FORM SAMPLES

ELIGIBILITY

IHSS INCOME ELIGIBILITY - ADULT

Name _____ Case No. _____ Month/Year _____

RECIPIENT

A. Income of aged, blind or disabled individual or couple (if individual has spouse not aged, blind or disabled, also complete Part B).

	UNEARNED	EARNED
1. Unearned income (list) (Do not show exempt income)		
a.	$	
b.	$	
c.	$	
2. Total unearned income (A1a to A1c)	$ 0.00	
3. Any income exclusion	$ 20	
4. Net unearned income (A2 minus A3)	$	
5. Earned income (Do not show exempt income)		$
6. Unused $20 exclusion (If A3 is greater than A2, enter the difference)		$
7. Earned income exclusion		$ 65
8. Total exclusions (A6 plus A7)		$ 65.00
9. Remaining earned income (A5 minus A8)		$
10. Net earned income (A9 x 1/2)		$ 0.00
11. Other earned income deductions		$
12. Total net earned income (A10 minus A11)		$
13. Total countable income (A4 plus A12)	$ 0.00	
14. SSI/SSP payment level	$	
15. IHSS share of cost (A13 minus A14)	$	

** If there is also a blind or disabled child in the family, the share of cost shown in Line C is not paid. Enter this amount on Form SOC 294C, Line A9. The share of cost will be the amount detemined in SOC 294C, Line B16.

SPOUSE

B. Income of aged, blind or disabled individual and spouse who is not aged, blind or disabled.

	UNEARNED	EARNED
1. Income of client's spouse	$	$
2. Allowance for children not blind or disabled		
a. Children's needs $ $ $		
b. Children's income $ $ $		
c. Net needs (a – b) $ $ $		
d. Total allowance (add B2c's)	$ 0.00	
3. Remaining unearned income (B1 minus B2d)	$	
4. Unmet children's needs (If B2d is greater than B1 unearned, enter the difference)		$
5. Remaining earned income (B1 minus B4)		$
6. Net income of spouse (B3 plus B5) -- If equal to or less than A15 is entered in C -- If greater than complete B7 through B20	$	
7. IHSS client's income (From A2 and A5)	$	$
8. Income of couple (B3 plus B7 unearned, B5 plus B7 earned)	$ 0.00	$ 0.00
9. Any income exclusion	$ 20	
10. Net unearned income (B8 minus B9)	$	
11. Unused $20 exclusion (If B9 is greater than B8 unearned, enter the difference)		$
12. Earned income exclusion		$ 65
13. Total exclusions (B11 plus B12)		$ 65.00
14. Remaining earned income (B8 minus B13)		$
15. Net earned income (B14 x 1/2)		$
16. Other earned income deductions		$
17. Total net earned income (B15 minus B16)		$
18. Total countable income (B10 plus B17)	$ 0.00	
19. SSI/SSP couple payment level	$	
20. IHSS share of cost (B18 minus B19)	$	
C. SHARE OF COST (higher of A15 or B20) **	$	

WORKER _____ DATE _____

IHSS INCOME ELIGIBILITY - CHILD

NAME	CASE NUMBER	MONTH

PARENT

A. Income deemed to a blind or disabled child living at home who is under 18.

☐ Income of parent and parent's spouse where neither is aged, blind or disabled.	Unearned	Earned
1. Gross income	$	$
2. Allowance for children not blind or disabled		
a. Children's needs		
b. Children's income	$ $ $	
c. Net needs (a minus b)	$ $ $	
d. Total allowance (add A2c's)	$	
3. Remaining unearned income (A1 minus A2d)	$	
4. Unmet children's needs (If A2d is greater than A1 unearned, enter the difference)		$
5. Remaining earned income (A1 minus A4)		$
6. Any income exclusion	$ 20	
7. Net unearned income (A3 minus A6)	$	
8. Unused $20 exclusion (If A6 is greater than A3, enter the difference)		$
9. Earned income exclusion		$ 65
10. Total exclusions (A8 plus A9)		$
11. Earned income (A5 minus A10)		$
12. Net earned income (A11 x 1/2)		$
13. Total income (A7 plus A12)	$	
14. Allowance for parent and spouse (1) (2)	$	
15. Income deemed to child (A13 minus A14)	$	
☐ Income parent(s) where one or both are aged, blind or disabled.		
16. Parent(s) income in excess of SSI/SSP payment level (from SOC 294A C)	$	

RECIPIENT

B. IHSS share of cost computation for blind or disabled child who is under 18.

	Unearned	Earned
1. Income deemed to child (from A15 or A16)**	$	
2. Unearned income (list) (Do not show exempt income)		
a.	$	
b.	$	
c.	$	
3. Total unearned income (B1 plus B2)	$	
4. Any income exclusion	$ 20	
5. Net unearned income (B3 minus B4)	$	
6. Earned income (Do not show exempt income)		$
7. Unused $20 exclusion (If B4 is greater than B3, enter the difference)		$
8. Earned income exclusion		$ 65
9. Total exclusions (B7 plus B8)		$
10. Remaining earned income (B6 minus B9)		$
11. Net earned income (B10 x 1/2)		$
12. Other earned income deductions		$
13. Total net earned income (B11 minus B12)		$
14. Total countable income (B5 plus B13)	$	
15. SSI/SSP payment level	$	
16. IHSS share of cost (B14 minus B15)	$	

** Note: If more than 1 eligible child, divide deemable income equally among them, except that if one child has exces income, it is deemed to other eligible children.

WORKER	DATE

APPLICATION FOR SOCIAL SERVICES

TO THE APPLICANT: *This form is subject to verification.*
NOTE: *Retain your copy of this application.*

*** SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

CASE NUMBER:	DATE OF APPLICATION:

1. NAME			*SOCIAL SECURITY NUMBER
ADDRESS			SEX ☐ Male ☐ Female
CITY	ZIP CODE	TELEPHONE ( )	BIRTHDATE

2. Are you a veteran? ☐ Yes ☐ No	ARE YOU A SPOUSE/CHILD OF A VETERAN? ☐ Yes ☐ No	IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER:

3. Do you receive SSI/SSP benefits? ☐ Yes ☐ No	IF "YES", CHECK YOUR TYPE OF LIVING ARRANGEMENT: ☐ Independent Living ☐ Board and Care ☐ Home of Another
SERVICES BEING REQUESTED:	

4. Have you received In-Home Supportive Services (IHSS) in the past? ☐ Yes ☐ No
If "YES", complete the following:

DATE AND COUNTY WHERE SERVICE WAS LAST RECEIVED	TOTAL MONTHLY HOURS	NAME USED (IF DIFFERENT FROM ABOVE)

5. **LIST FAMILY MEMBERS IN HOUSEHOLD**	**BIRTHDATE**	***SOCIAL SECURITY NUMBER**
NAME OF SPOUSE ☐ NAME OF PARENT ☐		
CHILD/OTHER RELATIVE		
CHILD/OTHER RELATIVE		

6. The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.

A. My ethnic origin is (*see reverse side for correct code):* ☐	B. I speak and understand English: ☐ Yes ☐ No My primary language is *(see reverse side for correct code:)* ☐

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1) Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2) Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3) Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4) Notifying the County IHSS office when I hire or fire a provider.

In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1) In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2) If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3) The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4) I will be responsible for paying for any services I receive that are not included in my IHSS authorization.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

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 the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

SIGNATURE OF APPLICANT:	DATE:
SIGNATURE OF APPLICANT'S REPRESENTATIVE: *(ONLY IF APPLICABLE)*	DATE: *(ONLY IF APPLICABLE)*
REPRESENTATIVE'S RELATIONSHIP TO APPLICANT: *(ONLY IF APPLICABLE)*	REPRESENTATIVE'S TELEPHONE NUMBER: *(ONLY IF APPLICABLE)* ( )
REPRESENTATIVE'S ADDRESS: *(ONLY IF APPLICABLE)*	

To report suspected fraud or abuse in the provision or receipt of IHSS services please call the fraud hotline 800-822-6222 or go to www.stopmedicalfraud@dhcs.ca.gov.

FOR AGENCY USE ONLY

INCOME ELIGIBLE:	STATUS ELIGIBLE:	VERIFICATION:	SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTATIVE:	TELEPHONE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO			( )
RECIPIENT STATUS: ☐ Refugee ☐ Cuban/Haitian Entrant			SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS *(EXPLAIN)*	

A. Ethnic Codes:

1. White
2. Hispanic
3. Black
4. Other Asian or Pacific Islander
5. American Indian or Alaskan Native
7. Filipino
C. Chinese
H. Cambodian
J. Japanese
K. Korean
M. Samoan
N. Asian Indian
P. Hawaiian
R. Guamanian
T. Laotian
V. Vietnamese

B. Language Codes:

O. American Sign Language (AMISLAN or ASL)
1. Spanish - NOA will be issued in Spanish
2. Cantonese
3. Japanese
4. Korean
5. Tagalog
6. Other non-English
7. English
9. Spanish - NOA will be issued in English
A. Other Sign Language
B. Mandarin
C. Other Chinese Languages
D. Cambodian
E. Armenian
F. Ilacano
G. Mien
H. Hmong
I. Lao
J. Turkish
K. Hebrew
L. French
M. Polish
N. Russian
P. Portuguese
Q. Italian
R. Arabic
S. Samoan
T. Thai
U. Farsi
V. Vietnamese

STATEMENT OF FACTS FOR IN-HOME SUPPORTIVE SERVICES

Note: *Your eligibility for In-Home Supportive Services (IHSS), under Welfare and Institutions Code Section 12300, will be determined by the information you provide on this form.*

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(1.) APPLICANT INFORMATION

NAME (FIRST, MIDDLE, LAST) | BIRTHDATE

HOME ADDRESS | CITY | ZIP CODE

MAILING ADDRESS (IF DIFFERENT) | HOME PHONE ( ) | MESSAGE PHONE ( )

PLACE OF BIRTH | SOCIAL SECURITY NUMBER | MEDI-CAL CARD NUMBER

ARE YOU:

☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

MARITAL STATUS: ☐ MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

☐ SINGLE (Date__/__/__) (Date__/__/__) (Date__/__/__) (Date__/__/__)

COMPLETE THE FOLLOWING:

NAME OF SPOUSE OR PARENT(S) *(IF YOU ARE UNDER 18 YEARS OF AGE)*

IS SPOUSE/PARENT(S):

☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

SPOUSE/PARENT(S) SOC. SEC. NO. | SPOUSE/PARENT(S) ADDRESS *(IF DIFFERENT THAN APPLICANT'S)*

(2.) **DO YOU RESIDE IN CALIFORNIA WITH THE INTENTION TO CONTINUE RESIDING HERE?** ☐ YES ☐ NO

(3.) ARE YOU A CITIZEN OF THE UNITED STATES? *(IF "YES", GO TO "ITEM 4")* ☐ YES ☐ NO

(A.) IF YOU ARE NOT A UNITED STATES CITIZEN, ARE YOU LAWFULLY ADMITTED TO PERMANENT RESIDENCE OR LEGALLY PERMITTED TO REMAIN IN THE U S.? ☐ YES ☐ NO

(B.) WHAT IS YOUR ALIEN REGISTRATION NUMBER?

(C.) WHAT IS NAME OF SPONSOR?

(D.) WHAT IS SPONSOR'S ADDRESS?

(4.) WHAT IS YOUR LIVING ARRANGEMENT?

MY HOME IS A: ☐ HOUSE ☐ APARTMENT ☐ ROOM ☐ ROOM & BOARD ☐ TRAILER/ MOTOR HOME ☐ OTHER

IN WHICH I: ☐ OWN/ AM BUYING ☐ RENT ☐ LIVE COST FREE ☐ RECEIVE BOARD AND CARE

LANDLORD'S NAME | AMOUNT OF RENT, BOARD AND/OR MORTGAGE PAID $_____/MONTH

ADDRESS | CITY | ZIP CODE

(5.) ARE THERE OTHERS LIVING IN THE HOUSEHOLD? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

NAME	RELATIONSHIP	AGE

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6. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN REAL PROPERTY OTHER THAN YOUR HOME? ☐ YES ☐ NO
(If "YES", GIVE THE INFORMATION BELOW: OR ON PAGE 4 PARAGRAPH 21.)

ADDRESS	CITY	COUNTY

STATE	ZIP CODE	PARCEL NUMBER

ASSESSED VALUE	TOTAL AMOUNT OWED ON MORTGAGE(S)	MONTHLY PAYMENT
$	$	$

ANNUAL TAXES	ANNUAL INSURANCE	ANNUAL ASSESSMENTS
$	$	$

HOW IS PROPERTY UTILIZED?	IF USED AS RENTAL, INDICATE AMOUNT OF RENT.	ARE TAXES INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO

OTHER PROPERTY EXPENSES	IS INSURANCE INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO

7. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN MOTOR VEHICLES (CARS, TRUCKS, MOTORCYCLES, BOATS, MOTORHOMES)? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

MAKE AND MODEL	YEAR	ESTIMATED VALUE	CHECK IF USED FOR WORK	CHECK IF USED FOR MEDICAL TRANS.	MODIFIED FOR DISABLED PERSON?

8. WHAT IS THE VALUE OF YOUR LIQUID RESOURCES?
(IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE RESOURCES OF PARENT(S) RESPONSIBLE FOR CHILD, INDICATE IF ANY RESOURCE IS EXCLUSIVELY FOR BURIAL EXPENSES FOR YOU OR YOUR IMMEDIATE FAMILY.)

LIQUID RESOURCES	(✓) IF NONE	ENTER VALUE UNDER OWNER: SELF	SPOUSE/PARENTS	JOINTLY	(✓) FOR BURIAL
CASH ON HAND AND/OR MONEY KEPT IN THE HOME		$	$	$	
CHECKING ACCOUNT		$	$	$	
SAVINGS ACCOUNT, CREDIT UNION TRUST FUNDS		$	$	$	
CHECKS OR CASH IN SAFETY DEPOSIT BOX		$	$	$	
STOCKS, BONDS, OR MUTUAL FUNDS NOTES, MORTGAGES, DEEDS		$	$	$	
IRA, CERTIFICATES OF DEPOSIT, MONEY MARKET		$	$	$	
OTHER *(SPECIFY)*:		$	$	$	

9. DO YOU, YOUR SPOUSE OR PARENT(S) (IF APPLICANT IS UNDER 18) HAVE ANY PERSONAL GOODS OR HOUSEHOLD EFFECTS WITH A COMBINED EQUITY VALUE OF MORE THAN $2,000? (E. G., HOUSEHOLD FURNISHINGS, CLOTHING, AND JEWELRY.) *(IF ADDITIONAL SPACE IS NEEDED, SPECIFY IN ITEM 21.)* ☐ YES ☐ NO
(IF "YES", GIVE INFORMATION BELOW:) (EXCLUDE REHABILITATION DEVICES AND EQUIPMENT.)

DESCRIPTION	CURRENT MARKET VALUE	AMOUNT OWED
A.	$	$
B.	$	$
C.	$	$

10. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY LIFE INSURANCE? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

NAME OF OWNER	NAME OF INSURED	NAME AND ADDRESS OF INSURANCE COMPANY

POLICY NUMBER	TOTAL FACE VALUE OF POLICY	CASH SURRENDER VALUE	WHEN WAS THE POLICY PURCHASED	IF THERE IS A LOAN AGAINST THE POLICY WHAT IS THE AMOUNT

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(11.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BURIAL FUNDS, INSURANCE, TRUSTS, SPACES OR CONTRACTS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

OWNER OF EACH ITEM	NAME OF EACH ITEM	TOTAL PURCHASE VALUE OF EACH ITEM	HOW MUCH IS OWED ON EACH ITEM	NAME AND ADDRESS OF COMPANY/SOURCE
			$	
			$	

(12.) HAVE YOU, YOUR SPOUSE OR PARENT(S) (IF A MINOR IS APPLYING) SOLD, TRANSFERRED OR GIVEN AWAY ANY PROPERTY, INCLUDING MONEY, IN THE LAST 36 MONTHS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	DATE OF TRANSFER	ESTIMATED VALUE	AMOUNT RECEIVED
		$	$
		$	$

(13.) ARE YOU OR YOUR SPOUSE EMPLOYED OR SELF-EMPLOYED? *(IF "YES", GIVE THE INFORMATION BELOW:) (IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER 18 INCLUDE EMPLOYMENT OF PARENT(S).)* ☐ YES ☐ NO

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	
OCCUPATION	GROSS SALARY PER PAY PERIOD $	HOW OFTEN PAID?

IF SELF-EMPLOYED, ATTACH VERIFICATION OF ALL ORDINARY AND NECESSARY BUSINESS EXPENSES, PRINCIPAL PAYMENTS OR ENCUMBRANCES AND PERSONAL INCOME TAX.

(14.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BUSINESS EQUIPMENT INVENTORY, OR MATERIAL? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	PURPOSE	ESTIMATED VALUE	AMOUNT OWED
		$	$
		$	$

(15.) IF YOU ARE BLIND OR DISABLED AND WORKING, DO YOU HAVE ANY WORK-RELATED EXPENSES DUE TO BLINDNESS OR DISABILITY? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

COST OF TRANSPORTATION TO AND FROM WORK	COST OF ITEMS OR SERVICES TO PREPARE FOR WORK	COST OF ITEMS OR SERVICES NEEDED FOR JOB PERFORMANCE
$	$	$

(16.) LIST INCOME RECEIVED EACH MONTH FROM SOURCES OTHER THAN EMPLOYMENT. IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE INCOME OF PARENT(S) RESPONSIBLE FOR CHILD.

TYPE OF INCOME	(✓) NONE	ENTER MONTHLY AMOUNT RECEIVED BY: SELF	SPOUSE/PARENT(S)	CLAIM NUMBER
A. SOCIAL SECURITY *(RETIREMENT, SURVIVOR, DISABILITY INSURANCE)*		$	$	
B. CASH CONTRIBUTIONS		$	$	
C. STATE DISABILITY/ UNEMPLOYMENT INSURANCE		$	$	
D. VETERAN'S PENSION/COMPENSATION		$	$	
E. V.A. AID AND ATTENDANCE CARE/ HOUSEBOUND ALLOWANCE		$	$	
F. GOVERNMENT PENSION		$	$	
G. PRIVATE AND/OR MILITARY RETIREMENT PENSION		$	$	
H. ALIMONY, CHILD SUPPORT		$	$	
I. RENTAL INCOME		$	$	
J. INTEREST, DIVIDENDS, ROYALTIES		$	$	
K. RAILROAD RETIREMENT PENSION		$	$	
L. WORKER'S COMPENSATION		$	$	
M. AFDC PAYMENTS		$	$	
N. OTHER: *(SPECIFY)*		$	$	

17. HAVE YOU, YOUR SPOUSE OR YOUR PARENT(S) APPLIED FOR OR DO YOU EXPECT TO START RECEIVING INCOME FROM ANY OF THE SOURCES LISTED IN "ITEM 16"? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

TYPE OF INCOME	PLACE APPLIED	DATE APPLIED	DATE EXPECTED

18. HAVE YOU, YOUR SPOUSE OR YOUR PARENTS HAD MEDICAL EXPENSES WITHIN THE LAST 3 MONTHS AND WANT MEDI-CAL FOR THOSE EXPENSES? ☐ YES ☐ NO

19. (A.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE ANY NON-CASH GIFTS OR CONTRIBUTIONS OF RENT, FOOD, CLOTHING OR OTHER ITEMS OF NEED? ☐ YES ☐ NO

(B.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE NON-CASH COMPENSATION IN RETURN FOR WORK? ☐ YES ☐ NO
(IF "YES" TO "(A)" OR "(B)", GIVE THE INFORMATION BELOW:)

ITEM CONTRIBUTED	FREQUENCY OF RECEIPT	CASH EQUIVALENT
		$
		$

20. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE HEALTH OR HOSPITALIZATION INSURANCE (INCLUDING PAID BY AN EMPLOYER)? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

INSURANCE CARRIER (CHECK APPLICABLE(S))	PERSON(S) INSURED
☐ MEDICARE *(CLAIM NO.*)	
☐ CHAMPUS	
☐ VETERAN'S ADMINISTRATION COVERAGE	
☐ KAISER	
☐ ROSS–LOOS	
☐ BLUE SHIELD	
☐ BLUE CROSS	
☐ PREPAID HEALTH PLAN	
☐ HEALTH MAINTENANCE ORGANIZATION *(SPECIFY:*)	
☐ OTHER CARRIER *(SPECIFY:*)	

21.

ITEM NUMBER	ADDITIONAL INFORMATION (ATTACH ADDITIONAL SHEETS IF NECESSARY)

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EXPECTED INCOME
How Verified:
a. _____
b. _____
c. _____

IN-KIND INCOME
30-775.11
How Verified: _____

PREMIUM PAYMENTS
Amount Paid: $ _____
How often: _____
How Verified: _____

SOC 310 VERIFICATION
☐ ELIGIBLE ☐ INELIGIBLE
REASON (IF INELIGIBLE):

SOCIAL SERVICE WORKER:

DATE:

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I HEREBY STATE BY MY SIGNATURE THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

I AGREE TO TELL THE COUNTY DEPARTMENT OF SOCIAL SERVICES WITHIN 10 DAYS IF THERE ARE ANY CHANGES IN MY INCOME, POSSESSIONS, OR EXPENSES, OR IN THE NUMBER OF PERSONS IN MY HOUSEHOLD, OR IF ANY CHANGE OF ADDRESS, AND I AGREE TO MEET ALL OTHER RESPONSIBILITIES EXPLAINED IN THE "MEDI-CAL RESPONSIBILITIES CHECKLIST" I HAVE RECEIVED.

I UNDERSTAND THAT I MAY BE ASKED TO PROVE MY STATEMENTS, BUT THAT THE COUNTY IS REQUIRED BY LAW TO KEEP THEM CONFIDENTIAL.

I UNDERSTAND THAT IF I AM DISSATISFIED WITH ANY ACTIONS TAKEN BY THE COUNTY DEPARTMENT OF SOCIAL SERVICES, I HAVE THE RIGHT TO A STATE HEARING.

I UNDERSTAND THAT I MUST DISPOSE OF ANY EXCESS RESOURCES WITHIN A SIX-MONTH PERIOD IN THE CASE OF REAL PROPERTY AND WITHIN THREE MONTHS IN THE CASE OF PERSONAL PROPERTY AND REPAY ANY OVERPAYMENTS WITH THE PROCEEDS OF THE DISPOSED PROPERTY.

I UNDERSTAND THAT IF I AM ELIGIBLE FOR IHSS SERVICES, I WILL BE PROVIDED A MEDI-CAL CARD AT NO SHARE-OF-COST TO ME IF I PAY THE IHSS SHARE OF COST I AM OBLIGATED TO PAY.

I UNDERSTAND THAT FEDERAL AND STATE LAW REQUIRE THE RECOVERY OF ALL MEDI-CAL BENEFITS RECEIVED AFTER AGE 55 FROM THE ESTATE OF A MEDI-CAL BENEFICIARY IF THERE IS NO SURVIVING SPOUSE, MINOR CHILDREN, OR PERMANENTLY AND TOTALLY DISABLED CHILDREN.

I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF WITNESS *(REQUIRED IF APPLICANT SIGNED BY MARK)*	DATE
SIGNATURE OF PERSON ACTING FOR APPLICANT (RELATIONSHIP: PARENT, GUARDIAN, CONSERVATOR)	DATE	SIGNATURE OF PERSON HELPING APPLICANT COMPLETE FORM	DATE

FORM SAMPLES

CASE MANAGEMENT, INFORMATION, AND PAYROLLING (CMIPS)

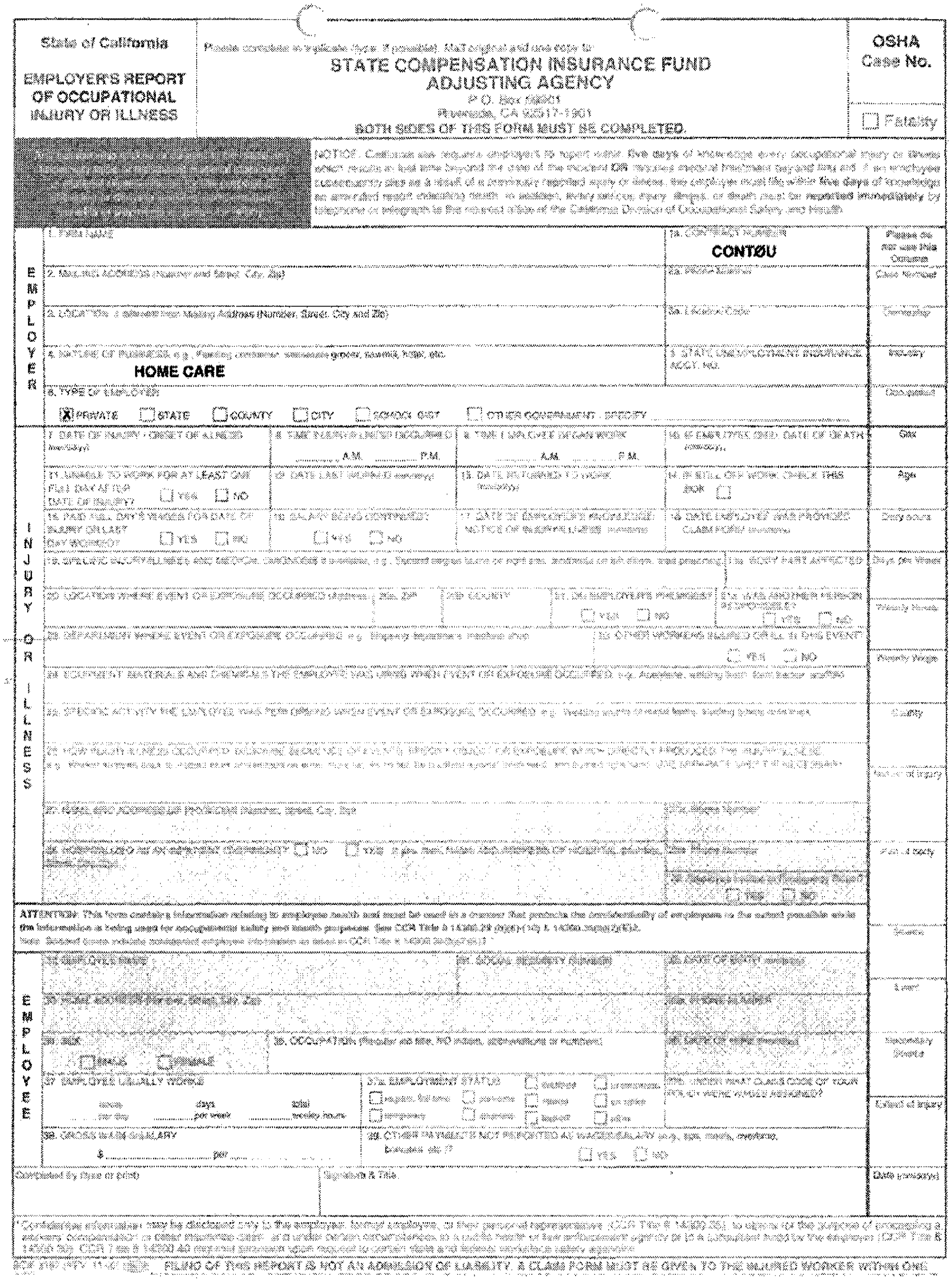


Fig. XIII-G- 3 – SCIF 3167

New Employee's Guide to

Workers' Compensation

Helpful information you should know if you are injured on the job or become ill due to your job.

Questions and Answers

What is workers' compensation?

At no cost to you, it is insurance that the law requires your employer to carry to help you if you are injured on the job or if you become ill due to your job.

What is a workers' compensation injury or illness?

An injury or illness that occurs due to employment is considered a workers' compensation injury or illness. Under workers' compensation law, you will receive help if you are injured, no matter who was at fault.

Workers' compensation covers various types of events, injuries, and illnesses. You could get hurt by one event at work, such as hurting your back in a fall, or by repeated exposures at work, such as hurting your wrist from doing the same motion over and over.

