 crime.

If a crime is listed on page 8, any subsections of that crime are also included. So, if the crime is PC section 288(j), it is included because PC section 288 covers all of the subsections. However, when a subsection is specified, such as PC section 288(a)(c), the other subsections of PC section 288(a) are not covered. Furthermore, PC section 288 and PC section 288.2 are entirely different sections. Thus, when PC section 288 is listed as exclusionary and it would include all subsections such as PC section 288(j); it would not include entirely different PC sections such as PC section 288.2.

18. The ACL states that in addition to the specifically listed Tier 2 crimes, the following are also disqualifying crimes:

- Any felony in which the defendant personally inflicts GBI on another person other than an accomplice or any felony in which the defendant personally uses a firearm; and
- Any felony in which the defendant personally used a dangerous or deadly weapon.

What is the interpretation if a CORI shows the following conviction?

> 245(A) (1) PC – Force/ASSAULT WITH A DEADLY WEAPON (ADW) NOT FIREARM: GBI LIKELY

Would that fall under the second bullet above? Also, is "GBI LIKELY" the same as "personally inflicts GBI" as stated in the first bullet above?

Response: ADW would cause the conviction to fall into the "Any felony in which the defendant personally used a dangerous or deadly weapon" category. This makes it unnecessary to determine whether "GBI LIKELY" is the same as "personally inflicts GBI." Also, see response to question #3.

19. We occasionally receive subsequent arrests for providers charged, but not convicted, of serious crimes. In one recent case, the provider was charged with several sexual crimes involving a child under the age of 14 years. The provider is currently in the county jail; however, in the event that he is released on bail, can we temporarily disqualify him as a provider pending disposition due to the severity of the charges?

Response: No. The statute specifies that Tier 2 exclusions are for convictions only. This individual has not been convicted of these crimes; therefore, he cannot be deemed ineligible to be a provider.

20. Clarification is needed regarding the scope of PC 261(Rape). If a CORI shows a conviction for one of the following crimes, would these fall under PC 261, in which case the individual would be disqualified

261.5 PC – SEX INTERCOURSE W/MINOR: SPECIAL CIRC
261.5(D) PC – SEX WITH MINOR: PERP 21+VICTIM-16

Response: Those sections are not part of PC section 261. PC section 261.5 is a separate section from PC section 261. At the current time, PC section 261.5 should not be considered an exclusionary crime. Therefore, the individual would be eligible to be a provider.

21. Our concern is regarding the potential violation of California Department of Justice (DOJ) policy forbidding the unauthorized dissemination of CORI results. The ACL proposes the use of a number of forms (specifically the SOC 862, SOC 852, SOC 852A, SOC 855B, SOC 858A, SOC 858B and SOC 859B) that will be mailed to both the provider applicant and/or the recipient that will contain information taken directly from the provider applicant's CORI results. Despite the use of disclaimers, we are concerned about the information's exposure to persons other than those intended to receive it. We are also concerned about the potential for DOJ to take away our privileged access to CORI results after an audit by DOJ because we are not in compliance with their explicit DOJ Custodian of Records policies/guidelines. Do we have anything from DOJ authorizing us to release CORI information to any other person or entity other than the subject of the CORI, i.e., to the recipient?

Response: The statute, (W&IC section 12305.87), authorizes release of the information regarding the applicant provider's criminal convictions to both the applicant provider and recipient, therefore it provides the authority for the release of the CORI information. The DOJ has reviewed and been consulted on the procedures for the release of the information by the counties on the various documents detailed in the question above.

22. A CORI shows convictions for PC section 273.6(a) (Violating a court [restraining] order) in conjunction with PC section 273.5(a) (Inflicting felony corporal injury on a spouse/ex-spouse/cohabitant). Neither of these crimes is included on the list of Tier 2 exclusionary crimes. In such a case, are only the specific PC sections considered, in which case this individual would not be excluded as a provider, or can the spirit of the law (exclusion of individuals convicted of abuse of a child, elder, or dependent adult) be considered, in which case this individual could be excluded?

Response: A felony conviction for PC 273.5(a) would be disqualifying only if the CORI contained information (or it could be positively determined through court records, information from a law enforcement agency, or some other official means/source) that the crime fit the parameters of one of the crimes specified in PC section 290(c), PC section 667.5(c), or PC section 1192.7(c), e.g., one of the different types of assault listed in PC section 1192.7(c). Absent this information, the county shall not disqualify the individual.

23. A CORI shows a conviction for PC section 243(d) (Battery with serious bodily injury). The conviction is not for PC section 243.4 (Sexual battery), which is included on the list of Tier 2 crimes. Since the conviction does not contain the ".4" designation, is it correct that this individual would not be excluded from being a provider?

Response: PC section 243.4 is not a subsection of PC section 243(d). These are separate PC sections and they do not refer to the same crime. A felony conviction for PC section 243.4 would be disqualifying. A felony conviction for PC 243(d) would be disqualifying only if the CORI contained information (or it could be positively determined through court records, information from a law enforcement agency, or some other official means/source) that the crime fit the parameters of one of the crimes specified in PC section 290(c), PC section 667.5(c), or PC section 1192.7(c), e.g., one of the different types of battery listed in PC section 1192.7(c). Absent this information, the county shall not disqualify the individual.

24. How should the county determine the 10 year exclusionary timeframe from incarceration when the release date shown on the CORI is a future date?

Response: The 10 years would be counted from the last day of incarceration regardless of whether the incarceration was for the parole violation or the underlying crime. It is the responsibility of the applicant provider to provide documentation of actual release date.

Provider Enrollment Process

25. The flow chart does not reflect that an applicant provider found ineligible to be enrolled based on a Tier 1 crime(s) has the right to appeal this to the Provider Enrollment Appeals Unit (PEAU).

Response: You are correct that an applicant provider found ineligible to be enrolled based on a Tier 1 crime does have the right to appeal this finding to the PEAU. The attached flow chart has been revised to reflect this.

26. Page 4 of ACL 11-12 does not state how much time the county is allowed before sending form SOC 857 (IHSS Program Notice to Recipient of Provider Eligibility Acknowledgement of Receipt of Waiver) to consumers after receiving a signed SOC 862 from the consumer. The ACL states the consumer must submit the signed SOC 862 to the county within ten days. What is the time frame for the county/PA/NPC to send form SOC 857 to the consumer?

Response: The county/PA/NPC must notify the recipient (using form SOC 857) within twenty days from the date of the receipt of the waiver request form.

27. What if a recipient fails to return the Recipient Request for Provider Waiver (SOC 862 form) to the county within 10 days; can the provider be paid retroactively for the authorized services?

Response: The 10 day period is not mandated by statute. It was established to encourage the recipient to promptly return the waiver request. If a recipient fails to return the waiver request within the specified time frame and the provider has been providing authorized services, once the waiver request is completed and returned to the county, the provider is eligible for retroactive payment for authorized services provided.

28. Is it necessary to require certified copies of expungements per PC section 1203.4 from Tier 2 applicants?

Response: The statute does not require an applicant to produce a "certified" copy of their expungement; therefore, the county may not require them to provide a certified copy. Obtaining a "certified" copy of an expungement would require the applicant to incur an expense without authority.

29. When a case is being transferred from one county to another, via the Inter-County Transfer (ICT) process, and the provider has completed all required steps in the sending county, but has not completed the background check in the receiving county, do we continue to pay the provider once we accept the case? Or, do we give the provider a specified amount of time to bring in the receipt showing he/she completed the background check so we may continue payment? If the provider does not complete any of the required steps, may we terminate him/her due to the lack of a background check?

Response: When a case is transferred from one county to another via the ICT process and their provider has been determined to be an eligible IHSS provider (completed all four requirements) in the sending county, the receiving county can continue to pay the provider. The current criminal background check is administered by DOJ which will include criminal convictions for all 58 counties within the State of California. Individual counties cannot require applicant providers to undergo another criminal background check if they have already been cleared in another county. See ACL 10-59 (December 9, 2010).

30. Are provider enrollment requirements the same for registry and non-registry providers?

Response: As it relates to approval or denial of an applicant provider based on the criminal background check, the provider enrollment requirements are exactly the same regardless of whether the applicant provider will be on the IHSS provider registry.

31. Please clarify whether we are suppose to use the Department of Health Care Services' (DHCS) Suspended and Ineligible (S&I) list and/or the Office of the Inspector General's List of Excluded Individuals and Entities (LEIE) to disqualify an applicant as an In-Home Supportive Services (IHSS) provider.

Response: The California Department of Social Services (CDSS) issued ACL 11-12 which set forth an expanded list of crimes that can be used as a basis to exclude an individual from providing services. The expanded list, found in W&IC section 12305.87, was added by Assembly Bill 1612 (Chapter 725, Statutes of 2010). Thus, the only individuals who, within the last ten years, have been convicted of, or incarcerated following a conviction for, one of the crimes listed in W&IC sections 12305.81 or 12305.87 can be found ineligible to be enrolled as an IHSS provider. The use of any other means to exclude a provider based on a criminal conviction, including the S&I and LEIE lists, is precluded.

32. If an applicant provider's background check has been cleared in one county, can the PA in another county require a registry provider to complete a background check in order to receive subsequent arrest notices?

Response: No. The current criminal background check is administered by DOJ which will include criminal convictions for all 58 counties within the State of California. Individual counties cannot require applicant providers undergo a criminal background check again if they have already been cleared in another county. See ACL 10-59 (December 9, 2010).

33. Another question/concern we have originates with the 4th paragraph at the top of page 4 of the ACL where it discusses the county's responsibility to verify signatures on the waiver form. How will we verify or authenticate a recipient's signature without some kind of signature card on file to use for comparison? Or, is it the state's intent that we simply confirm the name signed matches with the name of the recipient on file (in CMIPS)? I think that there is a definite opportunity for applicant providers to sign the recipient's name to this form in order to get their exclusionary crime waived.

Response: We understand the county/PA/NPC staff cannot absolutely attest to the authenticity of the signatures on the waiver form (SOC 862). However, we are asking staff to purposefully review the signatures, with authenticity in mind. If a signature appears falsified, it should be looked into, as it would be for any other information provided that appeared fraudulent. This same approach would be pursued in other scenarios when a signature does not appear genuine.

34. Page 3 of ACL 11-12 states "Upon determining that an applicant provider is ineligible because of a conviction for a Tier 2 crime, the county/PA/NPC shall inform both the applicant and any recipient(s) for whom the applicant provider is providing or wishes to provide services of the applicant's ineligibility." At the time we determine a provider is ineligible due to a Tier 2 crime they are typically not yet working for any recipient. How are we to determine who the "provider wishes

35. to provide services for?" There are no forms signed by the provider that indicate who they "wish to work for." The 426A recipient form (signed only by the recipient) may not represent the provider's "wish to work for that recipient" so we cannot send confidential crime info to any "pending" recipients; true or false? By our interpretation of this statement we would only send notifications to recipients for which the provider is already in E status. This should only occur if the crime is some "subsequent" crime and would never occur at initial application time.

Response: Upon the recipient's completion of form SOC 426A (IHSS Program Recipient Designation of Provider), a provider shall be named on the form. If this provider is found to be ineligible, due to a Tier 2 crime conviction(s), the county shall notify the recipient, via SOC 855B (IHSS Program Notice to Recipient of Provider Ineligibility Tier 2 Crimes). The recipient would also be notified of the provider's ineligibility due to a conviction that occurred after being hired (notification of this is done via SOC 859B, IHSS Program Notice to Recipient of Provider Ineligibility Tier 2 Crimes Ineligibility – Subsequent Conviction.).

36. Do we notify the recipient of the provider's Tier 2 crime, only if the provider wants to pursue a waiver or regardless of the provider's intentions?

