

## WELCOME TO THE IHSS TRAINING ACADEMY

## IHSS 101

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

This three-day training has been designed specifically for IHSS staff that have been newly hired, have limited IHSS experience, or require a refresher course. This course utilizes lecture, discussion, group, and individual activities to deliver course content.

### Topics will include:

- Uniformity Overview
- Functional Rankings
- IHSS Program Background
- Regulations
- Eligibility
- IHSS Programs
- Inter County Transfer
- Task Categories
- The Assessment
- The Home Visit
- The Interview
- Completing the Assessment – CMIPS (SOC 293)
- Shared Living
- Documentation
- Forms
- Providers
- Programs/Services that Interact with IHSS and How They Impact Assessments

### Objectives:

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

1. Explain the purpose and importance of uniformity in IHSS.
2. Define the components of the functional index ranking and how they relate to the need for human assistance.
3. Demonstrate the ability to utilize the Annotated Assessment Criteria and IHSS regulations in determining the functional ranking for an IHSS consumer.
4. Explain the relationship between functional index scores and the authorization of IHSS services.

5. Describe the IPO program and philosophy, enhanced assessment requirements, and how to complete the mandatory Individualized Back-Up Plan and Risk Assessment Form (SOC 864).
6. Describe how to apply the Hourly Task Guidelines, including the definition of exceptions.
7. Describe why the home visit is important, and steps the social worker can take to obtain an accurate assessment.
8. Demonstrate the application of shared living regulations including the appropriate proration of services.
9. Demonstrate the process of authorization of service hours using the Hourly Task Guidelines, including an ability to identify appropriate exceptions.
10. Identify IHSS program rules that direct assessment and authorization of services.
11. Become acquainted with IHSS program forms and tools; and recognize the importance and rationale for accurately documenting in the case record and within CMIPS.
12. Identify the order of the assessment process including the things to consider when an exception exists.
13. Have an understanding of the programs that interact with IHSS and how these programs affect the authorization of services.



# AGENDA

# IHSS 101

## DAY 1

Time	Topic	Notes
8:00 – 8:30	<b>Registration</b>	<ul style="list-style-type: none"> <li>Networking &amp; Continental Breakfast</li> </ul>
8:30 – 9:00	<b>Welcome/Introductions</b>	<ul style="list-style-type: none"> <li>Welcome &amp; Introductions</li> <li>Housekeeping</li> </ul>
9:00 – 10:00	<b>Program Context &amp; Task Category Activity</b>	<ul style="list-style-type: none"> <li>Overview of program history</li> <li>Laws, regulations, and IHSS policies</li> <li>Program administration and oversight</li> <li>Task Category using the AAC as reference</li> </ul>
10:00 – Noon <b>15 min break</b>	<b>What is Uniformity? Assigning the FI Ranking</b>	<ul style="list-style-type: none"> <li>Introduction to AAC and SOC 293</li> <li>Myrtle (video)</li> </ul>
<b>12:00 – 1:15</b>	<b>Lunch</b>	<b>75 minutes</b>
1:15 – 3:15 <b>15 min break</b>	<b>IHSS Scenarios &amp; Field Application</b>	<ul style="list-style-type: none"> <li>Jewel, Margaret &amp; May (videos)</li> </ul>
3:15 – 4:15 (45 min)	<b>Functional Index (FI) Ranking</b>	<ul style="list-style-type: none"> <li>Joe (video) Scenario-based exercise</li> </ul>
4:15 – 4:30	<b>Wrap-up</b>	<ul style="list-style-type: none"> <li>Review key concepts from the day</li> <li>Preview Day 2 content</li> </ul>

## DAY 2

Time	Topic	Notes
8:00 – 8:30	<b>Sign in</b>	<ul style="list-style-type: none"> <li>Continental Breakfast</li> </ul>
8:30 – 9:00	<b>Welcome Overview of Day 2</b>	<ul style="list-style-type: none"> <li>Welcome</li> <li>Learning objectives</li> <li>Activity – Making a Difference</li> </ul>

Time	Topic	Notes
9:00 – 10:30	<b>Intake &amp; Eligibility</b>	<ul style="list-style-type: none"> <li>• Intake types</li> <li>• SOC 873 – Health Care Certification</li> <li>• Inter-county transfer</li> <li>• Temporary absence from the state</li> <li>• Institutionalization</li> <li>• Types and definitions</li> <li>• IPO and SOC 864</li> </ul>
<b>10:30 – 10:45</b>	<b>Break</b>	<b>15 minutes</b>
10:45 – 11:30	<b>The Social Worker’s Role Task Categories--Intro Hourly Task Guidelines</b>	<ul style="list-style-type: none"> <li>• Focus on role and making a difference</li> <li>• Overview of Hourly Task Guidelines</li> </ul>
<b>11:30 – 12:45</b>	<b>Lunch</b>	<b>75 minutes</b>
12:45 – 1:45	<b>Task Categories</b>	<ul style="list-style-type: none"> <li>• Review all categories – definitions, hot spots, and things to consider during the assessment</li> </ul>
1:45 – 2:15	<b>The Assessment</b>	<ul style="list-style-type: none"> <li>• Process</li> <li>• Focus of the assessment</li> <li>• Variable assessments</li> </ul>
<b>2:15 – 2:30</b>	<b>Break</b>	<b>15 minutes</b>
2:30 – 3:15	<b>The Home Visit</b>	<ul style="list-style-type: none"> <li>• Preparation/Checklist</li> <li>• Gathering necessary forms</li> <li>• Personal safety</li> </ul>
3:15 – 4:15	<b>The Interview</b>	<ul style="list-style-type: none"> <li>• Interview skills</li> </ul>
4:15 – 4:30	<b>Wrap-up</b>	

### DAY 3

Time	Topic	Notes
8:00 – 8:30	<b>Sign in</b>	<ul style="list-style-type: none"> <li>• Continental Breakfast</li> </ul>
8:30 – 9:00	<b>Welcome Overview of Day 3</b>	<ul style="list-style-type: none"> <li>• Welcome &amp; Learning objectives</li> </ul>
9:00 – 10:00	<b>Shared Living and Shared Living Exceptions</b>	<ul style="list-style-type: none"> <li>• Shared living and shared living exceptions overview</li> </ul>
10:00 – 11:15 <b>15 min break</b>	<b>Assessment Documentation and Forms</b>	<ul style="list-style-type: none"> <li>• SOC 293 CMIPS – use and importance; CMIPS Screens</li> <li>• Tasks and Notifications</li> <li>• NOAs</li> <li>• Mandated reporter</li> </ul>
11:15 – 11:45	<b>The Home Visit (Activity)</b>	<ul style="list-style-type: none"> <li>• Sarah (Scenario-based exercise)</li> </ul>

Time	Topic	Notes
<b>11:45 – 1:00</b>	<b>Lunch</b>	<b>75 minutes</b>
1:00 – 2:00	<b>After the Home Visit</b>	<ul style="list-style-type: none"> <li>• Gathering information</li> <li>• Assigning FI</li> <li>• Other program and resources</li> </ul>
<b>2:00 – 2:15</b>	<b>Break</b>	<b>15 minutes</b>
2:15 – 2:45	<b>Authorization and Exceptions</b>	<ul style="list-style-type: none"> <li>• Authorization of hours</li> <li>• Hourly Task Guidelines</li> <li>• Exceptions</li> </ul>
2:45 – 3:15	<b>Documentation</b>	<ul style="list-style-type: none"> <li>• Importance of documentation</li> <li>• Key concepts</li> <li>• Narrative guide</li> </ul>
3:15 – 3:45	<b>Authorization of Hours (Activity)</b>	<ul style="list-style-type: none"> <li>• Sarah (Scenario-based exercise)</li> </ul>
3:45 – 4:15	<b>Caring for Self</b>	<ul style="list-style-type: none"> <li>• Why IHSS matters</li> <li>• Caring for self – commitments</li> </ul>
4:15 – 4:30	<b>Wrap-up</b>	<ul style="list-style-type: none"> <li>• Wrap up the day and the training</li> <li>• Evaluations</li> </ul>

# **IHSS TRAINING ACADEMY**

## ***IHSS 101***

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Documentation Worksheet  
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**3: Day 3 Slides**

**4: Uniformity – Assigning Functional Index**

Workbook  
Joe Scenario  
Overview of Schizophrenia

**5: History and Program Administration**

IHSS History  
CDSS Adult Programs Branch Policy Interpretation Form  
SB 1104  
CDSS All-County Information Notice (ACIN) [Example ACIN I-69-04]

**6: Eligibility**

IHSS Eligibility  
IHSS Program Categories  
Community First Choice Option (CFCO) Eligibility Criteria  
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CMIPS User's Manual: County Number Table  
ACL 12-36 [Program Policy for CMIPS II] ACL  
11-19 [IHSS Plus Option (IPO)]  
ACIN I-27-11 [Questions and Answers on IPO from the CWDA Regional Meeting]  
ACL 14-60 [CFCO Implementation]  
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#### **7: Task Categories**

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#### **8: The Home Visit**

The Home Visit Checklist

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Other Assessment Cues

Clarifying Information

Handling Difficult Situations

Communicating in Difficult Situations

Handling Hostility

Things to Consider When Dealing with Someone Who is Hostile

#### **9: Shared Living**

Shared Living Proration Chart

ACL 09-30 [Phase One In-Home Supportive Services (IHSS) Social Worker Training  
Questions/Comments and Answers]

ACL 08-18 [Phase One In-Home Supportive Services (IHSS) Social Worker Training  
Questions/Comments and Answers]

#### **10: Completing the Assessment - CMIPS**

CMIPS Evidence Screens

SOC 293 [Needs Assessment Form]

CMIPS Task List Job Aid

CMIPS Notifications List Job Aid

#### **11: Provider Eligibility**

SOC 839 [In-Home Supportive Services (IHSS) Recipient Time Sheet Signature  
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SOC 847 [Important Information for Prospective Providers about the In-Home Supportive  
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SOC 426 [IHSS Provider Enrollment Form]

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#### **12: Forms**

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Multipurpose Senior Services Program (MSSP)  
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Directory of Regional Centers  
Regional Center Map  
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#### **15: Documentation**