What is State Compensation Insurance Fund?

We are the insurance carrier your employer has chosen to provide its workers' compensation coverage. We have more than 95 years of experience providing workers' compensation throughout California.

Is workers' compensation the same as State Disability Insurance?

No. Workers' compensation is only for injuries or illnesses that occur due to employment. State Disability Insurance (SDI) is for injuries or illnesses that are not work-related, and it is a benefit that the Employment Development Department provides.

How does this coverage affect my own health insurance?

Workers' compensation is separate from personal health-care insurance. Workers' compensation insurance covers work-related injuries and illnesses only. There is no deductible—the insurance carrier pays all approved medical bills. It is important to let the treating doctor know if your injury is work-related.

How do I file a claim?

If you are injured on the job, as soon as you can, tell your supervisor that you have been hurt. Except for first-aid injuries, your employer will provide you with a claim form on which you can describe your injury, as well as how, when, and where it occurred. Return the completed form to your employer, who will send it to us. We will then contact you to explain the benefits to which you may be entitled.

What are my benefits and rights?

Within one day after an employee files a claim form, the law requires the employer to authorize medical treatment as required and limited by the law, until the claim is accepted or rejected, up to a limit of $10,000 in total. All medical treatment is provided in accordance with the medical treatment utilization schedule.

If State Fund accepts your claim, State Fund will pay all approved medical care that is reasonable, necessary, and supported by evidence-based treatment guidelines. This care may include doctors, hospital services, physical therapy, lab tests, x-rays, medicines, and related reasonable transportation expenses.

For injuries on or after January 1, 2004, there are limits on the number of chiropractic, occupational therapy, and physical therapy visits. These limits do not apply to visits after a surgery when they are based on a postsurgical treatment utilization schedule established by the administrative director (AD).

State Fund pays for all authorized treatment, so you should not receive any bills. The law states that you are not responsible for copayments or balance-due bills after we have paid the provider. If you receive any bills, or a medical provider or pharmacy demands payment up-front, contact your claims representative right away to direct you elsewhere.

We will also pay a portion of your lost wages if you cannot work due to the injury. This benefit is called temporary disability. If your injury or illness results in a permanent impairment that diminishes your future earning capacity, we will also pay you permanent disability benefits. In the event of a work-related death, we will pay death benefits to your qualified surviving dependents.

As of January 1, 2004, the Labor Code allows State Fund to review medical-treatment requests from your physician through a utilization review (UR) process. This

review process involves doctors and other health consultants reviewing your medical-treatment needs by following medical-treatment guidelines approved by the administrative director of the Division of Workers' Compensation (DWC). There are time limits to approve, modify, delay, or deny treatment requests from your physician.

How is temporary disability calculated?

The weekly temporary disability rate is two-thirds of your average weekly earnings, subject to minimum and maximum amounts that are determined by law. For injuries on or after January 1, 2007, the minimum and maximum temporary disability rates will increase to reflect the percentage increase in the state average weekly wage (published annually by the U.S. Department of Labor).

We recalculate temporary disability payments made two or more years after the injury to reflect the rates in effect at the time of payment.

When does temporary disability start and stop?

If you are unable to work for more than three calendar days, we will pay you temporary disability. This three-day "waiting period" will qualify for payment as of the fourth day of medically authorized lost time from work when you are unable to work for more than 14 calendar days, or if you are hospitalized as an inpatient. You will receive temporary disability (TD) payments every two weeks during the time you qualify for this benefit. Generally, temporary disability stops when you return to work, or when the treating physician releases you for work or says that your injury has reached a point of maximum improvement. For dates of injury on or after January 1, 2008, no TD will be paid beyond 104 compensable weeks within a period of five years from the date of injury. (Exempt are certain injuries that typically take longer to heal; they are subject to a cap of 240 weeks within a five-year period.) After the termination of the 104 weeks of TD payments, a timely Employment Development Department filing may result in your qualifying for additional state disability benefits.

How is permanent disability calculated and paid?

Your examining physician will report on any permanent impairment that may be considered a permanent disability. Under workers' compensation law, a permanent disability rating involves the use of a specialized formula. This formula considers your age and occupation at the time of your injury or illness, diminished future earning capacity, plus any permanent impairments that the examining physician may indicate. The permanent disability rating yields a specific dollar amount. The exact amount depends on the date of injury, the percentage of disability, and your average weekly earnings at the time of injury. Once permanent disability payments begin, you receive payments every two weeks at your permanent disability rate.

This rate is equal to two-thirds of your average weekly wages at the time of injury, subject to the established minimum and maximum rates. The following table lists the maximum permanent disability payments for each percentage range.

Maximum Permanent Disability Payments

Rating	For injuries on or after 1/1/06
Up to 14.75%	$230
15% to 24.75%	$230
25% to 69.75%	$230
70% to 99.75%	$270
Minimum per week	$130

When does permanent disability start and stop?

Generally, if we accept your claim and your treating physician has determined that you have permanent disability, payments begin within 14 days after the termination of temporary disability. If we know the extent of your permanent disability, we will continue the payments every two weeks until we have paid the full benefit. If we do not know the extent of your permanent disability, payments will continue every two weeks until we have paid a reasonable estimate of your permanent disability indemnity due.

How are death benefits calculated and paid?

The total death benefit depends on the number of surviving partial and total dependents at the time of injury or illness resulting in death. Once we determine the dependency, we pay the death benefit in installments at the decedent's temporary disability rate. However, the rate must be no less than $224 per week until we have paid the total death benefit, or, if dependency involves a minor child, until the minor child is 18 years old. For injuries on or after January 1, 2003, benefits will be paid to a dependent child for life when physically or mentally incapacitated from earning. The next table shows the distribution of maximum death benefits.

Death Benefit Maximums

	For injuries on or after 1/1/06
Single total dependent	$250,000
No total dependents and one or more partial dependents	$250,000
Single total dependent and one or more partial dependents	$290,000
Two total dependents	$290,000
Three or more total dependents	$320,000

What is the role and function of the primary treating physician?

Your treating doctor will decide what type of medical care you'll get for your injury or illness, determine when you can return to work, help identify the kinds of work you can do safely while recovering, refer you to specialists, if necessary, and write medical reports that will affect the benefits you receive.

Where do I get medical treatment?

If your injury or illness is due to employment, the State Fund Medical Provider Network will provide authorized medical treatment.

What is the State Fund Medical Provider Network?

State Fund's Medical Provider Network (MPN) is comprised of a group of physicians and other medical service providers in California, some who primarily treat occupational injuries and other providers who specialize in general areas of medicine. If necessary, the MPN will provide specialists to treat your injury or illness.

If your injury or illness is due to employment, the State Fund MPN physicians and other medical providers will provide authorized medical treatment. These medical providers will provide quality medical treatment based on the utilization schedule developed by the administrative director of the Division of Workers' Compensation (DWC).

To meet medical access standards, an MPN must have at least three physicians of each specialty expected to treat common injuries experienced by injured employees on the basis of the type of occupation or industry in which the employee is employed. An MPN must have a primary treating physician and a hospital for emergency health-care services or a provider of all emergency health-care services within 30 minutes or 15 miles of each covered employee's residence or workplace. An MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of a covered employee's residence or workplace.

How do I get medical treatment?

After you file a claim, your employer will refer you to an MPN facility for initial treatment within three business days for non-emergency services.

If you are temporarily working outside the geographical service area of the Medical Provider Network, and you are injured on the job, you should seek emergency treatment at the nearest emergency room. If you are injured on the job, but it is not an emergency, you should notify your adjuster, State Fund's Claims Reporting Center, or your primary treating physician. You must contact State Fund or your employer if additional treatment is needed, and continue authorized treatment with an available MPN physician.

How do I get emergency medical treatment?

If it's a medical emergency, call 911 or go to an emergency room right away. Your employer may advise you where to go for treatment. Tell the health-care provider who treats you that your injury or illness is job-related, and, if possible, give your employer's workers' compensation carrier information.

Can I change my doctor?

Yes, after the initial medical evaluation with an MPN doctor, you have the right to choose another primary treating physician or subsequent physician from the MPN.

How do I choose a doctor?

You may obtain a regional-area listing of MPN doctors by going to MEDfinder MPN at www.statefundca.com. You may also obtain a regional-area listing by calling or sending a written request to your claims adjuster, if one has been assigned to you, or by calling State Fund at 888-STATEFUND. If you wish to obtain a complete hard-copy list of all MPN providers, contact the State Fund MPN by sending an e-mail to scifmpn@scif.com, or by calling (866) 436-0204, or by sending a written request to:

State Compensation Insurance Fund
Attention: State Fund Medical Provider Network
900 Corporate Center Dr.
Monterey Park, CA 91754

After you receive a regional-area listing of MPN doctors, you may select a treating doctor (or any subsequent doctor) on the basis of the physician's specialty or recognized expertise in treating your particular injury or condition.

If there are less than three primary treating physicians within 15 miles of your location in a specialty appropriate to treat your injury, you may choose your own doctor or provider outside the MPN network. For assistance, you may contact your adjuster, if one has been assigned to you, or the State Fund Claims Reporting Center.

Am I able to predesignate a personal physician?

Yes, provided that you have predesignated the doctor or a multispecialty medical group of licensed doctors of medicine or osteopathy (MDs or DOs) that provides comprehensive medical services primarily for nonoccupational injuries and illness before you are injured and your employer offers group health coverage (HMO/PPO/HCO). Your predesignated physician must meet the following requirements:

- Must be your regular physician.
- Must be your primary care physician or your physician's integrated multispecialty medical group.

- Must be licensed per Business & Professions Code.
- Must have previously provided you treatment.
- Retains your medical records, including medical history.
- Agrees to be your predesignated physician.

To predesignate, you must give your employer the name and address of your physician or your physician's integrated multispecialty medical group *in writing*, before you are injured.

If you do not predesignate, your employer will arrange your initial treatment with a physician within the MPN. After this initial treatment, you will be able to choose your physician within the MPN.

Can I predesignate a personal chiropractor or acupuncturist?

No. But if the MPN is not applicable, and you have identified a personal chiropractor or acupuncturist in writing prior to the date of your injury, you may request a change from the employer's physician to your personal chiropractor or acupuncturist. This request for a change of physician may be made at any time after the initial treatment provided by your employer.

What do I do if I disagree with my doctor's diagnosis or treatment?

It is your responsibility to advise your adjuster of the dispute and request a second opinion. You will need to select a doctor or specialist from the list of MPN providers. You need to make an appointment with the selected doctor within 60 days. If you do not make the appointment within the 60-day period, you will not be allowed to have a second opinion with regard to this disputed diagnosis or treatment by this treating physician. (For more details on this MPN process, see *Employee's Guide to the State Fund Medical Provider Network*, form 13176.)

How can I return to work as soon as possible?

To help you return to work as soon as possible, you should actively communicate with your treating doctor, claims representative, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

May I file a workers' compensation claim if an injury occurs outside of work?

Your employer or your employer's carrier may not be liable for the payment of workers' compensation benefits for an injury resulting from your voluntary participation in any off-duty recreational, social, or athletic activity that is not part of your work-related duties.

Note: Workers' compensation fraud laws make it a felony for anyone to file a false or fraudulent statement or to submit a false report or any other document for the purpose of obtaining or denying workers' compensation benefits. Anyone caught performing these illegal acts will be prosecuted. If convicted, the penalty is up to five years in prison or a fine of up to $150,000 or double the value of the fraud, whichever is greater, or both imprisonment and fine. Restitution and other penalties may also apply.

What if I have a recurrence and require further medical care?

If you need more medical care for your injury after your original treatment has ended, you have one full year after your last treatment to notify us of your request for more medical care.

What if I have to change my line of work because of a workers' compensation injury?

For injuries on or after January 1, 2004, if your injury results in permanent disability, and you are unable to return to work within 60 days after the last payment of temporary disability, and your employer does not offer modified or alternative work, a nontransferable voucher for education-related costs is payable to a state-approved school. The voucher can be up to $10,000 depending on the level of your permanent disability. This benefit is called a Supplemental Job Displacement Benefit (SJDB). The following table shows the specific ranges of the benefit.

Supplemental Job Displacement Benefits (SJDB)

Permanent Disability Level	SJDB Voucher Amount
Less than 15%	Up to $4,000
15% to 25%	Up to $6,000
26% to 49%	Up to $8,000
50% to 99%	Up to $10,000

What protects me from discrimination for filing a workers' compensation claim?

It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or for testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state. If you believe you have experienced discrimination because of your injury, you should discuss your rights with an information and assistance officer of the DWC or with an attorney.

What if I have not received the benefits that I think should have?

If you have not received the benefits you think you should have, ask for an explanation from your State Fund claims representative. Misunderstandings and errors sometimes do occur, but you can resolve most of them by talking with your claims representative. If you are not satisfied with your claims representative's answers, you have several options. You have the right to consult with and be represented by an attorney. You can consult with an information and assistance officer of the DWC. You can also file an Application for Adjudication of Claim with the Workers' Compensation Appeals Board (WCAB) to resolve your claim formally. The information and assistance officer can help you file the Application for Adjudication of Claim.

Are there time limits for filing a claim?

Yes. Generally, the law requires you to provide your employer with notice of your injury within 30 days of the date of injury. In addition, should you disagree with any of our actions, in order to protect your rights you must commence proceedings before the WCAB by filing an Application for Adjudication of Claim within one year of the date of injury, or one year from the last furnishing of indemnity or medical-treatment benefits by your employer or State Fund. It is very important that you act promptly so as not to risk losing your benefits because you waited too long.

DIVISION OF WORKERS' COMPENSATION
INFORMATION AND ASSISTANCE OFFICERS

ANAHEIM	714/414-1801	RIVERSIDE	951/782-4347
BAKERSFIELD	661/395-2514	SACRAMENTO	916/928-3158
EUREKA	707/441-5723	SALINAS	831/443-3058
FRESNO	559/445-5355	SAN BERNARDINO	909/383-4522
GOLETA	805/968-4158	SAN DIEGO	619/767-2082
LONG BEACH	562/590-5240	SAN FRANCISCO	415/703-5020
LOS ANGELES	213/576-7389	SAN JOSE	408/277-1292
MARINA DEL REY	310/482-3820	SAN LUIS OBISPO	805/596-4159
OAKLAND	510/622-2861	SANTA ANA	714/558-4597
OXNARD	805/485-3528	SANTA ROSA	707/576-2452
POMONA	909/623-8568	STOCKTON	209/948-7980
REDDING	530/225-2047	VAN NUYS	818/901-5367

(800) 736-7401 (Recorded information only)

This pamphlet has been approved by the administrative director of the Division of Workers' Compensation.

Customer Contact Center

Policy Services

1-888-STATE FUND

(888) 782-8338 toll free

Claims Reporting Center

(888) 222-3211 toll-free

STATE COMPENSATION INSURANCE FUND

www.statefundca.com

To our policyholders:

California law requires employers to provide a form on which employees may indicate the name of their personal physician or personal chiropractor. The form must be provided to new hires either at the time the employee is hired or by the end of the first pay period.

This form is available from your State Fund representative at no cost to you. Keep a supply on hand. Document personnel records, indicating when this form was provided and when it was returned to you.

Employee's Predesignation of Personal Physician Form

- In order for an employee to predesignate a personal physician, the employer must offer group health insurance.
- The employee may use the predesignation of personal physician form to name a medical doctor or doctor of osteopathic medicine or the personal physician's integrated multispecialty medical group if all other requirements are met.
- The physician is not required to sign this form, but in lieu of a signature, other documentation of the physician's agreement is required.

For the employee:

If I am injured on the job, I wish to be treated by my personal physician or my personal physician's integrated multispecialty medical group, who meets all the following requirements: (1) is my regular physician; (2) is my primary care physician or integrated multispecialty medical group; (3) is licensed per Business & Professions Code; (4) has previously provided my treatment; (5) retains my records; (6) agrees to be my predesignated physician.

Or, I wish to be treated by my personal chiropractor or acupuncturist, who has treated me before and has my records. I understand my identification of a personal chiropractor or acupuncturist is allowed only if there is no medical provider network (MPN) applicable. If the MPN is not applicable, my personal chiropractor or acupuncturist may treat my injury during the first 30 days of the employer's medical control, but I must first be evaluated by my employer's physician before I may request a change to my personal chiropractor or acupuncturist.

EMPLOYEE'S INFORMATION:

NAME

ADDRESS

CITY STATE ZIP

YOUR DOCTOR'S INFORMATION:

NAME OF DOCTOR AND/OR NAME OF PERSONAL PHYSICIAN'S MULTISPECIALTY MEDICAL GROUP

ADDRESS

CITY STATE ZIP

PHONE

DOCTOR'S SIGNATURE

EMPLOYEE'S SIGNATURE DATE

Guía Para Nuevos Empleados

Sobre La Compensación

A Los Trabajadores

Información útil en caso de que sufra alguna lesión en el trabajo o se enferme a causa de su trabajo.

Preguntas y Respuestas

¿Qué es la compensación a los trabajadores?

Es un seguro que su empleador debe contratar, por ley y sin ningún costo para usted, para ayudarlo en caso de que sufra alguna lesión en el trabajo o se enferme a causa de su trabajo.

¿Qué es una enfermedad o lesión susceptible de compensación a los trabajadores?

Toda lesión o enfermedad causada por el trabajo es considerada lesión o enfermedad susceptible de compensación a los trabajadores. De acuerdo con la n legislación vigente en materia de compensación a los trabajadores, usted recibirá ayuda si sufre una lesión, independientemente de quién sea el culpable.

La compensación a los trabajadores cubre diferentes tipos de acontecimientos, lesiones y enfermedades. En el trabajo, usted puede lesionarse por un acontecimiento, (por ejemplo, lastimarse la espalda por una caída), o bien, por la reiteración de una determinada actividad, (por ejemplo, lastimarse la muñeca por la repetición constante de un movimiento).

¿Qué es State Compensation Insurance Fund?

Somos la compañía de seguros que ha elegido su empleador para suministrar la cobertura de compensación a los trabajadores. Contamos con más de 95 años de experiencia en el suministro de seguros por accidentes o enfermedades laborales en el estado de California.

¿Es la compensación a los trabajadores lo mismo que el Seguro Estatal por Incapacidad?

No. La compensación a los trabajadores es sólo para lesiones o enfermedades que ocurren debido al trabajo. El Seguro Estatal por Incapacidad (SDI) cubre lesiones o enfermedades que no están relacionadas con el trabajo. Es un beneficio que brinda el Departamento de Desarrollo del Empleo.

¿De qué manera afecta esta cobertura al seguro de salud?

La compensación a los trabajadores es independiente del seguro de salud personal. El seguro de compensación a los trabajadores sólo cubre lesiones y enfermedades relacionadas con el trabajo. No existe deducible, ya que la compañía de seguros paga todas las facturas médicas aprobadas. Es importante comunicar al médico tratante que su lesión está relacionada con el trabajo.

¿Cómo presento un reclamo?

Si se lesiona en el trabajo, comuníquele a su supervisor tan pronto como pueda que ha sufrido una lesión. Excepto en lesiones de primeros auxilios, su empleador le entregará un formulario de reclamos, en el que deberá describir su lesión y aclarar cómo, cuándo y dónde se produjo. Una vez completado el formulario, devuélvalo a su empleador para que nos lo envíe. Después nos pondremos en contacto con usted para explicarle sobre los beneficios a los cuales usted puede tener derecho.

¿Cuáles son mis derechos y beneficios?

Hasta tanto se acepte o rechace el reclamo, la legislación vigente obliga al empleador a autorizar tratamiento médico por un valor máximo de $10,000 en total dentro de las 24 horas posteriores a la presentación del formulario de reclamos, conforme a las disposiciones y limitaciones de la legislación. Todo tratamiento médico se realiza conforme a su correspondiente programa de utilización.

Si State Fund acepta su reclamo, pagará toda la atención médica aprobada que resulte razonable y necesaria y que esté sustentada por las pautas de tratamiento basadas en las pruebas. Esta atención puede incluir los gastos para médicos, servicios hospitalarios, terapia física, pruebas de laboratorios, radiografías, medicamentos y transporte relacionado.

En el caso de lesiones posteriores al 1ro de enero de 2004, existen restricciones en la cantidad de sesiones de terapia ocupacional, física y quiropráctica. Dichas restricciones no se aplican a sesiones después de una cirugía cuando están basadas en un programa de utilización postquirúrgica establecida por el direcor administrativo (AD).

State Fund pagará todo el tratamiento autorizado para que usted no reciba ninguna factura. La ley establece que usted no es responsable de las facturas con saldos pendientes o copagos después de que hayamos pagado al proveedor. Si recibe alguna factura o el proveedor de servicio de salud o de la farmacia le exige pago por adelantado, póngase en contacto de inmediato con el representante de reclamos para que lo derive a otro lugar.

También pagaremos parte del salario perdido si no puede trabajar debido a la lesión. Este beneficio se denomina discapacidad temporal (TD). Si su lesión o enfermedad ocasionara un problema permanente que redujera su capacidad de trabajo en el futuro, también le pagaremos beneficios por discapacidad permanente. Ante una muerte relacionada con el trabajo, pagaremos los beneficios garantizados en caso de muerte a las personas a su cargo que cumplan con los requisitos correspondientes.

A partir del 1ro de enero de 2004, el Código Laboral le permite a State Fund de revisar cada solicitud de tratamiento de su médico mediante el proceso denominado revisión de utilización (UR). Este proceso de revisión involucra a médicos y otros especialistas de la salud, que examinarán su necesidad de recibir tratamiento médico en función de pautas para tratamientos médicos aprobadas por el director administrativo del Division of Workers' Compensation (DWC). Existen plazos para aprobar, modificar, retrasar o rechazar las solicitudes de tratamiento de su médico.

¿Cómo se calcula la discapacidad temporal (TD)?

El coeficiente semanal de discapacidad temporal es dos tercios de sus ingresos medios semanales y está sujeto a cantidades mínimas y máximas determinadas por la ley. En el caso de lesiones posteriores al 1ro de enero de 2007, las tarifas de discapacidad temporal mínimas y máximas aumentarán para reflejas elporcentaje de aumento en el salario estatal semanal promedio (publicado anualmente por el Departamento de Trabajo de E.U.).

Nosotros volvemos a calcular los pagos por discapacidad temporal realizados en un período mínimo de dos años a partir de la lesión para que reflejen los coeficientes en vigencia en el momento del pago.

¿Cuándo comienza y cuándo finaliza la discapacidad temporal?

Si está imposibilitado de trabajar durante más de tres días consecutivos, le pagaremos por discapacidad temporal. Este "período de espera" de tres días le permitirá recibir el pago a partir del cuarto día de tiempo laboral perdido con autorización médica, si no puede trabajar durante más de 14 días consecutivos o si se lo debe hospitalizar. Recibirá pagos por discapacidad temporal cada dos semanas mientras reúna los requisitos para recibir este beneficio. Generalmente, la discapacidad temporal termina cuando regresa al trabajo o cuando el médico tratante permite que vuelva a trabajar o señala que su lesión ha alcanzado el punto de mejoramiento máximo. En caso de lesiones con fecha del 1ro de enero de 2008 o después, el TD no se pagará después de 104 semanas indemnizables dentro de un período de cinco años posteriores al pago inicial de dicho beneficio. (Quedan exceptuadas ciertas lesiones que demoran más tiempo en curarse. El límite máximo en estos casos es de 240 semanas dentro de un período de cinco años.) Luego del término de las 104 semanas de pagos TD, puede que oportunamente resulte un archivo del Departamento de Desarrollo de Empleo de su calificación para beneficios adicionales estatales de discapacidad.

¿Cómo se calcula y se paga la discapacidad permanente?

El médico que lo atiende informará todo problema permanente que pudiera considerarse discapacidad permanente. De acuerdo con la legislación vigente en materia de indemnizaciones por accidentes o enfermedades laborales, el cálculo de una discapacidad permanente requiere el uso de una fórmula especializada. Esta fórmula considera la edad y ocupación en el momento de la lesión o enfermedad y la reducción de la capacidad de trabajo en el futuro, además de todos los problemas permanentes que podría indicar el médico que lo revise. El cálculo de la discapacidad permanente da como resultado una cantidad específica de dólares. La cantidad exacta depende de la fecha de la lesión, el porcentaje de discapacidad y sus ingresos semanales medios en el momento de la lesión. Una vez iniciados los pagos, los recibirá cada dos semanas de acuerdo con su tasa de discapacidad permanente. Esta tasa equivale a dos tercios de su salario medio semanal en el momento de la lesión y está sujeto a los coeficientes mínimos y máximos establecidos. La siguiente tabla señala los pagos máximos por discapacidad permanente para cada rango de porcentajes.

Pago Máximo Por Discapacidad Permanente	
Clasificación	**Lesiones posteriores al 1/1/06**
Hasta 14.75%	$230
De 15% a 24.75%	$230
De 25% a 69.75%	$230
De 70% a 99.75%	$270
Mínimo por semana:	$130

¿Cuándo comienza y cuándo finaliza la discapacidad permanente?

Generalmente, si aceptamos su reclamo y su médico tratante ha determinado que usted padece de discapacidad permanente, los pagos comienzan dentro de los 14 días posteriores a la terminación de la dis-

capacidad temporal. Si conocemos la duración de su discapacidad permanente, continuaremos los pagos cada dos semanas hasta que hayamos abonado la totalidad del beneficio. Si no conocemos la duración de su discapacidad permanente, los pagos continuarán cada dos semanas hasta que hayamos pagado una tasa razonable en función de una valoración de la indemnización por discapacidad permanente.

¿Cómo se calculan y se pagan los beneficios en caso de muerte?

El beneficio total de muerte depende del número de sobrevivientes parciales y el número total de dependientes en el momento de la lesión o enfermedad resultante en la muerte. Una vez que determinemos quiénes son dependientes, pagaremos en plazos el beneficio en caso de muerte, de acuerdo con el coeficiente de discapacidad temporal del difunto. Sin embargo, la cantidad no será inferior a $224 por semana hasta que hayamos pagado el beneficio total en caso de muerte o, si la dependencia involucrara a un menor, hasta que haya cumplido los 18 años de edad. En el caso de lesiones posteriores al 1ro de enero de 2003, el niño dependiente recibirá los beneficios de por vida si tiene una discapacidad física o mental para trabajar en forma remunerada. La tabla siguiente muestra la distribución de los beneficios máximos garantizados en caso de muerte.

Beneficios Máximos En Caso De Muerte

	Lesiones posteriores al 1/1/06
Una persona totalmente dependiente	$250,000
Sin personas totalmente dependientes y una o más personas parcialment dependientes	$250,000
Una persona totalmente dependiente y una o más personas parcialmente dependientes	$290,000
Dos personas totalmente dependientes	$290,000
Tres o más personas totalmente dependientes	$320,000

¿Cuál es la función del médico tratante primario?

Su médico tratante decidirá qué tipo de atención médica recibirá por su lesión o enfermedad, determinará cuándo podrá regresar al trabajo, ayudará a identificar las clases de trabajo que usted puede realizar sin riesgos mientras se recupera, lo referirá a especialistas (en caso de ser necesario) y redactará informes médicos que condicionarán los beneficios que recibirá.

¿Dónde obtengo tratamiento médico?

Si su lesión o enfermedad se debe al trabajo, la State Fund Medical Provider Network le proporcionará tratamiento médico autorizado.

¿Qué es la State Fund Medical Provider Network?

La State Fund Medical Provider Network (MPN), utilizada de California, está conformada de un grupo de médicos y otros proveedores de servicios médicos en California, algunos de los cuales tratan lesiónes ocupacionales y otros proveedores que se especializan en áreas generales de la medicina. Si es necesario, la MPN proporcionará especialistas para tratar su lesión o enfermedad.

Si su lesión o enfermedad se debe al empleo, los médicos y otros proveedores de la MPN le brindarán tratamiento médico autorizado. Estos proveedores médicos proporcionarán tratamiento médico de calidad basado en el programa de utilización desarrollado por el director administrativo de la Division of Workers' Compensation (DWC).