Response: For clarification, please note that the recipient (not provider) requests a waiver to hire a named provider, by completing form SOC 862 (IHSS Request for Provider Waiver).

As one of the four requirements to become a provider, the provider shall complete and sign form SOC 426 (IHSS Program Provider Enrollment Form). By doing so, the provider agrees to the disclosure of any conviction information to a recipient (see SOC 426, Page 2, Bullet 1). Therefore, the recipient intending to hire a specific provider is entitled to that provider's conviction information. The recipient is also instructed to maintain the information in a confidential manner.

Forms & Notices

37. When completing the Notice to Applicant Provider of Provider Ineligibility due to Tier 2 Crimes (SOC 852A), is it necessary to complete the entire form including the entire applicant provider's disqualifying convictions?

Response: Yes. W&IC section 12305.87 requires that an applicant provider, who is denied eligibility to be an IHSS provider, be given the reason for the denial. In this case, the county must set forth in the denial notice (SOC 852A) both the Penal Code sections and plain language description of the disqualifying crimes of which the applicant provider has been convicted as the cause of the denial. If the applicant subsequently chooses to pursue a general exception, the CDSS Criminal Background Check Bureau, General Exception Unit, will also need this information to determine the nature of the criminal conviction and whether the applicant was justifiably disqualified for his or her conviction.

38. Can the SOC 426 be "provided without a client"?

Response: The SOC 426 may be completed and submitted without regard to whether an applicant provider has a recipient for whom he/she is already providing or intends to provide services (upon successful completion of the enrollment requirements).

39. For previously existing providers who complete a 426 and a 426A, who now are enrolling with a new recipient, do they need to complete just a 426A? Our question is; if a provider that is currently enrolled and already filled out the 426, and they pick up a new client, in which case they would need the recipient to fill out a 426A, do they also need to fill out another 426? In other words, each time they pick up a new client, do they fill out a 426 and a 426A?

Response: The provider only completes the SOC 426 once. The recipient completes the SOC 426A every time a new provider is selected. The counties are required to obtain the SOC 426 from providers and the SOC 426A from recipients. For recipients who select a new provider or who make a change in their existing provider, the SOC 426A must be completed at the time the recipient makes his/her selection/change.

40. ACL 11-12 states, "Counties shall begin using the revised SOC 426 and SOC 426C for all new provider applicants as of February 1, 2011."

Does "new applicant" mean when the provider first comes into the IHSS program and goes through orientation, or each time a provider starts for a new client? Before February 1, 2011, we sent out the 426 at each new hire, it included both provider and recipient information. Now I am wondering if it is expected for us to send this out with each new hire of an existing provider even though they are grandfathered in.

Response: The provider only completes the SOC 426 once. The recipient completes the SOC 426A every time a new provider is selected. The counties are required to obtain the SOC 426 from providers and the SOC 426A from recipients. For recipients who select a new provider or who make a change in their existing provider, the SOC 426A must be completed at the time the recipient makes his/her selection/change.

41. Can the individual who is granted a Power of Attorney sign the waiver form for a recipient they are the agent for?

Response: The individual who is granted a Power of Attorney has many legal responsibilities, one of which may be to serve as the authorized representative for the recipient. If the individual who has been granted Power of Attorney is the authorized representative, he or she may sign the waiver form.

42. Is an authorized representative (AR) allowed to sign the Individual Waiver, on behalf of the recipient, if the AR's CORI indicates a disqualifying crime?

Response: No. Assembly Bill (AB) 876 was signed by Governor Brown on July 7, 2011, prohibiting an applicant provider from signing his or her own individual waiver form as the recipient's authorized representative. However, if the authorized representative is not the provider, he or she may sign the waiver on behalf of the recipient.

43. There is currently no form that serves to inform the applicant provider that he or she has been approved via individual waiver to work for a specific client. However, the instructions state that we have to inform the applicant. The regular Notice of Provider Eligibility (SOC 848) won't work because it does not specify "for this client only."

Response: You are correct that the Notice of Provider Eligibility (SOC 848) is not appropriate for a county/PA to utilize to inform an otherwise ineligible provider that a waiver submitted by a recipient has been accepted and that he or she is now enrolled to provide services for that recipient only. We have remedied this situation through the development of a new form, Notice to Provider of Provider Eligibility Acknowledgement of Receipt of Waiver (SOC 870). This notice is detailed below and provided as Attachment B to this ACIN.

Notice to Provider of Provider Eligibility Acknowledgement of Receipt of Waiver (SOC 870): This notice informs the provider that the waiver submitted by his or her recipient has been received and processed by the county/PA/NPC. It also informs him/her that he/she has been approved to work and to receive payment from the IHSS program as an IHSS provider. This waiver receipt notice reiterates that the provider has been approved to serve as the IHSS provider only for the recipient who submitted the waiver. The notice also instructs the provider that if he/she wishes to work for multiple recipients or wishes to be added to the county provider registry, he/she will need to obtain a waiver from each recipient he/she works for or request a general exception.

ATTACHMENT B

IN-HOME SUPPORTIVE SERVICES PROGRAM (IHSS) NOTICE TO PROVIDER OF PROVIDER ELIGIBILITY ACKNOWLEDGEMENT OF RECEIPT OF WAIVER

(ADDRESSEE)

County of: _____

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

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider:

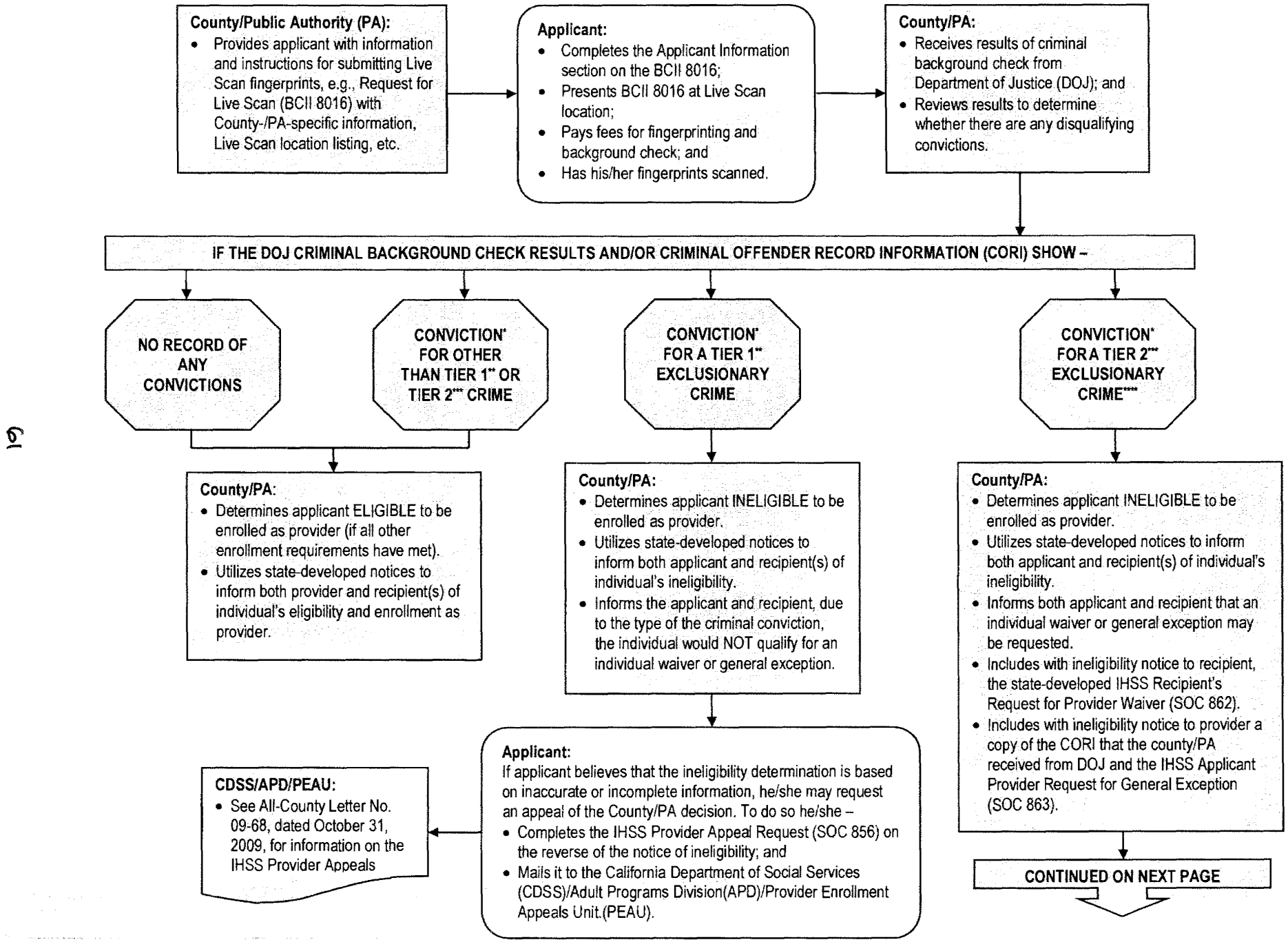
On _____, you were informed that, based on Welfare and Institutions Code, Section 12305.87, you were denied eligibility to work as an IHSS provider because you have been convicted of a felony crime.

On _____, the county/Public Authority/Non-Profit Consortium IHSS program office received the signed waiver request from _____.

You may begin work as an IHSS provider for this recipient as of the date of this notice. This waiver allows you to work for the above-named recipient only. If you wish to work for additional recipients, you will need to obtain a waiver from each of those individuals, or you may request a general exception. If you have already begun providing IHSS services for this individual, you may be eligible to receive retroactive payments for any authorized services you provided.

If you have any questions about this notice, call _____.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER CRIMINAL BACKGROUND CHECK PROCESS



IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER CRIMINAL BACKGROUND CHECK PROCESS

CONTINUED FROM PREVIOUS PAGE

Applicant:
If applicant believes that the ineligibility determination is based on inaccurate or incomplete information, he/she may request an appeal of the County/PA decision. To do so he/she –

- Completes the IHSS Provider Appeal Request (SOC 856) on the reverse of the notice of ineligibility; and
- Mails it to the California Department of Social Services (CDSS)/Adult Programs Division(APD)/Provider Enrollment Appeals Unit.(PEAU).

CDSS/APD/PEAU:

- See All-County Letter No. 09-68, dated October 31, 2009, for information on the IHSS Provider Appeals Process.

Recipient (or his/her Authorized Representative):
If he/she elects to hire the applicant despite his/her criminal convictions –

- Completes the SOC 862; and
- Returns it to the County/PA in person or by mail.

NOTE:

– Each recipient who chooses to hire the individual as his/her provider must complete a separate individual waiver request.

County/PA:

- Reviews the SOC 862 to ensure it's complete;
- Files it in recipient's case file; and
- Utilizes state-developed notices to inform both recipient and provider that individual has been enrolled as provider to work for that particular recipient only.

NOTE:

– If the individual is subsequently convicted of another Tier 2 crime, the County/PA must notify the recipient(s) and the recipient(s) must request a new individual waiver.

Applicant:
If applicant wishes to be listed on a provider registry, or to provide services for a recipient who has not requested an individual waiver, he/she must request a general exception. To do so, he/she –

- Completes the SOC 863; and
- Mails it along with all required back-up documentation to the CDSS/Caregiver Background Check Bureau (CBCB).

CDSS/CBCB/IHSS General Exception Unit:

- Notifies County/PA that applicant has requested a general exception and requests a copy of DOJ CORI;
- Evaluates all documentation received to determine whether applicant meets the criteria for granting a general exception; and
- Notifies applicant and County/PA of decision.

NOTE:

– If the decision is a denial, CBCB must –
  - o Notify the applicant by either personal service or registered mail; and
  - o Provide a statement of the reasons for the denial and a copy of the applicant's CORI.