The Wrong and the Better Way to Document  
Case Narrative Guide  
ACIN I-20-15 [Narrative Guide]

#### **16: Scenarios**

Sarah

#### **17: Glossary**

#### **Back Pocket**

The Cure: Refueling Your Tank

## HOURLY TASK GUIDELINES DOCUMENTATION WORKSHEET

Category	Documentation of Hours																		
<b>Domestic (Housework)</b> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 50%; padding: 5px;">FI Rank (Enter)</td> <td style="width: 50%;"></td> </tr> <tr> <td style="padding: 5px;">Guideline</td> <td style="padding: 5px;"><b>6.00 hours per month per household</b></td> </tr> </table>	FI Rank (Enter)		Guideline	<b>6.00 hours per month per household</b>	<p><b>Important:</b> This Worksheet Should Be Used in Conjunction with Time Per Task Tools For All Tasks Include Time for Clean Techniques/Universal Precautions When Required</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 30%;">Task</th> <th style="width: 15%;">Total Need</th> <th style="width: 20%;">Adjustments</th> <th style="width: 35%;">Authorized</th> </tr> </thead> <tbody> <tr> <td>Routine housework</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Additional time</td> <td></td> <td style="background-color: #cccccc;"></td> <td></td> </tr> </tbody> </table> <p>Reason for assistance:</p> <p>Additional information to document Need and Adjustments (include shared living factors and other factors such as size of dwelling, Alt. Resources, etc.):</p> <p>Reason for more or less time than guideline (extra bedding changes, etc.):</p>	Task	Total Need	Adjustments	Authorized	Routine housework				Additional time					
FI Rank (Enter)																			
Guideline	<b>6.00 hours per month per household</b>																		
Task	Total Need	Adjustments	Authorized																
Routine housework																			
Additional time																			
<b>Laundry</b> In-home <input type="checkbox"/> Out-of-home <input type="checkbox"/> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 50%; padding: 5px;">FI Rank (Enter)</td> <td style="width: 50%;"></td> </tr> <tr> <td style="padding: 5px;">Guideline In-Home</td> <td style="padding: 5px;"><b>1.00 hour per week</b></td> </tr> <tr> <td style="padding: 5px;">Guideline Out-of-Home</td> <td style="padding: 5px;"><b>1.50 hours per week</b></td> </tr> </table> <p><i>Note: Laundry facilities <u>on premises</u> of apartment complex, mobile home park, etc. are considered in-home (DSS Policy).</i></p>	FI Rank (Enter)		Guideline In-Home	<b>1.00 hour per week</b>	Guideline Out-of-Home	<b>1.50 hours per week</b>	<table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 30%;">Task</th> <th style="width: 15%;">Total Need</th> <th style="width: 20%;">Adjustments</th> <th style="width: 35%;">Authorized</th> </tr> </thead> <tbody> <tr> <td>Routine laundry</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Additional time</td> <td></td> <td style="background-color: #cccccc;"></td> <td></td> </tr> </tbody> </table> <p>Reason for assistance:</p> <p>Additional information to document Need and Adjustments (include laundry done separately, etc.):</p> <p>Reason for more or less time than guideline (extra laundry due to incontinence, etc.):</p>	Task	Total Need	Adjustments	Authorized	Routine laundry				Additional time			
FI Rank (Enter)																			
Guideline In-Home	<b>1.00 hour per week</b>																		
Guideline Out-of-Home	<b>1.50 hours per week</b>																		
Task	Total Need	Adjustments	Authorized																
Routine laundry																			
Additional time																			

### Shopping and Errands

FI Rank (Enter)	
Guideline Food Shopping	1.00 hour per week
Guideline Other Shopping/Errands	0.50 hours per week

Task	Total Need	Adjustments	Authorized
Food shopping			
Other shopping/errands			

Reason for assistance:

Additional information to document Need and Adjustments (include distance to nearest store consistent with needs and economy, need for shopping to be done separately, etc.):

Reason for more or less time than guideline:

### Meal Preparation

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

	Low	High
Rank 2	03:01	07:00
Rank 3	03:30	07:00
Rank 4	05:15	07:00
Rank 5	07:00	07:00

**Note: Compare Total Need with above range.**

Needs help with ☐ Breakfast ☐ Lunch ☐ Dinner

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

Reason for assistance:

Shared living exceptions (required when services not prorated):

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



## Meal Cleanup

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

	Low	High
Rank 2	01:10	03:30
Rank 3	01:45	03:30
Rank 4	01:45	03:30
Rank 5	02:20	03:30

**Note: Compare Total Need with above range.**

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

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

Reason for assistance:

Shared living exceptions:

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

## Ambulation

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

	Low	High
Rank 2	00:35	01:45
Rank 3	01:00	02:06
Rank 4	01:45	03:30
Rank 5	01:45	03:30

**Note: Compare Total Need with above range.**

### Walking Inside Home

From/To	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need Per Week

### Retrieving Assistive Device(s)

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

### Assistance From House To Car And Car To House For Medical Appt. & Alt. Resource

	Time Assessed	# of Times Per Month	Total Need Per Month	Total Need Per Week (Monthly Need ÷ 4.33)
From House to Car				
From Car to House				

Reason for assistance:

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

### Bathing, Oral Hygiene, and Grooming

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

	Low	High
Rank 2	00:30	01:55
Rank 3	01:16	03:09
Rank 4	02:21	04:05
Rank 5	03:00	05:06

**Note:** Compare Total Need with above range.

### Routine Bed Baths

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

	Low	High
Rank 2	00:30	01:45
Rank 3	01:00	02:20
Rank 4	01:10	03:30
Rank 5	01:45	03:30

**Note:** Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with getting in/out of tub/shower				
Oral hygiene				
Grooming				
Reason for assistance:				
Additional information to document exceptions to guidelines and identification of Alt. Resources:				

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Bed baths				
Reason for assistance:				
Additional information to document exceptions to guidelines and identification of Alt. Resources:				

**Dressing**

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

	Low	High
Rank 2	00:34	01:12
Rank 3	01:00	01:52
Rank 4	01:30	02:20
Rank 5	01:54	03:30

**Note:** Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with clothing, shoes, socks/stockings				
Assistance with putting on/taking off corsets, elastic stockings, braces, etc.				
Bringing tools to consumer				
Reason for assistance:				
Additional information to document exceptions to guidelines and identification of Alt. Resources:				

**Bowel and Bladder Care**

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

	Low	High
Rank 2	00:35	02:00
Rank 3	01:10	03:20
Rank 4	02:55	05:50
Rank 5	04:05	08:00

**Note:** Compare Total Need with above range.

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with getting on/off toilet/commode				
Wiping/cleaning consumer				
Assist with using, emptying, cleaning bedpans/commodes, urinals, etc.				
Application of diapers				
Changing barrier pads				
Reason for assistance:				
Additional information to document exceptions to guidelines and identification of Alt. Resources:				

## Menstrual Care

**Functional Index Rank does not apply.**

	Low	High
	0.28	0.80

	Low	High
	00:17	00:48

**Note: Compare Total Need with above range.**

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

Reason for assistance:

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

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

## Transfer

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

	Low	High
Rank 2	00:30	01:10
Rank 3	00:35	01:24
Rank 4	01:06	02:20
Rank 5	01:10	03:30

**Note: Compare Total Need with above range.**

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

Reason for assistance:

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

**Feeding**

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

	Low	High
Rank 2	00:42	02:18
Rank 3	01:10	03:30
Rank 4	03:30	07:00
Rank 5	05:15	09:20

**Note:** Compare Total Need with above range.

**Feeding Or Related Assistance With Consumption Of Food And Fluid Intake**

Task	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need
Breakfast				
Lunch				
Dinner				
Snacks				
Other Fluids				

Reason for assistance:

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

**Repositioning / Rubbing Skin**

**Functional Index Rank does not apply.**

	Low	High
	0.75	2.80

	Low	High
	00:45	02:48

**Note:** Compare Total Need with above range.

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

Reason for assistance:

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

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

*Functional Index Rank does not apply.*

	Low	High
	0.47	1.12

	Low	High
	00:28	01:07

*Note: Compare Total Need with above range.*

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

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

**Maintaining/Cleaning Prosthetic Devices And Vision And Hearing Aids**

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

**Setting Up Medications**

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

**Assistance With Self-Administration Of Medications**

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

Reason for assistance:

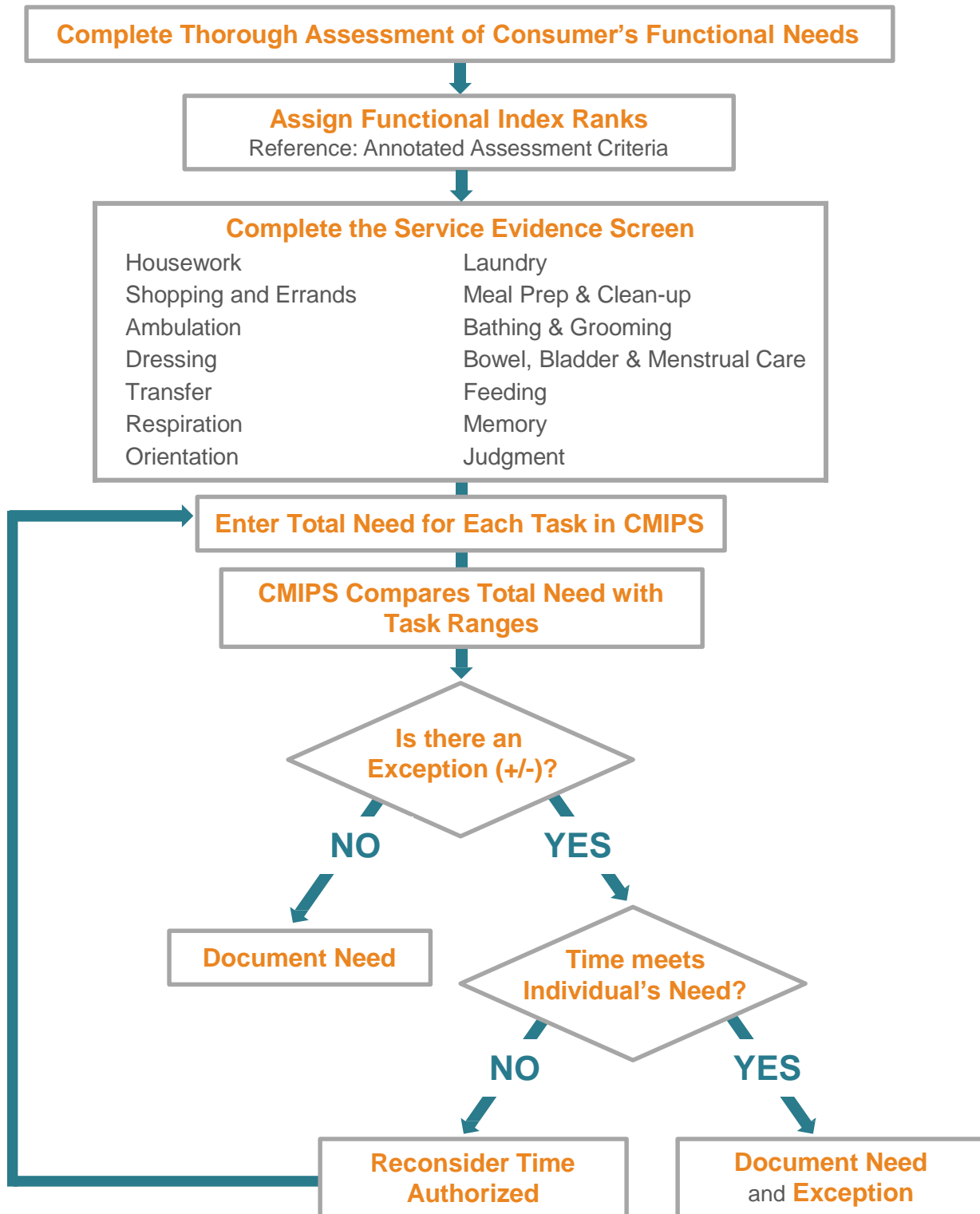
Additional information to document exceptions to guidelines and identification of Alt. Resources:

<b>Accompaniment to Medical Appts.</b>	<table border="1"> <thead> <tr> <th>Appt. Type (Specify doctor, dentist, etc.)</th><th>Frequency of Visits</th><th>Travel Time Each Way</th><th>Total Monthly Need</th><th>Average Weekly Need*</th></tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Reason for assistance:</p> <p>Additional information to document exceptions to guidelines and identification of Alt. Resources:</p> <p><b><i>*Remember that SOC 293 hours reflect weekly need, so monthly need must be divided by 4.33 to arrive at weekly need. (Example: 1.00 hour each way 1 time per month would be a monthly need of 2.00 hours ÷ 4.33 = .46 weekly)</i></b></p>	Appt. Type (Specify doctor, dentist, etc.)	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*															
Appt. Type (Specify doctor, dentist, etc.)	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*																	
<b>Accompaniment to Alt. Resources</b>  <i>Note: Assessed only when transport is to/from site where Alt. Resources provide IHSS-type services in lieu of IHSS. Example: Transport to Senior Center where consumer receives meal.</i>	<table border="1"> <thead> <tr> <th>Name of Alt. Resource</th><th>Frequency of Visits</th><th>Travel Time Each Way</th><th>Total Monthly Need</th><th>Average Weekly Need*</th></tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Reason for assistance:</p> <p>Additional information to document exceptions to guidelines and identification of Alt. Resources:</p> <p><b><i>*Remember that SOC 293 hours reflect weekly need, so monthly need must be divided by 4.33 to arrive at weekly need. (Example: 1.00 hour each way 1 time per month would be a monthly need of 2.00 hours ÷ 4.33 = .46 weekly)</i></b></p>	Name of Alt. Resource	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*															
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<b>Heavy Cleaning</b>	<table border="1"> <thead> <tr> <th>Task</th><th>Hours Assessed</th></tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table> <p>Reason for assistance:</p>	Task	Hours Assessed																		
Task	Hours Assessed																				

<p><b>Remove Ice, Snow</b></p> <p><i>Note: Limited to removal of snow, or other hazardous substances from entrances and essential walkways when access to the home is hazardous.</i></p>	<table border="1"> <thead> <tr> <th data-bbox="565 149 1287 195">Task</th> <th data-bbox="1287 149 1572 195">Hours Assessed*</th> </tr> </thead> <tbody> <tr> <td data-bbox="565 195 1287 235"></td> <td data-bbox="1287 195 1572 235"></td> </tr> <tr> <td data-bbox="565 235 1287 275"></td> <td data-bbox="1287 235 1572 275"></td> </tr> <tr> <td data-bbox="565 275 1287 315"></td> <td data-bbox="1287 275 1572 315"></td> </tr> </tbody> </table> <p>Reason for assistance:</p> <p><i>*Remember that this service is seasonal and should not be authorized on a yearly basis.</i></p>	Task	Hours Assessed*						
Task	Hours Assessed*								
<p><b>Yard Hazard Abatement</b></p> <p><i>Note: Limited to light work in the yard for removal of high grass or weeds and rubbish when constituting a fire hazard.</i></p>	<table border="1"> <thead> <tr> <th data-bbox="565 539 1287 585">Task</th> <th data-bbox="1287 539 1572 585">Hours Assessed*</th> </tr> </thead> <tbody> <tr> <td data-bbox="565 585 1287 625"></td> <td data-bbox="1287 585 1572 625"></td> </tr> <tr> <td data-bbox="565 625 1287 665"></td> <td data-bbox="1287 625 1572 665"></td> </tr> <tr> <td data-bbox="565 665 1287 705"></td> <td data-bbox="1287 665 1572 705"></td> </tr> </tbody> </table> <p>Reason for assistance:</p> <p><i>*Remember that this service should not be routinely authorized on an ongoing basis.</i></p>	Task	Hours Assessed*						
Task	Hours Assessed*								



## UTILIZATION OF HOURLY TASK GUIDELINES – PROCESS



[illegible]

# IHSS 101 Day 1



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**IHSS HISTORY**

**Before 1972**

- County administered welfare programs for aged, blind and disabled people

**January 1, 1973**

- SSI/SSP
- Attendant Care was replaced by the Homemaker Chore Program

**Consolidation**

- Consolidation of the Homemaker Chore Program into a single IHSS Program

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**IHSS HISTORY**

**Significant discrepancy**

- Significant discrepancy in average hours authorized from county to county
- Time per Task Standards for Domestic, Laundry, Shopping, and Errands

**CMIPS**

- CMIPS (Case Management Information and Payrolling System)
  - Payroll taxes
  - Help workers manage caseload
  - Collect program data

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**IHSS HISTORY**

**Uniformity**

- A way to quantify the level of need,
- Compare the level of impairment of consumers, and
- Compare the average level of impairment between workers, units, and counties.

1993	2004	2009	2012
PCSP (Personal Care Services Program) First Federal Participation program	IPW	IPO (replaced IPW)	CFCO

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**IHSS HISTORY**

**Demographic Changes**

- Originally primarily aged
- Increase in disabled
- Increase in children
- Increase in hours per case



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**IHSS TODAY**



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**IHSS TODAY**

- **Four Programs**
  - PCSP (Personal Care Services Program)
  - IPO (IHSS Plus Option)
  - Residual
  - CFCO
- **Quality Assurance Component**
  - Quality Assurance Bureau
  - Hourly Task Guidelines
  - IHSS Training Academy
- **Program Integrity Protocols**





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IHSS TODAY

**State *Statutes* Regulations, and IHSS Policies**

- United States Code (USC)
  - Code of Federal Regulations (CFR)
- Welfare and Institutions Code (WIC)
  - Manual of Policies and Procedures (MPP)
- All-County Letters (ACLs)
- All-County Information Notices (ACINs)
- All-County Program Manager Letters
- Policy Interpretations (PIs)
- CMIPS Manual
- CMIPS Informational Notification





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IHSS TODAY

**Regulations**

- Laws (statutes) are sometimes very general.
- Regulations are needed to apply specificity and detail prior to implementation of laws.
- State agency that has jurisdiction writes regulations which must go through an administrative process which includes time for public comment.





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IHSS TODAY

**Legal Remedies**

- At times, consumers, advocates or advocacy agencies may disagree with laws or regulations, or decisions made on individual cases.
- Disagreements may be handled in several ways:
  - Locally
  - State hearing
  - Court case





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IHSS TODAY

### IHSS Program Administration and Oversight

Counties

Counties are responsible for administering on a local basis.

CDSS

**CDSS is responsible for:**

- Overseeing how counties administer the program,
- Ensuring the applicable laws are followed, and
- Conducting administrative hearings.

DHCS

**DHCS is responsible for oversight and ensuring the integrity of programs that receive Federal Medicaid funding, including fraud investigation in IHSS.**

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IHSS TODAY

### IHSS Program Administration and Oversight

Other State Oversight

Federal Level

- Centers for Medicare and Medicaid (CMS) is responsible for overseeing how states administer the Medicaid program.
- In California, the Medicaid program is called Medi-Cal.

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IHSS TODAY

### IHSS Website

<http://www.cdss.ca.gov/agedblinddisabled/PG1296.htm>

Reference materials for workers

Reference materials for workers

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IHSS TODAY

Program Philosophy

Overall Philosophy	Eligibility	Needs Not Covered
Program scope defined by regulations MPP §30-757.	Covers persons who are aged, blind and disabled who meet eligibility requirements and need IHSS to avoid out of home care and remain safely in their homes.	Doesn't provide for every need a person may have: <ul style="list-style-type: none"> <li>Friendly visiting</li> <li>Socialization</li> <li>24-hour care</li> </ul>

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ACTIVITY: TASK CATEGORIES

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FUNCTIONAL ASSESSMENT OVERVIEW

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## FUNCTIONAL ASSESSMENT

Consumers with similar needs should receive similar services.

All consumers should have an equal opportunity to experience independence and safety.

The same standards should be used with all consumers.



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## FUNCTIONAL RANKINGS



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## FUNCTIONAL RANKINGS

### Functional Index Ranking

Consumer Dependence	Documents the social worker's assessment of the consumer's dependence on human assistance.
Level of Need	Focus is on level of need, not services provided.
FI Ranking	Higher FI ranking may not indicate a need for more hours.
Individual Need	Is based on individual need.