Para cumplir los estándares de acceso médico, una MPN debe contar con un mínimo de tres médicos de cada especialidad esperada para tratar lesiones comunes experimentadas por empleados, con base en el tipo de ocupación o industria en la cual trabaja el empleado. Una MPN debe contar con un médico de atención primaria y un hospital para servicios de atención médica de emergencia, o un proveedor de todos los servicios de atención médica de emergencia a una distancia no mayor de 30 minutos o 15 millas de la residencia o lugar de trabajo de cada empleado cubierto. Una MPN debe tener proveedores de servicios y especialistas de salud ocupacional a una distancia no mayor de 60 minutos o 30 millas de la residencia o lugar de trabajo de cada empleado cubierto.

¿Cómo obtengo tratamiento médico?

Si no se trata de una emergencia, luego de que presente el reclamo, su empleador lo enviará a un centro de la MPN para el tratamiento inicial, dentro de los tres días hábiles siguientes. Si está trabajando temporalmente fuera del área geográfica de servicios de la Medical Provider Network y se lesiona en su trabajo, debe solicitar tratamiento de urgencia en la sala de emergencias más cercana. Si usted necesita tratamiento médico no de emergencia, debe comunicarse con su ajustador de reclamos, el Centro de Atención de Reclamos las 24 horas de State Fund, o su médico de atención primaria. Si es necesario un tratamiento adicional y continuar el tratamiento autorizado con un médico disponible de la MPN, deberá ponerse en contacto con State Fund o con su empleador.

¿Cómo obtengo tratamiento médico de emergencia?

En caso de emergencia médica, llame al 911 o diríjase a una sala de emergencias de inmediato. Su empleador puede sugerirle dónde acudir para recibir tratamiento. Comuníquele al médico que lo atienda que su lesión o enfermedad está relacionada con el trabajo y, si es posible, dele información acerca de la compañía de seguros a cargo de la compensación a los trabajadores de su empleador.

¿Puedo cambiar mi doctor?

Sí; después de la evaluación médica inicial con un doctor de la MPN, usted tiene el derecho a elegir a otro médico de atención primaria o médico subsecuente de la MPN.

¿Cómo elijo un doctor?

Usted puede obtener una lista regional de médicos de la red MPN mediante el buscador MEDfinder MPN en www.statefundca.com. También puede obtener una lista regional llamando al State Fund al 888-STATEFUND. Si usted desea obtener una copia de la lista completa de todos los proveedores de la MPN, comuníquese con la MPN de State Fund enviando un correo electrónico a scifmpn@scif.com, llamando al (866) 436-0204, o enviando una petición por escrito a:

State Compensation Insurance Fund
Attention: State Fund Medical Provider Network
900 Corporate Center Dr.
Monterey Park, CA 91754

Después de que reciba una lista de los doctores de la MPN en el área regional, usted puede seleccionar a un doctor que brinde tratamiento (o a cualquier doctor subsecuente) basado en la especialidad de éste o su experiencia reconocida en el tratamiento de su lesión o enfermedad particular.

Si existen menos de tres médicos de atención primaria dentro de un radio de 15 millas de donde usted se encuentre, que tengan la especialidad que usted selecciona, es posible que se le permita elegir a su propio medico o proveedor fuera de la red MPN. Comuníquese con su ajustador de reclamos, si es que se le ha asignado uno, o al Centro de Atención de Reclamos las 24 horas de State Fund para obtener ayuda.

¿Puedo previamente designar un médico personal?

Sí, siempre que previamente designe al médico o a un grupo médico de multiespecialidades de doctores titulados en medicina u osteopatía (MDs or DOs) que provean un servicio médico completo principalmente a lesiones que no sean adquiridas en el trabajo y enfermedades que se hayan presentado antes de la lesión, y su empleador le ofrezca cobertura médica de grupo (HMO/PPO/HCO). El médico designado por usted debe cumplir con los siguientes requisitos:

- Debe ser su médico de cabecera.
- Debe ser su médico de atención primaria o el grupo médico de multiespecialidades del médico.
- Debe tener licencia conforme al Código de Negocios y Profesiones.
- Tiene que haberle provisto tratamiento previamente.
- Conserva sus registros médicos, incluida la historia clínica.
- Está de acuerdo en ser su médico previamente designado.

Para designar previamente, usted debe darle a su empleador el nombre y dirección de su médico personal o su grupo personal de doctores de multiespecialidades médicas *por escrito*, antes de sufrir una lesión.

Si no designa previamente ningún médico, su empleador acordará su tratamiento inicial con un médico de la MPN. Luego de este tratamiento inicial, podrá elegir un médico de la MPN.

¿Puedo previamente designar un quiropráctico o acupunturista personal?

No. Sin embargo, si la MPN no correspondiera por algún motivo y usted hubiera designado por escrito un quiropráctico o acupunturista personal antes de la fecha de su lesión, puede solicitar que se sustituya el médico elegido por su empleador por el quiropráctico o acupunturista personal de su elección. La solicitud para cambiar de médico puede realizarse en cualquier momento después del tratamiento inicial suministrado por su empleador.

¿Qué debo hacer si no estoy de acuerdo con el diagnóstico o tratamiento de mi médico?

Es su responsabilidad notificar al mediador de la situación y solicitar una segunda opinión. Deberá seleccionar un médico o especialista de la lista de la MPN. Debe fijar una cita con el médico seleccionado dentro de los 60 días. Si no fija la cita en el período de 60 días, no se le permitirá obtener una segunda opinión con respecto a este diagnóstico o tratamiento por este médico tratante en disputa. (Para obtener más detalles sobre este proceso de la MPN, consulte la *Guía de Empleado para la State Fund Medical Provider Network*, la forma 13176).

¿Cómo puedo volver a trabajar lo antes posible?

Para ayudarlo a regresar a su trabajo lo antes posible, se debe comunicar en forma activa con el médico tratante, el representante de reclamos y el empleador para conocer los tipos de trabajo que puede realizar mientras se recupera. Ellos podrán coordinar esfuerzos para que pueda regresar y realizar una tarea modificada o bien pueda encargarse de otro trabajo acorde a su salud. Este trabajo nuevo o modificado podrá ser temporal o extenderse durante cierto tiempo, según la naturaleza de su lesión o enfermedad.

¿Puedo presentar un reclamo de compensación a los trabajadores si la lesión se produce fuera de mi trabajo?

El empleador puede quedar exento del pago de los beneficios de compensación a los trabajadores en el caso de lesiones que se produjeran por la participación voluntaria del empleado en actividades recreativas, sociales o deportivas fuera del horario laboral que no formasen parte de las tareas de su trabajo.

Nota: la legislación en materia de fraude en la compensación a los trabajadores considera delito grave presentar una declaración falsa o fraudulenta o enviar un informe o cualquier documento falso con el propósito de obtener o rechazar beneficios de compensación a los trabajadores. A los culpables de tales ilícitos se les iniciará un procedimiento criminal. Los culpables de tales delitos serán castigados con cinco años de prisión como máximo o con una multa $150,000 o le doble del valor del fraude (el monto que sea mayor) o bien, serán sancionados con ambas penas (prisión y multa). También pueden corresponder indemnizacines y otras sanciones.

¿Qué ocurre si los síntomas reaparecen y necesito continuar con la atención médica?

Si necesita más atención médica por su lesión una vez que ha terminado su tratamiento original, tiene un año entero a partir de su último tratamiento para notificarnos que necesita más atención médica.

¿Qué ocurre si debo modificar mi línea de trabajo debido a la lesión susceptible de compensación a los trabajadores?

En el caso de lesiones posteriores al 1ro de enero de 2004, si la lesión le produce una discapacidad permanente, no puede regresar a su trabajo dentro de los 60 días posteriores al último pago recibido por discapacidad temporal y su empleador no le ofrece un trabajo alternativo o modificado, se le otorgará un vale no transferible para cubrir costos relacionados con su educación, que será pagadero a una escuela con autorización estatal. El vale no podrá superar los $10,000 y dependerá del nivel de discapacidad permanente. Este beneficio se denomina Beneficio Complementario Por Sustitución De Trabajo (SJDB). La siguiente tabla muestra las escalas específicas del beneficio.

Beneficios Complementarios Por Sustitución De Trabajo (SJDB)	
Nivel de discapacidad permanente	**Monto del vale de SJDB**
Inferior al 15%	Hasta $4,000
De 15% a 25%	Hasta $6,000
De 26% a 49%	Hasta $8,000
De 50% a 99%	Hasta $10,000

¿Qué me protege contra la discriminación por presentar un reclamo de compensación a los trabajadores?

Es ilegal que su empleador lo sancione o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por prestar declaración en un caso de compensación a los trabajadores de un tercero. En caso de comprobarse alguna de estas infracciones, podrá recibir los salarios perdidos, la reincorporación al trabajo, beneficios adicionales y los costos y gastos hasta los límites establecidos por el estado. Si considera que ha sido discriminado a causa de su lesión, deberá analizar sus derechos con un funcionario de información y asistencia del Division of Workers' Compensation del estado o bien con un abogado.

¿Qué ocurre si no recibo los beneficios que considero que debo recibir?

Si no ha recibido los beneficios que considera que debería recibir, solicite una explicación al representante de reclamos de State Fund. A veces se producen malentendidos y errores, aunque podrá resolver la mayoría de ellos hablando con su representante de reclamos.

Si no queda satisfecho con las respuestas del representante de reclamos, cuenta con diversas opciones. Tiene el derecho de consultar y ser representado por un abogado. Puede consultar a un funcionario de información y asistencia de Division of Workers' Compensation. También puede presentar una solicitud de arbitraje de reclamo, denominada Application for Adjudication of Claim, ante el Workers' Compensation Appeals Board (WCAB), para resolver su reclamo formalmente. El funcionario de información y asistencia puede ayudarlo a presentar esta solicitud de reclamo.

¿Existe algún límite de tiempo para presentar un reclamo?

Sí. Según la ley, el plazo del que normalmente dispone para notificar la lesión al empleador es de 30 días a partir de la fecha de dicha lesión. Además, en caso de que no esté de acuerdo con alguna de nuestras medidas, para proteger sus derechos debe iniciar una demanda ante el Workers' Compensation Appeals Board presentando una solicitud de arbitraje de reclamo antes de cumplirse un año de la fecha de la lesión o de la última indemnización o beneficio de tratamiento médico que le haya proporcionado su empleador o State Fund. Es muy importante actuar de inmediato para no arriesgarse a perder los beneficios por demorarse demasiado.

DIVISION OF WORKERS' COMPENSATION
FUNCIONARIOS DE INFORMACIÓN Y ASISTENCIA

ANAHEIM	714/414-1801	RIVERSIDE	951/782-4347
BAKERSFIELD	661/395-2514	SACRAMENTO	916/928-3158
EUREKA	707/441-5723	SALINAS	831/443-3058
FRESNO	559/445-5355	SAN BERNARDINO	909/383-4522
GOLETA	805/968-4158	SAN DIEGO	619/767-2082
LONG BEACH	562/590-5240	SAN FRANCISCO	415/703-5020
LOS ANGELES	213/576-7389	SAN JOSE	408/277-1292
MARINA DEL REY	310/482-3820	SAN LUIS OBISPO	805/596-4159
OAKLAND	510/622-2861	SANTA ANA	714/558-4597
OXNARD	805/485-3528	SANTA ROSA	707/576-2452
POMONA	909/623-8568	STOCKTON	209/948-7980
REDDING	530/225-2047	VAN NUYS	818/901-5367

(800) 736-7401 (Sólo información grabada)

Este folleto ha sido aprobado por el director administrativo del Division of Workers' Compensation (DWC).

Centro de Contacto al Cliente

Servicios de Pólizas

1-888-STATE FUND

(888) 782-8338 línea gratuita

Centro de Atención de Reclamos

(888) 222-3211 línea gratuita

www.statefundca.com

A nuestros asegurados:

La legislación del Estado de California obliga a los empleadores a suministrar un formulario en el que los empleados pueden indicar el nombre de su médico personal o de su acupunturista o quiropráctico personal. El formulario debe entregarse al nuevo empleado en el momento de la contratación o al finalizar el primer período de pago.

Un representante del State Fund le entregará este formulario sin costo alguno. Siempre tenga formularios a la mano. Documente los registros personales, indicando cuándo se le entregó este formulario y cuándo se le ha devuelto.

Formulario de Designación Previa del Médico Personal del Empleado

- Para que un empleado pueda previamente designar su médico personal, el empleador debe ofrecer seguro médico de grupo.
- Si se han cumplido todos los otros requerimientos, el empleado puede utilizar el formulario de designación previa del médico personal para nombrar a un doctor médico o un doctor de medicina osteopática o el grupo de médicos de multiespecialidades integradas de su médico personal.
- No se requiere la firma del médico en este formulario, pero en lugar de una firma, otra documentación del acuerdo del médico es requerida.

Para el empleado:

Si me lesiono en el trabajo, deseo que me atienda mi doctor personal o el grupo de médicos de multiespecialidades integradas de mi doctor personal, quien llena todos los siguientes requisitos: 1) Es mi médico regular; 2) Es mi médico primario de cuidado o grupo médico de multiespecialidades; 3) Tiene una licencia de aprobación del Business & Professions Code; 4) Me ha proporcionado tratamiento médico anteriormente; 5) Tiene y mantiene mi historial médico; 6) Acepta ser mi médico designado.

Ó, deseo que me atienda mi quiropráctico o acupunturista personal, quien es el que me ha atendido anteriormente y tiene mi historial. Estoy por entendido que identificar a un quiropráctico o acupunturista solamente es permitido cuando la medical provider network (MPN) no es aplicable. Si la MPN no aplica, mi quiropráctico o acupunturista personal podrá ofrecerme tratamiento durante los primeros 30 días del control médico del empleador, pero un doctor asignado por mi empleador deberá examinarme primero antes de solicitar que me cambien a mi quiropráctico o acupunturista personal.

INFORMACIÓN DEL EMPLEADO:

NOMBRE

DIRECCIÓN

CIUDAD ESTADO CÓDIGO POSTAL

INFORMACIÓN DE SU DOCTOR:

NOMBRE DEL DOCTOR Y/O EL NOMBRE DE GRUPO DE MÉDICOS DE MULTIESPECIALIDADES INTEGRADAS DE SU DOCTOR PERSONAL

DIRECCIÓN

CIUDAD: ESTADO CÓDIGO POSTAL

TELÉFONO

FIRMA DEL DOCTOR

FIRMA DE EMPLEADO FECHA

State of California-Health & Welfare Agency-
Department of Social Services

IN-HOME SUPPORTIVE SERVICES

PROVIDER ELIGIBILITY UPDATE

A

COUNTY	RECIPIENT #	CD.	PROVIDER NUMBER	SEQ. #	RECIPIENT NAME
(1)			(2)	(3)	(4)

B

LAST NAME	FIRST NAME	MI.	STATUS	ETHNIC	LANG.
(1)	(2)	(3)	(4) E L D X	(5)	(6)

C

STREET	CITY	STATE	ZIP CODE/CT
(1)	(2)	(3)	(4)

D

SOCIAL SECURITY #	DED./EXEMPT	TELEPHONE #	SEX	BIRTHDATE MONTH DAY YEAR	W-5	W-4
(1)	(2) P S C B O	(3)	(4) M F	(5)	(6)	(7)

E

COUNTY USE	REL. OF PROV.	# OF PROV.	RECOVERY
(1)	(2)	(3)	(4)

F, G, H

	ACTION	BEGINNING DATE	ENDING DATE	HOURS	SHARE/COST	RATE	SPLIT SHIFT	
F	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)
G	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)
H	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)

A

PROVIDER NUMBER
(2)

B

LAST NAME	FIRST NAME	MI.	STATUS	ETHNIC	LANG.
(1)	(2)	(3)	(4) E L D X	(5)	(6)

C

STREET	CITY	STATE	ZIP CODE/CT
(1)	(2)	(3)	(4)

D

SOCIAL SECURITY #	DED./EXEMPT	TELEPHONE #	SEX	BIRTHDATE MONTH DAY YEAR	W-5	W-4
(1)	(2) P S C B O	(3)	(4) M F	(5)	(6)	(7)

E

COUNTY USE	REL. OF PROV.	# OF PROV.	RECOVERY
(1)	(1)	(3)	(4)

F, G, H

	ACTION	BEGINNING DATE	ENDING DATE	HOURS	SHARE/COST	RATE	SPLIT SHIFT	
F	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)
G	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)
H	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)

I, J

COUNTY VALIDATION		
AUTHORIZATION	DATE	REMARKS
VALIDATION	DATE	REMARKS

IN-HOME SUPPORTIVE SERVICES PROGRAM
DIRECT DEPOSIT
ENROLLMENT/CHANGE/CANCELLATION FORM

To elect, change or cancel Direct Deposit, please read the attached instructions and complete all of the information requested.
A separate form must be completed for each type of enrollment action.
You are not eligible for direct deposit if you will send 100% of the funds deposited to your bank to another bank outside the US.

PLEASE TYPE OR PRINT CLEARLY USING A BALL POINT PEN.

TYPE OF ACTION
1. ☐ NEW
2. ☐ CHANGE
3. ☐ CANCEL

(TO BE COMPLETED BY THE RECIPIENT/GUARDIAN/CONSERVATOR)

A. RECIPIENT NUMBER ☐☐☐☐☐☐☐☐☐☐

B. NAME OF PAYEE (LAST, FIRST, MIDDLE) | TELEPHONE # ( )

ADDRESS (STREET, ROUTE, P.O. BOX) | CITY | STATE | ZIP CODE

C. NAME OF GUARDIAN/CONSERVATOR (LAST, FIRST, MIDDLE) | TELEPHONE # ( )

ADDRESS (STREET, ROUTE, P.O. BOX) | CITY | STATE | ZIP CODE

D. PAYEE SOCIAL SECURITY # ☐☐☐☐☐☐☐☐☐

E. TYPE OF DEPOSITOR ACCOUNT (CHECK ONE) ☐ Checking ☐ Savings

F. NAME AND ADDRESS OF FINANCIAL INSTITUTION

G. ROUTING # ☐☐☐☐☐☐☐☐☐

H. DEPOSITOR ACCOUNT # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I. BRANCH NAME & NUMBER

J. CHECK APPROPRIATE BOX

☐ I hereby authorize the County Welfare office to directly deposit my monthly advance payments.

☐ I hereby authorize the County Welfare office to change my Direct Deposit.

☐ I hereby cancel my Direct Deposit authorization.

K. SIGNATURE OF PAYEE/GUARDIAN/CONSERVATOR | DATE

White - County copy Yellow - Payee copy

STATE OF CALIFORNIA
IHSS PROGRAM

Dear IHSS Recipient:

As an alternative to receiving your monthly In-Home Supportive Services (IHSS) advance pay warrant by mail, the State Department of Social Services (SDSS) is offering you the option of having your advance payment electronically transferred to a financial institution (Bank, Savings and Loan, or Credit Union) of your choice. Direct Deposit through Electronic Fund Transfer (EFT) is limited to those financial institutions by law. Direct Deposit is optional. If you choose to continue receiving your advance pay by mail, you do not need to complete the attached form or take any action.

WHAT IS DIRECT DEPOSIT THROUGH EFT?

With Direct Deposit through EFT, your advance payment is electronically transferred to the financial institution of your choice. You will not receive a warrant through the mail. Instead, every month you will receive a deposit stub, by mail from the State Controller's Office, with information about your direct deposit and tax deductions. By the time you receive the deposit stub, your money will already be waiting in your account. This will save you a trip to the bank.

WHO IS ELIGIBLE FOR DIRECT DEPOSIT?

You are eligible for Direct Deposit if you have been an IHSS recipient for one year, receiving your payment in advance and you hire and pay your service providers.

You are not eligible for direct deposit if you will send 100% of the funds deposited to your bank to another bank outside the US.

ENROLLMENT INSTRUCTIONS:

*** PLEASE READ CAREFULLY ***

WHEN TO USE THE DIRECT DEPOSIT ENROLLMENT FORM SOC 404.

To enroll in Direct Deposit, complete the Type of Action section and, sections A through K on the attached form (SOC 404).

1. To sign up as a new enrollee.
2. To change Direct Deposit from checking to savings or vice versa.
3. To change Direct Deposit from one financial institution to another.
4. To change depositor account number within a financial institution.
5. To cancel Direct Deposit.

WHEN WILL MY FIRST DIRECT DEPOSIT TRANSACTION BE CREDITED TO MY ACCOUNT?

Your first transaction may occur from 60 to 90 days after your request is received by your County Welfare Office. The posting date of your deposit is the first day of the month, unless it is a weekend or holiday, then it is the first working day following the weekend or holiday.

IF THERE ARE ANY PROBLEMS WITH THE DIRECT DEPOSIT INFORMATION, IT CAN DELAY RECEIVING YOUR MONEY BY AS MUCH AS 14 DAYS.

INSTRUCTIONS CONTINUED ON BACK

ENROLLMENT INSTRUCTIONS.

1. To enroll in Direct Deposit, complete the Type of Action section and, sections A through K on the attached form (SOC 404).

2. A separate form must be completed for each type of action requested.

Example 1

FINANCIAL INSTITUTION CHECK NO. 4444
HOMETOWN, USA

PAY TO THE ORDER OF _____

I:112145678 I: 5765432109812 4444

Routing No. Dep. Acct. No. Ck. No.

Example 2

FINANCIAL INSTITUTION CHECK NO. 4444
HOMETOWN, USA

PAY TO THE ORDER OF _____

I:112145678 I: 4444 8765432109812

Routing No. Ck. No. Dep. Acct. No.

3. Please verify your depositor account number and routing number with your financial institution.

4. Attach your voided personal check to the upper left portion of the back of the white copy of the enrollment form if you are depositing your funds into your checking account. This will aid in verifying your depositor account number and routing number.

5. For savings account - secure your routing number and depositor number from your financial institution.

SEND THE WHITE COPY OF THE COMPLETED ENROLLMENT FORM TO YOUR COUNTY WELFARE OFFICE AND RETAIN THE YELLOW COPY FOR YOUR RECORDS.

CHANGING FINANCIAL INSTITUTIONS OR DEPOSITOR ACCOUNTS.

Your Direct Deposit will continue to be deposited into your designated account at your financial institution until the County Welfare Office is notified that you wish to redesignate your account and/or your financial institution. To redesignate, complete and submit a new enrollment form with the new information.

DO NOT CLOSE YOUR OLD ACCOUNT UNTIL YOUR FIRST PAYMENT IS DEPOSITED INTO YOUR NEWLY DESIGNATED ACCOUNT AND/OR FINANCIAL INSTITUTION.

CANCELLATION.

The agreement represented by this authorization remains in effect until cancelled by you by written notice to your County Welfare Office. In the event of your death or legal incapacity, it is the responsibility of your estate to notify your County Welfare Office by written notice. It is your responsibility or the responsibility of your estate to notify the receiving financial institution that the authorization has been cancelled. If you become ineligible for advance payment, your Direct Deposit will be cancelled immediately.

IHSS/CMIPS ELECTIVE STATE DISABILITY INSURANCE (SDI) FORM

This form is for elective State Disability Insurance Coverage (Unemployment Insurance Code Section 702.5) and is only for family member providers, who receive their paychecks from the State Controller's Office. **An eligible family member is the recipient's spouse, parent, or a child (includes adopted but not a stepchild or fosterchild) under the age of 18.** This Disability Insurance is not compulsory, and, by electing to be covered, the recipient and his/her family member provider agree to have State Disability Insurance premiums deducted from the family member provider's paychecks. Do not complete this form unless both the recipient/employer and the provider/employee wish to have the provider's services voluntarily covered for Disability Insurance under the provisions of Section 702.5 of the Code.

TO BE COMPLETED AND SIGNED BY THE RECIPIENT/EMPLOYER

RECIPIENT NAME		SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ( )
STREET ADDRESS	CITY	STATE	ZIP CODE

I, the undersigned, certify that the statements made in this application are true and correct to my best knowledge and belief. I hereby elect and make application to have the exempt family services considered as employment subject to the Unemployment Insurance Code for disability insurance only. **THE ELECTIVE AGREEMENT IS TO BE IN EFFECT FOR AT LEAST TWO COMPLETE CALENDAR YEARS OR UNTIL TERMINATION OF THE PROVIDER SERVICES.** The elective agreement may be terminated by filing a request for termination by January 31 of any year following two complete years of elective coverage.

RECIPIENT/EMPLOYER SIGNATURE	DATE

TO BE COMPLETED AND SIGNED BY THE PROVIDER/FAMILY MEMBER

PROVIDER NAME		SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER ( )	RELATIONSHIP TO RECIPIENT *(IF CHILD PLEASE CIRCLE)* NATURAL ADOPTED (STEPCHILD OR FOSTERCHILD NOT ELIGIBLE)	DATE OF BIRTH

1. Is the employment intended to be continuing and not intermittent or seasonal in nature? ☐ **YES** ☐ **NO**
2. Are you able to perform normal and customary provider services with IHSS? ☐ **YES** ☐ **NO**

Deductions for elective SDI will begin with your next warrant.

I elect to be covered by State Disability Insurance and agree to have the contributions for this insurance deducted from my paychecks.

SIGNATURE OF PROVIDER	DATE

COUNTY USE ONLY

RECIPIENT CASE NUMBER
COMMENTS

Note: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions of UI Code Sections 631, 702.5, 704 and 707.

ELIGIBILITY FOR DISABILITY INSURANCE BENEFITS UNDER THE CODE DOES NOT BEGIN WITH THE COMMENCEMENT DATE OF COVERAGE. GENERALLY, A MINIMUM OF 7 MONTHS MUST ELAPSE FROM THE COMMENCEMENT DATE OF COVERAGE BEFORE A VALID CLAIM MAY BE FILED BASED SOLELY ON WAGES REPORTABLE UNDER YOUR ELECTION.

Also note: Domestic services are not subject to Personal Income Tax Withholding, however, if a recipient and provider voluntarily agree, income tax can be withheld.

Wages and Contributions - Section 702.5: Contributions to be paid for 'Family Employment' elective coverage are to be based upon actual wages paid to covered family members for services performed up to a maximum wage limitation for the year for each family member. There is no provision in this section to permit the contributions to be based on other than actual wages paid. The amount of any disability benefits paid will also be determined on the basis of wages paid.

Social Security Number Disclosure: The disclosure of your Social Security Account Number is mandatory under the Federal Tax Reform Act of 1976. The number will be used for identification purposes and will be available only to authorized personnel within the Employment Development Department and other government agencies as permitted in Sections 322 and 1095 of the California Unemployment Insurance Code.

TERMINATION OF ELECTIVE SDI

Only the Recipient/Employer can apply to have elective SDI coverage stopped for his/her provider.

Elective SDI coverage can only be terminated during January after two complete years of elective coverage or upon terminating employment.

I request termination of elective SDI coverage for my provider.

SIGNATURE OF RECIPIENT	DATE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
IN-HOME SUPPORTIVE SERVICES PROGRAM

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

Distribution:
White - State Compensation Insurance Fund
Yellow - Employer's Copy
Pink - Employee's Copy
Goldenrod - Employee's Temporary Receipt

IN-HOME SUPPORTIVE SERVICES (IHSS)
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS
NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

If you are injured or become ill because of your job, you may be entitled to one or more of the following benefits provided for you as an Individual Provider of IHSS, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of the county's IHSS worker's knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

Failure to file this claim will make it impossible for you to receive any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury, you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1-800-736-7401. This service is provided to you at no cost. You also may consult an attorney.

ANY PERSON WHO MAKES, OR CAUSES TO BE MADE, ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

PART I - PROVIDER/EMPLOYEE: *Complete the "Employee" section and give the form to the county IHSS worker. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from the county.*

NAME OF EMPLOYEE	DATE OF INJURY OR ILLNESS / /	TIME OF DAY ☐ A.M. ☐ P.M.
HOME ADDRESS (NUMBER, STREET, CITY, ZIP CODE)		
WHERE DID ACCIDENT OR EXPOSURE OCCUR (NUMBER, STREET, CITY, ZIP CODE)		
DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED		
WHAT SPECIFIC PART OF YOUR BODY WAS INJURED?		
WHAT IS YOUR RELATIONSHIP TO THE IHSS RECIPIENT/EMPLOYER?		
SIGNATURE OF EMPLOYEE	SOCIAL SECURITY NO: – –	

I gave this form to the county IHSS worker on (date) _____, 20____.