APPROVES GENERAL EXCEPTION

DENIES GENERAL EXCEPTION

County/PA:

- Utilizes state-developed notices to inform applicant that he/she has been enrolled as provider.

NOTES:

* Conviction, or incarceration following a conviction, within the last 10 years.

** Tier 1 exclusionary crimes are:

- – Abuse of an elder or dependent adult (Penal Code Section 368);
- – Specified abuse of a child (Penal Code 273a, Subdivision (a)); and
- – Fraud against a government health care or supportive services program.

*** See Attachment for listing of Tier 2 exclusionary crimes.

****A conviction for a Tier 2 crime that has been expunged pursuant to PC section 1203.4, or for which an individual has obtained a certificate of rehabilitation, would not disqualify an individual from being an IHSS

Applicant:

- May request an administrative hearing by submitting a written request to CBCB within 15 business days of receipt of the written notice.

Office of Administrative Hearings:

- Conducts a hearing on the denial; and
- Sends written hearing decision to the applicant by certified mail.

County/PA:
If CBCB denial of general exception is overturned by hearing officer –

- Utilizes state-developed notices to inform applicant that he/she has been enrolled as provider.

FORMS COMMONLY USED IN THE IHSS PROGRAM

Form Number	Title	Status[1]	Form Use
Assessment			
SOC 293	Assessment Document	M	To record consumer information, Functional Index rankings, and authorization information.
SOC 293A	Needs Assessment – Face Sheet	O	To record important information regarding consumer, emergency contacts, diagnosis, physician information, medications, and household composition.
SOC 321	Request for Order and Consent – Paramedical Services	MIA/MSA	To be signed by physician indicating type of paramedical services required; amount of time to perform service and frequency of service.
SOC 332	Recipient/Employer Responsibility Checklist	M	Lists consumer responsibility as an employer. Social worker to review with consumer. Must be signed by consumer, social worker and provider. Copy provided to consumer.
SOC 426A	Recipient Designation of Provider	M	Required for recipients to designate a provider.
SOC 431	Personal Care Services Program Contract Agency Enrollment	M	Required for employees of contract agencies for programs that receive federal financial participation.
SOC 450	Voluntary Services Certification	MIA	Required when someone volunteers services when they could otherwise be paid by IHSS.
SOC 821	Assessment of Need for Protective Supervision for In-Home Supportive Services Program	MIA	To be used together with information obtained during assessment and information from other individuals /organizations in assessing the need for Protective Supervision. Must be sent to healthcare professional.
SOC 825	Protective Supervision 24-Hours-a-Day Coverage Plan	O	Used to document how 24 hour per day need for Protective Supervision is being met.
SOC 827	Individual Emergency Back-up Plan	M	To be completed for each PCSP and IHSS Residual consumer at the time of initial assessment or reassessment.
SOC 846	Provider Enrollment Agreement	MIA	Required for all programs that receive federal financial participation (PCSP and IPO). Must be completed before timesheets processed.

[1] O = Optional; M = Mandatory for all cases; MIA = Mandatory if applicable; MSA = Mandatory, but county may request State Approval for Modification.

FORMS COMMONLY USED IN THE IHSS PROGRAM

Form Number	Title	Status[2]	Form Use
SOC 864	Individualized Back-up Plan and Risk Assessment	M	To be completed for each IPO consumer at the time of initial assessment and every year at reassessment.
SOC 873	Health Care Certification	M	Required for every recipient.
PUB 13	Civil Rights Pamphlet	M	Required for every case, every year.
No Number	Documentation Worksheet	O	Optional form developed through IHSS Training Academy to document authorized hours.
NA 690	Notice of Action	M	Required for every action.
Eligibility			
SOC 294A	IHSS Income Eligibility – Adult	MIA	Used when applicant is an adult to determine whether Medi-Cal or IHSS Share of Cost is lower.
SOC 294C	IHSS Income Eligibility – Child	MIA	Used when applicant is a minor child to determine whether Medi-Cal or IHSS Share of Cost is lower.
SOC 295	Application for Social Services	M	Required for all social service programs.
SOC 310	Statement of Facts for In-Home Supportive Services	MIA	Used only for IHSS Residual Program. (MC-210, Medi-Cal Statement of Facts, is an alternative to using SOC 310.)
Case Management, Information, and Payrolling (CMIPS)			
PUB 203	In-Home Supportive Services Guide to Workers' Compensation Benefits for Individual Providers	MIA	Every Individual Provider must be given this brochure that describes their Workers' Compensation coverage and their responsibility to report an accident or injury that occurs while working as an IHSS provider and explains the timeframes required.
SCIF 3167	Employer's Report of Occupational Injury or Illness	MIA	Within 7 calendar days of notification of on-the-job injury, county staff must complete and submit this form that describes the injury as they understand it.
SCIF 13268	Provider's Predesignation of Personal Physician	MIA	If the Individual Provider chooses, s/he may designate the physician of choice to treat him/her in the event of an on-the-job injury. It must be completed before any injury on this form.

[1] O = Optional; M = Mandatory for all cases; MIA = Mandatory if applicable; MSA = Mandatory, but county may request State Approval for Modification.

FORMS COMMONLY USED IN THE IHSS PROGRAM

Form Number	Title	Status[3]	Form Use
SOC 311	Provider Eligibility Form	MIA	Puts providers into the CMIPS system. Links provider and consumer.
SOC 404	Direct Deposit Enrollment/ Change/Cancellation	MIA	To be completed by IHSS consumers who have received services for at least one year and are paid directly in advance. Allows payments directly into bank account of consumer.
SOC 409	IHSS/CMIPS Elective State Disability Insurance (SDI)	MIA	Form allows certain providers (parents of minor children who receive IHSS or spouses of IHSS consumers) to elect to participate in State Disability Insurance (SDI) program.
SOC 412	IHSS Employee's Claim for Workers' Compensation Benefits/Notice of Potential Eligibility for Benefits	MIA	The county must provide a copy of this form to any IP who claims to have been injured on the job within 24 hrs of notification of an injury. The form must be completed by the IP and submitted to SCIF within 7 calendar days.
SOC 413	Notice to Employees: Workers' Compensation – State Compensation Insurance Fund	MIA	County must provide every consumer, (or the consumer's guardian or conservator if applicable), served by an Individual Provider a copy of this form about Workers' Compensation.
APS			
SOC 341	Report of Suspected Dependent Adult/Elder Abuse	MIA	Required to report of suspected dependent adult/elder abuse. Must be completed by county staff when report is made by telephone.
SOC 341A	Statement Acknowledging Requirement to Report Suspected Abuse of Dependent Adults and Elders	M	All county IHSS staff must sign this form.
SOC 342	Report of Suspected Dependent Adult/Elder Financial Abuse – For Use By Financial Institutions	M	Form used by financial institutions to report suspected dependent adult/elder financial abuse. Officers or employees of institutions are mandated reporters.
SOC 343	Investigation of Suspected Dependent Adult/Elder Abuse	M	Form used to document investigation of suspected dependent adult/elder abuse.

[1] O = Optional; M = Mandatory for all cases; MIA = Mandatory if applicable; MSA = Mandatory, but county may request State Approval for Modification.

FORMS COMMONLY USED IN THE IHSS PROGRAM

Form Number	Title	Status[4]	Form Use
CPS			
SS 8572	Suspected Child Abuse Report	MIA	Required whenever child abuse is suspected. Consumer or not. Must be completed by county staff when report is made by telephone.

[1] O = Optional; M = Mandatory for all cases; MIA = Mandatory if applicable; MSA = Mandatory, but county may request State Approval for Modification.

FORM SAMPLES

ASSESSMENT

IN-HOME SUPPORTIVE SERVICES
NEEDS ASSESSMENT-FACE SHEET

A. RECIPIENT INFORMATION

NAME:	CASE NO:	TELEPHONE: ( )	DOB (MO/DATE/YR)	SEX: *(CIRCLE ONE)* M F

ADDRESS (NUMBER, STREET):			IHSS COMPANION CASE(S), NAME(S) AND NUMBERS:
CITY:	STATE:	ZIP CODE:	

RECIPIENT'S STATEMENT OF NEED:	SPECIAL DIRECTIONS:
EMERGENCY CONTACTS/INSTRUCTIONS:	ALTERNATE RESOURCES USED: *(LIST SOURCE AND SERVICE PROVIDED)*
SPECIAL CONDITIONS/MEDICAL PROBLEMS:	

B. MEDICAL INFORMATION

DIAGNOSIS/PROGNOSIS:	DATE OF MEDICAL REQUEST:

PHYSICIAN:	TELEPHONE: ( )	PHYSICIAN:	TELEPHONE: ( )
PHYSICIAN:	TELEPHONE: ( )	PHYSICIAN:	TELEPHONE: ( )

MEDICATIONS/PURPOSE

1.	4.	7.
2.	5.	8.
3.	6.	9.

C. OTHER PERSONS IN HOUSEHOLD

NAME	AGE	RELATIONSHIP	RECEIVE IHSS		HOURS AT SCHOOL/ WORK	REASON PERSON CANNOT PROVIDE IHSS TO RECIPIENT
			YES	NO		

COMMENTS:

WORKER:	TELEPHONE: ( )	DISTRICT OFFICE:	DATE:

REQUEST FOR ORDER AND CONSENT - PARAMEDICAL SERVICES

PATIENT'S NAME
MEDI-CAL IDENTIFICATION NUMBER

TO:

Dear Doctor:

This patient has applied for In-Home Supportive Services (IHSS) and stated that he/she needs certain paramedical services in order for him/her to remain at home. You are asked to indicate on this form what specific services are needed and what specific condition necessitates the services.

In-Home Supportive Services is authorized to fund the provision of paramedical services, if you order them for this patient. For the purpose of this program, paramedical services are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health and which the recipient would perform for himself/herself were he/she not functionally impaired. These services will be provided by In-Home Supportive Services providers who are not licensed to practice a health care profession and will rarely be training in the provision of health care services. Should you order services, you will be responsible for directing the provision of the paramedical services.

Your examination of this patient is reimbursable through Medi-Cal as an office visit provided that all other applicable Medi-Cal requirements are met.

If you have any questions, please contact me.

SIGNED	TITLE	TELEPHONE NUMBER	DATE

TO BE COMPLETED BY LICENSED PROFESSIONAL

NAME OF LICENSED PROFESSIONAL	OFFICE TELEPHONE

OFFICE ADDRESS (IF NOT LISTED ABOVE)

TYPE OF PRACTICE

TYPE OF PRACTICE

☐ Physician/Surgeon ☐ Podiatrist ☐ Dentist

CONTINUED ON BACK

RETURN TO: (COUNTY WELFARE DEPARTMENT)

Does the patient have a medical condition which results in a need for IHSS paramedical services?" ☐ YES ☐ NO
Is YES, list the condition(s) below:

List the paramedical services which are needed and should be provided by IHSS in your professional judgement.

TYPE OF SERVICE	TIME REQUIRED TO PERFORM THE SERVICE EACH TIME PERFORMED	FREQUENCY*		HOW LONG SHOULD THIS SERVICE BE PROVIDED?
		# OF TIMES	TIME PERIOD	

* Indicate the number of times a service should be provided for a specific time period: (Example: two times daily, etc.)

Additional comments:

☐ IF CONTINUED ON ANOTHER SHEET, CHECK HERE

CERTIFICATION

I certify that I am licensed to practice in the State of California as specified above and that this order falls within the scope of my practice. In my judgement the services which I have ordered are necessary to maintain the recipient's health and could be performed by the recipient for himself/herself were he/she not functionally impaired.

I shall provide such direction as is needed, in my judgement, in the provision of the ordered services.

I have informed the recipient of the risks associated with the provision of the ordered services by his/her IHSS provider.