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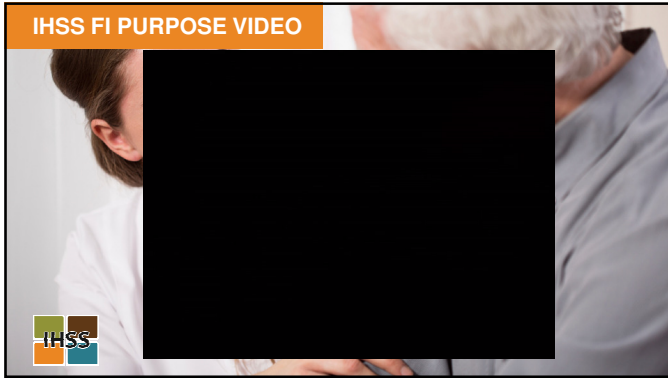
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FUNCTIONAL RANKINGS

Functional Index Ranking

Functional Index Ranking

- Evaluates effect of recipient's physical, cognitive and emotional ability.
- Consumer's habits may differ from actual abilities.
- Medical diagnosis is an indicator, but does not dictate need.
- Assistive devices may improve functional ability.

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FUNCTIONAL RANKINGS

Functional Index Scales Include

<ul style="list-style-type: none"> <li>Housework</li> <li>Laundry</li> <li>Shopping and errands</li> <li>Meal preparation and cleanup</li> <li>Ambulation</li> <li>Bathing and grooming</li> <li>Dressing</li> </ul>	<ul style="list-style-type: none"> <li>Bowel, bladder, and menstrual care</li> <li>Transfer</li> <li>Feeding</li> <li>Respiration</li> <li>Memory</li> <li>Orientation</li> <li>Judgment</li> </ul>
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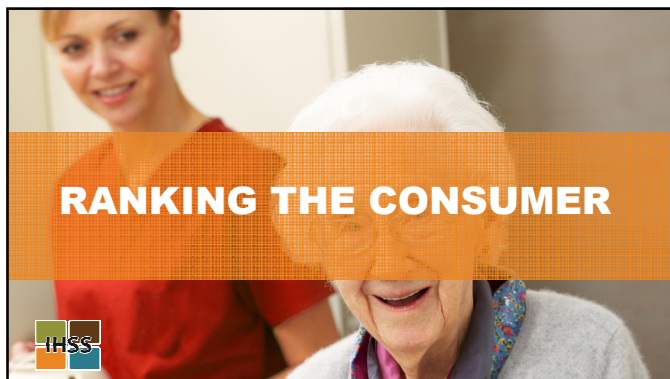
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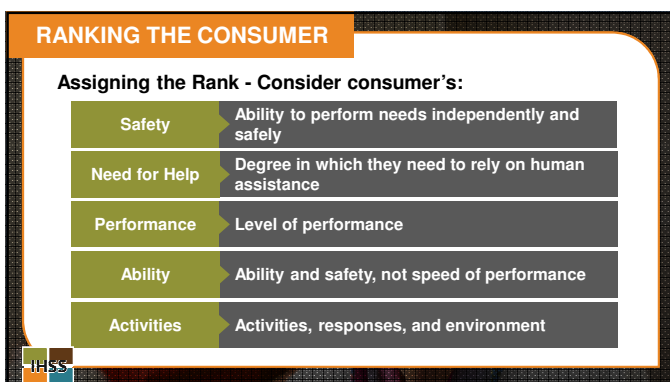
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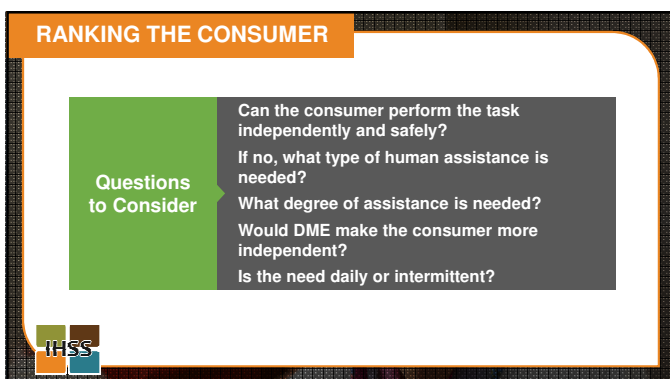
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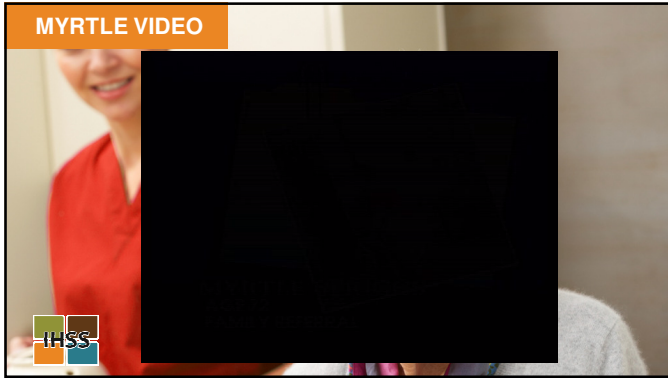
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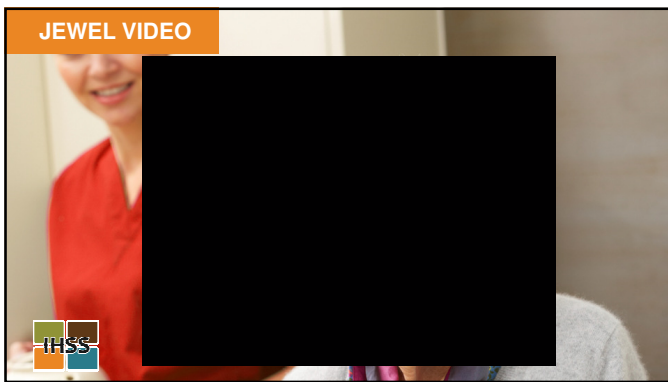
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# IHSS 101 Day 1

COMPLETE FUNCTIONAL  
INDEX RANKINGS: JOE



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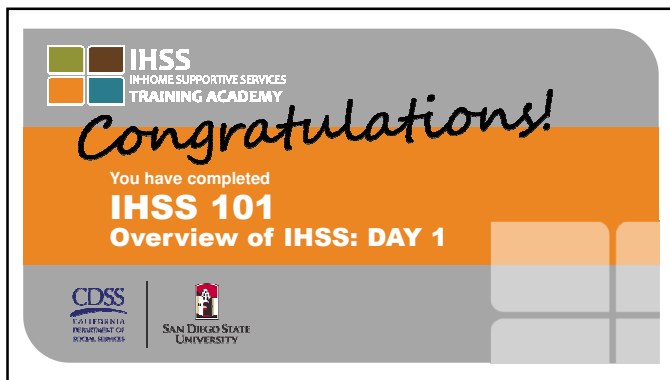
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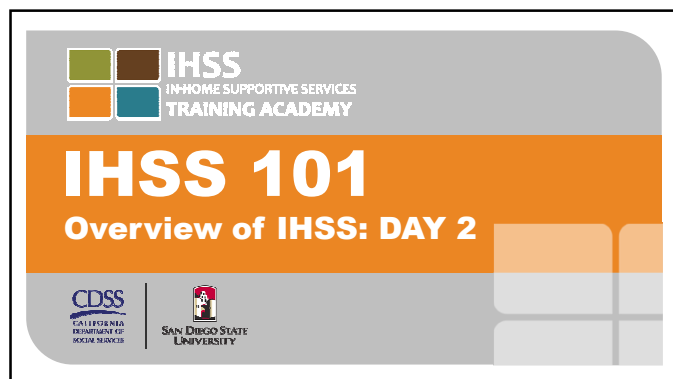
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**INTAKE, ELIGIBILITY, AND ASSESSMENT**

**INTAKE (ACL 12-36)**

Inquiry
Referral
Application

**IHSS**

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**INTAKE, ELIGIBILITY, AND ASSESSMENT**

**INTAKE (ACL 12-36)**

<b>Inquiry</b>	<ul style="list-style-type: none"><li>Non person-specific call with informational inquiry regarding IHSS program</li><li>No action needed</li></ul>
Referral	
Application	

**IHSS**

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**INTAKE, ELIGIBILITY, AND ASSESSMENT**

**INTAKE (ACL 12-36)**

Inquiry	<ul style="list-style-type: none"><li>Person specific call by third party who does not have legal authority</li><li>Record contact information as referral</li><li>Follow up regarding need/desire for application</li></ul>
<b>Referral</b>	
Application	

**IHSS**

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### INTAKE, ELIGIBILITY, AND ASSESSMENT

#### INTAKE (ACL 12-36)

Inquiry

Referral

Application

- If desire stated must take application
- Cannot deny or dissuade based on information communicated during a phone call or face-to-face visit
- Assess for eligibility and NOA sent with county's determination

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### INTAKE, ELIGIBILITY, AND ASSESSMENT

WHO'S ELIGIBLE?	OWN HOME
<ul style="list-style-type: none"> <li>Aged, blind or disabled</li> <li>Financial (low income and resources)                             <ul style="list-style-type: none"> <li>SSI</li> <li>Medi-Cal (Share of Cost)</li> </ul> </li> <li>Own home</li> <li>California residence</li> <li>U.S. citizen or legal resident with certain restrictions</li> <li>Threshold level of need (at risk of placement)</li> </ul>	<p>For IHSS purposes, an individual's own home is the place in which that individual chooses to reside except an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or board and care facility [MPP §30-701(o)(2)], even if she/he chooses to live there.</p>

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### INTAKE, ELIGIBILITY, AND ASSESSMENT

#### OTHER THINGS TO CONSIDER

- Inter-County Transfer
- Temporary Absence from the State
- Institutionalization
  - Hospitalization
  - Incarceration
  - Board and Care
  - Skilled Nursing Facility (SNF)