PART 2 – *COUNTY IHSS WORKER: COMPLETE THIS SECTION AND PROMPTLY GIVE THE EMPLOYEE A COPY AS A RECEIPT. SIGNING OF THIS FORM DOES NOT NECESSARILY CONSTITUTE ACCEPTANCE OF A CLAIM.*

NAME OF EMPLOYER	IHSS NO.	TELEPHONE
DATE OF KNOWLEDGE OF INJURY / /	DATE CLAIM FORM WAS PROVIDED TO EMPLOYEE / /	DATE CLAIM FORM WAS RECEIVED FROM EMPLOYEE / /
SIGNATURE OF IHSS WORKER		SSW NO.

STATE
COMPENSATION
INSURANCE
FUND

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

EMPLOYER: YOU ARE REQUIRED BY LAW TO POST THE INFORMATION CONTAINED ON THIS NOTICE IN A CONSPICUOUS LOCATION FREQUENTED BY EMPLOYEES AND WHERE SUCH NOTICE MAY BE EASILY READ BY EMPLOYEES DURING THE COURSE OF THE WORK DAY.

NOTICE TO EMPLOYEES

DEPARTMENT OF SOCIAL SERVICES IN-HOME SUPPORTIVE SERVICES PROGRAM

Our Workers' Compensation Insurer is: **STATE COMPENSATION INSURANCE FUND**

If a job injury occurs...

If you become injured or ill because of your job, you will be entitled to automatic benefits under the California Workers' Compensation Law. These benefits include:

Medical Care–All authorized medical expenses are fully covered. If you need medical care, you will be referred to a local doctor. Should you still need care 30 days after reporting the injury, you may be treated by a physician of your own choice. (You may be treated by your own personal physician immediately following your injury if you have notified your employer in writing before the injury occurs of the name and address of your personal physician.) For further information, please contact your Employer's County Social Services Worker.

Disability Income–If hospitalized, or unable to work for more than three days, you will receive income equal to two-thirds of your average weekly pay, up to a legal maximum per week. If you receive a permanent disability, additional payments will be provided.

Rehabilitation–If your injury or illness prevents you from returning to your same job, you may be eligible for vocational rehabilitation and retraining.

Death Benefits–Should the injury cause death, a benefit will be paid to dependents.

***Important**–Always immediately notify your Employer's County Social Services Worker of any work-related injury or illness. If you have any questions or would like more details about workers' compensation benefits, please call the Office of Benefit Assistance and Enforcement at 1-800-736-7401.*

When a job injury occurs...

Be sure that:

Necessary first aid and appropriate emergency treatment is provided immediately as required by the nature of the injury (even if the employee has previously notified the employer that he wishes to be treated by his own personal physician).

The injured employee is taken to a doctor or a hospital, as necessary.

The accident is reported immediately! Any delay in reporting may delay workers' compensation benefits.

Emergency Phone Numbers:

Social Services Worker (name and telephone)

Hospital (name and telephone)

Ambulance (name and telephone)

Fire (telephone) **Police** (telephone)

Concerning off-duty recreational, social or athletic activity.

Your employer or its insurance carrier may not be liable for the payment of workers' compensation benefits for any injury which arises out of an employee's voluntary participation in any off-duty recreational, social, or athletic activity which is not a part of the employee's work-related duties.

This notice is in compliance with Section 3550 of the Labor code which states in part that every employer subject to the compensation provision of the code shall post, and keep posted, in a conspicuous location a notice which shall state the name of the current compensation insurance carrier of such employer. In addition, this posting notice follows State administrative guidelines under the "employee information" law for providing information to employees about workers' compensation benefits.

SOC 413 (10/90)

Fig. XIII-G- 2 – SOC 413

FORM SAMPLES

APS

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED:

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information [Ombudsman use only - WIC 15636(a)]

*NAME (LAST NAME FIRST)	*AGE	DATE OF BIRTH	SSN	GENDER ☐ M ☐ F	ETHNICITY	LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (SPECIFY)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)	*CITY	*ZIP CODE	*TELEPHONE
			( )
*PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	*CITY	*ZIP CODE	*TELEPHONE
			( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES ALONE ☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ Check if ☐ Self-Neglect

NAME OF SUSPECTED ABUSER

☐ CARE CUSTODIAN (type)_____ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER_____

☐ HEALTH PRACTITIONER (type)_____ ☐ SPOUSE ☐ OTHER RELATION_____

ADDRESS	*ZIP CODE	TELEPHONE	GENDER	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR
		( )	☐ M ☐ F							

C. REPORTING PARTY: *Check appropriate box if reporting party waives confidentiality to:* ☐ ✓ All ☐ ✓ All but victim ☐ ✓ All but perpetrator

*NAME (PRINT)	SIGNATURE	OCCUPATION	AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW KNOWS OF ABUSE	(STREET)	(CITY)	(ZIP CODE)	(E-MAIL ADDRESS)	TELEPHONE
					( )

D. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)

☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL

☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL
- ☐ ASSAULT/BATTERY
- ☐ CONSTRAINT OR DEPRIVATION
- ☐ SEXUAL ASSAULT
- ☐ CHEMICAL RESTRAINT
- ☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION
f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).* ☐ ✓CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS):	TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER	TRUST ACCOUNT: ☐ YES ☐ NO
POWER OF ATTORNEY: ☐ YES ☐ NO	DIRECT DEPOSIT: ☐ YES ☐ NO	OTHER ACCOUNTS: ☐ YES ☐ NO

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(family, significant others, neighbors, medical providers and agencies involved, etc.)*

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
		( )	

I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME IF CONTACT PERSON ONLY ✓ CHECK ☐	*RELATIONSHIP

*ADDRESS	*CITY	*ZIP CODE	*TELEPHONE
			( )

J. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	*TELEPHONE	DATE/TIME
	( )	

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

AGENCY NAME	ADDRESS OR FAX #	☐ Date Mailed: ☐ Date Faxed:

L. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:

2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

Approved by: Assigned to (optional):

3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:

4. APS/Ombudsman/Law Enforcement Case File Number:_____

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. **"Elder,"** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **"Dependent Adult,"** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete items with an asterisk (*) when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Fairview Developmental Center, or Agnews Developmental Center).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease Day Care Resource Centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The Office of the State Long-Term Care Ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy

agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

Health Practitioner (WIC) "15610.37 'Health practitioner' means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

Officers and Employees of Financial Institutions (WIC) "15630.1. (a) As used in this section, "mandated reporter of suspected financial abuse of an elder or dependent adult" means all officers and employees of financial institutions. (b) As used in this section, the term "financial institution" means any of the following: (1) A depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)). (2) An institution-affiliated party, as defined in Section 3(u) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)). (3) A federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752), including, but not limited to, an institution-affiliated party of a credit union, as defined in Section 206(r) of the Federal Credit Union Act (12 U.S.C. Sec. 1786 (r)). (c)As used in this section, "financial abuse" has the same meaning as in Section 15610.30. (d)(1)Any mandated reporter of suspected financial abuse of an elder or dependent adult who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records, or transactions, in connection with providing financial services with respect to an elder or dependent adult, and who, within the scope of his or her employment or professional practice, has observed or has knowledge of an incident that is directly related to the transaction or matter that is within that scope of employment or professional practice, that reasonably appears to be financial abuse, or who reasonably suspects that abuse, based solely on the information before him or her at the time of reviewing or approving the document, records, or transaction in the case of mandated reporters who do not have direct contact with the elder or dependent adult, shall report the known or suspected instance of financial abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency."

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCO coordinators, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine.

Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

GENERAL INSTRUCTIONS (Continued)

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

(1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
(2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
(3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
(4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

Per WIC Section 15630(b)(4)(A), in a long-term care facility, a mandated reporter who the California Department of Health Services determines, upon approval by the Bureau of Medi-Cal Fraud and the Office of the State Long-Term Care Ombudsman (OSLTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse:

(1) The mandated reporter is aware that there is a proper plan of care.
(2) The mandated reporter is aware that the plan of care was properly provided and executed.
(3) A physical, mental, or medical injury occurred as a result of care pursuant to clause (1) or (2).
(4) The mandated reporter reasonably believes that the injury was not the result of abuse.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.
Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS BUREAU.

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE

NAME

POSITION FACILITY

California law REQUIRES certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility. [Welfare & Institutions Code ("W&I") section 15630(a)] **Care custodians** include administrators or employees of any CDSS licensed facility, including support and maintenance staff, or persons providing care or services for elders or dependent adults. [W&I §§ 15610.17(e)&(j)]

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any California resident, 65 years or older. [W&I § 15610.27]
Dependent adult means any California resident, aged 18 through 64, who has physical or mental limitations that restrict his/her ability to carry out normal activities or to protect his/her rights including, but not limited, to persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. [W&I § 15610.23]

WHEN REPORTING ABUSE IS REQUIRED

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse. This must be done BY TELEPHONE IMMEDIATELY or as soon as practically possible, and BY WRITTEN REPORT WITHIN TWO (2) WORKING DAYS. [W&I § 15630(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both. [W&I § 15630(h)]

CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The duties of mandated reporters are individual and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting, ensure confidentiality, and apprise supervisors and administrators of reports may be established, provided they are not inconsistent with the reporting law. [W&I § 15630(f)]

The reporting person, the report, and the information on the report, shall be kept confidential and may be disclosed ONLY as provided by law. Any violation of confidentiality is a MISDEMEANOR CRIME. [W&I § 15633(a)]

ABUSE THAT MUST BE REPORTED

Abuse of an elder or dependent adult that must be reported includes: 1) physical abuse; 2) neglect; 3) financial abuse; 4) abandonment; 5) isolation; and 6) abduction. [W&I § 15630(b)]

DEFINITIONS OF ABUSE

Physical abuse means any of the following: (1) **assault** (an unlawful attempt, coupled with a present ability, to commit a violent injury on another person); or assault with a deadly weapon; (2) **battery** (willful and unlawful use of force or violence upon another person); (3) **unreasonable physical constraint, or prolonged or continual deprivation of food or water;** (4) **sexual assault** (as defined in the Penal Code); or (5) **use of a physical or chemical restraint or psychotropic medication** for (a) punishment, or (b) a period beyond that for which the medication was ordered, or (c) any purpose not authorized by the physician and surgeon. [W&I § 15610.63]

Neglect means the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise. [W&I § 15610.57(a)] Neglect Includes, but is not limited to, the following: (a) failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (b) failure to provide medical care for physical and mental health needs (unless the sole reason is voluntarily relying on treatment by spiritual means through prayer alone in lieu of medical treatment); (c) failure to protect from health and safety hazards; or (d) failure to prevent malnutrition or dehydration. [W&I § 15610.57(b)]

Financial abuse occurs when a person or entity does any of the following: (1) takes, secretes, appropriates, or retains real or personal property of an elder or dependent adult to a wrongful use or with intent to defraud, or both; or (2) assists in any of these acts. [W&I § 15610.30(a)]

Abandonment means the desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody. [W&I § 15610.65]

Isolation means any of the following: (1) acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) telling a caller or prospective visitor that an elder or dependent adult is not present or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons (3) false imprisonment (the unlawful violation of the personal liberty of another); or (4) physical restraint for the purpose of preventing the elder or dependent adult from meeting with visitors. [W&I § 15610.43(a)] These acts shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety. [W&I § 15610.43(c)]

Abduction means the removal from California and the restraint from returning, or the restraint from returning, of any elder or dependent adult who does not have the capacity to consent to the removal or restraint. [W&I § 15610.06]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

If the abuse is alleged to have occurred in a long-term care facility, including a licensed or unlicensed residential facility serving adults or elders or an adult day program, you must report to either local law enforcement or the local long-term care ombudsman. [W&I § 15630(b)(1)(A)] If the abuse is alleged to have occurred anywhere other than a long-term care facility, you must report to either local law enforcement or county adult protective services. [W&I § 15630(b)(1)(C)]

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY.

I, _____, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE | DATE

FOR USE BY FINANCIAL INSTITUTIONS
REPORT OF SUSPECTED DEPENDENT ADULT/ELDER FINANCIAL ABUSE

[CONFIDENTIAL - Not subject to public disclosure]

DATE COMPLETED:

TO BE COMPLETED BY REPORTING PERSON. PLEASE PRINT OR TYPE.

A. VICTIM

NAME (LAST NAME FIRST)	AGE	DATE OF BIRTH	SSN	GENDER ☐ M ☐ F	LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (*SPECIFY*)

ADDRESS (IF FACILITY, INCLUDE NAME)	CITY	ZIP CODE	TELEPHONE
			( )

PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	CITY	ZIP CODE	TELEPHONE
			( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER

B. INCIDENT INFORMATION - WHERE INCIDENT OCCURRED

PLACE OF INCIDENT (✓ CHECK ONE)

☐ FINANCIAL INSTITUTION ☐ OWN HOME ☐ CARE FACILITY ☐ OTHER (Specify) ☐ UNKNOWN

ADDRESS WHERE INCIDENT(S) OCCURRED	DATE/TIME OF INCIDENT(S)

C. REPORTER'S OBSERVATIONS

(ATTACH ADDITIONAL PAGES IF NECESSARY)

D. TARGETED ACCOUNT

ACCOUNT NUMBER: (LAST 4 DIGITS)	TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER	TRUST ACCOUNT: ☐ YES ☐ NO
POWER OF ATTORNEY: ☐ YES ☐ NO	DIRECT DEPOSIT: ☐ YES ☐ NO	OTHER ACCOUNTS: ☐ YES ☐ NO

E. SUSPECT INFORMATION

NAME OF SUSPECTED ABUSER(S)	ADDRESS	DATE OF BIRTH	AGE (ESTIMATE IF UNKNOWN)

RELATIONSHIP TO VICTIM

☐ CARE CUSTODIAN ☐ PARENT ☐ SON/DAUGHTER ☐ HEALTH PRACTITIONER ☐ SPOUSE ☐ UNKNOWN ☐ OTHER

F. OTHER PERSON(S) BELIEVED TO HAVE KNOWLEDGE OF ABUSE - (family, significant others, neighbors, medical providers and agencies involved, etc.)

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP

G. TELEPHONE AND WRITTEN REPORTS

TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman

NAME OF OFFICIAL CONTACTED BY PHONE	TELEPHONE ( )	DATE/TIME

REPORTED BY	TITLE	TELEPHONE ( )	DATE/TIME

NAME OF FINANCIAL INSTITUTION	ADDRESS

WRITTEN REPORT SENT TO Enter information about the agency receiving a copy of this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

NAME OF AGENCY	ADDRESS OR FAX #	☐ Date Mailed: ☐ Date Faxed:

H. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:
2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

Approved by: Assigned to (optional):

3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:
4. APS/Ombudsman/Law Enforcement Case File Number:_____

Use SOC 341 to report other types of abuse

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER FINANCIAL ABUSE
FINANCIAL INSTITUTIONS ONLY
GENERAL INSTRUCTIONS

PURPOSE OF THE FORM

This form is to be used by officers and employees of financial institutions ("mandated reporter(s)") to report suspected financial abuse suffered by a dependent adult or elder. Other types of dependent adult or elder abuse may be reported using form SOC 341. This form is available on http://www.dss.cahwnet.gov/cdssweb/On-lineFor_298.htm#SOC.

An "elder is any person residing in California who is 65 years of age or older. A "dependent adult" is anyone residing in California who is between the ages of 18 and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons whose physical or mental disabilities have diminished because of age. It also includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility.

The oral or written report may be made to the adult protective services agency (APS) in the county where the apparent victim resides, or to a law enforcement agency in the county where the incident occurred. If the mandated reporter knows the apparent victim resides in a long-term care facility, the report must be provided to the local ombudsman or local law enforcement agency. The mandated reporter must first report the incident by telephone, followed by a written report within two working days, using the form. See http://www.dss.cahwnet.gov/pdf/apscolist.pdf for a list of APS offices by county or http://www.aging.state.ca.us/html/programs/ombudsman_contacts.html for county ombudsman offices.

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be financial abuse, or is told by an elder or a dependent adult that he or she has experienced behavior constituting financial abuse, shall report the known or suspected instance of abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Officers and employees of financial institutions are mandated reporters of suspected financial abuse of an elder or dependent adult residing in California (WIC 15630.1). Financial abuse of an elder or dependent adult generally means the taking of real or personal property of an elder or dependent adult to a wrongful use, or assisting in doing so (WIC 15610.30). A mandated reporter who has direct contact with the elder or dependent adult, or who does not have direct contact but reviews or approves the elder's or dependent adult's financial documents, records, or transactions, and who reasonably believes that financial abuse has occurred, must report the incident by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency (WIC 15630.1(d)(1)).

IDENTITY OF THE REPORTING PARTY

The identity of all persons reporting suspected financial abuse shall be confidential and only disclosed among APS agencies, local law enforcement agencies, Long-Term Care Ombudsman (LTCO) coordinators, Bureau of Medi-Cal Fraud and Elder Abuse of the Office of the Attorney General, licensing agencies or their counsel, Investigators of the Department of Consumer Affairs who investigate elder and dependent adult abuse, the Office of the District Attorney, the Probate Court, and the Public Guardian, or upon waiver of the confidentiality by the mandated reporter or by court order.

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

GENERAL INSTRUCTIONS (Continued)

FAILURE TO REPORT
Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

WRITTEN REPORT
If any item of information is unknown, write "unknown" beside the item.

1. **Part A: Victim** Provide information as indicated to the extent known to you or available from financial institution records. If the apparent victim is residing at a location other than his or her address of record, indicate in "Present Location."

2. **Part B: Incident Information** Please check the appropriate box to indicate where the incident occurred. If the incident occurred at another location, please enter the address of the incident location.

3. **Part C: Reporter's Observations** Complete this part carefully and completely. Please include any of the following, as applicable:
   - Statements made by the apparent victim or the suspect;
   - Changes to banking patterns or practices; unusual account activity, such as large withdrawals or large wire transfers;
   - Abrupt changes to legal or financial documents, such as a power of attorney or trust instrument;
   - Sudden confusion by the apparent victim regarding his or her personal financial matters;
   - Repeated telephone calls to the financial institution by the apparent victim repeatedly asking the same question(s);
   - Establishment of unnecessary credit for the apparent victim himself or herself or another person;
   - Apparent victim's belief that he or she has won a lottery;
   - Observations regarding changes to the apparent victim's appearance or demeanor, etc.; or
   - Other concerns by the financial institution's officer or employee not listed above.

   Please attach additional pages, if necessary.

4. **Part D: Targeted Account** Complete information as indicated regarding the targeted account of the apparent victim. To ensure confidentiality, indicate only the last 4 digits of that account number. When making the report by telephone, the mandated reporter will be asked to provide the full account number. A trust account includes not only a Totten or informal trust arrangement through a deposit account, but also formal trust arrangements through a financial institution's trust department. If the apparent victim has other accounts with the financial institution, check "yes." If more than one account is affected, indicate on separate page.

5. **Part E: Suspect Information** This information is of particular importance to an agency's ability to conduct an investigation. Attach additional pages if more than one suspect is involved.

6. **Part F: Other Persons Believed to Have Knowledge of Abuse** This section is intended to identify any other persons who have knowledge of the incident(s).

7. **Part G: Telephone and written reports** This part shall be completed by the mandated reporter for statistical reporting to financial institutions, and county, state, and federal entities.

8. **Distribution of SOC 342 copies** The mandated reporter shall send the original and one copy to the appropriate agency, after the telephone report is made; keep one copy for the reporter's file. The receiving agency shall place the original copy in the case file and send a copy to the cross-reporting agency, if applicable. DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS OPERATIONS BUREAU.

CONFIDENTIAL REPORT -
NOT SUBJECT TO PUBLIC DISCLOSURE

INVESTIGATION OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE – Page 1 of 2

TO BE COMPLETED BY APS SOCIAL WORKER

DEPENDENT ADULT/ELDER NAME (LAST NAME FIRST)	APS CASE NO.	SSN

A. APS INVESTIGATION INFORMATION - ADDITIONAL SPACE ON PAGE TWO

1. DATE(S) AND TIME(S) OF INCIDENT(S)	2. DATE(S) AND TIME(S) INVESTIGATED BY APS

3. NAME OF SUSPECTED ABUSER

4. SUMMARY OF ALLEGATIONS

5. DESCRIBE CHARACTERISTICS OF VICTIM'S ENVIRONMENT (LIVING QUARTERS, ADEQUACY OF CARE, FINANCIAL ARRANGEMENTS, ETC.)

6. ABUSE/SELF-NEGLECT INDICATORS OBSERVED OR REPORTED AT TIME OF INVESTIGATION (CIRCLE ALL THAT APPLY)

a. Physical Indicators: Bruises Burns Welts Fractures Dislocations Lacerations Abrasions Skin Irritations Skin disorders Bedsores Friction burns Untreated injuries Untreated medical/dental problem Stomachaches Malnuturition Dehydration Pallor Sunken eyes/cheeks Fleas Lice/nits No food/water Signs of confinement Poor hygiene Unwashed clothing/bedding Inadequate heating Unsanitary conditions Unsafe housing

b. Behavioral Indicators: Fear Denial Trembling Implausible/conflicting stories Regressive behavior Helplessness Non-responsiveness Resignation Agitation Depression Sleeping disturbances Excessive sleeping

c. Sexual Abuse Indicators: Sexually transmitted disease Genital discharge/infection Genital trauma (Bruises, etc.) Difficulty walking/sitting Excessive body consciousness Fecal soiling Inappropriate sexual behavior

d. Financial Indicators: Unusual bank account activity Inappropriate interest by relative/caretaker Isolated Numerous unpaid bills Lack of affordable necessities/amenities Promise of lifelong care Inappropriately executed/exercised Power of Attorney Forged signature Personal belongings/valuables missing Recent will/transfer of property

7. DESCRIBE PHYSICAL EVIDENCE OF ABUSE/SELF-NEGLECT (CLARIFY INDICATORS ABOVE OR INCLUDE ADDITIONAL INFORMATION)

8. DESCRIBE HOW/WHY ABUSE APPEARS TO HAVE BEEN COMMITTED (MAY INCLUDE WEAPONS USED, POSSIBLE MOTIVE, ETC.)

B. STATEMENTS - ADDITIONAL SPACE ON PAGE TWO. A SIGNED STATEMENT (OPTIONAL) MAY BE OBTAINED FROM ANY OF THE PARTIES LISTED BELOW.

9. VICTIM'S STATEMENT (INCLUDE REPORTS OF THREATS, INTIMIDATION, HARASSMENT)

10. ASSESSMENT OF VICTIM'S WILLINGNESS AND ABILITY TO COOPERATE WITH INVESTIGATION AND PROSECUTION

PRINT APS SOCIAL WORKER NUMBER	SIGNATURE OF APS SOCIAL WORKER	DATE

CONFIDENTIAL REPORT -
NOT SUBJECT TO PUBLIC DISCLOSURE

INVESTIGATION OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE – Page 2 of 2

TO BE COMPLETED BY APS SOCIAL WORKER

DEPENDENT ADULT/ELDER NAME (LAST NAME FIRST)	APS CASE NO.	SSN

11. SUSPECTED ABUSER'S STATEMENT

12. STATEMENT(S) OF OTHER PERTINENT PARTIES (INCLUDE ADDRESS/TELEPHONE NUMBER IF NOT ON SOC 341)

13. ARE OTHER AGENCIES INVOLVED IN INVESTIGATION? ☐ YES ☐ NO IF SO, GIVE AGENCY NAME AND NAME AND TELEPHONE NUMBER OF CONTACT PERSON

C. USE THIS SPACE FOR ADDITIONAL INFORMATION OR STATEMENTS - IF CONTINUATION FROM PREVIOUS ITEM, PLEASE SPECIFY ITEM NUMBER.

D. OUTCOME OF APS INVESTIGATION

14. ALLEGATIONS AND FINDINGS

PERPETRATED BY OTHERS:			
☐ Physical	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Sexual	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Financial	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Neglect	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Abandonment	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Isolation	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Abduction	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Psychological	☐ Confirmed	☐ Inconclusive	☐ Unfounded

PERPETRATED BY SELF:			
☐ Physical Care	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Medical Care	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Health and Safety	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Malnutrition/Dehydration	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Financial	☐ Confirmed	☐ Inconclusive	☐ Unfounded

15. COMMENTS

PRINT APS SOCIAL WORKER NUMBER	SIGNATURE OF APS SOCIAL WORKER	SIGNATURE OF APS SUPERVISOR

INSTRUCTIONS FOR COMPLETING THE SOC 343
Page 1 of 2

Heading - Give client's name, APS case number and social security number.

Part A - APS Investigation Information

1. Give date(s) and time(s) of incident(s) as reported.

2. Give date(s) and time(s) the incident(s) are actually investigated by APS.

3. Give suspected abuser's name.

4. Give summary of allegations as reported.

5. Describe the pertinent characteristics of the victim's environment including conditions of his/her present living quarters, the adequacy of care being provided, what types of financial arrangements the victim has, etc.

6. Circle all the abuse/self-neglect indicators that are observed or reported by the victim at the time of the APS investigation.

7. Describe the physical evidence of abuse/self-neglect observed or reported by the victim at the time of the APS investigation. This section may be used to clarify the indicators reported under A6 above.

8. Describe how or why the abuse appears to have been committed. This requires a subjective determination by the APS worker performing the investigation.

Part B - Statements

9. Summarize the victim's statement as given to the APS worker performing the investigation.

10. Give an assessment of the victim's willingness and ability to cooperate with an investigation and prosecution. This requires a subjective determination by the APS worker doing the investigation.

Footing - Give APS social worker number, APS social worker signature, and date the SOC 343 was completed.

INSTRUCTIONS FOR COMPLETING THE SOC 343
Page 2 of 2

Heading - Give client's name, APS case number and social security number.

Part B - Statements (continued)

11. Summarize the suspected abuser's statement.

12. Summarize the statements of any other pertinent parties, identifying the person by name, address and telephone number if this information is not already included on the SOC 341.

13. Indicate if other agencies are involved in the investigation. If so, give the agency name and telephone number of a contact person.

Part C - Additional Space

Use this additional space to continue any items under parts A or B.

Part D - Outcome of APS Investigation

14. Indicate allegations and findings.

15. Use this space for additional comments.

Footing - Give APS social worker number, APS social worker signature, and APS supervisor signature.

FORM SAMPLES

CPS

Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS — Street / City / Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS — Street / City / Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip			TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE	
PHYSICALLY DISABLED? ☐ YES ☐ NO	DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME	
IN FOSTER CARE? ☐ YES ☐ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)	
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ☐ YES ☐ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK	

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip	HOME PHONE ( )		BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip	HOME PHONE ( )		BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip			TELEPHONE ( )	
OTHER RELEVANT INFORMATION				

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT
NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)	

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

10-116 NOTICE OF ACTION 10-116

.1 A written notice of action, containing information about the right to request a hearing, shall be provided to the applicant or client when an:

.11 Application is denied.

.12 Approval action is taken which includes a service fee or an hourly or other limitation.

.13 Existing authorization is adversely altered, discontinued or reduced, or a service fee is changed.

.2 An oral approval may be used if a fee is not involved, or the approval does not involve limitation on the payment or hours of services authorized.

.3 Timeliness: Notices shall be mailed or otherwise provided in a timely manner.

.31 An approval or denial notice shall be provided within 30 days of the date the application is signed.

.32 A notice of action reducing or discontinuing a service payment shall be mailed or released at least ten days in advance of the effective date of the intended action. The ten-day count does not include the day of mailing or the effective day of the action.

.4 Scope/Adequacy

.41 An approval notice shall inform the applicant of the effective date.

.42 A notice which denies, reduces, discontinues or suspends a service, or which increases a fee, shall include the information concerning the recipient's circumstances which has been used to make the determination and shall cite the regulations which support the action.