SIGNATURE ▶ | DATE

PATIENT'S INFORMED CONSENT

I have been advised of risks associated with provision of the services listed above and consent to provision of these services by my In-Home Supportive Services provider.

SIGNATURE ▶ | DATE

IN-HOME SUPPORTIVE SERVICES
Recipient/Employer Responsibility Checklist

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

1) Provide required documentation to my Social Worker to determine continued eligibility and need for services. Information to report includes, but is not limited to, changes to my income, household composition, marital status, property ownership, phone number, and time I am away from my home.

2) Find, hire, train, supervise, and fire the provider I employ.

3) Comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

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

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

5) Ensure standards of compensation, work scheduling and working conditions for my provider.

6) Inform my Social Worker of any future change in my provider(s), including:

   ___ Name
   ___ Address
   ___ Telephone Number
   ___ Relationship to me, if any
   ___ Hours to be worked and services to be performed by each provider

7) Inform my provider that the gross hourly rate of pay is $_____, and that Social Security and State Disability Insurance taxes are deducted from the provider's wages.

8) Inform my provider that he/she may request that Federal and/or State income taxes be deducted from his/her wages. Instruct the provider to submit Form W-4 (for federal income tax withholding) and/or Form DE 4 (for state income tax withholding).

9) Inform my provider that he/she is covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.

10) Inform my provider that he/she will receive an information sheet that will state my authorized services and the authorized time given to perform those services. Inform the provider that he/she is not paid to perform work when I am away from my home (for example, when in a hospital or away on vacation).

11) Pay my share of cost, if any.

12) Verify and sign my provider's timesheet for each pay period, showing the correct day(s) and the total number of hours worked. I understand I can be prosecuted under Federal and State laws for reporting false information or concealing information. I understand that when required, it will be necessary for me to place my fingerprint on my provider's timehsheet to verify the correct day(s) and hours worked. This will be necessary, so my provider can be paid.

13) Ensure my provider signed his/her timesheet.

14) Advise my provider to mail his/her signed timesheet to the appropriate address at the end of each pay period.

_____ _____
Recipient' Signature Date

_____
Printed Name

INSTRUCTIONS FOR USE OF THE RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST

1. This form is used for review with recipients receiving service from Individual Providers **only**.

2. Counties shall use this form to assure that recipients have been advised of and understand their basic responsibilities as employers of IHSS providers.

3. Review each item with the recipient and explain how the recipient can comply with each requirement.

4. Leave a copy of the form with the recipient.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
RECIPIENT DESIGNATION OF PROVIDER

INSTRUCTIONS:

- Use black or blue ink. Print information clearly.
- You (or your legally authorized representative) must fill out both sides of this form to let the county know who you have chosen to provide your services.
- You (or your legally authorized representative) must sign the declaration at the bottom to show that you understand and agree to all of the terms and conditions listed.
- If you have multiple providers, you must fill out a separate form for each person who will be providing services.
- Please return this form to the county. The county will keep the original form and give you a copy.
- You must let the county know if you change your provider(s). You must tell the county within 10 calendar days of the change.

1. Recipient's Name:	
2. County IHSS Case #:	
3. Provider's Name:	
4. Provider's Address:	
City, State, ZIP Code:	
5. Provider's Telephone Number:	
6. Provider's Date of Birth:	
7. Provider's Gender (check box):	☐ Male ☐ Female
8. Provider's Relationship to Recipient (if any):	☐ Parent ☐ Child ☐ Spouse/Domestic Partner ☐ Conservator ☐ Guardian ☐ Other: _____
9. Provider's Start Date:	

RECIPIENT DECLARATION

- I DECLARE that the person named above is my choice to provide IHSS for me as authorized by the county.
- I UNDERSTAND that the above-named person cannot be paid federal and/or state IHSS funds for any services provided to me until he/she has completed the entire provider enrollment process, which includes completing, signing and returning (in person) the Provider Enrollment Form (SOC 426), submitting fingerprints and being cleared of disqualifying crimes through a criminal background check, completing a provider orientation, and signing and returning the Provider Enrollment Agreement (SOC 846).
- I UNDERSTAND that I will be informed by the county if the person I have chosen to be my provider does not complete the provider enrollment process or if he/she is determined ineligible to be a provider.
- I UNDERSTAND that if the above-named person has been convicted of a felony which requires me to submit a provider waiver for that individual to work for me as an IHSS provider, that individual cannot sign the waiver document as my authorized representative.
- **I UNDERSTAND that if I choose to receive services from this person before he/she is enrolled as a provider, and he/she is ultimately found ineligible, or after I have been informed that he/she is ineligible, I will be responsible for paying him/her with my own money.**
- I UNDERSTAND AND AGREE that neither the County nor the State is liable for any claims and/or losses to any person caused by the above named person I choose to hire as my IHSS provider. I agree to hold harmless the State and County, their officers, agents, and employees, and take responsibility for any and all claims and/or losses to any person caused by the named person I choose to hire as my IHSS provider.
- I UNDERSTAND AND AGREE that the county can provide information about my authorized services and service hours to the provider named above.

RECIPIENT'S OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE:	DATE:
PRINTED NAME:	

PERSONAL CARE SERVICES PROGRAM
CONTRACT AGENCY ENROLLMENT

Instructions:

- *This form is to be completed in duplicate.*
- *This form must be completed for each contract and prior to enrollment by each public or private agency contracted to provide services under the Personal Care Services Program.*
- *Part I is to be completed by the authorized representative of the contract agency.*
- *Part II is to be completed by the County.*
- *The original form is to be maintained by the County and a copy given to the contract agency.*

PART I - CONTRACT AGENCY

CONTRACT AGENCY NAME	STATE CONTRACT NUMBER
ADDRESS (Street, City, Zip)	PHONE ( )

CERTIFICATION STATEMENT

- I certify that all employees of this agency are qualified to provide the care authorized.
- I certify that all claims submitted to the County for services to recipients of the Personal Care Services Program and provided by this agency will be provided as authorized for the recipient.
- I understand that payment of these claims will be from federal and/or state funds and that any false statement, claim, or concealment of information may be prosecuted under federal and/or state laws.
- I agree that services will be offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE	DATE

PART II - RECORD RETENTION

The County shall ensure that the contract agency shall keep all records which are necessary to fully disclose the extent of services to the client for a minimum of three years from the date of service during the effective dates of this contract. At the expiration of this contract the County shall keep said records for a minimum of three years from the date of service. On request, the County shall furnish records for audit to the State of California or the U.S. Department of Health and Human Services or their duly appointed representatives.

SIGNATURE AND TITLE OF AUTHORIZED COUNTY REPRESENTATIVE	COUNTY	DATE

PART III - HEALTH SERVICES APPROVAL

The Department certifies that the agency named above will be an enrolled Medi-Cal provider of personal care services.

California Department of Health Services

VOLUNTARY SERVICES CERTIFICATION

(PLEASE TYPE OR PRINT CLEARLY)

RECIPIENT NAME	RECIPIENT CASE NUMBER	COUNTY
PROVIDER NAME	PROVIDER TELEPHONE NUMBER	PROVIDER SOCIAL SECURITY NUMBER (OPTIONAL)*
PROVIDER STREET ADDRESS	CITY	ZIP CODE

SERVICES TO BE PROVIDED	DAYS AND/OR HOURS PER MONTH SERVICES ARE TO BE PROVIDED

I agree to provide the above listed services voluntarily. I know that I have the right to be compensated but choose not to accept any payment, or reduced payment for the provision of these services

PROVIDER SIGNATURE	DATE
SOCIAL SERVICE WORKER SIGNATURE	DATE

* FOR IDENTIFICATION PURPOSES ONLY (AUTHORITY: WELFARE & INSTITUTIONS CODE SECTION 12302.2)

ASSESSMENT OF NEED FOR PROTECTIVE SUPERVISION FOR IN-HOME SUPPORTIVE SERVICES PROGRAM

☐ Release of Information Attached

Attending Physician's / Medical Professional's mailing address	PATIENT'S NAME:	PATIENT'S DOB: / /
	MEDICAL ID#: (IF AVAILABLE)	COUNTY ID#:
	IHSS SOCIAL WORKER'S NAME:	
	COUNTY CONTACT TELEPHONE #:	COUNTY FAX #:

Your patient is an applicant/recipient of **In-Home Supportive Services** (IHSS) and is being assessed for the need for Protective Supervision. Protective Supervision is available to safeguard against accident or hazard by observing and/or monitoring the behavior of non self-directing, confused, mentally impaired or mentally ill persons. This service is not available in the following instances:

(1) When the need for protective supervision is caused by a physical condition rather than a mental impairment;
(2) For friendly visitation or other social activities;
(3) When the need for supervision is caused by a medical condition and the form of supervision required is medical;
(4) In anticipation of a medical emergency (such as seizures, etc.);
(5) To prevent or control antisocial or aggressive recipient behavior.

Please complete this form and return it promptly. Thank you for your assisting us in determining eligibility for Protective Supervision.

(Welfare and Institutions Code §12301.21)

DATE PATIENT LAST SEEN BY YOU:	LENGTH OF TIME YOU HAVE TREATED PATIENT:
DIAGNOSIS/MENTAL CONDITION:	PROGNOSIS: ☐ Permanent ☐ Temporary - Timeframe:

PLEASE CHECK THE APPROPRIATE BOXES

MEMORY

☐ No deficit problem ☐ Moderate or intermittent deficit (explain below) ☐ Severe memory deficit (explain below)

Explanation: _____

ORIENTATION

☐ No disorientation ☐ Moderate disorientation/confusion (explain below) ☐ Severe disorientation (explain below)

Explanation: _____

JUDGMENT

☐ Unimpaired ☐ Mildly Impaired (explain below) ☐ Severely Impaired (explain below)

Explanation: _____

1. Are you aware of any injury or accident that the patient has suffered due to deficits in memory, orientation or judgment? ☐ Yes ☐ No
   If Yes, please specify: _____
2. Does this patient retain the mobility or physical capacity to place him/herself in a situation which would result in injury, hazard or accident? ☐ Yes ☐ No
3. Do you have any additional information or comments? _____

CERTIFICATION

I certify that I am licensed to practice in the State of California and that the information provided above is correct.

SIGNATURE OF PHYSICIAN OR MEDICAL PROFESSIONAL:	MEDICAL SPECIALTY:	DATE:
ADDRESS:	LICENSE NO.:	TELEPHONE: ( )

RETURN THIS FORM TO: *COUNTY'S MAILING ADDRESS, CITY, CA,: ATTN; SW-NAME*

PROTECTIVE SUPERVISION
24-HOURS-A-DAY COVERAGE PLAN

PLEASE PRINT

NAME OF IHSS RECIPIENT:	RECIPIENT'S TELEPHONE #:
ADDRESS OF IHSS RECIPIENT:	
NAME OF PRIMARY CONTACT RESPONSIBLE:	CONTACT'S TELEPHONE #:
RELATIONSHIP TO RECIPIENT:	

As the primary contact for arranging the 24-hour-a-day coverage plan for the above named Recipient, I acknowledge my understanding of the following:

- A 24-hour-a-day coverage plan has been arranged and is in place.

  The continuous 24-hour-a-day coverage plan can be met regardless of paid In-Home Supportive Service (IHSS) hours along with various alternate resources (i.e.; Adult or Child Day Care Centers, community resource centers, Senior Centers, respite centers, etc.)

- The 24-hour-a-day coverage plan will be provided at all times.

- If there is any change to the 24-hour-a-day coverage plan (i.e. hospitalization, attendance in day-care programs, travel, etc.) I will immediately **notify the IHSS social worker.**

- The above name Recipient has an established need for 24-hour-a-day Protective Supervision if he/she is to remain safely in the home. The IHSS social worker has also discussed with me the appropriateness of out-of-home care as an alternative to 24-hour-a-day Protective Supervision.