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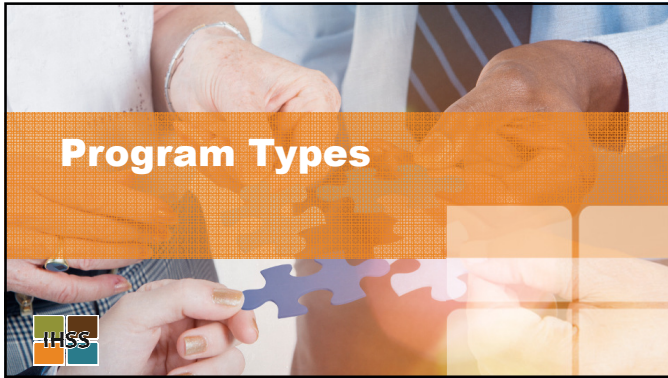
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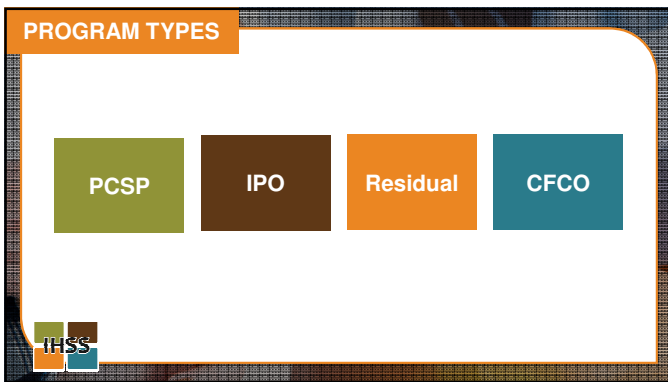
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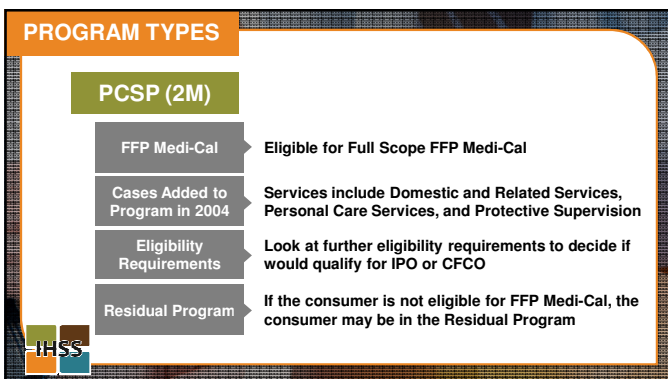
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**PROGRAM TYPES**

**IPO (2L)**   **CFCO (2K)**

**Home and Community-Based Services**

- Federal Program – Administered by CDSS
- Medi-Cal funding
- Eligibility similar with important differences
- Provides for self-directed personal assistance services

**IHSS**

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**PROGRAM TYPES**

**PCSP**   **IPO**   **Residual**   **CFCO**

**HOME AND COMMUNITY - BASED SERVICES**

**Philosophy**

- Self-direction
- Person-centered
- Participant-directed care needs

**IHSS**

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**Eligibility**

**IHSS**

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**ELIGIBILITY**

**IHSS PROGRAM: IPO (2L)**

ELIGIBLE	NOT ELIGIBLE
Eligible for Full Scope FFP Medi-Cal	<p>Not eligible for Personal Care Services due to one or more of the following:</p> <ul style="list-style-type: none"> <li>▪ Consumer has a spouse for a provider; or</li> <li>▪ Consumer is a minor child with a parent for a provider; or</li> <li>▪ Consumer receives Advance Pay; or</li> <li>▪ Consumer receives Restaurant Meal Allowance</li> </ul>

**IHSS**

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**ELIGIBILITY**

**IHSS PROGRAMS: CFCO (2K)**

Community First Choice Option

Must be eligible for Full-Scope, Federal Financial Participation (FS FFP) Medi-Cal

+

Meet CFCO Nursing Facility Level Of Care (NF LOC) eligibility based on...

→

ONE of the following criteria

**IHSS**

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**ELIGIBILITY**

**IHSS PROGRAMS: CFCO**

Nursing Facility Level Of Care (NF LOC) eligibility is:

Have a total assessed need of:

195 or more IHSS hours per month

(excluding heavy cleaning and yard hazard abatement)

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OR

**IHSS**

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**ELIGIBILITY**

**IHSS PROGRAMS: CFCO**

Have a total assessed need of: **195 or more IHSS hours per month** **+** have 3 or more of the following services with the designated FI Ranks:

SERVICE	FI RANK
Eating	3-6
Bowel & Bladder /Menstrual Care	3-6
Bathing/Grooming	4-5
Dressing	4-5
Mobility Inside	4-5
Transferring	4-5
Respiration	5-6
Paramedical	Yes

**OR**

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**ELIGIBILITY**

**IHSS PROGRAMS: CFCO**

Have a combined FI Rank of 6 in Mental Functioning

FUNCTIONAL RANKS			
Housework	5	Laundry	5
Shopping and Errands	5	Meal Prep and Clean-up	5
Ambulation	5	Bathing and Grooming	1
Dressing	1	Bowel, Bladder and Menstrual Care	1
Transfer	1	Feeding	1
Respiration	1	Memory	2
Orientation	2	Judgment	2

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**ELIGIBILITY**

**IHSS PROGRAMS: CFCO (2K)**

**Required Services**

- Assistance with ADLs, IADLs and health related tasks
- Acquisition, maintenance and enhancement of skills necessary for the individual to accomplish the tasks
  - Teaching and Demonstration
- Back-up Systems to ensure continuity of services and supports
  - SOC 864
- Voluntary training for recipients on how to manage care providers

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**ELIGIBILITY**

IPO	CFCO
<ul style="list-style-type: none"> <li>FS FFP Medi-Cal</li> <li>Goal to promote independence</li> <li>S.P.A.M.</li> <li>Risk Assessment (SOC 864)</li> </ul>	<ul style="list-style-type: none"> <li>FS FFP Medi-Cal</li> <li>Goal to promote independence</li> <li>S.P.A.M.</li> <li>Risk Assessment (SOC 864)</li> <li>NF LOC</li> <li>Teaching and Demonstration</li> <li>Voluntary training for recipients</li> </ul>

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**ELIGIBILITY**

Not eligible for Full Scope FFP Medi-Cal

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Meet the IHSS eligibility criteria [MPP 30-755]



IHSS

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**ELIGIBILITY**

**INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT FORM (SOC 864)**

What is important...

- Individuals are making informed decisions
- You have conversations about risk to ensure individuals are informed
- You document communication pertaining to risks, options, and supports utilizing this form

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ELIGIBILITY



Completing the Individualized Back-Up Plan and Risk Assessment Form (SOC 864)



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ELIGIBILITY



WHAT IS THE SOCIAL WORKER'S ROLE?



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ELIGIBILITY

ULTIMATE GOALS OF THE SOCIAL WORKER

Assess	To assess needs and authorize hours and tasks needed for the consumer to stay safely in their home
Help Implement and Manage	To help the consumer implement and manage an appropriate care plan
Identify Resources	To identify and make referrals to resources which may augment IHSS and contribute to their ability to remain safely in the home and/or reduce the need for IHSS
Identify Risk Factors	To identify risk factors and address the risk factors appropriately



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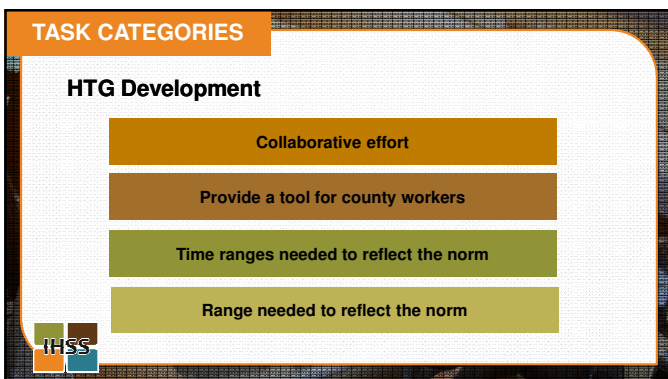
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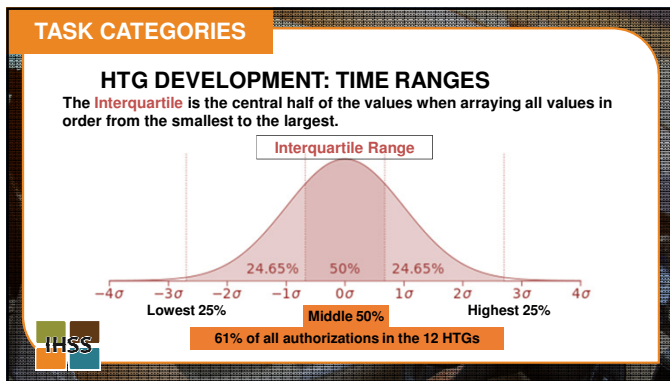
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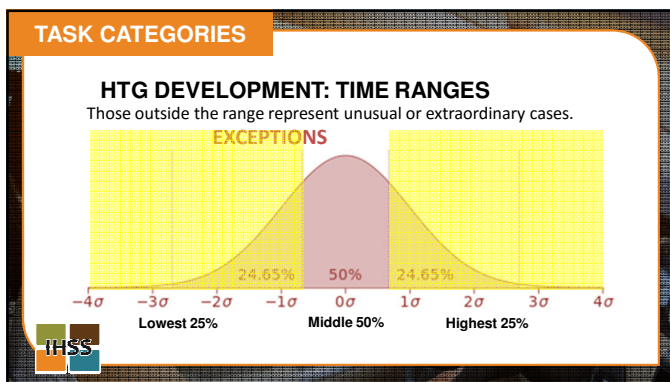
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**TASK CATEGORIES**

### HTG Core Elements

- Do not replace the individualized assessment process.
- HTG ranges relate to the consumer's FI.
- No individual can have a range of time applied unless the time range meets his/her needs.
- When individual assessment indicates a need for time different than the HTG range, the different amount of time (exception) shall be authorized up to the allowable program limits (195/283 caps).
- The need for the authorized service level shall be documented in the case file.