.43 Notice which alter an existing service authorization shall indicate the circumstances under which the service will continue during the hearing process, if a hearing is requested.

.44 All written notices of action shall contain information about the right to request a hearing, and shall meet the requirements for standardized notice formats, including the procedure for exercising that right.

10-116 NOTICE OF ACTION (Continued) **10-116**

.5 Exceptions

.51 Notice is not required for information and referral service.

.52 The agency may dispense with timely notice but shall send an adequate notice not later than the effective date of the action when:

.521 The agency has factual information confirming the death of the recipient.

.522 The agency receives a signed statement from the recipient that the recipient no longer wishes the service.

.523 A limited term services authorization ends, providing the recipient had been informed in writing at the time of approval that the allowance would terminate on a specified date.

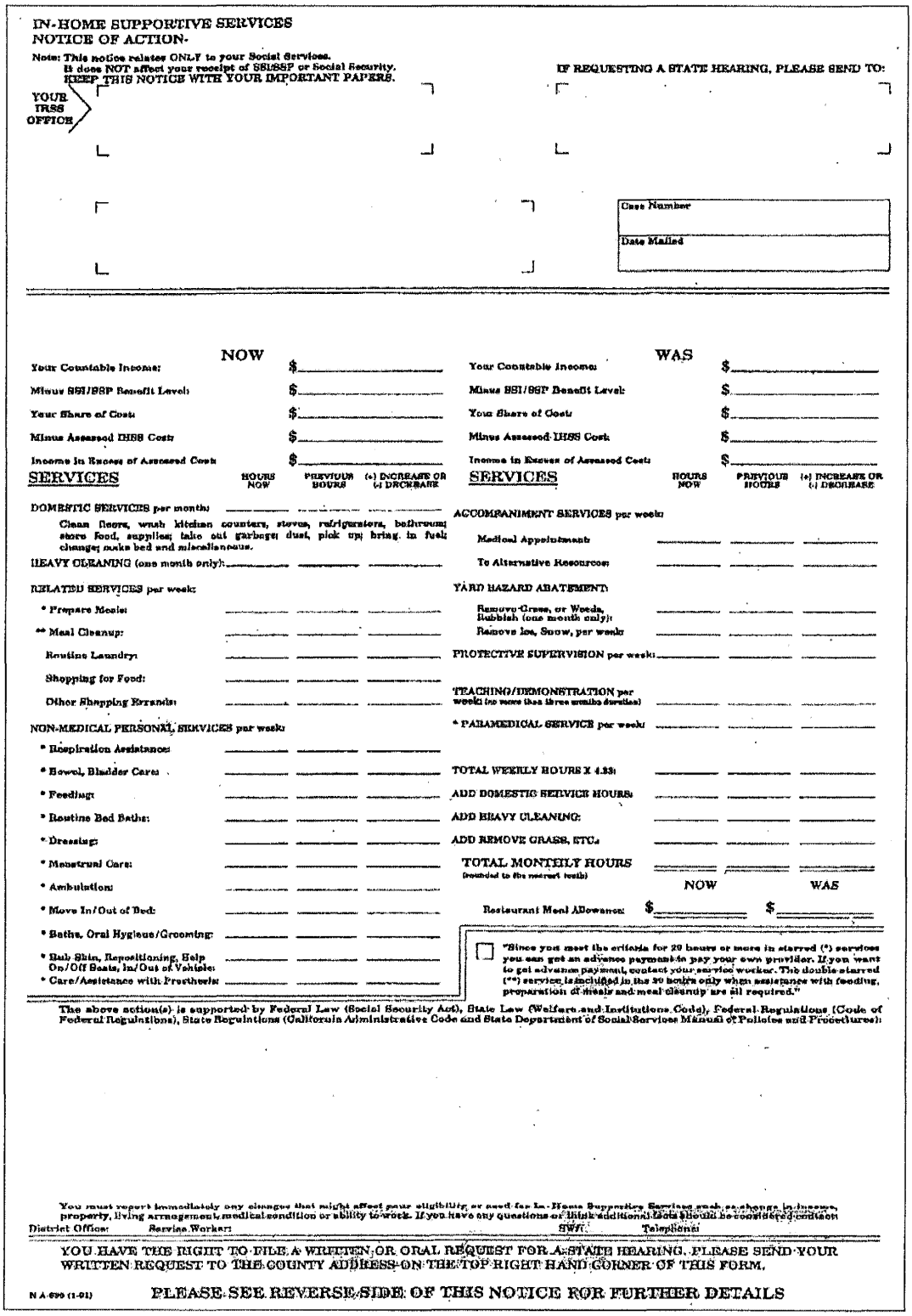
.524 The agency receives a signed statement from the recipient, in response to a prior notice from the agency that a service fee has been increased, that the recipient will not pay the new fee or no longer wishes the service at the new fee.

.525 The agency receives information that a recipient has been admitted or committed to an institution in which continued services of the Primary would not qualify for federal financial participation.

.526 A notice to the last address of record has been returned undelivered and a new address is not known.

.527 The agency receives definitive information that the client has been accepted for the same service in another jurisdiction.

.528 The agency receives a signed statement from the recipient that the recipient will not supply essential eligibility information previously requested in writing by the agency. The original request for information shall clearly state that service will be mandatorily withheld if the essential information is not received by the specified date. A timely notice shall be sent if the requested information is not received on the specified date.



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.

IF REQUESTING A STATE HEARING, PLEASE SEND TO:

YOUR IHSS OFFICE

Case Number

Date Mailed

	NOW	WAS
Your Countable Income:	$	$
Minus SSI/SSP Benefit Level:	$	$
Your Share of Cost:	$	$
Minus Assessed IHSS 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, bathroom; 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:			
* Bath 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 service worker. The double starred (**) service is included in the 20 hours only when assistance with feeding, preparation of meals and meal cleanup 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 think additional facts should be considered, contact

District Office: Service Worker: SWI: 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 (1-91) PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

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

Notice of Action Messages NA 690

The Notice of Action (NOA) is used communicate case status, authorization or changes to an IHSS recipient case. IHSS Notices of Action are printed in English or Spanish. The Spanish version is produced when the primary language of the recipient is indicated as Spanish (Field F5 – 1 Spanish). A copy of a blank Spanish NOA can be obtained from the CDSS IHSS/CMIPS Unit upon request.

The following message are either system generated by specific case actions and entries or manually entered by county staff and are used to communicate with the recipient actions associated with the IHSS case.

The Notice of Action field descriptions

Field: **IN-HOME SUPPORTIVE SERVICES NOTICE OF ACTION**

Description: The **TYPE OF ACTION** prints, centered, at the top of the form to the right of the header. The message corresponding with the TYPE OF ACTION prints above the HOW/WAS area field E. TYPE of ACTION messages are system generated from SOC 293, Field F1, STATUS and other actions taken on a recipient case.

Type of Action	Message
APPROVAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN APPROVED EFFECTIVE MM/DD/YYYY. YOU ARE AUTHORIZED TO RECEIVE SERVICES LISTED BELOW.
DENIAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN DENIED.
DISCONTINUANCE	YOUR ELIGIBILITY FOR IN-HOME SERVICES WILL BE DISCONTINUED EFFECTIVE MM/DD/YYYY.
LEAVE	YOUR IN-HOME SERVICES HAVE BEEN TEMPORARILY SUSPENDED EFFECTIVE MM/DD/YYYY.
PROVISIONAL APPROVAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN PROVISIONALLY APPROVED EFFECTIVE MM/DD/YYYY. YOU ARE AUTHORIZED TO RECEIVE SERVICES LISTED BELOW.
REASSESSMENT CHANGE	YOUR AUTHORIZATION FOR IN-HOME SERVICES HAS BEEN CHANGED EFFECTIVE MM/DD/YYYY.
REASSESSMENT NO CHANGE	UPON REASSESSMENT WE FIND THERE IS NO CHANGE FROM YOUR PREVIOUS AUTHORIZATION FOR IN-HOME SERVICES EFFECTIVE MM/DD/YYYY.

Field: ADDRESS

Description: The following address fields print on at the top section of the NOA:

- The Recipients IHSS District Office
- The State Hearing Office
- The Recipient or Guardian/conservator's mailing address

Field: CASE NUMBER
Description: The recipient IHSS case number

Field: DATE MAILED
Description: The date the NOA was mailed. This date is system generated if the NOA meets the "Due Process" criteria which requires notification of the recipient within 13 days. The thirteen days are counted from the day of data entry.
If a NOA does not meet the DUE PROCESS criteria, this field will be hand written by the Service Worker, the date the NOA was mailed.

To the right of the date the Medi-Cal Secondary Aid Code will be indicated. This indication (2L, 2M or 2N) assists County Staff in knowing the appropriate NOA 350 insert to include in the mailing.

Field: TYPE OF ACTION MESSAGE
Description: Additional message associated with the TYPE OF ACTION previously indicated at the top center of the NOA.

Field F: THE SHARE OF COST – NOW/WAS
Description: The monies currently (NOW) and previously (WAS) associated with Share of Cost calculations. These fields will appear blank if there is no SOC associated with the recipient case.

Field: THE SERVICES – NOW/WAS
Description: Indicates the hours currently (NOW) and previously (WAS) assessed for services.

Field: ADVANCE PAYMENT NOTIFICATION
Description: A notice of eligibility for advance payment to severely impaired recipients. The box in the lower left section of the document will be checked.

Field: NOA MESSAGES
Description: Verbiage associated with automated and manual NOA code reasons associated to action messages. ***(See NOA Codes below.)***

Field: DISTRICT OFFICE
Description: The District Office within the county responsible for the recipient case.

Field: SERVICE WORKER
Description: The name (Last Name, First Name) of the Service Worker responsible for the recipient case.

Field: SW#
Description: A numeric value associated with the Service Worker.

Field: TELEPHONE
Description: The telephone number of the Service Worker associated to the recipient case.

Field: RIGHT TO REQUEST A STATE HEARING – Reverse side of NOA
Description: The Right to Request a State Hearing definition is printed on the back side of the NOA Form

Due Process

- CMIPS has an automated "Due-Process" notification. The DATE MAILED field on a NOA will only be printed on the Notice if there is a thirteen day lead time. The thirteen days are counted from the day of data entry.
- Whenever a date is not printed in the Date Mailed section, the County Social Worker is responsible for entering the date mailed.

Notice of Action Codes

Notice of Action messages are automated, system generated, or manually generated by an end user. Automated messages are triggered from entries on the RELA, RELB and RELC screens. Manual messages are necessary because data, not entered in CMIPS affects the action(s) taken on a recipient case. Familiarity with the various messages will assist when a manually generated message must be initiated.

Refer to Section V-A SOC 293 Field by Field Description and Section V-B SOC 293- Special Instructions – *Field ZZ1 – ZZ2 for detailed instructions to print NOA messages.*

The Notice of Action messages, listed in this document, are numbered sequentially, but some sequence numbers have been skipped allowing for future assignments.

- Automated Notice of Action codes are numbered 300 through 399. These codes do not need to be keyed in Field ZZ2, Reason Code.
- Manual Notice of Action codes are numbered 400 through 600. They are entered on the SOC 293 in Field ZZ2, RSN. CD, then entered into CMIPS. Up to four codes may be entered. Manually generated codes 550 through 600 are designated as "boiler plate" messages. When used, after the NOA is printed, it is returned to the County Social Worker to fill in the blanks. Therefore, field ZZ1 must always be coded as a C – County.
- Notice of Action codes numbered 600 through 799 is reserved for future use.
- Notice of Action codes numbered 800 through 998 has been reserved for special circumstances such as litigation or mass mailings.
- Code 999 is used when the county adjusts hours rather than accepting the system generated prorated hours in a prorated month; for example, approve payment for total authorized hours in the otherwise prorated month. ***Refer to Section V-B, Special Instructions, Reason Code 999.***

All Notice of Action messages incorporated into CMIPS have been reviewed and approved by CDSS. If an additional Notice of Action message is needed, please contact CDSS. Do not use the existing messages inappropriately.

Pound signs (#) in the following list of messages represent values that are supplied by the system. Items in italics are separate notes to the reader and are not part of the actual NOA messages.

Automated Messages

Eligibility Status

301 Application provisionally approved pending disability determination. MPP 30-759.31

302 Application provisionally approved pending a determination of blindness. MPP 759.32

303 As a result of a new state law your total monthly authorized hours of ###.## have been reduced by 3.6-percent to ###.## (w&ic 12301.06) please see the insert for more information about the new law.

305 Your eligibility was determined under Substantial Gainful Activity Rules. MPP 30-755.114

308 Your hours of service are increased because you receive services in the Personal Care Services Program. MPP 30-780, MPP 30-700; W&IC 14132.95(g)

309 Your hours of service are decreased because you are no longer eligible for the Personal Care Services Program. The IHSS maximum for the non-severely impaired is 195 hours a month. MPP 30-765; W&IC 12303.4(a)(1) & (2), 12303.4(b)(1) & (2)

310 Effective MMDDYYYY your eligibility has been transferred from the IHSS Plus Waiver Program to Personal Care Services Program. You may be eligible to receive additional hours of service per month depending on your assessed need.

311 Effective MMDDYYYY your eligibility has been transferred from the IHSS Plus Waiver Program to the IHSS – Residual Program.

312 Effective MMDDYYYY, your eligibility has been transferred from the Personal Care Services Program to IHSS Plus Waiver Program.

313 Effective MMDDYYYY your eligibility has been transferred from the Personal Care Services Program to the IHSS – Residual Program.

314 Effective MMDDYYYY your eligibility has been transferred from the IHSS - Residual Program to In-Home Services Plus Waiver Program.

315 Effective MMDDYYYY your eligibility has been transferred from the IHSS - Residual Program to Personal Care Services Program. You may be eligible to receive additional hours of service per month depending on your assessed need.

316 Effective MMDDYYYY you have been approved to participate in the IHSS Plus Waiver Program because you receive advance pay or restaurant meal allowance, or you receive services from your spouse or you are under the age of 18 and receive services from a parent.

317 Effective MMDDYYYY you have been approved to participate in the Personal Care Services Program. You may be eligible to receive additional hours of service per month depending on your assessed need.

318 Effective MMDDYYYY you have been approved to participate in the IHSS - Residual Program.

319 Effective MMDDYYYY, you have been provisionally approved for the IHSS – Residual program pending your Medi-Cal Eligibility Determination. If the Medi-Cal Eligibility Determination indicates you are eligible for other programs you will receive an additional Notice of Action.

Living Arrangements

320 You are the only person counted in your household. MPP 30-763

321 There are ## *(from field G2)* people living in your household included in determining your share of services. MPP 30-763

322 You are eligible to receive only the above services because you are a minor child living with your parent provider. MPP 30-763

Advance Payment – Direct Deposit

331 You can no longer get an advance payment to pay your service provider. This is because you no longer meet the criteria of 20 hours or more per week of starred (* and **) services. MPP 30-769.731

335 You receive payment in advance. Ask your Social Service Worker about direct deposit to your bank. W&IC 12304.3

336 Your application request for direct deposit has been processed. W&IC 12304.3

337 You are no longer eligible for an advance payment; therefore your direct deposit payment option has been canceled. W&IC 12304.3

338 You have requested a cancellation of your advance pay/direct deposit option. W&IC 12304.3

339 Your State Hearing request for direct deposit has been processed. W&IC 12304.3

Restaurant Meal Allowance

340 You have chosen to receive a Restaurant Meal Allowance instead of Meal Preparation Services. MPP 30-757.134

341 You will no longer receive a Restaurant Meal Allowance because you have chosen to receive Meal Preparation Services. MPP 30-757.134

342 Your Restaurant Meal Allowance is increased due to an increase to the state maximum payment. MPP 30-757.134

Share of Cost

345 Your Share of Cost is $####.##.

348 A State Law decreased the SSI/SSP benefit levels. Your share of cost of $ ####.## now exceeds the assessed IHSS cost of ####.## Hours X $ ###.## per hour plus the restaurant meal allowance of $ ### which equals $ #####.##. Since your excess income exceeds the cost of IHSS, your services are discontinued. W&IC 12000.015, W&IC 12304.5

349 The change in your IHSS Share of Cost shown above is effective ##/##/## because of cost of living adjustments to the Social Security payments available to you which are $ #####.##, $ #####.##, $ #####.##. If the Social Security amount you receive is different than reported here, contact your service worker within ten calendar days. MPP 30-755.233

352 You no longer have a share of cost because you receive SSI/SSP. Your Medi-Cal card will continue through SSI/SSP. MPP 30-755.111

353 The change in your IHSS Share of Cost shown above is effective ##/##/## because of Cost of Living Adjustments to SSI/SSP benefit levels and to the social security payments available to you which are $ #####.##, $ #####.##, $ #####.##. If the social security amount you receive is different than reported here, contact your service worker within ten calendar days. MPP 30-755.233

354 The change in your share of cost shown above is effective ##/##/##. MPP 30-755.233

Overpayments/Underpayments

356 You have a monthly overpayment adjustment of $ ###.##. MPP 30-768

Proration, Time Limited Authorizations, Presumptive Eligibility & Refused Services

360 Heavy cleaning services are authorized one time only during the month of ##/##/## *(MN02 or ZZ3)*. MPP 30-757.121

361 Removal of Grass, Weeds and Rubbish services are authorized one time only during the month of ##/##/## *(ZZ3)*. MPP 30-757.161

362 You have been receiving IHSS on a provisional basis. Your eligibility has been established because disability has been determined. MPP 30-755

363 You have been receiving IHSS on a provisional basis. Your eligibility has been established because blindness has been determined. MPP 30-755

364 Your services are prorated in the amount of ###.# *(MN05)* authorized hours ##/##/## *(MN02)* through ##/##/## *(MN03)*. Beginning the next month you are authorized to receive the services listed above. MPP 30-759.4 and .5

365 Your services are prorated in the amount of ###.# *(M5)* authorized hours ##/##/## *(M2)* through ##/##/## *(M3)*. MPP 30-759.4 and 5

366 Due to a mid-month reassessment, your total services for ##/## *(ZZ3)* are prorated in the amount of ###.# *(N5)* authorized hours. Beginning the next month you are authorized to receive the service hours listed above. MPP 30-759.4 and .5

368 You have refused your service need for _____, _____,_____, _____. MPP 30-761.2

369 You have refused some help in _____, _____, _____. MPP 30-761.2

Income, Resources, Other Eligibility Factors

370 Your services assessment included consideration of Alternative Resources for _____, _____, _____. MPP 30-763.6

371 Alternative Resources available to you for _____, ____, ____, have been reduced. MPP 30-763.6

372 No change. MPP 30-761.21

373 Your share of cost of $ #####.## *(K3)* exceeds the assessed IHSS – Residual cost of ####.# *(aa6)* hours X $ ###.## *(L1&L2)* per hour which equals $ #####.##. W&IC 12304.5, MPP 30-753(b)(2), MPP 30-764.12 and MPP 30-775

374 Alternative Resources available to you for ____, ____, ____, have been increased. MPP 30-763.6

375 You have been found in need of additional hours of service. MPP 30-763.1

376 Your In-Home Service hours have been reduced. MPP 30-763

377 All of your In-Home Service needs are met by alternative resources available to you for ____, ____, ____. MPP 30-763.6

378 No change has occurred on your total monthly hours, only the above services have changed. MPP 30-761.21

379 Your share of cost of $ ####.## *(K3)* exceeds the assessed IHSS - Residual cost of ####.# hours X $###.## per hour plus the restaurant meal allowance of $ ### which equals $ #####.##. W&IC 12304.5, MPP 30-753(b)(2), MPP 30-764.12, MPP 30-755 and MPP 30-757.134

State Maximums

386 The statutory maximum number of hours of ###.## decreases the number of your authorized hours to ###.##. Therefore, you have an Unmet Need of ###.## service hours. W&IC 12303.4

387 The statutory maximum number of In-Home Service hours is ###.##. Therefore, you have an Unmet Need of ###.## service hours. W&IC 12303.4

Worker Generated Messages

The following NOA messages must be generated by a worker since all of the data is not on a data entry form.

Recipient Request

400 You have requested withdrawal of your application for service. MPP 30-009.213
NOTE TO WORKER: *When using this code, enter status D in Field F1 to clear the recipient file. The code will override denial/termination messages.*

401 You have requested a reduction of service hours. MPP 30-009.213

402 You have requested a change from arrears to advance payment to pay your own provider. MPP-30-769.731

403 You have requested a change from advance to arrears payment. MPP 30-769.731

404 Your services were erroneously discontinued and have been restored. *(No new application date is required.)* MPP 30-755.1

405 Your authorization for all services is time limited and will end on ##/##/##. MPP 30-759.5

406 Emergency services above are authorized subject to a complete needs assessment. MPP 30-759.8

407 You have requested termination of all service hours. MPP 30-009.213

408 Your request for services was erroneously denied and In-Home Services have been approved. *(No new application date is required.)* MPP 30-755.1

409 Because you have elected to terminate your participation in the In-Home Supportive Services Plus Waiver Program, your In-Home Services will be terminated effective MMDDYYYY.

Electronic Funds Transfer

415 Your application for Direct Deposit by Electronic Funds Transfer of your advance payment has been denied because you have not been a recipient of IHSS for at least one year and/or you are not eligible for advance pay. W&IC 12304.3

Residence

421 You are residing in a community care facility. MPP 30-701

422 You are residing in the home of relatives and receiving a board and care payment. MPP 30-701 and MPP 46-140.11(b)

424 You are an alien not lawfully admitted for permanent residence in the U.S. MPP 30-770.4

425 You do not have California State residence. MPP 30-770.4

426 You have been out of the country for a full calendar month or for 30 days in a row. MPP30-770.46

427 You are not living in your own home. MPP 30-701

428 Whereabouts unknown. MPP 30-755.21

429 You are residing in a hospital. MPP 30-701

430 You are residing in an intermediate care facility. MPP 30-701

431 You are residing in a skilled nursing facility. MPP 30-701

Income, Resources and Other Eligibility Factors

440 You are not 65 or older, blind or so disabled that you cannot be expected to be able to work at any job for the next 12 months. MPP 30-771

442 You have not provided sufficient information to establish eligibility or need for service. MPP 30-760.1

443 You have no assessed need for services and you can remain safely in your own home without services and, if applicable, retain your employment. MPP 30-761

444 To the estate of ########################## *(B1)*: We have been notified of the death of ############################## (B2) # (B3) ######################## (B1). MPP 30-763.1
NOTE TO WORKER: This code will suppress all other messages.

445 The In-Home Supportive Services Program has been notified that you are not eligible for federally-funded Medi-Cal.

State Hearings

461 To comply with a recent State Hearing order. *(No new application date is required.)* MPP 22-027

462 You have been authorized additional In-Home Services and you have conditionally withdrawn a request for State Hearing. MPP 22-054

463 You have requested a State Hearing prior to the date a decrease of services was to be effective. MPP 22 022.5

464 You have requested a State Hearing prior to the date a change in your share of cost was to be effective. MPP 22-022.5

465 You have requested a State Hearing prior to the date a discontinuance of services was to be effective. *(No new application date is required.)* MPP 22-022.5

Leave Codes

470 You are temporarily ineligible for In-Home Services because you are hospitalized. MPP 30-701

471 You are temporarily ineligible for In-Home Services because you are staying in a skilled nursing facility. MPP 30-701

472 You are temporarily ineligible for In-Home Services because you are staying in an intermediate care facility. MPP 30-701

473 You are temporarily ineligible for In-Home Services because you are staying in a community care facility. MPP 30-701

474 You are temporarily suspended from receiving California paid In-Home Services because you have been absent from the State for a period exceeding six months. In-Home Services shall not be resumed until you have returned to California and a reassessment of need has been completed. MPP 30-770.45

477 You are temporarily ineligible for IHSS – Residual because your SOC exceeds assessed needs for IHSS. W&IC 12304.5

Able and Available Spouse

490 Your spouse is able and available to provide domestic, related, heavy cleaning, yard hazard abatement and teaching and demonstration services at no cost to you. MPP 30-763.41

491 Your spouse is able and available to provide domestic services at no cost. MPP 30-763.41

492 Your spouse is able and available to provide related services at no cost. MPP 30-763.41

493 Your spouse is able and available to provide yard hazard abatement services at no cost. MPP 30-763.41

494 Your spouse is able and available to provide teaching and demonstration services at no cost. MPP 30-763.41

495 Your spouse is able and available to provide heavy cleaning services at no cost. MPP 30-763.41

496 Your spouse is able and available to provide partial meal preparation services at no cost. MPP 30-763.41

497 Your spouse is able and available to provide partial transportation services at no cost. MPP 30-763.41

498 Your spouse is able and available to provide partial protective supervision services at no cost. MPP 30-763.41

499 Your spouse is able and available to provide transportation services at no cost. W&IC 12301

500 Your spouse is able and available to provide protective supervision services at no cost. W&IC 12301

Health Care Certification

507 You did not provide the county with a health care certification as required to authorize services (WIC 12309.1). There is an English and Spanish version of this NOA Message.

Change from Advance to Arrears Payment

510 You are changed from advance to arrears payment because you failed to meet your obligation to submit your providers' timesheets within 90 days of payment. MPP 30-767.133

511 You are changed from advance to arrears payment because you failed to meet your obligation to provide timely payment to your providers. MPP 30-767.133

512 You are changed from advance to arrears payment because you failed to meet your obligation by using your payment for other than purchase of authorized IHSS. MPP 30-767.133

Restaurant Meal Allowance

520 You are no longer eligible for a restaurant meal allowance because you have no need for meal preparation services. MPP 30-757.134

521 You are no longer eligible for an In-Home Service restaurant meal allowance because you are eligible to receive that allowance from the Social Security Administration. MPP 30-757.134

522 You have requested discontinuance of the restaurant meal allowance. MPP 30-757.134

523 You are not eligible for a restaurant meal allowance in place of meal preparation services because you are not aged or disabled. MPP 30-757.134

Share of Cost

526 Your request for reimbursement of overpaid share of cost for the period MM/YYYY because you were not included in the State's payment of medically recognized expenses for that period is denied. Contact your IHSS Social Worker for additional details.

527 You are being reimbursed $XXXXX.XX of overpaid share of cost for the period of MM/CCYY because you were not included in the State's payment of medically recognized expenses for that period.

528 The change in your IHSS Share-of-Cost shown above is due to the April1, 2005 Cost of Living Adjustments to your SSI/SSP benefit level. If your provider(s) timesheets for services rendered after April1, 2005 were processed or payment was received before ##/##/##, the previous share-of-cost was used and you may be reimbursed for each

month affected. If your provider(s) timesheets or payments for services rendered after April1, 2005 are processed after ##/##/##, the updated share-of-cost will be used. If you paid a higher share-of-cost to your provider, for these services, you must arrange to be reimbursed from your provider(s). MPP 30-755.233.

532 Pay your share of cost for IHSS – Residual to your individual provider. MPP 30-755.233

533 Pay your share of cost for IHSS – Residual to the County Welfare Department. MPP 30-755.233

534 Pay your share of cost for IHSS – Residual to the agency who provides your services. MPP 30-755.233

535 You are not eligible to receive IHSS – Residual because you have not paid your obligated share of cost for In-Home Services. MPP Section 30-755.233(a)

536 Pay $_____share of cost to your Individual Provider and pay $_____share of cost to the county social services department. MPP Section 30-755.233(b)(2)

537 Pay $_____share of cost to your contract provider and pay $_____share of cost to your county social services department. MPP Section 30-755.233(b)(2)

538 Pay $_____share of cost to your Individual Provider and pay $_____share of cost to your contract provider. MPP Section 30-755.233(b)(2)

539 You are not eligible to receive IHSS – Residual because you stated you will not pay your share of cost for In-Home Services. MPP Section 30-755.233(d)

Time for Task

540 As a result of reassessment of your need for In-Home Services of laundry, food shopping, and other shopping/errands, the changes shown above have been made in your authorization for In-Home Services in accordance with statewide standards. MPP 30-758

Mode of Service Delivery

550 You will be contacted by our contract service agency to schedule the days that services will be provided. MPP 30-767.1

554 Please contact your County Social Worker when you select an individual provider. MPP 30-767.1

555 You will be contacted by a county welfare employee to schedule the days that service will be provided. MPP 30-767.1

Income Eligible to PCSP

561 The recipient, spouse, or recipient's parents may be able to request reimbursement for Medi-Cal services, including PCSP services that were provided and paid for within three months before application for PCSP on _____. This reimbursement is a Medi-Cal decision

Teaching and Demonstration

580 MPP 30-757.18 You will receive the following teaching and demonstration services. These services are limited to no more than three months: _____, _____, _____, _____.