NAME OF CARE PROVIDER (1):	CONTACT PHONE #:
NAME OF CARE PROVIDER (2):	CONTACT PHONE #:
NAME OF CARE PROVIDER (3):	CONTACT PHONE #:

Describe the implementation of the Protective Supervision 24-Hour-A-Day Coverage Plan:

SIGNATURE OF PRIMARY CONTACT RESPONSIBLE:	DATE:
SIGNATURE OF IHSS SOCIAL WORKER:	CONTACT PHONE #:

State of California – Health and Human Services Agency
IN-HOME SUPPORTIVE SERVICES (IHSS)
PROTECTIVE SUPERVISION
24-HOURS-A-DAY COVERAGE PLAN (SOC 825)

INSTRUCTIONS

The IHSS Protective Supervision 24-Hours-A-Day Coverage Plan (SOC 825) is an optional form for County use. The SOC 825 is intended to ensure that recipients who need Protective Supervision have the 24-hours of care needed for their health and safety 24 hours a day. The recipient's social service worker and the IHSS care provider(s), whether a family member, friend, or no relation at all, should discuss together a plan or schedule of 24 hours a day of coverage for the recipient.

NAME OF IHSS RECIPIENT: Enter the full name of the IHSS recipient.

RECIPIENT'S TELEPHONE NUMBER: Enter the contact telephone number for the recipient.

ADDRESS OF IHSS RECIPIENT: Enter the recipient's home address where the majority of the 24-hours-a-day coverage will be performed.

NAME OF PRIMARY CONTACT RESPONSIBLE: Enter the name of the person with primary responsibility for coordinating the recipient's 24-Hours-A-Day Coverage Plan.

PRIMARY CONTACT'S TELEPHONE NUMBER: Enter the telephone number for the primary contact responsible.

RELATIONSHIP TO RECIPIENT: Enter the relationship of the primary contact to the recipient, (i.e., family member, IHSS care provider, friend, etc.).

NAME OF CARE PROVIDER(S) (1), (2), (3), and CONTACT TELEPHONE NUMBER(S): Enter the name(s) of each care provider responsible for the recipient's care during the 24 hours a day of coverage. Enter a contact telephone number for each care provider.

If more than three (3) care providers are responsible for this recipient, an additional sheet of paper can be attached with name(s) and contact telephone number(s).

Describe the implementation of the Protective Supervision 24-Hours-A-Day Coverage Plan:

Enter the planned schedule, or explanation of the plan in which the above provider(s) will ensure the recipient is cared for the entire 24-hour period. An additional sheet of paper can be attached if more space is needed to describe the 24-Hours-A-Day Coverage Plan.

SIGNATURE OF PRIMARY CONTACT RESPONSIBLE and DATE: Once the 24-Hours-A-Day Coverage Plan is developed, the primary contact responsible will sign and date the form when the Plan is discussed with the social worker authorizing the need for Protective Supervision.

SIGNATURE OF IHSS SOCIAL WORKER and CONTACT TELEPHONE NUMBER: When the 24-Hours-A-Day Coverage Plan is discussed and signed and dated by the primary contact, the county social service worker will sign the form and add their contact telephone number.

A copy of the form is to be provided to the primary contact and retained in the County case file.

In-Home Supportive Services (IHSS) Program

INDIVIDUAL EMERGENCY BACK-UP PLAN

Participant Name: _____ Date: _____

Case #: _____ Declined to participate: ☐

If your Care Provider does not arrive and you need assistance, call:

Family Member: _____

Friend: _____

Neighbor: _____

County Social Services Worker: _____

County IHSS Social Services Office: _____

Public Authority: _____

If you need to report abuse and/or neglect of elderly or disabled individuals, call:

Adult Protective Services: _____

Other important numbers:

Doctor's Office: _____

Medi-Cal Office: _____

Advocacy Group(s): _____

Police Department: _____

Fire Department: _____

Other: _____

If you have an emergency, call 911

Social services staff discussed the above information with the recipient and/or his/her Authorized Representative and all parties are aware of what to do in case of an emergency.

Signature of Participant: _____ Date: _____

Signature of: _____ Date: _____

Authorized Representative, if applicable

Signature of: _____ Date: _____

County Social Services Staff

IN-HOME SUPPORTIVE SERVICES (IHSS)
PROVIDER ENROLLMENT AGREEMENT

I, _____, UNDERSTAND I AM REQUIRED TO ATTEND THE IHSS PROVIDER
(PRINT NAME)

ORIENTATION TO BE ELIGIBLE TO PROVIDE IHSS. HOWEVER, IF I HAVE BEEN A PROVIDER (ON OR BEFORE OCTOBER 31, 2009), I HAVE THE OPTION TO ATTEND AN IHSS ORIENTATION OR I MAY RECEIVE THE PROVIDER ORIENTATION INFORMATION DIRECTLY FROM THE COUNTY IHSS OFFICE.

1. During the required orientation for IHSS providers:
   - I was given the requirements to be an eligible IHSS provider and a description of the IHSS program. I was informed of my responsibilities as an IHSS provider.
   - I was informed of the consequences of committing fraud in the IHSS program.
   - I was given the Medi-Cal toll-free telephone fraud hotline number, 1-800-822-6222 and Internet Web site, http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx for reporting suspected fraud or abuse in the IHSS program.
2. I received a demonstration of, and understand, how to complete my timesheet. If I have been a provider (on or before October 31, 2009), I received information on the new timesheet and understand how to complete it.
   - I understand the timesheet should indicate only the authorized services I performed for the recipient and the time needed to perform those authorized services. I understand that my signature on my timesheet verifies that the information I reported on it is true and correct.
   - I understand that, if I am convicted of fraudulently reporting information on my timesheet, in addition to any criminal penalties, I may be required to pay civil penalties of at least $500, and not more than $1,000, for each violation of fraud.
   - I understand that when required, it will be necessary for me to place my fingerprint on my timesheet in order to be paid.
3. I understand that I am required to complete Form I-9, a form kept on file by the recipient, which states that I have the legal right to work in the United States.
4. I understand I have the option to submit Form W-4 to request federal income tax withholding and/or Form DE 4 to request state income tax withholding from my wages. I understand that if I do not submit Form W-4 and/or DE 4, no withholding will be taken out of my wages.
5. I understand services cannot be performed when the recipient is away from his/her home (for example, when the recipient is in the hospital or away on vacation). I will contact the recipient's social worker for approval of any services that may be performed when the recipient is away from the home.
   - I understand that, in the future, I will receive an information sheet that names the recipient and the services I am authorized to perform for that recipient.
6. I will cooperate with state or county staff to provide requested information related to the evaluation of a recipient's IHSS case.

I UNDERSTAND THE IHSS PROGRAM RULES EXPLAINED AT THE PROVIDER ORIENTATION OR BY THE PROVIDER ORIENTATION INFORMATION GIVEN TO ME BY THE COUNTY IHSS OFFICE. I ACCEPT THE RESPONSIBILITY TO FOLLOW ANY INFORMATION PROVIDED BY THE COUNTY. I UNDERSTAND THAT FAILURE TO FOLLOW THE REQUIREMENTS PROVIDED TO ME MAY RESULT IN BEING TERMINATED AS AN IHSS PROVIDER.

_____ _____
Provider's Signature Date

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

SECTION 1 – RECIPIENT'S INFORMATION

RECIPIENT'S NAME:	CASE NUMBER:

INDIVIDUALIZED BACK-UP PLAN

SECTION 2 – SUPPORT CONTACTS

If you need non-emergency assistance, and/or your IHSS care provider has not arrived as scheduled, call:

	Name	Phone
Family Member:		
Friend/Neighbor:		
County Social Services Worker:		
County IHSS Social Services Office:		
Public Authority:		
Other:		

Other important numbers available to you, if needed:

Doctor's Office:		
Advocacy Group(s):		
Police Department:		
Fire Department:		
Other:		

If you need to report abuse, fraud and/or neglect, call:

Adult Protective Services:	
Child Protective Services:	
Deaf or Hard of Hearing Resource Hotline:	(916) 558-5670
Fraud & Elder Abuse Hotline:	(800) 722-0432
Medi-Cal Fraud Hotline:	(800) 822-6222
Social Security Administration Fraud Hotline:	(800) 269-0271

If you have an emergency, call: 911
An emergency is an immediate threat to your health, welfare and/or safety.

Distribution: Original/Case File Copy/Recipient

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

RECIPIENT'S NAME	CASE NUMBER

RISK ASSESSMENT

SECTION 3 – GENERAL RISK ASSESSMENT

A. IHSS Assessment

During this IHSS assessment process, you and your social worker identified risks based on those personal care and domestic and related services for which you may need assistance. Assistance may be met through IHSS or with other formal or informal services.

B. Additional Risk Areas

The following are additional risk areas that you and your social worker discussed that may be outside the scope of the IHSS program (check all that apply):

	Comments
B1. Living Arrangements ☐ Lives with others who may assist ☐ Lives alone, relatives/friends nearby who may assist ☐ Lives alone, no relatives/friends nearby	
B2. Evacuation/Environmental Factors ☐ Can evacuate independently ☐ Can evacuate, but only with supervision/verbal direction ☐ Needs physical assistance to evacuate home in an emergency ☐ Able to access food/water independently ☐ Aware of emergency or crisis numbers/contacts ☐ Able to control lights, heat, cooling or other utilities	
B3. Communication ☐ Communicates without difficulty ☐ Hearing impairment, communication limited ☐ Speech impairment, communication limited ☐ Can speak or hear with the use of assistive device(s) Assistive device(s): _____ ☐ Able to place and receive calls independently ☐ Can use telephone only with assistive device(s) Assistive device(s): _____	

SECTION 4 – DISASTER PREPAREDNESS

In preparation for a disaster, such as hot and cold weather emergencies, fires, floods, and earthquakes, you and your social worker discussed the following:

- Your individual health needs that will be listed in the County's Disaster Preparedness Assessment Plan (if utilized by your county).

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

RECIPIENT'S NAME:	CASE NUMBER:

AGREEMENT AND SIGNATURES

SECTION 5 – AGREEMENT AND SIGNATURES

By signing below, you, your social worker, and any other individual(s) you have chosen to be involved in this process, are confirming you discussed and agree with the information contained in this Individualized Back-Up Plan and Risk Assessment.

Recipient

Signature:_____ Date:_____

County Staff

Signature:_____ Date:_____

Print Name and Title:_____

Authorized Representative

Signature:_____ Date:_____

Print Name and Relationship:_____

Other

Signature:_____ Date:_____

Print Name and Relationship:_____

In the event there have been no changes in the Individualized Back-Up Plan and Risk Assessment from the prior year, the Recipient/Social Worker can sign below confirming no change.

Recipient /Authorized Representative

Signature:_____ Date:_____

County Staff

Signature:_____ Date:_____

Print Name and Title:_____

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

RECIPIENT'S NAME:	CASE NUMBER:

INSTRUCTIONS

Use this form to work with the recipient to allow him/her independence and choice in decisions related to his/her Individualized Back-Up Plan and Risk Assessment.

Ensure that discussion and negotiation occurs between the social worker, the recipient, and any others whom the recipient wants involved while working through this process. **After completion, a copy of the Individualized Back-Up Plan and Risk Assessment shall be provided to the recipient. The original form shall be filed in the recipient's case file. Social worker shall encourage the recipient to post page 1 in an easily accessible area.**

SECTION 1: Fill in the recipient's name, and case number. This information will need to be added to each page until CMIPS II can auto-fill.