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TASK CATEGORIES

SERVICES NOT AFFECTED BY HTGs

SERVICES	
Domestic services	Ambulation
Preparation of meals	Moving in and out of bed (transfer)
Meal clean-up	Bathing, oral hygiene, grooming
Routine laundry etc.	Rubbing skin, repositioning, etc.
Shopping for food	Care and assistance with prosthesis
Other shopping and errands	Accompaniment to medical appointment
Heavy cleaning	Accompaniment to alternative resources
Respiration	Remove grass, weeds, rubbish
Bowel and bladder care	Remove ice, snow
Feeding	Protective supervision
Routine bed baths	Teaching and demonstration
Dressing	Paramedical services
Menstrual care	Meal allowance

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TASK CATEGORIES

HOURLY TASK GUIDELINES

SERVICES	
Domestic services	Ambulation
Preparation of meals	Moving in and out of bed (transfer)
Meal clean-up	Bathing, oral hygiene, grooming
Routine laundry etc.	Rubbing skin, repositioning, etc.
Shopping for food	Care and assistance with prosthesis
Other shopping and errands	Accompaniment to medical appointment
Heavy cleaning	Accompaniment to alternative resources
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Menstrual care	Meal allowance

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TASK CATEGORIES

TASK CATEGORY ACTIVITY

- Things that are surprising
- Highlight good questions
- Overview of Hot Spots

SERVICES	
Domestic services	Ambulation
Preparation of meals	Moving in and out of bed (transfer)
Meal clean-up	Bathing, oral hygiene, grooming
Routine laundry etc.	Rubbing skin, repositioning, etc.
Shopping for food	Care and assistance with prosthesis
Other shopping and errands	Accompaniment to medical appointment
Heavy cleaning	Accompaniment to alternative resources
Respiration	Remove grass, weeds, rubbish
Bowel and bladder care	Remove ice, snow
Feeding	Protective supervision
Routine bed baths	Teaching and demonstration
Dressing	Paramedical services
Menstrual care	Meal allowance

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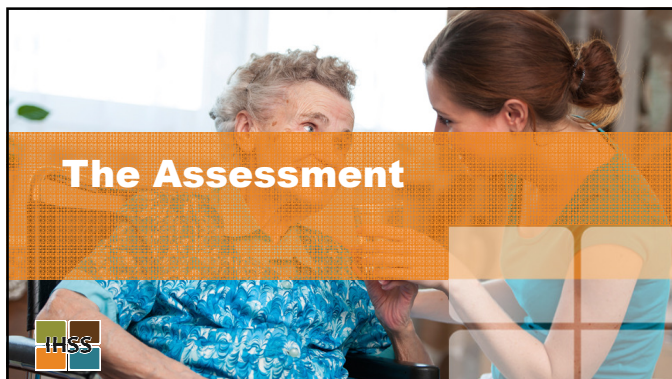
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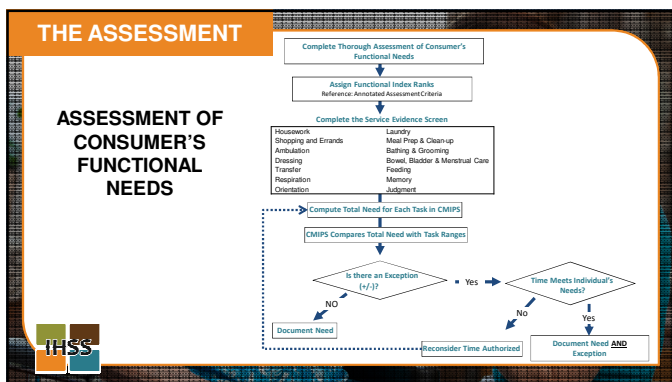
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**THE ASSESSMENT**

**The Assessment Process Should:**

- Identify the degree of the consumer's ability to perform IHSS tasks independently and safely.
- Identify the degree of the consumer's need to rely on human assistance of some sort.
- Identify the frequency with which the task must be performed and how long it takes to perform the task.
- Include careful observation to ascertain information that most accurately identifies the consumer's need.

The IHSS logo is in the bottom left corner.

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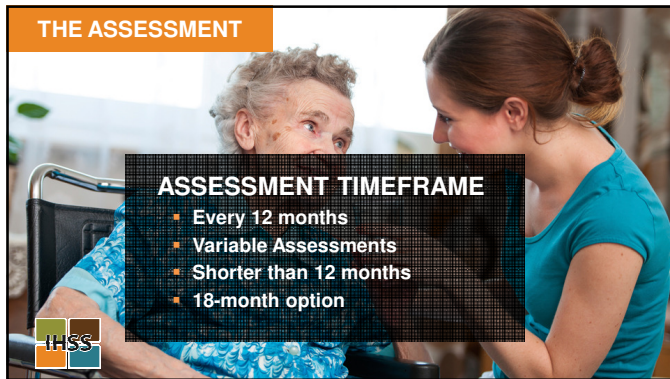
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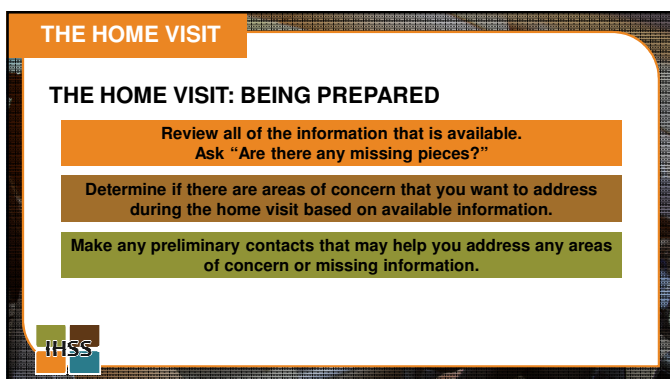
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**THE HOME VISIT**

**THE HOME VISIT: BEING PREPARED**

Print	Print CMIPS packet.
Gather	Gather any other necessary forms.
Use Checklist	Use a checklist to help prepare.



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**THE HOME VISIT**

**PERSONAL SAFETY FOR THE HOME VISIT**

Be proactive.
Be prepared.
Be alert.



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**THE HOME VISIT** **Safety Considerations: Meth Lab Video**





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**THE HOME VISIT**

**INTERVIEWING SKILLS**

**Purpose of the Initial Interview**

- Build rapport with the consumer.
- Explain the program and its components.
- Gain information about the consumer's situation, functional abilities, and limitations.

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**THE HOME VISIT**

The interview is a two-way process. The consumer is looking at the social worker for cues that they understand and care. The social worker is looking for information to support service needs.

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**THE HOME VISIT**

**Teach Back Activity: Interview**

- Building rapport
- Asking the right questions
- Other assessment cues
- Clarifying information
- Handling difficult situations

**IHSS**



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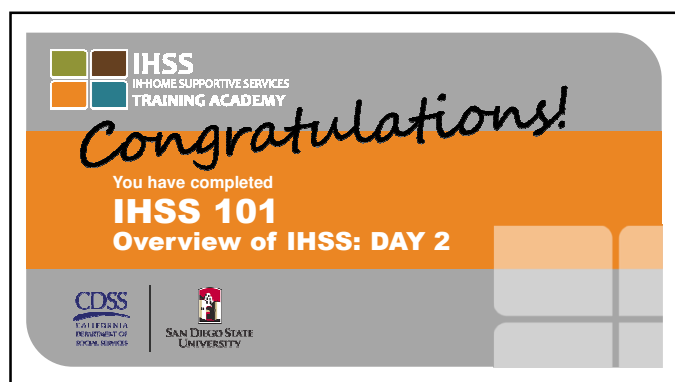
**IHSS**  
IN-HOME SUPPORTIVE SERVICES  
TRAINING ACADEMY

*Congratulations!*

You have completed  
**IHSS 101**  
Overview of IHSS: DAY 2

**CDSS**  
CALIFORNIA  
DEPARTMENT OF  
SOCIAL SERVICES

**SAN DIEGO STATE  
UNIVERSITY**



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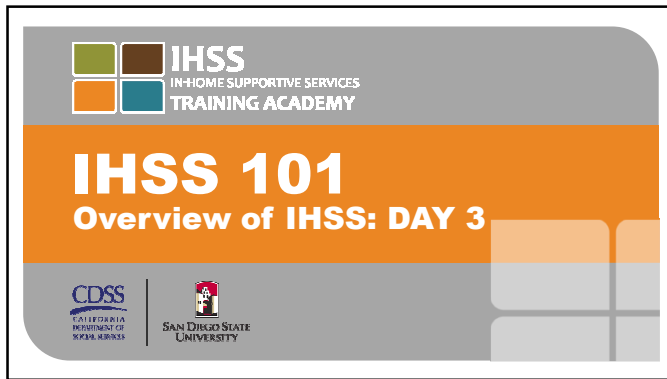
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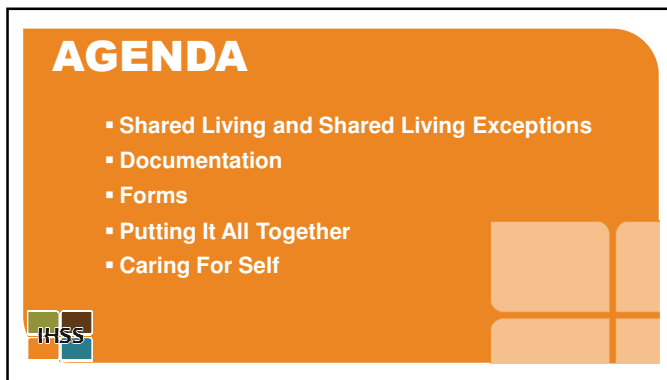
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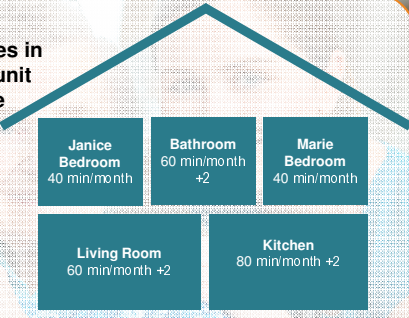
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**SHARED LIVING**

Consumer resides in the same living unit with one or more persons.



The diagram shows a house with a gabled roof. Inside, there are five rooms represented by boxes:

- Janice Bedroom**: 40 min/month
- Bathroom**: 60 min/month +2
- Marie Bedroom**: 40 min/month
- Living Room**: 60 min/month +2
- Kitchen**: 80 min/month +2

IHSS logo

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**SHARED LIVING**

**“Proration”**  
is a process of determining the consumer’s individual need when the consumer has housemates.  
IHSS pays only for the consumer’s share of services met in common with housemates.