Recipient Request

581 MPP 30-761 You can remain safely in your own home without additional services although you have requested additional service hours for: _____, _____, _____, _____

582 MPP 22-028 To comply with a recent State Hearing order you will be in receipt of a one time payment for the period of _____ to _____ for underassessed hours of the following services:

SSI/SSP Personal and Real Property

583 MPP30-755.113 You have disposed of resources for less than fair market value. This makes you ineligible for IHSS for the period _____ through _____.

584 MPP 30-773 You have personal and/or real property in excess of SSI/SSP standards which are listed below:
Property SSI/SSP Standard

Inter-county Transfer

585 W&IC 11102 You have moved to a different county and will continue to receive services from the county of _____ effective _____.

586 We will continue to authorize services as your eligibility for In-Home Services has been transferred from the county of _____ effective _____. W&IC 11102

California Residence

588 MPP 30-770.4 You are absent from the State of California and it appears you no longer intend to maintain California State residency. You have indicated your intent to reside outside the State of California by _____.

589 MPP 30-770.4 You have been continuously absent from the State of California for more than 60 days and it appears you no longer intend to maintain California State residency. You have indicated your intent to reside outside the State of California by _____.

Personal Care Services Program

593 You are not eligible for IHSS program services because you are eligible for those services under the Personal Care Services Program (PCSP). You are not authorized to receive PCSP services, even though you are eligible, because you have failed to complete the provider enrollment/certification by the due date _____ as required by PCSP. MPP 30-757.1, MPP 30-760.15, CCR 51204 and WIC 14132.95(a)(3)

594 You can no longer receive services under the Personal Care Services Program (PCSP) because you have elected to receive IHSS advance payments. However, you may be eligible for services under the IHSS program. MPP 30-780.4

XIV. Reason Code 999

Notice of Action code 999 is a worker generated code used to adjust or manually change hours rather than accepting the system generated prorated hours in a prorated month. An example would be if the worker wants to approve payment for all the authorized hours for a month that is prorated.

There are two requirements when adjusting/manually changing hours.

- Manual changes or adjustments can only be made on a prorated segment on a case in T or L status
- A manual change or adjustment of hours cannot be more than the total hours displayed in field aa5. For example, if the hours displayed in field aa5 are 50.00, 51.00 hours may not be assigned to the eligibility segment.

A. To change the hours on a T or L Status case with a prorated M line segment:

1. Access the RELC screen in a "**C**" change mode.
2. Tab to field ZZ2, RSN CD, enter Reason Code **999**.
3. Tab to field aa6 and enter the desired hours. For example, if the current hours displayed are 25.00 and 50.00 hours are required, key in 50.00.
4. Press <**Enter**> to process through all screens until RELA presents in "I" mode.
5. The hours in field M5 on the RELB screen will be updated with the adjustment.

B. To change the hours for a prorated N or O line segment:

1. Access RELB screen in the "C" Change mode.
2. Tab to the SEGMENT NUMBER field.
3. Enter 2, to access the N line segment or 3, to access the O line segment, press <**Enter**>. The RELC grid for the N or O segment will be displayed.
4. Tab to field ZZ2 and enter Reason Code **999**.
5. Tab to field aa6 and key in the desired hours, press <**Enter**> until RELA presents in "I" mode.
6. Field N5 or O5 on the RELB screen will be updated with the adjustment.

CDSS
JOHN A. WAGNER
DIRECTOR

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

ARNOLD SCHWARZENEGGER
GOVERNOR

September 16, 2009

ALL-COUNTY LETTER NO. 09-47

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

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

SUBJECT: STATUTORY CHANGES IN THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES' PROGRAM FOR PAYMENT OF MEDI-CAL RECOGNIZED EXPENSES (OTHERWISE KNOWN AS THE SHARE-OF-COST BUYOUT PROGRAM), INCLUDING ITS ELIMINATION EFFECTIVE OCTOBER 1, 2009

REFERENCE: ALL-COUNTY LETTER 09-27

This All-County Letter (ACL) provides counties with information regarding implementation of two statutory changes to the California Department of Social Services' (CDSS) program for payment of Medi-Cal Recognized Expenses (MRE) for Personal Care Services Program (PCSP) and In-Home Supportive Services (IHSS) Plus Waiver (IPW) program recipients. This payment of MRE is otherwise known as the Share-of-Cost (SOC) Buyout Program. First change is initiated by Senate Bill (SB) X3 6, Chapter 13, Statutes of 2009, amended Welfare and Institutions Code (WIC) §12305.1 to require that, in order to be eligible for the payment of MRE, individuals in PCSP or IPW must be eligible for and receive services under one of those programs before July 1, 2009, and continue to receive those services. Second change initiated by Assembly Bill (AB) X4 4, Chapter 4, Statutes of 2009, amended WIC §12305.1 to provide that an individual who meets the above criteria for MRE payments shall have his or her MRE payment eliminated as of October 1, 2009. This change to state law entirely eliminates all MRE payments beginning with the month of October 2009.

As a result of SB X3 6 and AB X4 4, those individuals who become eligible for PCSP or IPW, on or after July 1, 2009, will not be eligible for the payment of MRE. Additionally, individuals who became eligible for the IHSS Residual (IHSS-R) program on or after July 1, 2009, are not be eligible for the payment of MRE.

IHSS recipients who leave any of the above programs, or lose eligibility and subsequently regain eligibility for services through these programs between July 1, 2009 and October 1, 2009, are not eligible for the payment of MRE. In addition, on October 1, 2009, MRE payments will be eliminated for all recipients.

SB X3 6 IMPLEMENTATION PROVISIONS BETWEEN JULY 1, 2009 AND OCTOBER 1, 2009

Recipients who will lose eligibility for payment of MRE

1. Recipients who are discontinued from, or have a break in, Medi-Cal eligibility on or after July 1, 2009.

    a. This will apply regardless of the reason the recipient loses, or has a break in, Medi-Cal eligibility. The determination as to whether a recipient was discontinued from Medi-Cal will be based on whether the recipient is on the Monthly MEDS Renewal File.

        i. If the recipient loses Medi-Cal eligibility between July 1, 2009 and October 1, 2009, they may file a request for a State Hearing to potentially recoup paid excess SOC and have their payment of MRE restored.

    b. Loss of eligibility for payment of MRE will not occur if the only break in Medi-Cal eligibility is due to an Inter-County Transfer. If a recipient's payment of MRE is terminated in the Cash Management, Information, and Payrolling System (CMIPS) due to an Inter-County Transfer between July 1, 2009 and October 1, 2009, it can only be restored by CDSS Conlan II staff.

2. Recipients who are discontinued from one of the IHSS programs (PCSP, IPW, or IHSS-R); for example, the recipient fails to comply with the annual IHSS reassessment process.

    a. This will apply regardless of the reason the recipient loses, or has a break in, IHSS program eligibility.

        i. If the recipient loses program eligibility between July 1, 2009 and October 1, 2009, they may file a request for a State Hearing to potentially recoup paid excess SOC and have their payment of MRE restored.

b. Loss of eligibility for payment of MRE will not occur if the only break in IHSS program eligibility is due to an Inter-County Transfer. If a recipient's payment of MRE is terminated in CMIPS due to an Inter-County Transfer between July 1, 2009 and October 1, 2009, it can only be restored by CDSS Conlan II staff.

3. Recipients on Leave (L) status for more than 30 consecutive days.

   a. This includes retroactive leave days when the social worker is informed of the recipient's leave status after the fact.

      i. If the recipient alleges a county error occurred between July 1, 2009 and October 1, 2009 that results in Leave status for more than 30 consecutive days, the recipient may file a request for a State Hearing to potentially recoup paid excess SOC and have their payment of MRE restored.

4. Recipients who have no active provider listed in CMIPS for more than 30 consecutive days.

   a. This rule will apply regardless of the reason the recipient has no active provider listed in CMIPS for more than 30 consecutive days.

      i. If the recipient alleges a county error occurred between July 1, 2009 and October 1, 2009, resulting in no provider listed in CMIPS for more than 30 consecutive days, the recipient may file a request for a State Hearing to potentially recoup paid excess SOC and have their payment of MRE restored.

Potential SOC buyout recipients who may file a state hearings appeal or Conlan II claim to have their payment of MRE restored.

1. Recipients who applied for services prior to July 1, 2009, but did not receive program approval until after July 1, 2009, and had someone providing program services which were subsequently authorized. These recipients meet the SOC Buyout eligibility criteria of receiving services before July 1, 2009, and therefore would be eligible for payment of MRE beginning with the month of August 2009.

   a. Recipients in this category should be instructed by county staff to file a Conlan II claim to potentially be eligible for payment of MRE.

   b. Recipients who did not actually receive services prior to July 1, 2009, will not be eligible for payment of MRE, although retroactive program payment eligibility rules still apply.

2. Recipients who received program approval and were receiving program services prior to July 1, 2009, were eligible for but did not receive the payment of MRE prior to July 1, 2009.

    a. Recipients in this category should be instructed by county staff to file a Conlan II claim to potentially be eligible for payment of MRE

3. Recipients who were eligible for the payment of MRE as of June 30, 2009, but missed the payment because CMIPS and Medi-Cal Eligibility Determination Systems (MEDS) failed to communicate properly and the Medi-Cal Eligibility (MELG) screen did not pick up MEDS eligibility correctly.

    a. Recipients in this category should be instructed by county staff to file a Conlan II claim to potentially be eligible for payment of MRE.

Payment of MRE eligibility for IHSS-R recipients who move to the PCSP or IPW Program

1. Recipients who are receiving payment of MRE, have services through IHSS-R and subsequently become eligible for PCSP or IPW, will continue to be eligible for payment of MRE until it is eliminated on October 1, 2009.

COUNTY INFORMATION

The following is general information regarding payment of MRE changes and additional county responsibilities:

- CDSS Conlan II staff will have the ability to restore the recipient's eligibility for the payment of MRE when appropriate until October 1, 2009. Counties will not have the ability to override the system and make a recipient eligible for payment of MRE.

- County responsibilities for determining IHSS-R SOC amounts **(This direction applies until implementation of CMIPS II. Once CMIPS II is implemented, only the first bullet below will apply)**:

    - Counties need to determine IHSS-R SOC amounts for all recipients who are not eligible for federal financial participation. FFP on the MELG screen will be "No".

- CMIPS interface with MEDS will continue as Medi-Cal eligibility is required for PCSP and IPW. PCSP and IPW recipients are responsible for their MC SOC, and payments to their providers will continue to apply toward "spend down" of their MC SOC.

- Counties need to continue to determine IHSS-R SOC amounts for recipients who have a Medi-Cal SOC greater than zero (Medi-Cal SOC is displayed on the RELB or MELG screen). This will ensure recipients pay their correct SOC if they lose PCSP or IPW eligibility. If PCSP or IPW eligibility is re-established, this SOC payment can be used toward meeting

- the Medi-Cal SOC by the recipient providing proof of this payment to their Medi-Cal eligibility worker.

- Counties do not need to continue to determine IHSS-R SOC amounts for recipients who have Medi-Cal with zero SOC. However, counties should consider that for recipients who receive Medi-Cal under A&D FPL (1h or 6h), not having an IHSS-R SOC amount determined could result in a recipient underpayment of SOC if they lose PCSP or IPW eligibility. Counties should make a decision based on individual business practices whether to continue to determine IHSS-R SOC amounts for recipients who receive Medi-Cal under A&D FPL.

Note: Recipients who do not comply with determination of Medi-Cal eligibility are NOT eligible for IHSS-R and should be discontinued from IHSS services (W&IC 14132.951 (d)(1)(2)).

- Please note that when a recipient loses eligibility for the payment of MRE, this will increase their remaining Medi-Cal SOC and potentially decrease their provider's paycheck.

  - The provider and recipient will continue to receive Explanation of SOC letters from CDSS informing them of the correct amount of the SOC to be collected from the recipient.

AB X4 4, OCTOBER 1, 2009 ELIMINATION OF PAYMENT OF MRE FOR ALL RECIPIENTS

CDSS mailed September 5, 2009, an informing notice to current recipients of the payment of MRE (SOC Buyout). The notice informs the recipients of the changes required under SB X3 6, and of the elimination of the payment of MRE, effective October 1, 2009, as required by AB X4 4.

Additionally, CDSS, through its CMIPS vendor, will issue to MRE (SOC Buyout) recipients a Notice of Action (NOA), providing the required ten-day notice that informs these recipients of the elimination of the payment of MRE (SOC Buyout). The NOA will also remind the PCSP/IPW recipients that a letter will be sent to them each time one of their provider's payments is processed telling them how much they need to pay their provider, or the IHSS-R recipients that their IHSS share of cost will be deducted each month from their provider's paycheck and they will be sent a letter telling them to pay that amount to their provider. If recipients should have questions regarding the NOA, there is a toll free number listed on the back of the NOA form where questions can be directed.

Any questions regarding this ACL should be directed to the Adult Programs Branch, at (916) 229-4000.

Sincerely,

Original Document Signed By:

EVA L. LOPEZ
Deputy Director
Adult Programs Division

CDSS
JOHN A. WAGNER
DIRECTOR

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

ARNOLD SCHWARZENEGGER
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

May 26, 2010

ALL-COUNTY INFORMATION NOTICE: I-44-10

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY IHSS PROGRAM MANAGERS

SUBJECT: MODIFICATIONS TO THE NOTICE OF ACTION (NOA) 350 MESSAGE STUFFER

REFERENCE: ACL 09-47 (September 16, 2009) Statutory Changes in the California Department of Social Services' Program for Payment of Medi-Cal Recognized Expenses (Otherwise Known as the Share Of Cost Buyout Program), Including its Elimination Effective October 1, 2009; and Creation of Welfare and Institutions Code (WIC) 14132.952.

This All-County Information Notice (ACIN) provides counties with information regarding modifications to the Notice of Action (NOA) 350 message stuffer. These modifications are being made to reflect the elimination of the Share of Cost (SOC) Buyout program and the replacement of the In-Home Supportive Services (IHSS) Plus Waiver (IPW) program, which expired September 30, 2009, with the In-Home Supportive Services Plus Option (IPO) effective October 1, 2009.

The previous version of the NOA message stuffer included language about the SOC comparison and Buyout, which has been removed from the current version. Additionally, the IPW name was changed to reflect the new IPO program. A copy of the revised NOA 350 message stuffer (version 1/11/2010) is attached.

All-County Letter 09-47 previously instructed counties to continue to calculate the In-Home Supportive Services – Residual (IHSS-R) Program SOC amount for recipients who have a Medi-Cal SOC greater than zero. This is the amount for which a recipient would be responsible under the IHSS-R Program if terminated from the Medi-Cal Program. The NOA 350 message stuffer should be included any time this calculation is done and displayed on the NOA (NA 690).

We are in the process of translating the NOA 350 message stuffer into the three additional threshold languages – Spanish, Armenian and Chinese. Copies will be provided to each county as soon as they are available. As a reminder, 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 (Manual of Policies and Procedures Division 21, Civil Rights Nondiscrimination, section 115).

If you have any questions regarding any of these changes, please call the Waiver and Policy Development Unit at (916) 229-4000.

Sincerely,

Original Document Signed By:

EILEEN CARROLL, Chief
Adult Programs Branch
Adult Programs Division

Attachment

Note: This notice relates ONLY to your Social Services.
It does NOT affect your receipt of SSI/SSP, Social Security or Medi-Cal.

(A) ☐ IHSS PLUS OPTION (IPO) PROGRAM

(B) ☐ PERSONAL CARE SERVICES PROGRAM (PCSP)

You get IHSS as a service of your Medi-Cal through either the IHSS Plus Option (IPO) or the Personal Care Services Program (PCSP). A box is checked above next to (A) or (B) to tell you which program you get services from. See your Medi-Cal notice for information about your Medi-Cal eligibility and any Medi-Cal share of cost you may have to pay.

If you have a Medi-Cal share of cost, a letter will be sent to you each time one of your provider's payments is processed telling you how much you need to pay your provider. You will only pay the IHSS share of cost indicated at the top of your attached In-Home Supportive Services (IHSS) Notice of Action (NA 690) if you are discontinued from Medi-Cal.

OR

(C) ☐ IHSS-RESIDUAL (IHSS-R) PROGRAM

You get IHSS from the IHSS-Residual program. Your IHSS share of cost is displayed at the top of your attached In-Home Supportive Services (IHSS) Notice of Action (NOA 690). If you have an IHSS share of cost, that amount will be deducted each month from your provider's paycheck and you will be sent a letter telling you to pay that amount to your provider. If you are Medi-Cal eligible and have a Medi-Cal share of cost, you may provide proof of the amount you paid your provider to your Medi-Cal eligibility worker and that amount will be used toward meeting your Medi-Cal share of cost.

14: Additional Program Resources

PROGRAMS/SERVICES THAT INTERACT WITH IHSS

The following programs provide services that are identical or similar to those provided by IHSS. They are all publicly funded with a combination of federal, state and/or county funding. Help provided by other agencies, churches, family or friends are Alternative Resources to IHSS to the extent that they meet the needs of a consumer that IHSS would otherwise provide. However, if other agencies, churches, family or friends provide assistance to a consumer that IHSS would not provide (such as paying bills or taking the consumer to a movie), there is no impact to IHSS.

Program/Service	Sponsor/Funder	IHSS Treatment	Authority for Exemption
Adult Day Health Care (ADHC) / Community Based Adult Services (CBAS)	California Department of Aging (CDA) and local site	Services they provide are Alternative Resources to IHSS.	N/A
AIDS Waiver	California Department of Health Care Services (CDHCS)	IHSS authorization not impacted by these services.	ACL
Alzheimer's Day Care Resource Centers (ADCRC)	CDA and local site	Services they provide are Alternative Resources to IHSS.	N/A
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	CDHCS	If the IHSS is provided by the EPSDT provider, EPSDT services are considered an Alternative Resource to IHSS.	ACL 02-43
Home Health Agency care	Medi-Cal and/or Medicare	Services they provide are Alternative Resources to IHSS.	N/A
In-Home Operations (IHO) Waiver	CDHCS	IHSS authorization not impacted by these services; IHO augments them.	ACL
Linkages	Local (not available in all counties)	N/A – Linkages provides case management services.	N/A

Program/Service	Sponsor/Funder	IHSS Treatment	Authority for Exemption
Institutional Deeming Waiver	Department of Developmental Services (DDS) and local Regional Centers	IHSS eligibility available to anyone certified under this waiver, regardless of income and resources. IHSS authorization not impacted by these services.	MPP 30-780.2 and MPP 30-785(b)(2)(B); DHS regulation section 51350(b) and ACL 98-53
Meals on Wheels	CDA, California Area Agencies on Aging (AAA) and local organization	Services they provide are Alternative Resources to IHSS meal preparation and, to some extent, shopping.	N/A
Multipurpose Senior Services Program (MSSP)	CDA and local site	IHSS authorization not impacted by these services.	ACL
Regional Center Services	DDS and local Regional Centers	IHSS authorization not impacted by these services.	ACL 98-53

Area Agencies on Aging - By County

The California Department of Aging contracts with and provides leadership and direction to Area Agencies on Aging (AAA) that coordinate a wide array of services to seniors and adults with disabilities at the community level and serve as the focal point for local aging concerns. You can locate an AAA in your area by calling 1-800-510-2020 or find your county phone number below.

http://www.aging.ca.gov/ProgramsProviders/AAA/AAA_Listing.asp

County	Phone Number
Alameda	(510) 577-1900
Alpine	(209) 532-6272
Amador	(209) 532-6272
Butte	(530) 898-5923
Calaveras	(209) 532-6272
Colusa	(530) 898-5923
Contra Costa	(925) 229-8434
Del Norte	(707) 442-3763
El Dorado	(530) 621-6150
Fresno	(559) 600-4405
Glenn	(530) 898-5923
Humboldt	(707) 442-3763
Imperial	(760) 339-6450

Inyo	(760) 873-6364
Kern	(661) 868-1000
Kings	(559) 582-3211, ext. 2824
Lake	(707) 262-4517
Lassen	(530) 842-1687
Los Angeles (City)	(213) 252-4000
Los Angeles (County)	(213) 738-4004
Madera	(559) 600-4405
Marin	(415) 499-7396
Mariposa	(209) 532-6272
Mendocino	(707) 262-4517
Merced	(209) 385-7550
Modoc	(530) 842-1687
Mono	(760) 873-6364
Monterey	(831) 755-3403
Napa	(707) 644-6612
Nevada	(916) 486-1876
Orange	(714) 567-7500

Placer	(916) 486-1876
Plumas	(530) 898-5923
Riverside	(951) 867-3800
Sacramento	(916) 486-1876
San Benito	(831) 688-0400
San Bernardino	(909) 891-3900
San Diego	(858) 495-5885
San Francisco	(415) 355-3555
San Joaquin	(209) 468-2202
San Luis Obispo	(805) 925-9554
San Mateo	(650) 573-2700
Santa Barbara	(805) 925-9554
Santa Clara	(408) 296-8290
Santa Cruz	(831) 688-0400
Shasta	(530) 842-1687
Sierra	(916) 486-1876
Siskiyou	(530) 842-1687
Solano	(707) 644-6612

Sonoma	(707) 565-5950
Stanislaus	(209) 558-8698
Sutter	(916) 486-1876
Tehama	(530) 898-5923
Trinity	(530) 842-1687
Tulare	(559) 730-2553 or (800) 321-2462
Tuolumne	(209) 532-6272
Ventura	(805) 477-7300
Yolo	(916) 486-1876
Yuba	(916) 486-1876

Updated June 18, 2012

Multipurpose Senior Services Program

Overview

Local Multipurpose Senior Service Program (MSSP) sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

Clients eligible for the program must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff make this certification determination based upon Medi-Cal criteria for placement.

Under a federal Medicaid Home and Community-Based, Long-Term Care Services Waiver, MSSP provides comprehensive care management to assist frail elderly persons to remain at home. The program, which began in 1977 with eight sites, has expanded to 38 sites statewide and can serve up to 11,789 clients per month.

The services that may be provided with MSSP funds include:

- Adult Day Care / Support Center
  Community-based programs that provide non-medical care to meet the needs of adults with disabilities; a variety of social, psychosocial, and related support services in a protective setting, necessary to reach a therapeutic goal.
- Housing Assistance
  May include provision of physical adaptations and assistive devices, emergency assistance in situations that demand relocation, temporary lodging expenses in particular situations, and assistance to restore utility services.
- Chore and Personal Care Assistance
  Services are provided by individuals to elderly persons who need outside help to maintain independent living. Chore is for purposes of household support and applies to the performance of household tasks rather than to the care of the client. Personal Care provides assistance to maintain bodily hygiene, personal safety, and activities of daily living.
- Protective Supervision
  Insures provision of supervision to persons in their own homes who are very frail or otherwise may suffer a medical emergency. Such supervision does not require medical skills and can be performed by an individual trained to identify the onset of a medical crisis and able to summon aid in the event of an emergency.
- Care Management
  Assists clients in gaining access to needed waiver and other local services regardless of the funding source. Care managers are responsible for ongoing monitoring of the provision of services included in the client's plan of care. Additionally, care managers initiate and oversee the process of assessment and reassessment of a client's level of care and the monthly review of plans of care.
- Respite
  Includes the supervision and care of a client while the family or other individuals who normally provide full-time care take short-term relief or respite which allows them to continue as caretakers.
- Transportation
  Provides access to the community (e.g., non-emergency medical transportation to health and social service providers) and special events for clients who do not have means for transportation.
- Meal Services
  Includes meals served in congregate settings or meals delivered to clients who are homebound, unable to prepare their own meals and have no caretaker at home to prepare meals for them.

- Social Services
  Includes social reassurance / friendly visiting, individual or group counseling, and money management.
- Communications Services
  Includes translation and interpretive services and the provision of emergency response systems.

Frequently Asked Questions

My father is only 63 years old, but otherwise he seems to meet the other requirements for MSSP. Can MSSP still help? If not, what do I do now?

- Since you must be at least age 65 to enroll in MSSP, your father wouldn't be eligible for this program at this time. Your **local Area Agency on Aging (AAA)** can provide information and refer you to other services in your father's community. The local AAA is listed in the telephone business white pages, or call 1-800-510-2020 for the AAA nearest his home.

What does it mean to be "certifiable for nursing facility placement?" I don't want to have to go into a nursing home.

- Being "certifiable" or "eligible" for nursing facility placement just means that you have disabilities that would qualify you to be in a nursing facility - it does not mean that you have to go into a nursing facility. A nurse who works for MSSP makes the certification. The goal of MSSP services is to see that people get the help they need to stay in their own homes as long as possible.

Why do you have to be on Medi-Cal to be on MSSP?

- The Medi-Cal program funds MSSP, so all enrollees of MSSP have to meet Medi-Cal eligibility criteria.

If I was to enroll in the MSSP program, could I still keep my In-Home Supportive Services caregiver?

- Yes, you can keep your same In-Home Support Services caregiver, as In-Home Supportive Services is a separate program from MSSP.

What if I need a service not covered by MSSP?

There is no guarantee that MSSP will be able to pay for every service you need. When a need is identified, the first option is always to check whether family or friends can help. If these resources can't address your needs, then we look to other agencies in your community that have programs for which you might be able to qualify (e.g., In-Home Supportive Services, Meals on Wheels, etc.). MSSP will only consider spending its program funds once these additional sources of help are explored. This determination is based on several factors, including the type of service (only a few things can be paid for by MSSP), the availability of the service in your local area, and your willingness to participate in the program.

Updated March 28, 2012
http://www.aging.ca.gov/Programs/MSSP/

About ADHC/CBAS

Adult Day Health Care

The Adult Day Health Care (ADHC) Program is a licensed community-based day health program that provides services to older persons and adults with chronic medical, cognitive, or mental health conditions and/or disabilities that are at risk of needing institutional care. The majority of ADHC participants are Medi-Cal beneficiaries. Through March 31, 2012, ADHC services were an optional benefit under the Medi-Cal Program for individuals eligible for Medi-Cal.

Community-Based Adult Services

Effective April 1, 2012, a new program similar to ADHC – Community-Based Adult Services (CBAS) – has begun under California's "Bridge to Reform" 1115 Medicaid waiver. Former ADHC participants who meet the more stringent CBAS eligibility standards will begin receiving CBAS services in approved CBAS centers. In addition to meeting Medi-Cal program and waiver requirements, CBAS providers must maintain an ADHC license.

Under an interagency agreement, the ADHC (now CBAS) Program is administered between the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDPH licenses ADHC centers and CDA certifies them for participation in the Medi-Cal Program.

The primary objectives of the program are to:

- Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
- Delay or prevent inappropriate or personally undesirable institutionalization.

The Program stresses partnership with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence.

Each center has a multidisciplinary team of health professionals who conduct a comprehensive assessment of each potential participant to determine and plan services needed to meet the individual's specific health and social needs. Services provided at the center include the following: professional nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; hot meals and nutritional counseling; and transportation to and from the participant's residence.