SECTION 2: Through discussion with the recipient/others involved in the development of this plan, fill in the recipient's choices and preferences of back-up contacts, as well as other important numbers identified, if needed. Discuss abuse, fraud and neglect with the recipient, the process to report abuse, fraud and neglect, and include the local APS/CPS numbers in their area. Reinforce with the recipient to call 911 if he/she has an emergency.

SECTION 3A: If assistance will be met through other formal or informal services, complete the SOC 450, Voluntary Services Certification, as needed. Identified risks may be mitigated through the authorization of hours in the service plan. If the recipient refuses any service, clearly document the service refused and the identified risks, and that the recipient elects to assume the risks associated with not receiving the service.

SECTION 3B: Also, discuss with the recipient additional risk areas that could be mitigated or improved through discussion and planning (Back-Up Plan).

SECTION 4: Discuss disaster preparedness with the recipient/others involved in the development of the plan. Include a discussion of how individual health needs may be addressed in the event of a disaster.

Section 5: With the recipient's/others' participation, review all sections verifying that each area was discussed during the process. Ensure that all appropriate individuals sign the form to confirm agreement with the information on the form.

Comments/Notes:

Distribution: Original/Case File Copy/Recipient

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

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

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.

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

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

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

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

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

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

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

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

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

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

Under certain limited circumstances, such as when services are requested because you are being discharged from a hospital or nursing facility and you need services to return safely to your home, or the county determines that you are at risk of placement in out-of-home care, the county may grant an exception that would allow you to get IHSS on a temporary basis before the county receives the completed SOC 873 or alternative documentation. However, even if an exception is granted, you will still be required to provide one of these documents for the county within the 45-day timeframe to determine if you can continue getting IHSS.

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

DUE BY: ____/____/____

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

COUNTY OF: _____

Notice Date: _____
IHSS Office Address: _____

IHSS Office Telephone Number: _____
Social Worker Name: _____

DUE BY: _____

(ADDRESSEE)

To: In-Home Supportive Services (IHSS) Recipient

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

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

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

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

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

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

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

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

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

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

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

CDSS
WILL LIGHTBOURNE
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

July 27, 2011

REASON FOR THIS TRANSMITTAL

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

ALL-COUNTY LETTER NO.: 11-55

TO: ALL COUNTY WELFARE DIRECTORS
IHSS PROGRAM MANAGERS

SUBJECT: **IN-HOME SUPPORTIVE SERVICES (IHSS) MEDICAL CERTIFICATION FORM SOC 873**

The purpose of this All-County Letter is to instruct counties on the implementation of Senate Bill (SB) 72 as it relates to obtaining certification from a licensed health care professional for all In-Home Supportive Services (IHSS) applicants and recipients.

BACKGROUND

SB 72 added Section 12309.1 to the Welfare and Institutions Code (WIC) that requires the development of a medical certification form. The completed medical certification form must be received prior to the authorization of IHSS services for new applicants and to allow the continuation of IHSS services for recipients. In order for IHSS to be authorized or continued, WIC section 12309.1 requires the medical certification form include a declaration from a licensed health care professional that the applicant/recipient is unable to independently perform some activity of daily living and that without the assistance of IHSS services, the applicant/recipient would be at risk of placement in out-of-home care. The form must also include a description of any condition or functional limitation that has resulted in, or contributed to, the applicant/recipient's need for assistance. The California Department of Social Services (CDSS), in consultation with the Department of Health Care Services and stakeholders, developed the In-Home Supportive Services Program Medical Certification Form (SOC 873) to meet the requirements of WIC section 12309.1.

COUNTY RESPONSIBILITIES

For IHSS applicants, beginning August 1, 2011, counties must inform each applicant or their authorized representative of the new certification requirements using SOC 874 the "IHSS Program Notice to Applicant of Medical Certification Requirement" (attached).

Applicants have 45 calendar days from the date the county requests the SOC 873, to provide the county with a completed and signed SOC 873 or alternative documentation in lieu of the SOC 873. Before IHSS services can be authorized counties must ensure that both questions 5 and 6 on the SOC 873 are answered "yes." If both questions 5 and 6 are answered "yes", the county may continue to assess the applicant's need for IHSS and determine eligibility. Once the applicant is determined eligible for services, eligibility may go back to the effective date of the application. If either question 5 or 6 is answered "no", then the application must be denied based on no need for services using Notice of Action (NOA) code 443. If the SOC 873 or alternative documentation is not provided within the 45 calendar day timeframe the application for IHSS services must be denied using NOA message 507.

For IHSS recipients beginning August 1, 2011, counties must inform each recipient or their authorized representative of the new certification requirements using SOC 875 the "IHSS Program Notice to Recipient of Medical Certification Requirement" (attached) at or before the first in-home reassessment). Recipients will have 45 calendar days from the date of the in-home reassessment to provide the completed and signed SOC 873 or alternative documentation to the county. In order to complete the reassessment and reauthorize hours, counties must ensure that both questions 5 and 6 on the SOC 873 are answered "yes." If both questions 5 and 6 are answered "yes" the county may complete the reassessment following normal procedures. If either question 5 or 6 is answered "no" IHSS services must be terminated based on no need for services using NOA code 443. If the SOC 873 or alternative documentation is not provided within the 45 calendar day timeframe, and good cause does not exist, services must be terminated using NOA message 507.

After the initial SOC 873 or alternative documentation is received and the county finds the applicant/recipient eligible for IHSS services, a new SOC 873 is not required at subsequent reassessments. Counties may request a new SOC 873 or their own county medical certification form at their discretion but a new SOC 873 is not required for continued eligibility.

The SOC 873 must be signed by a licensed health care professional. In accordance with WIC section 12309.1(a), "Licensed health care professional" means an individual licensed in California by the appropriate regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. A licensed health care professional includes, but is not limited to, a physician, physician's assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist or public health nurse.

Counties must give the applicant/recipient the option to take the SOC 873 to their licensed health care professional to be completed and returned to the county. However, if the applicant requests assistance in obtaining the SOC 873 from the licensed health professional, the county must assist; this includes sending the SOC 873 directly to the applicant/recipient's licensed heath care professional. In either case, the applicant/recipient is ultimately responsible for ensuring the completed SOC 873 is returned to the county within the appropriate timeframes. An applicant/recipient, legal guardian, conservator, or a person with power of attorney for medical purposes (who is recognized by the licensed health care professional) may sign "Part B" of the SOC 873. Counties may contact the licensed health care professional for clarification or additional information if the SOC 873 is not completed properly. Questions 5, 6, and 7 (when questions 5 and 6 are answered "yes") on the SOC 873 are pivotal for determining eligibility and are required to be answered to meet the requirements in WIC section 12309.1.

Counties are expected to use the SOC 873 or alternative documentation submitted by the applicant/recipient as a factor in assessing the need for IHSS, but it shall not be the sole determining factor, unless questions 5 or 6 are answered "no". The SOC 873 or alternative documentation is used to help the social worker evaluate the applicant/recipient's present condition and the need for out-of-home care if IHSS services are not provided. The social worker must consider all relevant documentation in making the IHSS determination.

ALTERNATIVE DOCUMENTATION

In lieu of obtaining the SOC 873, applicants/recipients may provide alternative documentation to the county. Acceptable alternative documentation must be dated no earlier than 60 calendar days prior to submission and include all the following elements:

- A statement or description indicating the applicant/recipient is unable to independently perform one or more activities of daily living,
- A description of the applicant/recipient's condition or functional limitation that has contributed to the need for assistance, and
- A signature from a licensed health care professional.

Alternative documentation may include, but is not limited to, hospital or nursing facility discharge plans, minimum data set forms, and individual program plans, all of which must meet the criteria shown above. County designed medical certification forms are not acceptable alternative documentation. Counties must accept alternative documentation that they determine meet all the conditions listed above.

GOOD CAUSE

The timeframe for recipients to obtain the SOC 873 or alternative documentation may be extended for good cause. Good cause extensions, however, cannot be granted for applicants. Good cause means a substantial and compelling reason beyond the recipient's control, and in order to be granted, the recipient 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. Recipients must notify the county of the need for a good cause extension no later than 35 calendar days from the in-home assessment. After the 35th day, a good cause extension can no longer be granted. Examples of good cause may include, but are not limited to; serious illness or hospitalization of the recipient or the county confirms with the licensed health care professional that additional time is needed to complete the SOC 873.

Timeframe extensions granted for good cause should not be extended for more than 45 calendar days beyond the mandated 45-day timeframe for a maximum total of 90 days.

CMIPS AND CMIPS NOTICE OF ACTION (NOA) MESSAGES

To meet the mandated requirements SB 72, Legacy Case Management, Information, and Payrolling System (CMIPS) will be modified to include two new fields on the RELA screen to allow entry and tracking of the required data. A Medical Certification Date (MC DATE) field and associated Medical Certification Reason Code (MC CODE) field will be used to track the date the medical certification was requested and received and what type of documentation was received. Counties will be required to enter in the date when they request and subsequently receive the documentation and use the appropriate type code. The reason codes for the MC CODE field include:

- M – Medical Certification Received
- A – Alternative Documentation Received
- E – Exception
- P – Pending (to be used when waiting for documentation to be received)

For new applicants, counties will not be able to authorize services on the case unless a date is entered in the MC DATE field and the MC CODE field has an "M", "A" or "E" indicated. When entering the case into CMIPS counties should enter the date they requested the medical certification and enter a "P". If the county has already received the medical certification they should enter the receipt date in the MC DATE field and appropriate reason code in the MC CODE field.

For existing recipients, the MC DATE and MC CODE field must contain a valid value (M, A, E or P) for the system to allow the user to move forward to RELC and authorize the new hours after a reassessment. When entering the reassessment into CMIPS counties must enter the face-to-face date in the MC DATE field and enter a "P" in the MC CODE field if they have not received the medical certification documentation. Once the county receives the medical certification they should update the MC DATE field and MC CODE fields with the receipt date and appropriate reason code. Counties should continue to utilize the Face to Face Date field on RELB when entering authorization information for both initial assessments and reassessments.

Counties should be aware that certain actions are either required or not allowed once the new medical certification fields are used. The following effects should be noted:

- The system will not allow a user to delete a "P" from the MC CODE field. The field will only accept one of the other valid types of "M", "A" or "E".
- A soft edit has been added to the RELA screen that will be triggered if the MC DATE and/or MC TYPE field are blank. The user will be able to override this edit.
- A hard edit has been added to the RELB field that is triggered when a change has been made to the FACE-TO-FACE DATE field and the MC DATE and/or MC TYPE fields are blank. A user cannot override this edit and must return to the RELA screen and fill in the MC DATE and MC CODE fields with the appropriate values.

To assist counties with the tracking of cases that are delinquent in submitting their medical certification, a new file will be added to the existing county download which includes a list of recipients who are in danger of losing their services due to non-compliance with the medical certification requirement. This file will provide the necessary data and allow counties the flexibility to incorporate it into their existing business processes. In order for this report to be useful to the counties, it is imperative that counties utilize the MC DATE and MC CODE fields to identify which cases are "pending" medical certification so they may be identified on the monthly file.

CDSS has developed NOA messages for use on the NA 690 when an applicant/recipient fails to provide the SOC 873. As with any denial or termination, timely and adequate notice rules apply. The following NOA message 507 should be used in conjunction with the NA 690 to inform an applicant/recipient that his/her services have been denied or terminated for failure to provide the SOC 873:

CMIPS NOA Message 507

You did not provide the county with a medical certification as required to authorize services. (WIC 12309.1).

CMIPS II NOA Messages

The following messages are designed to be used (upon implementation of CMIPS II) on the corresponding IHSS Notice of Action Denial (NA 1252) or Termination (NA 1255).

Applicant Denial Message (MXX-XX):

The county has denied your application for In-Home Supportive Services (IHSS). Here is why:

When you applied for IHSS, the county informed you that you had to provide a medical certification from a licensed health care professional to the county stating that you cannot do some activities of daily living on your own and without help to do these activities you would be at risk of placement in out-of-home care.