IHSS logo

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**SHARED LIVING**

Some IHSS services must be prorated when the consumer is in a shared living arrangement.  
These services are:

- Domestic
- Laundry
- Meal Preparation and Cleanup
- Shopping for Food, Errands
- Heavy Cleaning, Yard Hazard Abatement, Snow Removal
- Protective Supervision, Teaching and Demonstration

IHSS logo

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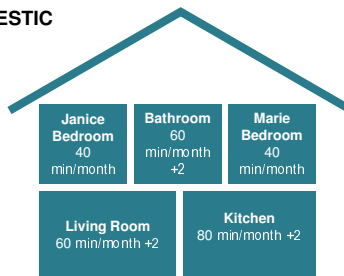


**SHARED LIVING**

**PRORATION OF DOMESTIC**

When prorating, consider rooms/areas used:

- In common
- Solely by consumer
- Solely by others



Janice Bedroom 40 min/month

Bathroom 60 min/month +2

Marie Bedroom 40 min/month

Living Room 60 min/month +2

Kitchen 80 min/month +2

IHSS

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**SHARED LIVING**

**PRORATION OF RELATED**

When prorating, consider:

- Needs met in common
- The number of people sharing the service
- Whether practices differ on some days

Days	Breakfast	Lunch	Dinner	Snacks /Liquids
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

IHSS

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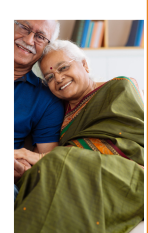
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**SHARED LIVING**

**EXCEPTIONS...**

- Able and Available Spouse
- Live-In Provider
- Consumer moves in with a relative primarily to receive care
- Landlord – Tenant (consumer is Landlord)
- Landlord – Tenant (consumer is Tenant)
- Consumer is a child and lives with parent(s)
- Consumer has a child under the age of 14 who is not eligible and does not need IHSS



IHSS

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DOCUMENTATION

**CULTURE OF INFORMATION: CMIPS**

- Provides modern, web-based case management functionality
- Replaces old data transfers with over 50 interfaces
- More timely verifications and interactions
- Centralized processing of payroll
- Significantly enhanced access to timesheet information



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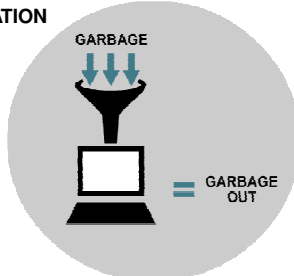
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DOCUMENTATION

**ASSESSMENT DOCUMENTATION**

- Complete all CMIPS screens accurately.
- Data from CMIPS can impact:
  - How services are authorized
  - Response to consumer in the event of a disaster
- Provides essential statistical information.



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DOCUMENTATION

## COMPLETING ASSESSMENT DOCUMENTATION

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DOCUMENTATION

## TASKS AND NOTIFICATIONS

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DOCUMENTATION

## NOTICE OF ACTION (NOA)

- Timely and adequate notice
- Reason Codes
- How to count 10 days
- Exceptions to the 10-day notice

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DOCUMENTATION

THE IHSS PROVIDER

- Provider Modes
- IHSS Providers selected by the consumer
- Homemaker
- Public Authority
- Provider Orientation Process





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DOCUMENTATION

Completing the Provider Detail Screen

- Provider Eligibility
- Puts providers into the CMIPS system
- Links provider and consumer





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Forms





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**FORMS**

What forms must the social worker know about?



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**FORMS**

Being a Mandated Reporter



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**FORMS**

ACTIVITY: The Home Visit

Sarah



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FORMS

AFTER THE HOME VISIT

- Gather necessary information from other resources
  - Who else has important information?
- Health Care Certification
- Assign Functional Index (FI) rankings
- Referrals
- Alternative resources
- Durable Medical Equipment (DME)
- Documentation





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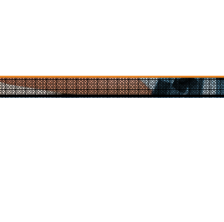
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FORMS

PROGRAMS THAT INTERACT WITH IHSS

- Area Agencies on Aging (AAA)
- Multipurpose Senior Services Program (MSSP)
- County Case Management Programs
- Community Based Adult Services Program (CBAS)
- Alzheimer's Day Care Resource Center Program
- Regional Centers
- VA Aid and Attendance Program
- Waivers





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FORMS

ACTIVITY: Addressing Issues

Sarah





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FORMS

**WHEN AUTHORIZING SERVICES**

- IHSS operates under a "safety" standard, not a "comfort" standard.
- MPP 30-761.25 states:

*"no services shall be determined to be needed which the consumer is able to perform in a safe manner without an unreasonable amount of physical or emotional stress."*



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FORMS

**WHEN AUTHORIZING SERVICES**

- Consider functional rankings first
- Break service up into components
- Ask about the frequency and duration of each task
- Consult existing regulatory guidelines
- Document exceptions
- Think critically – "What is the need?"
- Consider "good days" and "bad days"
- Consider that at reassessment, functional rankings may change





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FORMS

**WHEN AUTHORIZING SERVICES**

### Hours

- Need not assessed based on diagnosis
- Health Care Certification SOC 873
- Need versus practice
- Independence versus dependence
- Safety
- Apply Hourly Task Guidelines
  - Refer to regulations
  - Compare to ranges
  - Document exceptions





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FORMS

**EXCEPTIONS...**

- Occur when needs require time for services that are outside of the Hourly Task Guidelines
- Can be above or below the guidelines
- Are **expected** because assessments are individualized
- Cannot be made due to inefficiency of incompetence of the provider
- Must be documented

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FORMS

**CLARIFICATION: FI RANK 2**

- If Consumer
  - Needs simple reminding
  - Is compliant
  - Reminding can be given while the provider is completing other tasks
- Then
  - No time would be authorized

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FORMS

**CLARIFICATION: FI RANK 2**

- If Consumer
  - Prompting takes the undivided attention of the provider
- Then
  - Time should be authorized

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

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FORMS

**CLARIFICATION: FI RANK 2**

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



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**Putting It All Together**



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PUTTING IT ALL TOGETHER

**ACTIVITY: Importance of Documentation**





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**PUTTING IT ALL TOGETHER**

**IMPORTANCE OF GOOD DOCUMENTATION**

- Creates a visual picture of the social worker's visit.
- Provides historical record important for coverage when you are out in the field.
- Provides continuity for case transfers and inter-county transfers.
- Substantiates authorization at state hearings.
- Adherence to federal and state laws, regulations and policies.
- Aids in the investigation of potential fraud.


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**PUTTING IT ALL TOGETHER**

**DOCUMENTATION TIPS**

- Detailed
- Concise
- Non-judgmental
- Focused


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**PUTTING IT ALL TOGETHER**

**ACTIVITY: Authorization of Hours**

Sarah





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Bathing, Oral Hygiene, and Grooming			Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
FI Rank (Enter)	4						
	Low	High					
Rank 2	0.50	1.92	Assistance with bathing (getting in/out of tub, washing body and hair)	20 min		7	02:20
Rank 3	1.27	3.15					
Rank 4	2.35	4.08	Blow dry/brush hair after bathing	10 min		7	01:10
Rank 5	3.00	5.10	Oral hygiene	Independent			
	Low	High	Grooming				
Rank 2	00:30	01:55					
Rank 3	01:16	03:09					
Rank 4	02:21	04:06					
Rank 5	03:00	05:06					
Note: Compare Total Need with above range.			Reason for assistance: Additional information to document exceptions to guidelines and identification of Alt. Resources:				
Total Assessed Need	Adjustments	Individual Assessed Need	Alternative Resources Refused/Voluntary	Net Adjusted Need			
03:30		03:30	02:00	01:30			

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Meal Preparation			Needs help with <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner				
FI Rank (Enter)	Low	High	Meal	Example of Typical Meal	Need Per Meal	# of Days Per Week	Total Need
			Breakfast	No Assistance			
Rank 2	3.02	7.00	Lunch	Meat, veg, potato	1 hour	3	03:00
Rank 3	3.50	7.00	Dinner	No Assistance			
Rank 4	5.25	7.00	Snacks				
Rank 5	7.00	7.00					
	Low	High	Total 03:00				
Rank 2	03:01	07:00					
Rank 3	03:30	07:00					
Rank 4	05:15	07:00					
Rank 5	07:00	07:00					
Note: Compare Total Need with above range.			Reason for assistance: Shared living exceptions (required when services not provided). Additional information to document exceptions to guidelines and identification of Alt. Resources such as MOW:				
Total Assessed Need	Adjustments	Individual Assessed Need	Alternative Resources Refused/Voluntary	Net Adjusted Need			
03:00		03:00		03:00			

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Ambulation			Walking Inside Home				
FI Rank (Enter)	Low	High	From/To	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need Per Week
Rank 2	0.58	1.75		Independent			
Rank 3	1.00	2.10	Requiring Assistance (Device(s))				
Rank 4	1.75	3.50	Device	Time Assessed	# of Times Per Day	# of Days Per Week	Total Need Per Week
Rank 5	1.75	3.50		Independent			
	Low	High	Assistance From House To Car And Car To House For Medical Appt. & Alt. Resource				
Rank 2	00:38	01:48					
Rank 3	01:00	02:08	Assisting transfer in and out of car and with putting scooter in and out of car for trip to M.D.	20 min	1 x mo MD	20 min	00:05
Rank 4	01:45	03:30	Assistance pulling scooter in and out of back van for trip to PT	20 min	2 x week		00:40
Rank 5	01:45	03:30					
Note: Compare Total Need with above range.			TOTAL 00:45				
Total Assessed Need	Adjustments	Individual Assessed Need	Alternative Resources Refused/Voluntary	Net Adjusted Need			
00:45		00:45	00:40	00:05			