Updated April 26, 2012
http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Program_Overview.asp

Community-Based Adult Services (CBAS) Providers
September 6, 2012

Open

Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX
Alameda							
Alzheimer's Services of the East Bay - Berkeley	Alzheimer's Services of the East Bay, Incorporated	2320 Channing Way	Berkeley	94704	Alameda	(510) 644-8292	(510) 540-6771
Alzheimer's Services of the East Bay - Hayward	Alzheimer's Services of the East Bay, Incorporated	561 A Street	Hayward	94541	Alameda	(510) 888-1411	(510) 888-1357
Berkeley Adult Day Health Center	West Oakland Health Council, Inc.	1890 Alcatraz Avenue	Berkeley	94703	Alameda	(510) 601-0168	(510) 428-1603
Hong Fook Adult Day Health Care	Family Bridges, Inc.	275 14th Street	Oakland	94612	Alameda	(510) 839-9673	(510) 839-9674
Hong Fook Center - Harrison Street	Family Bridges, Inc.	1388 Harrison Street	Oakland	94612	Alameda	(510) 302-0460	(510) 302-0466
Lifelong Medical Care Adult Day Health Care	Lifelong Medical Care	10700 MacArthur Boulevard, Suite 14A	Oakland	94605	Alameda	(510) 563-4390	(510) 563-4387
Butte							
Peg Taylor Center for Adult Day Health Care	Innovative Health Care Services, Inc.	124 Parmac Road	Chico	95926	Butte	(530) 342-2345	(530) 342-3584
Contra Costa							
Guardian Adult Day Health Center	Guardian Adult Health Centers of California	3905 San Pablo Dam Road	El Sobrante	94803	Contra Costa	(510) 669-1005	(510) 669-1008
Mt. Diablo Center for Adult Day Health Care	Rehabilitation Services of Northern California	490 Golf Club Road	Pleasant Hill	94523	Contra Costa	(925) 682-6330	(925) 682-6375
The Bedford Center	Rehabilitation Services of Northern California	1811 C Street	Antioch	94509	Contra Costa	(925) 778-4171	(925) 778-4251
Fresno							
Adult Day Health Care of Fresno and Clovis	ADHC of Fresno and Clovis	5757 North First Street	Fresno	93710	Fresno	(559) 227-8600	(559) 227-8200
Clovis Adult Day Health Care, Inc.	Clovis Adult Day Health Care, Inc.	50 West Bullard, #113	Clovis	93612	Fresno	(559) 298-3996	(559) 298-2074
Heritage Adult Day Health Care Center	Heritage Adult Day Health Care Center	5377 N. Fresno Street	Fresno	93710	Fresno	(559) 222-0304	(559) 222-2132
Heritage West	Heritage West ADHC, LLC	3677 W. Beechwood Avenue	Fresno	93711	Fresno	(559) 261-0707	(559) 261-9995
Valley Adult Day Health Care Center	Valley Adult Day Health Care Center, Inc.	4835 E. McKinley Avenue	Fresno	93703	Fresno	(559) 454-0386	(559) 454-0387
Humboldt							
Adult Day Health Care of Mad River	Adult Day Health Care of Mad River	3800 Janes Road	Arcata	95521	Humboldt	(707) 822-4866	(707) 825-8059
Eureka Adult Day Health Services	Humboldt Senior Resource Center, Inc.	1901 California Street	Eureka	95501	Humboldt	(707) 444-8254	(707) 444-3581

Community-Based Adult Services (CBAS) Providers

September 6, 2012

Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX
Imperial							
Alegria Adult Day Health Care Center	Bernardo Ng, M.D.	1101 C.N. Perry Avenue	Calexico	92231	Imperial	(760) 768-8419	(760) 768-8491
DayOut ADHC - Brawley	DaCare, Inc.	147 N. 8th Street	Brawley	92227	Imperial	(760) 344-5665	(760) 344-3422
DayOut ADHC - El Centro	DaCare, Inc.	757 Main Street	El Centro	92243	Imperial	(760) 337-8393	(760) 337-8449
Kern							
Chateau D'Bakersfield Adult Day Health Care Center	Loma Linda Management Company, Inc.	824 18th Street	Bakersfield	93301	Kern	(661) 322-4085	(661) 323-1059
Delano Adult Day Health Care Center	Delano Adult Day Health Care Center	1457 Glenwood Street	Delano	93215	Kern	(661) 725-7070	(661) 725-9300
Los Angeles							
2nd Century Adult Day Health Care Center	2nd Century Adult Day Healthcare, Inc.	2121 Beverly Boulevard	Los Angeles	90057	Los Angeles	(213) 483-1117	(213) 483-1127
A & S/Franklin ADHC	Abramed Corporation	3200 Santa Monica Boulevard	Santa Monica	90404	Los Angeles	(310) 255-0999	(310) 255-0941
A Day Away... ADHC	Med Site - Hacienda Heights	15060 Imperial Highway	La Mirada	90638	Los Angeles	(562) 902-5305	(562) 902-0835
A Plus Adult Day Health Care	A Plus Adult Day Health Care, Inc.	5500 Valley Boulevard	Los Angeles	90032	Los Angeles	(323) 223-0881	(323) 222-0478
ABC Day Health Center	Advanced Medical Care, Inc.	417 Alpine Street	Los Angeles	90012	Los Angeles	(213) 481-0888	(213) 481-2883
ABC Therapy Center	San Gabriel ADHC Associates, LLC	863 S. Atlantic Boulevard	Monterey Park	91754	Los Angeles	(626) 570-0778	(626) 570-9665
Active ADHC	JW BJW - ADHC, LLC	2385 Pacific Avenue	Long Beach	90806	Los Angeles	(562) 426-7772	(562) 426-0797
Antelope Valley Adult Day Health Care Center	Life's Golden Horizons, Inc.	42212 10th Street West, #8	Lancaster	93534	Los Angeles	(661) 949-6278	(661) 949-6768
Ararat Adult Day Health Care Center	HiChoice Health Care, Inc.	721 S. Glendale Boulevard	Glendale	91205	Los Angeles	(818) 240-1721	(818) 240-2160
Arcadia Adult Day Health Care Center	Arcadia ADHC, Inc.	15 Las Tunas	Arcadia	91007	Los Angeles	(626) 447-9700	(626) 446-5405
Arcadia of Hollywood Adult Day Health Care	Arcadia Adult Day Health Care Center, LLC	860 N. Highland Avenue	Los Angeles	90038	Los Angeles	(323) 466-4122	(323) 466-2340
Babylon Adult Day Health Care Center	Babylon Adult Daycare Center, Inc.	5955 Lindley Avenue	Tarzana	91356	Los Angeles	(818) 996-9300	(818) 996-9173
Beverly Adult Day Health Care Center	Beverly Adult Day Health Care , Inc.	316 N. Western Avenue	Los Angeles	90004	Los Angeles	(323) 957-9777	(323) 957-9741
Burbank ADHC	Burbank ADHC, Inc.	2609 W. Burbank Boulevard	Burbank	91505	Los Angeles	(818) 563-9255	(818) 563-9265
C & C Carson Adult Day Health Care Center	Carson Adult Day Health Care Center, Inc.	451 E. Carson Plaza Drive, Suite 105	Carson	90746	Los Angeles	(310) 354-0031	(310) 354-3939
Carson Adult Day Health Care Center	Westin Enterprises, Inc.	23517 S. Main Street, Suite 110	Carson	90745	Los Angeles	(310) 522-3860	(310) 522-3866
Casa Colina Adult Day Health Care Center	Casa Colina Comprehensive Outpatient Rehabilitation Services, Inc.	255 East Bonita Avenue, Bldg. #5	Pomona	91767	Los Angeles	(909) 596-7733	(909) 596-4943
Casa Del Sol Adult Day Health Care Center	Fairmont Healthcare Corp.	13907 East Amar Road, Suite D	La Puente	91746	Los Angeles	(626) 338-4606	(626) 338-6545
Center for Healthy Living	Center for Healthy Living, Inc.	15220 Vanowen Street	Van Nuys	91405	Los Angeles	(818) 780-2466	(818) 780-2465
Central Adult Day Health Care Center	Qualitycare Health Services Corporation	1825 Beverly Boulevard	Los Angeles	90057	Los Angeles	(213) 413-6966	(213) 413-5276
Christ the King Adult Day Health Care Center	Five Aces Health Care Corporation	18800 Amar Road, Suites D-4 to D-8	Walnut	91789	Los Angeles	(626) 581-4034	(626) 581-1752
Christian Adult Day Health Care Center	Christian Adult Day Health Care Center	4419 Eagle Rock Boulevard	Los Angeles	90041	Los Angeles	(323) 550-8167	(323) 550-1768

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Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX
Compton Adult Day Health Care Center	Compton Adult Day Health Care Center, Inc.	14925 S. Atlantic Avenue	Compton	90221	Los Angeles	(310) 764-2023	(310) 223-5921
Crown City Adult Day Health Care Center	Crown City Adult Day Health Care Center, Inc.	122 North El Molino Avenue	Pasadena	91101	Los Angeles	(626) 583-8822	(626) 583-8844
Daily Dreams Adult Day Health Care Center	LVGS Corp.	1320 W. Magnolia Boulevard	Burbank	91506	Los Angeles	(818) 729-9191	(818) 729-0921
Daylight - Hollywood Adult Day Health Care Center	Hollywood Adult Day Health Care, Inc.	5300 Santa Monica Boulevard, Suite 100	Los Angeles	90029	Los Angeles	(323) 464-2066	(323) 464-0629
Daylight - LA Adult Day Health Care Center	Daylight Adult Day Health Care, Inc.	2367 W. Pico Boulevard	Los Angeles	90006	Los Angeles	(213) 736-9999	(213) 736-1717
Daylight Adult Day Health Care Center	Daylight Adult Day Health Care, Inc.	915 East Colorado Street	Glendale	91205	Los Angeles	(818) 553-3818	(818) 553-3845
Daylight Adult Day Health Care Center (Site 2)	Daylight Adult Day Health Care, Inc.	905 East Colorado Street	Glendale	91205	Los Angeles	(818) 550-7722	(818) 553-3680
E & V Adult Day Health Care Center	E & V Adult Day Health Care, Inc.	2005 N. Wilmington Avenue	Compton	90222	Los Angeles	(310) 537-6291	(310) 537-6298
East Valley Adult Day Health Care Center	East Valley Adult Day Health Care Center, Inc.	8134 Foothill Boulevard	Sunland	91040	Los Angeles	(818) 951-8608	(818) 951-9547
Echo Park Adult Day Health Care Center	Adult Day Health Centers of America, Inc.	302 N. Laveta Terrace	Los Angeles	90026	Los Angeles	(213) 482-5900	(213) 482-5916
EL ARCA Adult Day Health Care Center	East Los Angeles Remarkable Citizens' Association, Inc.	3839 Selig Place	Los Angeles	90031	Los Angeles	(323) 223-3079	(323) 223-4867
El Camino ADHC Center	El Camino ADHC, Inc.	15429 Crenshaw Boulevard, Suite D	Gardena	90249	Los Angeles	(310) 679-7624	(310) 679-6346
El Monte Adult Day Health Care Center	Comfort Life, LLC	9537 Telstar Avenue, #119	El Monte	91731	Los Angeles	(626) 401-2888	(626) 401-3588
Emerald Health Services, Inc.	Emerald Health Services, Inc.	17160-C Colima Road	Hacienda Heights	91745	Los Angeles	(626) 581-9959	(626) 581-9929
Encino Adult Day Health Care Center	Galla Corporation	17815 Ventura Boulevard, Suite 109	Encino	91316	Los Angeles	(818) 774-2173	(818) 654-2635
Evergreen Adult Day Health Care Center	Sinitik Adult Health Care, Inc.	606 W. Las Tunas Drive	San Gabriel	91776	Los Angeles	(626) 282-7397	(626) 282-5829
Everlasting Adult Day Health Care Center	Everlasting Adult Day Care, Inc.	4515 Eagle Rock Boulevard	Los Angeles	90041	Los Angeles	(323) 739-0946	(323) 739-0951
Family ADHC - Lomita	Family Adult Day Health Care, Inc.	2280 Lomita Boulevard	Lomita	90717	Los Angeles	(310) 602-0123	(310) 602-0124
Family Care ADHC	Family Care ADHC, Inc.	6440 Coldwater Canyon Boulevard	North Hollywood	91606	Los Angeles	(818) 762-0373	(818) 762-0035
Felices Dias Adult Day Health Care Center	Felices Dias Adult Day Health Care Center, Inc.	2309 S. Flower Street	Los Angeles	90007	Los Angeles	(213) 746-6611	(213) 746-6690
Forever Young Adult Day Health Care Center	Persian-American Adult Day Health Care Center, Inc.	9820 Topanga Canyon Boulevard, Suite F	Chatsworth	91311	Los Angeles	(818) 775-0377	(818) 775-0038
Forever Young Adult Day Health Care Center	Forever Young Adult Day Health Care, Inc.	4265-73 Maine Avenue	Baldwin Park	91706	Los Angeles	(626) 960-2800	(626) 960-2855
Friendly Adult Day Health Care	Friendly Adult Day Healthcare Center, Inc.	7235 Foothill Boulevard	Tujunga	91042	Los Angeles	(818) 353-3224	(818) 353-1315

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Friendly Adult Day Health Care - North Hollywood	Friendly Adult Day Healthcare Center, Inc.	10858 Oxnard Street	North Hollywood	91606	Los Angeles	(818) 509-1619	(818) 509-1623
Genesis II Adult Day Health Care	ASB Associates, Inc.	20247 Saticoy Street	Winnetka	91306	Los Angeles	(818) 882-2829	(818) 882-2774
GetTogether Adult Day Health Care	LOV GetTogether, Inc.	16636 South Crenshaw Boulevard	Torrance	90504	Los Angeles	(310) 965-0110	(310) 527-2027
Glendale Adult Day Health Care Center	Glendale Adult Day Health Care Center, Inc.	6900 San Fernando Road	Glendale	91201	Los Angeles	(818) 566-6688	(818) 566-6816
Glendale Gardens Adult Day Health Care Center	AM Healthcare, Inc.	700 S. Central Avenue	Glendale	91204	Los Angeles	(818) 507-4998	(818) 507-4999
Glendale Hills Adult Day Health Care Center	GAA, LLC	550 N. Glendale Boulevard, Suite A	Glendale	91206	Los Angeles	(818) 241-3400	(818) 241-3403
Glenoaks Adult Day Health Care Center	T.I.L.S., Inc.	3201 N. Glenoaks Boulevard	Burbank	91504	Los Angeles	(818) 848-0432	(818) 848-9943
Golden Acres Adult Day Health Care Center	Golden Acres Adult Day Health Care Center, Inc.	12041 Strathern Street	North Hollywood	91605	Los Angeles	(818) 767-1361	(818) 767-1370
Golden Age Adult Day Health Care Center	Golden Age Adult Day Health Care Center, Inc.	18332 Ventura Boulevard	Tarzana	91356	Los Angeles	(818) 345-9393	(818) 705-5566
Golden Years Adult Day Health Services	Golden Years Services, Inc.	60 E. Live Oak Avenue	Arcadia	91006	Los Angeles	(626) 447-0202	(626) 447-0403
Good Health Adult Day Health Care Center	Good Health Adult Day Health Care, Inc.	988 N. Hill Street, Suite 111	Los Angeles	90012	Los Angeles	(213) 680-8880	(213) 680-8862
Good Life Adult Day Health Care Center	Buena Vida ADHC, LLC	1617 West Beverly Boulevard	Los Angeles	90026	Los Angeles	(213) 250-9191	(213) 250-9595
Graceful Senescence Adult Day Health Care	Graceful Senescence Adult Day Health Care, Inc.	120 W. El Segundo Boulevard	Los Angeles	90061	Los Angeles	(310) 538-5808	(310) 538-5406
Grand Adult Day Health Care Center	Grand Adult Health Day Care, Inc.	6752 White Oak Avenue	Van Nuys	91406	Los Angeles	(818) 344-3456	(818) 344-3321
Hayim Tovim Adult Day Health Care	Rav Tov Committee to Aid New Immigrants, Inc.	1061 S. Fairfax Avenue	Los Angeles	90019	Los Angeles	(323) 937-5646	(323) 937-0491
Health Guard ADHC	Health Guard, Inc.	894-896 North Fair Oaks Avenue	Pasadena	91103	Los Angeles	(626) 683-5400	(626) 683-5756
Healthy Solutions Adult Day Health Care Center	Integrated Support Solutions, Inc.	14558 Sylvan Street	Van Nuys	91411	Los Angeles	(818) 787-2828	(818) 787-2823
HealthyLife Adult Day Health Care	HealthyLife, Inc.	137 N. Virgil Avenue	Los Angeles	90004	Los Angeles	(213) 637-9700	(213) 389-1407
Helping Hands Adult Day Health Care Center	Helping Hands Adult Day Health Care Center, Inc.	9051-9079 Woodman Avenue	Arleta	91331	Los Angeles	(818) 830-7158	(818) 892-1310
HMS ADHCC	Hzor Medical Services	740 E. Washington Boulevard	Pasadena	91104	Los Angeles	(626) 345-1240	(626) 345-1335
Home Avenue Adult Day Health Care Center	HomeAvenue, Inc.	8114 Telegraph Road	Downey	90240	Los Angeles	(562) 927-7660	(562) 927-6455
Inglewood Community Adult Day Health Care Center	Inglewood Community Adult Day Health Care Ctr, Inc.	11910 West Pico Boulevard	Los Angeles	90064	Los Angeles	(310) 445-3373	(310) 445-3383
Joy ADHC	Health N Joy, Corp.	11832 E. Rosecrans Avenue, #137	Norwalk	90650	Los Angeles	(562) 807-2244	(562) 807-2274
Joyful Adult Day Health Care Center	Joyful Adult Day Health Care	18951 Colima Road	Rowland Heights	91748	Los Angeles	(626) 333-2222	(626) 369-8926

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Kenwood Adult Day Health and Social Services Center	Sunnyday ADHC, Inc.	213 S. Kenwood Street	Glendale	91205	Los Angeles	(818) 637-7880	(818) 637-2014
KHEIR ADHC Center - Vermont	Korean Health, Education, Information and Research Center	3030 W. 8th Street, Suite 100	Los Angeles	90005	Los Angeles	(213) 389-6565	(213) 389-6262
Kingsley Place Adult Day Health Care	Kingsley Place Adult Day Health Care	548 S. Kingsley Drive	Los Angeles	90020	Los Angeles	(213) 383-3303	(213) 384-1772
Kingsley Place Adult Day Health Care Center II	Kingsley Place Adult Health Day Care II	3020 Wilshire Boulevard, Suite 150	Los Angeles	90010	Los Angeles	(213) 387-9097	(213) 387-9098
La Puente Adult Day Health Care	Da Zhen Travel Agency	656 Glendora Avenue	La Puente	91744	Los Angeles	(626) 369-1113	(626) 934-7986
Lake View Adult Day Health Care Center	AGS Management Services, Inc.	12040 Foothill Boulevard, Units #110-115	Lakeview Terrace	91342	Los Angeles	(818) 890-3133	(818) 890-3163
Lancaster Adult Day Health Care Center	Magna Care, Inc.	858 West Jackman Street, Suite 101	Lancaster	93534	Los Angeles	(661) 948-1228	(661) 948-8109
L'Chaim Adult Day Health Care Center	Russian Jewish Community Cultural Center, Inc.	7636 Santa Monica Boulevard	West Hollywood	90046	Los Angeles	(323) 650-8118	(323) 650-8504
Life Sharing Health Care - Norwalk Division	Southern California Health Care	13000 San Antonio Drive	Norwalk	90650	Los Angeles	(562) 863-6431	(562) 929-4374
LMS Health Partners	LMS Health Partners, Inc.	1227-1231 South La Cienega Boulevard	Los Angeles	90035	Los Angeles	(310) 300-1111	(310) 360-1575
Lomita Adult Day Health Care Center	Lomita Health Management, Inc.	1234 W. Lomita Boulevard, Suite E	Harbor City	90710	Los Angeles	(310) 539-4800	(310) 539-4813
Long Beach Adult Day Health Care Center	Merrill Healthcare Services, Inc.	1771 E. 4th Street	Long Beach	90802	Los Angeles	(562) 590-9083	(562) 590-9243
Longlife Adult Day Health Care Center	Spirit of Health, Inc.	2001 W. 48th Street	Los Angeles	90062	Los Angeles	(323) 299-4649	(323) 299-4651
Los Angeles ADHC Center	LHP Adult Day Care Center, Inc.	1424 W. Olympic Boulevard	Los Angeles	90015	Los Angeles	(213) 384-3224	(213) 384-1986
Lotus Blossom Therapy Center	Lotus Blossom Community Services, Inc.	1305 W. Beverly Boulevard	Montebello	90640	Los Angeles	(323) 346-0360	(323) 346-0361
M & T Adult Day Health Care Center	M & T Adult Day Health Care Center, Inc.	820 West Valley Boulevard	Alhambra	91803	Los Angeles	(626) 943-0070	(626) 943-0077
Marina Del Rey ADHC	Calloway Healthcare, LLC	2929 Washington Boulevard	Marina Del Rey	90292	Los Angeles	(310) 821-3599	(310) 821-3387
Mayfair Adult Day Health Care	Mayfair Adult Day Health Care, Inc.	3711 S. La Brea Avenue	Los Angeles	90016	Los Angeles	(323) 299-8788	(323) 299-8726
Mejor Vida Adult Day Health Care Center	Better Life Adult Day Health Center, Inc.	13550 Sherman Way	Van Nuys	91405	Los Angeles	(818) 780-3900	(818) 780-1414
Mikkon Adult Day Health Care Center	Mikkon Corporation	2211-2213 E. Garvey Avenue, North, Suite A1-A2	West Covina	91791	Los Angeles	(626) 967-0812	(626) 967-9286
Montebello Adult Day Health Center	MTB Adult Day Care, Inc.	833 W. Beverly Boulevard	Montebello	90640	Los Angeles	(323) 728-9111	(323) 728-9113
Morningside Adult Day Health Care Center	Lucas Health Partners, LLC	3216-28 W. Manchester Boulevard	Inglewood	90305	Los Angeles	(310) 412-0200	(310) 412-0600
Mountainview Adult Day Health Care	Mountainview ADHC, Inc.	23751-57 Roscoe Boulevard	West Hills	91304	Los Angeles	(818) 999-9234	(818) 716-8030
National Adult Day Health Care Center	RJR Care, Inc.	11251 and 11261-B National Boulevard	Los Angeles	90064	Los Angeles	(310) 943-5400	(310) 943-5401
New Life Adult Day Health Care Center - Artesia	Artesia Adult Day Health Care, Inc.	12220 South Street	Artesia	90701	Los Angeles	(562) 916-7898	(562) 916-7571

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New Sunrise Adult Day Health Care Center	New Sunrise Adult Day Health Care, Inc.	9350 Reseda Boulevard	Northridge	91324	Los Angeles	(818) 701-0010	(818) 701-0090
New Valley Adult Day Health Care Center	Add Smile Health Services, Inc.	1710 South Del Mar Avenue, Suites 111-117	San Gabriel	91776	Los Angeles	(626) 280-6660	(626) 280-1868
Ocean Community Care Center	Ocean Community Care Services, Inc.	1448 18th Street	Santa Monica	90404	Los Angeles	(310) 586-7606	(310) 586-7600
Oceanview Adult Day Health Care Center	Oceanview Adult Day Health Care Center	1500 Main Street	Venice	90291	Los Angeles	(310) 581-6700	(310) 581-3556
Olympus Adult Day Health Care	Olympus ADHC, Inc.	11611 W. Washington Boulevard	Los Angeles	90066	Los Angeles	(310) 572-7272	(310) 572-6092
ONEgeneration Adult Day Healthcare Program	ONEgeneration	17400 Victory Boulevard	Van Nuys	91406	Los Angeles	(818) 708-6625	(818) 708-6620
Pacific ADHC, Inc.	Pacific ADHC, Inc.	5562 Reseda Boulevard	Tarzana	91356	Los Angeles	(818) 776-8700	(818) 776-8789
Pomona Adult Day Health Care Center	Gene Care, Inc.	324 Paloma Drive	Pomona	91767	Los Angeles	(909) 623-7000	(909) 623-7041
Prairie Place Adult Day Health Care Center	Magic Circle Adult Day Health Care Centers, Inc.	105 South Prairie Avenue	Inglewood	90301	Los Angeles	(310) 674-8345	(310) 674-8282
Quality Time II Adult Day Health Care	Quality ADHC, Inc.	5350 Atlantic Avenue	Long Beach	90805	Los Angeles	(562) 728-4300	(562) 728-4350
Ramona Adult Day Health Care Center	First Venture Enterprises, Inc.	13310 Ramona Boulevard, Unit K	Baldwin Park	91706	Los Angeles	(626) 960-9757	(626) 960-5787
Robertson Adult Day Health Care Center	Robertson Adult Day Health Care, Inc.	369 South Robertson Boulevard	Beverly Hills	90211	Los Angeles	(310) 289-7711	(310) 289-7367
S. Mark Taper Foundation Adult Day Health Care Center	St. Barnabas Senior Center of Los Angeles	672 S. Carondelet Street	Los Angeles	90057	Los Angeles	(213) 388-4445	(213) 388-9551
Salida Del Sol Adult Day Health Care	Salida Del Sol Adult Day Health Care, LLC	5648-5650 Vineland Avenue	North Hollywood	91601	Los Angeles	(818) 760-7727	(818) 760-7747
San Fernando Valley ADHC Center	San Fernando Valley Adult Day Healthcare, LLC	10660 White Oak Avenue	Granada Hills	91344	Los Angeles	(818) 832-1418	(818) 832-1420
San Fernando Valley Adult Day Health Care Center	Lady of Grace, Inc.	10351 Balboa Boulevard	Granada Hills	91344	Los Angeles	(818) 831-6651	(818) 831-9822
Santa Clarita ADHC	Visiting Nurse Community Services, Inc.	23911 Calgrove Boulevard	Santa Clarita	91321	Los Angeles	(661) 253-0700	(661) 253-0706
Sherman Way Adult Day Health Care Center	Sherman Way Adult Day Health Care Center, Inc.	18301 Sherman Way	Reseda	91335	Los Angeles	(818) 654-0123	(818) 654-0121
Shiraz Adult Day Health Care Center	Lankershim ADHC, Inc.	6907 N. Lankershim Boulevard	North Hollywood	91605	Los Angeles	(818) 764-3336	(818) 764-6336
Silver Lake Adult Day Health Care Center	Silver Lake Adult Day Care, Inc.	3339 W. Temple Street	Los Angeles	90026	Los Angeles	(213) 383-0050	(213) 383-0035
Silver Strand Care Adult Day Health Care Center	Silver Strand Care, LLC	6464 Vesper Avenue	Van Nuys	91411	Los Angeles	(818) 904-9888	(818) 904-0888
Silver Wisdom Adult Day Health Care Center	Silver Wisdom Adult Day Healthcare Center, Inc.	1714 N. Ivar Avenue	Hollywood	90028	Los Angeles	(323) 464-9161	(323) 464-9166
Sinai Adult Day Health Care	Omid ADHC Corporation	6075-6077 West Pico Boulevard	Los Angeles	90035	Los Angeles	(323) 933-6611	(323) 933-1269