The county asked you to provide a medical certification by
_____(Date)_____.

You did not provide the county with a medical certification as required by state law. Therefore, you cannot be found eligible for IHSS.

You can reapply for IHSS if you provide the county with a medical certification.

(Please note that the appropriate regulation section (WIC 12309.1) will be inserted into the rules area at the bottom of the NOA.).

Recipient Termination Message (MXX-XX):

As of _____DATE)_____, the In-Home Supportive Services (IHSS) you have been getting will stop. Here is why:

At your reassessment on ____(DATE)___, the county informed you that you had to provide a medical certification from a licensed health care professional stating that you cannot do some activities of daily living on your own and without help to do these activities you would be at risk of placement in out-of-home care.

The county asked you to provide a medical certification by __(DATE)___.

You did not provide the county with a medical certification as required by state law to continue to receive IHSS services.

If you provide the county with a medical certification, the county will assess your need and/or eligibility for IHSS. (Please note that the appropriate regulation section (WIC 12309.1) will be inserted into the rules area at the bottom of the NOA).

TRANSLATIONS

CDSS is in the process of translating the SOC 873, SOC 874 and SOC 875. Language Translation Services (LTS) will make available camera ready copies of Spanish, Armenian and Chinese translated forms and letters as soon as they have been completed. You may access these forms and letters at:

http://www.cdss.ca.gov/cdssweb/PG183.htm

Your county forms coordinator should distribute translated forms to each program and location. Each county shall 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 by state regulation (MPP Division 21, Civil Rights Nondiscrimination, section 115).

For questions, please contact Victoria Rodriguez, Analyst, Adult Programs Branch, Operations and Technical Assistance Unit, at (916) 653-3850, or by e-mail at: Victoria.Rodriguez@dss.ca.gov.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Attachments

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

CDSS

WILL LIGHTBOURNE
DIRECTOR

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	

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

CDSS
WILL LIGHTBOURNE
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

REASON FOR THIS TRANSMITTAL

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

December 6, 2011

ALL-COUNTY INFORMATION NOTICE NO. I-74-11

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

SUBJECT: REVISED IN-HOME SUPPORTIVE SERVICES PROGRAM HEALTH CARE CERTIFICATION FORM AND RELATED NOTICES; CLARIFICATION ON INTER-COUNTY TRANSFERS IN RELATION TO HEALTH CARE CERTIFICATION REQUIREMENTS

REFERENCE: ALL-COUNTY LETTER NO. 11-55, DATED JULY 27, 2011
ALL-COUNTY LETTER NO. 11-76, DATED NOVEMBER 10, 2011

This All- County Information Notice (ACIN) transmits the revised In-Home Supportive Services (IHSS) Program Health Care Certification Form (SOC 873), Notice to Applicant of Health Care Certification Requirement (SOC 874), and Notice to Recipient of Health Care Certification Requirement (SOC 875). It also provides a clarification on policy regarding inter-county transfers of IHSS cases in relation to the health care certification requirements.

Effective immediately, counties shall begin using the revised SOC 873, SOC 874 and SOC 875. Below is a summary of the most significant revisions to the form and the notices and an explanation of the reasons for them.

REVISIONS TO THE SOC 873

- Throughout the form (e.g., the title, etc.), all references to the term "medical certification" have been changed to "health care certification."

  This change was made because the term "health care" better conforms with the language used in Welfare and Institutions Code (WIC) Section 12309.1, as well as

the intent of the statute. "Health care" is also a broader term and more consistent with the IHSS program being based on a social service model rather than a medical model.

- At the bottom of Page 1, an endnote providing the statutory definition of Licensed Health Care Professional (WIC 12309.1(a)(1)), as well as the examples specified in statute, has been added:

  > *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.*

  The endnote was added to ensure that LHCPs understand the definition as it applies to the certification requirements and can determine whether they are authorized to complete the certification when asked by an applicant or recipient.

  Several counties that border other states have inquired whether they may accept an SOC 873 (or alternative documentation) completed by an LHCP who is licensed in the bordering state. The counties have indicated that refusing to accept documentation from an out-of-state LHCP presents a significant obstacle for recipients who either reside in areas where the nearest LHCP is located in the bordering state, or who are receiving treatment from an LHCP affiliated with the military services (e.g., the Veterans Health Administration). In response to these inquiries, the California Department of Social Services (CDSS) is granting counties the flexibility to make exceptions on a case-by-case basis and accept an SOC 873 (or alternative documentation) completed by a LHCP who has been licensed in another state but who is an approved Medi-Cal provider, if the applicant/recipient has been receiving treatment from the out-of-state LHCP.

  Counties have requested additional clarification on the specific types of LHCPs, in addition to the examples listed in WIC Section 12309.1, from whom they may accept a completed SOC 873 or alternative documentation. For the purposes of completing the health care certification, a LHCP is a licensed individual whose primary responsibilities are to diagnose and/or provide treatment and care for physical or mental diseases or conditions which cause or contribute to an individual's functional limitation. Based on this definition, counties may accept an SOC 873 or alternative documentation completed by a Marriage and Family Therapist (MFT) or a Licensed Clinical Social Worker (LCSW). However, they may not accept forms completed by

a pharmacist or an x-ray technician, as these individuals' primary responsibilities are not diagnosis and/or provision of treatment/care.

- The items in Section C have been reordered and renumbered. The items that, on the prior version of the form, were the last four items in the section (Items # 5 – 8) are now listed first (Items # 1 – 4).

- At the beginning of Section C, the following note has been added: *NOTE: ITEMS # 1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.* Also, before Item #5, the following note has been added: *Please complete Items # 5 – 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.*

  Both the reordering/renumbering and the addition of these notes were done to emphasize the relative importance of the information that the LHCP provides in Items # 1 through 4 in assisting the IHSS worker to determine an individual's eligibility for IHSS compared with the information he/she provides in Items # 5 through 8.

  Please note that the reordering and renumbering of items in this section alters the instructions provided in ACL No. 11-55 for determining whether an individual is eligible for IHSS based on the SOC 873 requirements. In that ACL, Items # 5 and 6 were identified as being of primary importance in making the eligibility determination. Due to the reordering/renumbering of this section, Items # 1 and 2 are now the most critical indicators. Therefore, all references to Items # 5 through 8 in ACL No. 11-55 will now refer, correspondingly, to Items # 1 through 4.

  If the LHCP has answered "Yes" to Items #1 and 2 on the SOC 873, but he/she has failed to complete Items #3 and 4, the county may, at its discretion, contact the LHCP to obtain the information about the individual's physical and/or mental condition or functional limitation that has resulted in or contributed to his/her need for IHSS, or it may send the SOC 873 back to the LHCP to be completed. If the county opts to contact the LHCP, it should notate the outcome of the contact on the SOC 873, initial any such notation and document the case file accordingly. If the county cannot obtain the necessary information in the course of the contact, or if Items #1 or 2 are unanswered, the county must send the SOC 873 back to the LHCP to be completed. The time allowed for the LHCP to complete and/or clarify his/her original responses shall not be counted against the 45-day time limit. Counties should follow their standard operational procedures in deciding how much time to allow for return of the clarifying SOC 873.

REVISIONS TO THE SOC 874

- Throughout the notice (e.g., the title, etc.), all references to the term "medical certification" have been changed to "health care certification" in order to conform with the language used in the statute.

- Information about alternative documentation requirements has been updated to reflect that, in order to be valid, the document must be signed by a LHCP *within the last 60 days.*

- Language has been added near the bottom of the notice explaining that, under certain limited circumstances, an exception may be granted which would allow an individual to temporarily receive services prior to providing the completed SOC 873 or alternative documentation to the county. The individual is still required to provide one of the documents in order to continue receiving services.

REVISIONS TO THE SOC 875

- Throughout the notice (e.g., the title, etc.), all references to the term "medical certification" have been changed to "health care certification" in order to conform with the language used in the statute.

- The following language has been deleted from the notice: "If the county does not receive the SOC 873 by the 35th day, a notice will be sent informing you that your IHSS will stop, unless you had previously contacted the county and were given more time to submit the form."

  This language was deleted to reflect a change in policy regarding the time frame for mailing Notices of Action (NOAs) to recipients who fail to provide the SOC 873 (or alternative documentation) within 45 days, and for which good cause does not exist. CDSS is modifying this policy to address county concerns regarding workload and operational challenges of having to send the NOA 10 days in advance of the 45th day to ensure that services do not continue beyond the 45 days. Effective immediately, unless there is good cause, counties shall send the termination NOA on the 45th day following the in-home assessment, and shall follow normal procedures for timely notice.

- Information about alternative documentation requirements has been updated to reflect that, in order to be valid, the document must be signed by a LHCP *within the last 60 days.*

- Language has been added to indicate that if a recipient is not able to obtain a completed SOC 873 or alternative documentation from his/her LHCP within 45 days, the individual should contact the county prior to the due date to explain the reason for his/her inability to meet the due date and inquire whether an extension can be granted.

  This language has been added to clarify that, as stated in ACL 11-76, dated November 10, 2011, recipients may request a good cause extension up to the 45th calendar day from the date of the in-home assessment.

Stakeholders requested the inclusion of language on the SOC 873, SOC 874, and SOC 875 relating to WIC section 14131.07, which pertains to limits on the number of provider visits a Medi-Cal recipient is allowed each year, and whether a visit to a provider for the purpose of completing the SOC 873 should be counted against the limit. However, because the California Department of Health Care Services is the state agency responsible for disseminating information about this statutory provision, until further notice, this information cannot be included on any of CDSS' forms or notices.

AVAILABILITY OF THE REVISED SOC 873, SOC 874 AND SOC 875

The form and notices referenced in this ACIN are designated as "Required – No Substitutes Permitted." Camera-ready copies of the English versions of them are now available on the California Department of Social Services (CDSS) Forms/Brochures web page at:

http://www.dss.cahwnet.gov/cdssweb/PG183.htm.

The SOC 873, SOC 874 and SOC 875 are being translated into the current threshold languages (Spanish, Armenian, and Chinese) and, upon completion, camera-ready copies of the translations will be posted on the CDSS Translated Forms and Publications web page at:

http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

Please note that the entire SOC 873 is being translated into the threshold languages so that individuals with limited English proficiency are informed of the specific information being requested from the LHCP. The county should provide the translated version to the recipient/applicant; however, the English version should be provided to the LHCP, either by the county or by the individual.

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.

CLARIFICATION REGARDING INTER-COUNTY TRANSFERS (ICTs)

Counties have requested clarification regarding ICTs in relation to the health care certification requirements. When a county receives an ICT, if the SOC 873 or alternative documentation has already been provided by the recipient in the sending county, there is no need for the receiving county to obtain a new one. However, if the SOC 873 or alternative documentation has not already been provided by the recipient in the sending county, the receiving county shall request one at or before the face-to-face assessment with the recipient, which the receiving county is required to complete during the transfer period, pursuant to MPP 30-759.94. The SOC 873 (or alternative documentation) shall be due 45 days following the face-to-face assessment. However, since an ICT case is entered as a new application in the receiving county, a systems limitation prevents services from being authorized when the 'P' code is entered in the MC field in CMIPS. In ICT cases where the receiving county has completed the in-home assessment but is awaiting the SOC 873, the county should temporarily enter 'E' in the MC field to prevent unnecessary interruption of services while the SOC 873 is pending.

Should you have questions regarding the Health Care Certification requirements, please contact the Adult Programs Policy and Operations Bureau at (916) 651-5350.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Attachments

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

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

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.*

- You cannot get your wheelchair into examination, interview rooms or restrooms.
- Men get referred to job training for better paying jobs than women.
- The county does not want you to have training because they say you are "too old."
- You are not allowed to adopt a baby because you are of a different race.

Discrimination Complaints

If you think you have been discriminated against, you may submit a complaint application separately to the County or the State, and the Federal Government. The Federal agency that you must complain to depends on which program your complaint is about.

You can file a discrimination complaint with:

1. FOR ALL PROGRAMS ADMINISTERED BY YOUR COUNTY WELFARE DEPARTMENT: The County's Civil Rights Coordinator. Ask your county office for the name, address and phone number of their Civil Rights Coordinator. He/she will independently investigate your complaint.
2. Civil Rights Bureau
   California Department of Social Services
   744 P Street, MS 8-16-70
   Sacramento, CA 95814
   (916) 654-2107
   (866) 741-6241 (Toll-Free)
3. FOR THE CALFRESH PROGRAM:
   United States Department of Agriculture
   Director, Office of Civil Rights,
   Room 326-W, Whitten Bldg.
   1400 Independence Avenue, S.W.,
   Washington, D.C. 20250-9410
   (202) 720-6382 (voice and TTY)
4. FOR ALL OTHER PROGRAMS:
   Health and Human Services
   Office of Civil Rights
   90 7th Street, Suite 4-100
   San Francisco, CA 94103
   (415) 437-8310 (voice)
   (415) 437-8311 (TDD)

Time Limits to Take Action

If you suffer discrimination, you must submit your complaint within 180 days of the actual discrimination. If the discrimination also affected the level of your benefits and services, you must also ask for a state hearing within 90 days. A discrimination investigation cannot change your benefit levels or services...only a state hearing can do that.

Limits on Certain Rights

Although you have the right to privacy and confidentiality, there are certain laws that allow limited exceptions. You can ask the county for the laws.

Questions

If you have any questions about the rights listed here, call the Public Inquiry Unit: toll free (800) 952-5253. The TDD toll-free telephone number is (800) 952-8349.

Programs Covered by This Pamphlet

- Adoption Assistance Program (AAP)
- Adult Protective Services
- Alcohol and Drug Program
- California Food Assistance Program (CFAP)
- Medi-Cal
- CalWORKs
- CalWORKs Child Care
- CalWORKs Welfare-to-Work Program/Services
- Cash Assistance Program for Immigrants (CAPI)
- Child Welfare Services
- Denti-Cal
- Early & Periodic Screening, Diagnosis, and Treatment (EPSDT)
- CalFresh (Food Stamps)
- Foster Care
- In-Home Support Services
- Kinship Guardian Assistance (Kin-GAP)
- Mental Health
- Multipurpose Senior Services Program (MSSP)
- Personal Care Services Program (PCSP)
- Refugee Cash Assistance
- Social Services

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES

This pamphlet is available from your Local County Welfare Office and at www.cdss.ca.gov in the following languages:

• Arabic	• Japanese	• Russian
• Armenian	• Korean	• Spanish
• Cambodian	• Lao	• Spanish Large Print
• Chinese	• Mien	• Tagalog
• Farsi	• Portugese	• Ukranian
• Hmong	• Punjabi	• Vietnamese

Also Available in large print, Braille, and Audio CD

PUB 13 (6/11)

Your Rights

Under California Welfare Programs

... for people applying for or receiving public aid in California

Tell us if you need help because of a disability

Ask for a free interpreter

Your Rights

All people and organizations providing public assistance must respect your rights. They can help you understand and apply for benefits and services.

- You have the right to an interpreter free of charge.
- Ud. tiene derecho a un intérprete gratis
- Вы имеете право на услуги Переводчика
- 你有权利自由译员
- May karapatan kang magkaroon ng tag ugnay na walang bayad.
- Quý vị có quyền được một thông dịch viên miễn phí.
- .Koj muaj txoj cai yuav ib tus neegtxhais lus Hmoob rau koj.
- لديك الحق في الحصول على مترجم دون أية تكلفة.
- Դուք անվճար թարգմանչի իրավունք ունեք:
- [illegible]
- 여러분은 무료 통역 서비스를 받을 권리가 있습니다
- [illegible]
- [illegible]
- [illegible]
- Ви маєте право на безкоштовного перекладача.
- Você tem o direito a um/a interprete gratuito/a!
- あなたは無料の通訳の権利を有しています。
- Meih maaih leiz haih duqv dauh faan waac mienh tengx meih maiv zuqc bun nyaanh.

You Have a Right to...

1. Understand what is happening with your application and aid.
2. Get written and oral explanations about your application and aid.
3. Get a receipt for any documents you turn in.
4. See your case record.
5. See state and county laws and regulations.
6. Ask a judge to review any county decision about your eligibility, benefits, or services.
7. Not face discrimination in receiving program benefits or services.
8. File a complaint about discrimination.
9. Get extra help from county staff to make sure you get your benefits if you have a disability or impairment that makes it hard to understand the program rules.
10. Have your information kept confidential.
11. Be treated with courtesy and respect.

If You Are Having Problems with Your Aid or Services:

1. Keep records of all your information, documents, and contacts with the county.
2. Get a receipt when you turn anything in.
3. You can bring someone with you to a meeting with your worker.
4. Complain. There are 4 ways to do this:

- *Informal:* You can ask to speak to a supervisor to talk about problems with a worker or to go over the rules and the proposed action on your aid or services.
- *State Hearing:* Ask for a state hearing if there is a problem with your aid or services. **You must ask for a hearing within 90 days of the county's action.** You may be able to file after 90 days if you have a good reason, like illness or a disability.
- *Discrimination complaint:* If you feel that the county has discriminated against you, you can make a discrimination complaint to the County's Civil Rights Coordinator or to the State Civil Rights Bureau, and to the Federal Government. You must do this within 180 days of the discrimination. For more on this, see the section beginning "Prohibited Discrimination."

  If the discrimination also affects your benefits or services, **you must also ask for a state hearing** if you wish to challenge the county's decision on your benefits or services.
- *Grievance:* You can file a complaint with the county if they have a grievance procedure. **This does not protect your benefits** in the way that asking for a state hearing does.

State Hearings

- You can ask for a state hearing any time you disagree with a county's action on your benefits or services.
- You can also ask for a state hearing if the county is not giving you benefits or services which you think you should get.
- A state hearing is heard by a state Administrative Law Judge. The county will have someone at the hearing to explain why they took their action.
- A state hearing is not a court hearing. You do have the right to have a representative with you. There are free legal services in every county. They are listed on the back of your county notices. You can bring witnesses. You have the right to a free interpreter. Ask the county how to get one.
  - If your problem is with General Assistance or general relief, you must ask for a county hearing.
  - If your problem is with Social Security benefits, you must contact the Social Security Administration.

Continuing Your Aid or Services Pending a State Hearing

The county must give you a notice at least 10 days before any action to change your aid or services takes place. If you ask for a hearing before the action takes place, you can get "aid paid pending" your hearing. This means your aid stays the same until you get a hearing decision.

You MUST ask for a hearing on any new notice you get, if you disagree.

How to Request a State Hearing

1. Phone: Ask for a State Hearing by contacting the CA Department of Social Services at (800) 743-8525 or (800) 952-5253
2. Fill out the back of your Notice of Action (NOA) or send a written request to:
   CDSS, State Hearing Division
   744 P Street M.S. 09-17-37
   Sacramento, CA 95814

Prohibited Discrimination

Under State law, welfare agencies may not provide you aid, benefits or services that is different from aid provided to others on the basis of

Race, Color, National Origin (including language), Ethnic Group Identification, Age, Disability, Religion, Sex, Sexual Orientation, Political Affiliation, Marital Status, or Domestic Partnership

Federal laws also prohibit discrimination on several, although not all, of the bases listed above.
Federal Law also prohibits :

1. Delaying or denying the placement of a child for adoption or into foster care on the basis of race, color or national origin of the adoptive or foster parents, or the child;
2. Denying to any individual the opportunity to become a foster or adoptive parent on the basis of race, color or national origin of the individual or child involved.

Examples of Discrimination

- The County does not give you a free interpreter.
- A worker tells a certain ethnic group about more programs and services than people of other ethnicities.
- The County won't help you get audio tapes of a program orientation to help you with a disability that makes it hard for you to read.
- A worker learns of your religion or politics and then treats you differently.
- You can't get to appointments because the county building does not have an elevator.

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION

Note: This notice relates ONLY to your Social Services. It does NOT affect your receipt of SSI/SSP or Social Security. KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

YOUR IHSS OFFICE

IF REQUESTING A STATE HEARING, PLEASE SEND TO:

Case Number

Date Mailed

NOW		WAS	
Your Countable Income:	$	Your Countable Income:	$
Minus SSI/SSP Benefit Level:	$	Minus SSI/SSP Benefit Level:	$
Your Share of Cost:	$	Your Share of Cost:	$
Minus Assessed IHSS Cost:	$	Minus Assessed IHSS Cost:	$
Income in Excess of Assessed Cost:	$	Income in Excess of Assessed Cost:	$

SERVICES	HOURS NOW	PREVIOUS HOURS	(+) INCREASE OR (-) DECREASE
DOMESTIC SERVICES per month: Clean floors, wash kitchen counters, stoves, refrigerators, bathrooms; store food, supplies; take out garbage; dust, pick up, bring in fuel; change; make bed and miscellaneous.			
HEAVY CLEANING (one month only):			
RELATED SERVICES per week:			
* Prepare Meals:			
** Meal Cleanup:			
Routine Laundry:			
Shopping for Food:			
Other Shopping Errands:			
NON-MEDICAL PERSONAL SERVICES per week:			
* Respiration Assistance:			
* Bowel, Bladder Care:			
* Feeding:			
* Routine Bed Baths:			
* Dressing:			
* Menstrual Care:			
* Ambulation:			
* Move In/Out of Bed:			
* Baths, Oral Hygiene/Grooming:			
* Rub Skin, Repositioning, Help On/Off Seats, In/Out of Vehicle:			
* Care/Assistance with Prosthesis:			

SERVICES	HOURS NOW	PREVIOUS HOURS	(+) INCREASE OR (-) DECREASE
ACCOMPANIMENT SERVICES per week:			
Medical Appointments:			
To Alternative Resources:			
YARD HAZARD ABATEMENT:			
Remove Grass, or Weeds, Rubbish (one month only):			
Remove Ice, Snow, per week:			
PROTECTIVE SUPERVISION per week:			
TEACHING/DEMONSTRATION per week (no more than three months duration):			
* PARAMEDICAL SERVICE per week:			
TOTAL WEEKLY HOURS X 4.33:			
ADD DOMESTIC SERVICE HOURS:			
ADD HEAVY CLEANING:			
ADD REMOVE GRASS, ETC.:			
TOTAL MONTHLY HOURS (rounded to the nearest tenth)			

	NOW	WAS
Restaurant Meal Allowance:	$	$

☐ "Since you meet the criteria for 20 hours or more in starred (*) services you can get an advance payment to pay your own provider. If you want to get advance payment, contact your social worker. The double-starred (**) service is included in the 20 hours only when assistance with feeding, preparation of meals and meal clean-up are all required."

The above action(s) is supported by Federal Law (Social Security Act), State Law (Welfare and Institutions Code), Federal Regulations (Code of Federal Regulations), State Regulations (California Administrative Code and State Department of Social Services Manual of Policies and Procedures).

You must report immediately any changes that might affect your eligibility or need for In-Home Supportive Services such as change in income, property, living arrangement, medical condition or ability to work. If you have any questions or [illegible]

District Office Service Worker SW# Telephone

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING. PLEASE SEND YOUR WRITTEN REQUEST TO THE COUNTY ADDRESS ON THE TOP RIGHT HAND CORNER OF THIS FORM.

NA 690 (1-01) PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

Fig. V-F- 1 – English Language – Notice of Action