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Spring Adult Day Health Care	Spring Adult Day Health Care, Inc.	18555 Farjardo Street	Rowland Heights	91748	Los Angeles	(626) 965-7833	(626) 964-5483
St. Gabriel Adult Day Health Care Center	All Day Healthcare, Inc.	5419 Sunset Boulevard, Suite B	Los Angeles	90027	Los Angeles	(323) 993-9400	(323) 993-9410
St. Mary's Adult Day Health Care Center	Montebello Adult Day Health Care, Inc.	1827 S. Brand Boulevard	Glendale	91204	Los Angeles	(818) 543-5900	(818) 543-5902
Star Community Adult Day Health Care Center	Star Community ADHC, Inc.	4410 N. Peck Road	El Monte	91732	Los Angeles	(626) 450-0700	(626) 450-0770
Starlite Adult Day Health Care Center	Starlite Health, LLC	9825 E. Garvey Avenue	El Monte	91733	Los Angeles	(626) 350-0011	(626) 350-0077
Sunflower Day Health Care Center	Millennium Adult Health Care, Inc.	136 Cook Avenue	Pasadena	91107	Los Angeles	(626) 356-3838	(626) 356-3638
Sunny Cal Adult Day Health Care Center	Sunny Cal Adult Day Health Care, Inc.	8450 E. Valley Boulevard, #122-B	Rosemead	91770	Los Angeles	(626) 307-7772	(626) 307-7776
Sunny Days Adult Day Health Care	More Love, LLC	3739 Overland Avenue	Los Angeles	90034	Los Angeles	(310) 815-9115	(310) 815-8195
SunnyDay Adult Day Health Care	Evermost Health Management, Inc.	10530 Lower Azusa Road	El Monte	91731	Los Angeles	(626) 350-3886	(626) 444-2747
Sunrise Adult Day Health Care	Sunrise Westside Adult Day Health Care, Inc.	7014 W. Sunset Boulevard	Los Angeles	90028	Los Angeles	(323) 935-2300	(323) 463-0550
Sunshine Adult Day Health Care Center	Valley Health Care Services, Inc.	6939 Van Nuys Boulevard	Van Nuys	91405	Los Angeles	(818) 988-7779	(818) 988-7787
Temple City Adult Day Health Care	Community Care Adult Day Health Care, Inc.	9917 Las Tunas Drive	Temple City	91780	Los Angeles	(626) 614-8999	(626) 614-8095
The Best of Times Adult Day Health Care	THE BEST OF TIMES ADHC-2, INC.	4350 11th Avenue	Los Angeles	90008	Los Angeles	(323) 292-2898	(323) 292-2126
Ultra Care Plus ADHC	Ultra Care Plus, Inc.	38424 10th Street East, Suite A	Palmdale	93550	Los Angeles	(661) 538-0899	(661) 947-5029
Unicare Adult Day Health Care Center	Unicare Adult Day Health Care, Inc.	9736 E. Garvey Avenue	South El Monte	91733	Los Angeles	(626) 279-9082	(626) 279-9032
Universal Adult Day Health Care Center	Universal Adult Day Health Care Center, Inc.	3847 Grand View Boulevard	Los Angeles	90066	Los Angeles	(310) 915-5252	(310) 915-0707
Valley Village	Valley Village	20835 Sherman Way	Canoga Park	91306	Los Angeles	(818) 587-3600	(818) 587-3618
Valley Village Adult Day Health Care Center-Sunland	Valley Village	8727 Fenwick Street	Sunland	91040	Los Angeles	(818) 446-0366	(818) 446-0298
Venus Adult Day Health Care Center	Venus Adult Day Health Care Center, Inc.	1809 W. Magnolia Boulevard	Burbank	91506	Los Angeles	(818) 843-7872	(818) 843-7805
Victory Adult Day Health Center	HiChoice Health Care, Inc.	1745 S. Victory Boulevard	Glendale	91201	Los Angeles	(818) 500-4114	(818) 500-4120
Vineland Adult Day Health Care Center	Mevaga Corp.	5629 Vineland Avenue	North Hollywood	91601	Los Angeles	(818) 753-0714	(818) 753-0916
Vista Adult Day Health Care Center	Trimica, LLC	6061 Atlantic Boulevard	Maywood	90270	Los Angeles	(323) 773-3555	(323) 773-3444
Well and Fit Adult Day Health Care Center	Well and Fit Adult Day Health Care, Inc.	820 N. Diamond Bar Boulevard	Diamond Bar	91765	Los Angeles	(909) 860-0061	(909) 860-6801
Wellcare Adult Day Health Care	HiChoice Health Care, Inc.	6740 Kester Avenue	Van Nuys	91405	Los Angeles	(818) 988-2273	(818) 988-2336
West Covina Adult Day Health Care Center	Excel Healthcare, Inc.	1633 N. Hacienda Boulevard	La Puente	91744	Los Angeles	(626) 918-9887	(626) 918-6647
Western Adult Day Health Care	Hanmaeum Senior Services, Inc.	2001 W. Olympic Boulevard	Los Angeles	90006	Los Angeles	(213) 736-0001	(213) 736-6581

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Whittier Adult Day Health Care Center	Whittier Adult Day Health Care Center, Inc.	14268 E. Telegraph Road	Whittier	90604	Los Angeles	(562) 944-6986	(562) 944-3748
Wilshire Adult Day Health Care Center	Sorores, Inc.	3921 Wilshire Boulevard, #100	Los Angeles	90010	Los Angeles	(213) 383-0900	(213) 383-7085
Yasmine Adult Day Health Care	Yasmine Corporation	19531 Parthenia Street	Northridge	91324	Los Angeles	(818) 718-7800	(818) 718-2777
Your Day Adult Day Health Care Center	SKK Heritage, Inc.	15719-21 Vanowen Street	Van Nuys	91406	Los Angeles	(818) 781-8777	(818) 781-8775
Marin							
Marin Adult Day Health Center	LifeLong Medical Care	1905 Novato Boulevard	Novato	94947	Marin	(415) 897-6884	(415) 897-1585
Merced							
Day Break Adult Day Health Care Center	Castle Family Health Centers, Inc.	1251 Grove Avenue, Suite E	Atwater	95301	Merced	(209) 357-0765	(209) 357-2580
DayOut ADHC - Merced	DaCare, Inc.	1460 Merced Avenue	Merced	95340	Merced	(209) 388-9175	(209) 388-9178
Monterey							
Monterey Peninsula Wisdom Adult Day Health Care Center by the Sea	Monterey Peninsula Wisdom Adult Day Health Care Center	1910 North Davis Road	Salinas	93907	Monterey	(831) 442-0100	(831) 442-2800
Napa							
Adult Day Services of Napa Valley	Napa Valley Hospice & Adult Day Services	414 South Jefferson Street	Napa	94559	Napa	(707) 258-9087	(707) 258-9090
Orange							
ABC Westminster Day Health Center	Magnolia Adult Day Health Care, Inc.	202 Hospital Circle	Westminster	92683	Orange	(714) 894-5880	(714) 894-5879
Acacia Adult Day Services	Acacia Adult Day Services	11391 Acacia Parkway	Garden Grove	92840	Orange	(714) 530-1566	(714) 530-1592
Alzheimer's Family Services Center	Alzheimer's Family Services Center	9451 Indianapolis Avenue	Huntington Beach	92646	Orange	(714) 593-9630	(714) 593-9632
Anaheim V.I.P. Adult Day Health Care Center	Community SeniorServ, Inc.	1158 North Knollwood Circle	Anaheim	92801	Orange	(714) 220-2114	(714) 220-1406
Commonwealth Adult Day Health Care Center	The Spring Highland Fields Corporation	7811 Commonwealth Avenue	Buena Park	90621	Orange	(714) 522-4960	(714) 522-4961
Cypress Adult Day Health Care Center	Meridian Healthcare Corp.	4470 Lincoln Avenue, Suite 1, 2, 3	Cypress	90630	Orange	(714) 826-9664	(714) 826-9614
Evergreen World ADHC	Evergreen World, Inc.	9856 Westminster Avenue	Garden Grove	92844	Orange	(714) 638-1818	(714) 638-3828
Happy (Brea) Adult Day Health Care	H.H.J., Inc.	595 W. Lambert, #101	Brea	92821	Orange	(714) 990-0333	(714) 990-0368
Helping Hands for Better Living	Helping Hands for Better Living, Inc.	10281 Chapman Avenue	Garden Grove	92840	Orange	(714) 530-4489	(714) 530-9917
Irvine Health Foundation Adult Day Health Services Center	Irvine Adult Day Health Services, Inc.	20 Lake Road	Irvine	92604	Orange	(949) 262-1123	(949) 551-0841
Regent West Adult Day Health Care Center	West East Advanced Care, Inc.	4717 W. 1st Street	Santa Ana	92703	Orange	(714) 531-7561	(714) 531-7674

Community-Based Adult Services (CBAS) Providers

September 6, 2012

Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX
Rehabilitation Institute of Southern California	Rehabilitation Institute of Southern California	1800 East La Veta Avenue	Orange	92866	Orange	(714) 633-7400	(714) 633-0738
Rehabilitation Institute of Southern California - Fullerton	Rehabilitation Institute of Southern California	130 Laguna Road	Fullerton	92835	Orange	(714) 680-6060	(714) 871-3640
RIO San Clemente Leo Fessenden Adult Day Health Care Center	Rehabilitation Institute of Southern California	2021 Calle Frontera	San Clemente	92673	Orange	(949) 498-7671	(949) 361-3361
Santa Ana/Tustin V.I.P. Adult Day Health Care Center	Community SeniorServ, Inc.	1101 South Grand Avenue, Suite L	Santa Ana	92705	Orange	(714) 558-1216	(714) 564-0386
Sarang Adult Day Health Care Center	Philemon Healthcare Corporation	5171 Lincoln Avenue	Cypress	90630	Orange	(714) 236-0852	(714) 236-0021
South County Adult Day Services	South County Senior Services, Inc.	24300 El Toro Road Building A, Suite 2000	Laguna Woods	92653	Orange	(949) 855-9444	(949) 855-4093
Sultan Adult Day Health Care Center	Pacific GIS, Inc.	125 W. Cerritos Avenue	Anaheim	92805	Orange	(714) 778-9000	(714) 778-9010
Riverside							
Adult Day Services Center of Riverside	Care Connexxus, Inc., Adult Day Services	4130 Adams Street, Suite B	Riverside	92504	Riverside	(951) 509-2500	(951) 509-2578
Camelot Adult Day Health Care Center	Orchid Court, Incorporated	650 Camino Real Circle	Hemet	92543	Riverside	(951) 766-7840	(951) 766-7034
Inland Empire Adult Day Health Care Center	Inland Empire Adult Day Health Care Center, Inc.	135 N. McKinley Street	Corona	92879	Riverside	(951) 808-9600	(951) 808-9178
Inland Grace Adult Day Health Care Center	Inland Grace Adult Day Health Care Center	10150 Indiana Street	Riverside	92503	Riverside	(951) 343-1001	(951) 343-1061
St. Christopher Adult Day Health Care Center	Puissance International Corporation	4180 Green River Road	Corona	92880	Riverside	(951) 549-6060	(951) 549-6064
Sacramento							
Altamedix ADHC	Altamedix Corporation	4234 North Freeway Boulevard, #500	Sacramento	95834	Sacramento	(916) 648-3999	(916) 648-1919
Eskaton Adult Day Health Center Carmichael	Eskaton Properties, Inc.	5105 Manzanita Avenue, Suite C	Carmichael	95608	Sacramento	(916) 334-0296	(916) 348-6715
Health for All ADHC, Meadowview	Health For All, Inc.	2730 Florin Road	Sacramento	95822	Sacramento	(916) 391-5591	(916) 391-0264
Help to Recovery	Easter Seal Society of Superior California	3205 Hurley Way	Sacramento	95864	Sacramento	(916) 679-3120	(916) 485-2653
Rancho Cordova Adult Day Health Care Center	Ararat Adult Day Health Care, Inc.	10086 Mills Station Road	Sacramento	95827	Sacramento	(916) 369-1113	(916) 369-1138

Community-Based Adult Services (CBAS) Providers

September 6, 2012

Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX
San Bernardino							
Health Guard Inland	Health Guard Inland, LLC	268 McArthur Way	Upland	91786	San Bernardino	(909) 920-1165	(909) 949-3800
Loma Linda University Medical Center Adult Day Health Services	Loma Linda University Medical Center	11406 Loma Linda Drive-East	Loma Linda	92354	San Bernardino	(909) 558-6198	(909) 558-6270
Mission Adult Day Health Care Center	Travelworld USA, Inc.	4439 Mission Boulevard, Suite J	Montclair	91763	San Bernardino	(909) 548-3858	(909) 548-3853
San Bernardino Adult Day Health Care Center	Catleya Health Services, Inc.	1102 S. Arrowhead Avenue	San Bernardino	92408	San Bernardino	(909) 381-9952	(909) 381-9983
Tender Heart Adult Day Health Care	RGGS, Inc.	9499 I Avenue	Hesperia	92345	San Bernardino	(760) 244-8776	(760) 244-9456
San Diego							
AmeriCare Adult Day Health Care Center	AmeriCare ADHC, Inc.	340 Rancheros Drive, Suite 196	San Marcos	92069	San Diego	(760) 682-2424	(760) 471-5104
Casa De Oro Adult Day Health Care Center	Casa De Oro ADHC, Inc.	9805 Campo Road, Suite 130	Spring Valley	91977	San Diego	(619) 462-0881	(619) 462-0084
Casa Pacifica ADHC Center	J Gelt Corporation	1424 30th Street, Suite C	San Diego	92154	San Diego	(619) 424-8181	(619) 424-8151
Clairemont Villa Adult Day Health Center	Clairemont Villa Adult Day Health Center, Inc.	5150 Murphy Canyon Road, Suite 101	San Diego	92123	San Diego	(858) 576-8575	(858) 576-8424
Elm ADHC Center	CA Reliable Medical Systems, Inc.	1220 Elm Avenue	Imperial Beach	91932	San Diego	(619) 827-0573	(619) 271-1284
Golden Life ADHC Center	CA Reliable Medical Systems, Inc.	7373 University Avenue, Suite 101	La Mesa	91941	San Diego	(619) 433-3398	(619) 337-1499
Highlander Adult Day Health Care Center	Nationwide Enterprises	2525 Highland Avenue	National City	91950	San Diego	(619) 474-0015	(619) 336-9567
Hope Adult Day Health Care Center	Liners Corporation	11239 Camino Ruiz, Suite A	San Diego	92126	San Diego	(858) 653-5916	(858) 653-5295
Horizons Adult Day Health Care Center	Horizons Adult Day Health Care Center, Inc.	1415 E. 8th Street, Suite 5	National City	91950	San Diego	(619) 474-1822	(619) 474-1826
Loving Care Adult Day Health Center	Loving Care ADHC Limited	2565 Camino Del Rio South, #201	San Diego	92108	San Diego	(619) 718-9777	(619) 718-9772
Neighborhood House Adult Day Health Care Center	Neighborhood House Association	851 South 35th Street	San Diego	92113	San Diego	(619) 233-6691	(619) 233-6693
North County Adult Day Health Care Center	Adult Protective Services, Inc.	1221 W. Vista Way	Vista	92083	San Diego	(760) 758-2210	(760) 758-6827
Open Arms ADHC	Open Arms ADHC, Inc.	540 National City Boulevard	National City	91950	San Diego	(619) 474-2026	(619) 474-2773
Poway Adult Day Health Care Center	Poway Adult Day Health Care Center, LLC	12250 Crosthwaite Circle	Poway	92064	San Diego	(858) 748-5044	(858) 748-5405
Ramona Adult Day Health Care	Ramona Senior Care, Inc.	2138-A San Vicente Road	Ramona	92065	San Diego	(760) 789-1553	(760) 789-1555
Redwood Elderlink	Redwood Senior Homes & Services	1151 South Redwood Street	Escondido	92025	San Diego	(760) 480-1030	(760) 737-0170
San Ysidro Adult Day Healthcare Center	Centro de Salud de la Comunidad de San Ysidro, Inc.	3364 Beyer Boulevard	San Ysidro	92173	San Diego	(619) 205-1373	(619) 600-4867
The George G. Glenner Alzheimer's Family Centers, Inc. - Chula Vista	The George G. Glenner Alzheimer's Family Centers, Inc.	280 Saylor Drive	Chula Vista	91910	San Diego	(619) 420-1703	(619) 420-0196

Community-Based Adult Services (CBAS) Providers

September 6, 2012

Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX
The George G. Glenner Alzheimer's Family Centers, Inc. - Encinitas	The George G. Glenner Alzheimer's Family Centers, Inc.	335 Saxony Road	Encinitas	92024	San Diego	(760) 635-1895	(760) 436-0949
Western Adult Day Health Care Center	Western Consulting & Ancillary Services, Inc.	240 S. Magnolia Avenue	El Cajon	92020	San Diego	(619) 631-7222	(619) 631-9228
San Francisco							
Bayview Hunters Point Adult Day Health Care Center	Bayview Hunter's Point Multipurpose Senior Services, Inc.	1250 LaSalle Avenue	San Francisco	94124	San Francisco	(415) 826-4774	(415) 826-0178
Circle of Friends Adult Day Health Care	Circle of Friends Adult Day Health Care, Inc.	1550 Steiner Street	San Francisco	94115	San Francisco	(415) 614-2233	(415) 614-0453
Golden State Adult Day Health Care	Golden State Adult Day Health Care, Inc.	738 La Playa Street	San Francisco	94121	San Francisco	(415) 387-2750	(415) 387-2712
L'Chaim Adult Day Health Care	Jewish Family and Children's Services	2534 Judah Street	San Francisco	94122	San Francisco	(415) 449-2900	(415) 449-2944
Self-Help for the Elderly Adult Day Services	Self-Help for the Elderly	408 22nd Avenue	San Francisco	94121	San Francisco	(415) 677-7556	(415) 666-1899
SteppingStone Golden Gate Day Health	North and South of Market Adult Day Health Corporation	350 Golden Gate Avenue	San Francisco	94102	San Francisco	(415) 359-9210	(415) 359-9282
SteppingStone Mabini Day Health	North and South of Market Adult Day Health Corporation	55 Mabini Street	San Francisco	94107	San Francisco	(415) 882-7301	(415) 882-7390
SteppingStone Mission Creek Day Health	North and South of Market Adult Day Health Corporation	930 Fourth Street	San Francisco	94158	San Francisco	(415) 974-6784	(415) 974-6785
SteppingStone Presentation Day Health	North and South of Market Adult Day Health Corporation	301 Ellis Street	San Francisco	94102	San Francisco	(415) 923-0245	(415) 923-0275
San Mateo							
Coastside Adult Day Health Center	Coastside Adult Day Health Center	645 Correas Street	Half Moon Bay	94019	San Mateo	(650) 726-5067	(650) 726-8743
Mills-Peninsula Senior Focus Center Adult Day Health	Mills-Peninsula Health Services	1720 El Camino Real, Suite 10	Burlingame	94010	San Mateo	(650) 696-3660	(650) 696-3633
Santa Barbara							
Santa Maria Wisdom Center	Life Steps Foundation, Inc.	1414 North Broadway, Suite A	Santa Maria	93454	Santa Barbara	(805) 349-9810	(805) 349-9160
Santa Clara							
Avenidas Rose Kleiner Senior Day Health Center	Avenidas	270 Escuela Avenue	Mountain View	94040	Santa Clara	(650) 289-5499	(650) 691-1119
Gardner Adult Day Health Care	Gardner Family Health Network, Inc.	130 North Jackson Avenue	San Jose	95116	Santa Clara	(408) 579-6100	(408) 579-6120
Golden Castle ADHC Center	Golden Castle ADHC Center, Inc.	1137 San Antonio Road, Suite B	Palo Alto	94303	Santa Clara	(650) 964-1964	(650) 964-1978
Grace Adult Day Health Care Center	NAVA Incorporated	1197 E. Arques Avenue	Sunnyvale	94085	Santa Clara	(408) 731-8686	(408) 245-0142
Prestige Adult Day Health Care	Prestige ADHC Inc.	1765 South Main Street, Suite 101	Milpitas	95035	Santa Clara	(408) 586-9000	(408) 586-8000

Community-Based Adult Services (CBAS) Providers

September 6, 2012

Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX
Silicon Valley Adult Day Health Care Center	Silicon Valley Community Healthcare Resource, Inc.	1533 California Circle, Suite 100	Milpitas	95035	Santa Clara	(408) 956-8578	(408) 956-8638
Santa Cruz							
Elderday Santa Cruz	Salud Para La Gente	100 Pioneer Street, Suite C	Santa Cruz	95060	Santa Cruz	(831) 458-3481	(831) 458-2945
Shasta							
Golden Umbrella Adult Day Healthcare Center	Golden Umbrella, Inc.	200 Mercy Oaks Drive	Redding	96003	Shasta	(530) 223-6034	(530) 226-3095
Solano							
Solano Adult Day Health Care Center	Pansophy, Inc.	100 Corporate Place, Suite D	Vallejo	94590	Solano	(707) 642-6811	(707) 642-6917
Stanislaus							
Miller's Place Adult Day Health Care	Doctors Medical Center Foundation	730 McHenry Avenue	Modesto	95350	Stanislaus	(209) 521-0507	(209) 521-0694
Ventura							
Advanced Adult Day Health Care Center	Dynamic Life Health Services, Inc.	2315 Kuehner Drive, Suite 121	Simi Valley	93063	Ventura	(805) 526-7629	(805) 526-7620
Among Friends ADHC Center	American Trade Mark Corporation	851 South "A" Street	Oxnard	93030	Ventura	(805) 385-7244	(805) 385-7246
Millennium Care Adult Day Health Care Center	Anna Gold Co., Inc.	2150 Winifred Street	Simi Valley	93065	Ventura	(805) 583-0859	(805) 583-8957
Oxnard Family Circle Adult Day Health Care Center	Family Circle, Inc.	5000 South "C" Street	Oxnard	93033	Ventura	(805) 385-4180	(805) 385-4170
Ventura County Adult Day Health Care	Reimbursement Consultants, Inc.	1700 N. Lombard Street, Suite 150	Oxnard	93030	Ventura	(805) 278-4321	(805) 278-4322
Yolo							
Golden Days Adult Day Health Care Center	McGlothlin Enterprises, Inc.	1215 Merkley Avenue	West Sacramento	95691	Yolo	(916) 371-6011	(916) 371-6061
Yolo Adult Day Health Center	County of Yolo Health Services Agency	20 North Cottonwood Street	Woodland	95695	Yolo	(530) 666-8828	(530) 666-8826

Total Open Centers:	**256**

Community-Based Adult Services (CBAS) Providers

September 6, 2012

Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX

Currently Not Open

Center Name	Licensee Name	Address	City	Zip Code	County	Center Phone	Center FAX
Alzheimer's Services of the East Bay - Oakland	Alzheimer's Services of the East Bay, Incorporated	400-29th Street, Suite 105	Oakland	94609	Alameda	(510) 268-1410	(510) 268-1419
On Lok Senior Health Services - Fremont Center (PACE)	On Lok Senior Health Services	159 Washington Boulevard	Fremont	94539	Alameda	(510) 249-2700	(510) 249-0255
Elderlife Adult Day Health Care Center	Kern Medical Center	1111 Columbus Avenue, #5000	Bakersfield	93305	Kern	(661) 326-6595	(661) 326-6593
Genesis Adult Day Health Care	ASB Associates, Inc.	20061 Saticoy Street, Suite 101	Winnetka	91306	Los Angeles	(818) 349-7475	(818) 349-4220
KHEIR Adult Day Health Care Center - South Bay	Korean Health, Education, Information and Research Center	14627-14645 S. Western Avenue	Gardena	90249	Los Angeles	(310) 225-3001	(310) 225-3006
Life Steps Foundation, Inc., Circle of Friends	Life Steps Foundation, Inc.	365 East Beach Avenue	Inglewood	90302	Los Angeles	(310) 673-9915	(310) 673-0131
UltraLife Adult Day Health Care	UltraLife Senior Care Planning Council	1022 E. Garvey Avenue	Monterey Park	91755	Los Angeles	(626) 307-8806	(626) 307-8808
Yucaipa Adult Day Center	JonBec Care Incorporated	12980 Second Street	Yucaipa	92399	San Bernardino	(909) 790-4012	(909) 790-3615
Quantum Adult Day Health Care	Quantum Health, Inc.	4087 Colts Way	San Diego	92115	San Diego	(619) 819-1254	(619) 819-1253
Laguna Honda Hospital ADHC Center	City and County of San Francisco, Department of Public Health	375 Laguna Honda Boulevard	San Francisco	94116	San Francisco	(415) 759-2300	(415) 759-2374
Southwest Adult Day Services	Southwest Community Health Center	684 Benicia Drive	Santa Rosa	95409	Sonoma	(707) 573-4565	(707) 576-6637

Total "Currently Not Open" Centers:	11

PACE CENTERS
April 24, 2012

Center Name	Licensee Name	Address	City	Zipcode	County	Center Phone	Center Fax
AltaMed Adult Day Health Care Center	AltaMed Health Services Corporation	5425 E. Pomona Boulevard	Los Angeles	90022	Los Angeles	(323) 728-0411	(323) 728-1535
AltaMed Downey Adult Day Health Care	AltaMed Health Services Corporation	12130 Paramount Boulevard	Downey	90242	Los Angeles	(562) 923-9414	(562) 923-9451
AltaMed El Monte Adult Day Health Care	AltaMed Health Services Corporation	10418 Valley Boulevard, Suite A	El Monte	91731	Los Angeles	(626) 258-1600	(626) 258-1609
AltaMed Golden Age Adult Day Health Care	AltaMed Health Services Corporation	3820 Martin Luther King, Jr. Boulevard	Lynwood	90262	Los Angeles	(310) 632-0415	(310) 639-2734
AltaMed Grand Plaza Adult Day Health Care	AltaMed Health Services Corporation	701 Cesar Chavez Avenue, Suite 201	Los Angeles	90012	Los Angeles	(213) 217-5300	(213) 217-5396
AltaMed Rugby Plaza Adult Day Health Care	AltaMed Health Services Corporation	6330 Rugby Plaza, Suite 200	Huntington Park	90255	Los Angeles	(323) 277-7678	(323) 728-1535
Center for Elders' Independence - Berkeley	Center for Elders Independence	1497 Alcatraz Avenue	Berkeley	94702	Alameda	(510) 433-1150	(510) 452-8836
Center for Elders' Independence - San Pablo	Center for Elders Independence	1955 San Pablo Avenue	Oakland	94612	Alameda	(510) 433-1151	(510) 452-8837
Center for Elders' Independence - Site II (Josie Barrows Center)	Center for Elders Independence	7200 Bancroft Avenue	Oakland	94605	Alameda	(510) 433-1152	(510) 452-8838
Center for Elders' Independence (Site I)	Center for Elders Independence	275 Eastmont Town Center	Oakland	94605	Alameda	(510) 433-1153	(510) 452-8839
Lifeways PACE at the Coronet	Institute on Aging	3575B Geary Boulevard	San Francisco	94118	San Francisco	(415) 447-1000	(415) 447-1035
On Lok Lifeways by Institute on Aging (IOA)	Institute on Aging	2700 Geary Boulevard	San Francisco	94118	San Francisco	(415) 447-8900	(415) 447-1250
On Lok Senior Health Services	On Lok Senior Health Services	225 30th Street	San Francisco	94131	San Francisco	(415) 550-2230	(415) 647-6332
On Lok Senior Health Services - Fremont Center	On Lok Senior Health Services	159 Washington Boulevard	Fremont	94539	Alameda	(510) 249-2700	(510) 249-0255
On Lok Senior Health Services - Mission Street Center	On Lok Senior Health Services	4430 Mission Street	San Francisco	94112	San Francisco	(415) 337-2858	(415) 337-2867
On Lok Senior Health Services - Montgomery	On Lok Senior Health Services	1000 Montgomery Street	San Francisco	94133	San Francisco	(415) 292-8883	(415) 292-8625
On Lok Senior Health Services - Powell	On Lok Senior Health Services	1441 Powell Street	San Francisco	94133	San Francisco	(415) 292-8650	(415) 292-8666
On Lok Senior Health Services - San Jose Center	On Lok Senior Health Services	299 Stockton Avenue	San Jose	94125	Santa Clara	(408) 535-4600	(408) 535-4661
On Lok Senior Health Services - William Gee Center (Jade)	On Lok Senior Health Services	1333 Bush Street	San Francisco	94109	San Francisco	(415) 292-8888	(415) 292-8475
On Lok Senior Health Services - William Gee Center (Rose)	On Lok Senior Health Services	1333 Bush Street	San Francisco	94109	San Francisco	(415) 292-8888	(415) 292-8745
St. Paul PACE	CESD	111 Elm Street	San Diego	92103	San Diego	(619) 677-3800	
Sutter SeniorCare	Sutter Health Sacramento Sierra Region	7000 Franklin Boulevard, Suite 1020	Sacramento	95823	Sacramento	(916) 424-8412	(916) 424-3249
Sutter SeniorCare II	Sutter Health Sacramento Sierra Region	1234 U Street	Sacramento	95818	Sacramento	(916) 446-3100	(916) 446-3699