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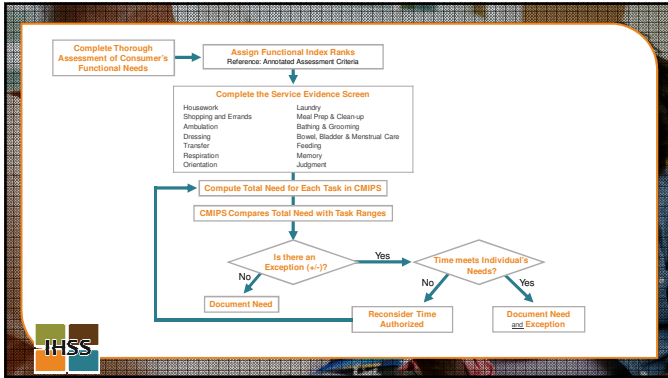
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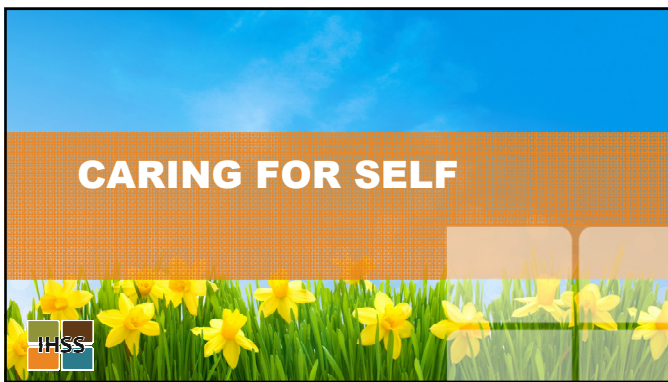
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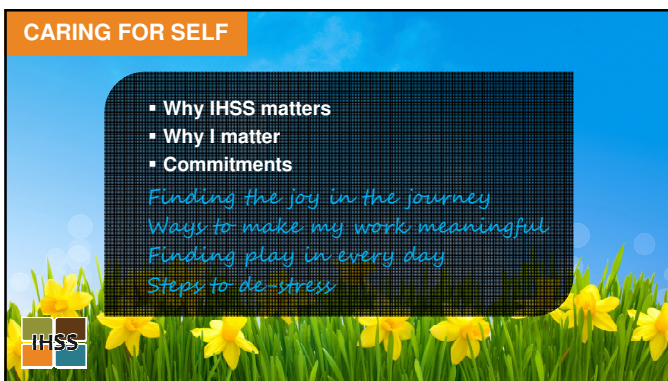
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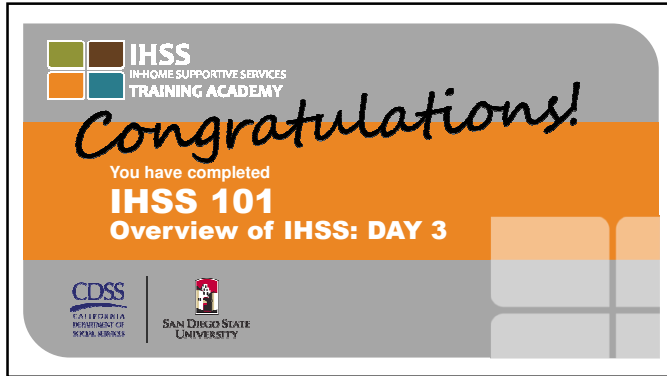
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## CASE STUDY – MYRTLE SPRIGGS

### ASSESSMENT WORKSHEET

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_

Housework

Laundry

Meal Preparation & Clean-up

Ambulation

Bathing & Grooming

Judgment

### FUNCTIONAL INDEX RANKINGS

	Housework	Laundry	Ambulation	Bathing & Grooming	Judgment
Self					
Group Consensus Score					



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## CASE STUDY – JEWEL BROWN

### ASSESSMENT WORKSHEET

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_

Laundry

Meal Preparation & Clean-up

Dressing

Transfer

Feeding

Memory

Orientation

### FUNCTIONAL INDEX RANKINGS

	Laundry	Meal Prep & Clean-up	Dressing	Transfer	Feeding	Memory	Orientation
Self							
Group Consensus Score							





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## CASE STUDY – MARGARET IDELL

### ASSESSMENT WORKSHEET

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_

Ambulation

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Bathing & Grooming

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Dressing

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Bowel, Bladder & Menstrual Care

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Transfer

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Feeding

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### FUNCTIONAL INDEX RANKINGS

	Ambulation	Bathing & Grooming	Dressing	Bowel, Bladder, & Menstrual Care	Transfer	Feeding
Self						
Group Consensus Score						



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**CASE STUDY – MAY IDELL**

**ASSESSMENT WORKSHEET**

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_  
Ambulation

\_\_\_\_\_  
Bathing & Grooming

\_\_\_\_\_  
Dressing

\_\_\_\_\_  
Feeding

\_\_\_\_\_  
Respiration

**FUNCTIONAL INDEX RANKINGS**

	<b>Ambulation</b>	<b>Bathing &amp; Grooming</b>	<b>Dressing</b>	<b>Feeding</b>	<b>Respiration</b>
<b>Self</b>					
<b>Group Consensus Score</b>					



## FUNCTIONAL INDEX RANKING SCENARIO

### JOE

Joe is a 19-year-old male, living in a house with his parents, Nola and Jim, and his siblings, Kathy (age 11), and Billy (age 10). Joe was diagnosed with Schizophrenia at age 16. Joe has never gotten a drivers license. He states that he is afraid of strangers, believes people are following him, and afraid to go anywhere without at least one of his parents. According to his mother, Joe will not take his medications without direct and persistent encouragement because he believes that someone is trying to kill him through the medications. She expressed frustration that it seems to take her longer and longer to get him to take his medication.

Nola states that Joe would not eat if she did not make him eat three meals a day. She also states that Joe does not go near the stove because he believes there are transmitters hidden in the stove which are trying to take over his mind. Joe requires other family members to eat a few bites of their food before he eats his. When asked during the home visit about his ability to assist his family when they are cleaning up after meals, Joe stated “that is woman’s work.” His mother states that Joe refuses to help clean up after meals for this reason. Joe does, however, enjoy doing laundry, and is always willing to assist his mother with the family’s laundry. His mother complained that she has a difficult time getting Joe to clean his room and sometimes it takes her several days to get him to make his bed.

Joe’s mother states great frustration with Joe’s ongoing refusal to bathe or to change his clothing. She further states that she must be in the room with him when he bathes and dresses, because without constant reminding and supervision, he would just get in the shower, barely wet his hair, put back on the same clothing, and be done. She also says Joe has obsessive thoughts about his teeth (brushing them 4-6 times during the day) and that she does not trust him to shave without close supervision.

According to Joe’s father, Jim, on at least two separate occasions, Joe tried to harm his brother when the two were home without parental supervision because his brother took one of Joe’s Pokémon cards. The father further stated that Joe recently killed the family cat. His mother finally had to leave her job to provide 24-hour care to Joe because of his behavior.

Joe’s parents request Domestic and Related Services and Personal Care.

#### **Mother (Nola)**

Nola is a 45-year-old woman who has left her job of 5 years to care for her son. Her husband Jim is a truck driver and gone from the home more than he is there. Nola had an older brother who had been diagnosed with Schizophrenia and killed himself at age 21. She has always blamed her mother for not staying home with him. Until Joe was 16 years old, Nola had been very active in her other children’s lives. Recently, Joe’s siblings have begun to resent him because their mother has less time to spend with them. Nola feels guilty that she is not making it to their school activities. In addition, their friends have stopped coming over to the house because Joe is sometimes aggressive towards them. Nola does not know what to do, and

believes one of the reasons Jim is on the road so much is so that he does not have to deal with Joe's behavior.

### **Father (Jim)**

Jim is a 47-year-old man. He is a truck driver and gone from the home more than he is there. He is frustrated by his son's behavior because he is unable to control it. He is also worried about his family's safety while he is on the road. Jim states that on at least two separate occasions when his sons were home without parental supervision, Joe tried to harm Billy for taking one of his Pokémon cards. The father further stated that Joe recently killed the family cat.

### **Doctors**

Joe has two doctors: his medical doctor and his psychiatrist. Joe's medical doctor has completed a medical evaluation form for Joe, stating he is not at risk of placement, that he is physically able to provide all personal care, and assist with domestic and related services. His diagnosis is Schizophrenia.

Joe's psychiatrist completed the medical evaluation form stating that Joe is able to do light housekeeping, but is at risk of placement and needs personal care services. He also stated, "Patient's schizophrenia compromises his ability to perform complex tasks, or to plan. He can, however, perform simple tasks and follow sequential instructions, especially when properly supervised."

### **Group Tasks**

Utilizing the Annotated Assessment Criteria, assign the FI Ranking for all categories.

Housework	Laundry	Shopping and Errands	Meal Prep and Clean up	Mobility Inside	Bathing and Grooming	Dressing	Bowel, Bladder & Menstrual Care	Moving in and out of Bed (Transfer)	Eating	Respiration	Memory	Orientation	Judgment

## SCHIZOPHRENIA – an overview

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### What is schizophrenia?

Schizophrenia is a chronic, severe, and disabling brain disorder. It affects about 1 percent of Americans.

People with schizophrenia may hear voices other people don't hear or they may believe that others are reading their minds, controlling their thoughts, or plotting to harm them. These experiences are terrifying and can cause fearfulness, withdrawal, or extreme agitation. People with schizophrenia may not make sense when they talk, may sit for hours without moving or talking much, or may seem perfectly fine until they talk about what they are really thinking. Because many people with schizophrenia have difficulty holding a job or caring for themselves, the burden on their families and society is significant as well.

### What are the symptoms of schizophrenia?

The symptoms of schizophrenia fall into three broad categories:

- **Positive symptoms** are unusual thoughts or perceptions, including hallucinations, delusions, thought disorder, and disorders of movement.
- **Negative symptoms** represent a loss or a decrease in the ability to initiate plans, speak, express emotion, or find pleasure in everyday life. These symptoms are harder to recognize as part of the disorder and can be mistaken for laziness or depression.
- **Cognitive symptoms**(or cognitive deficits) are problems with attention, certain types of memory, and the executive functions that allow us to plan and organize. Cognitive deficits can also be difficult to recognize as part of the disorder but are the most disabling in terms of leading a normal life.

### When does it start and who gets it?

Psychotic symptoms (such as hallucinations and delusions) usually emerge in men in their late teens and early 20s and in women in their mid-20s to early 30s. They seldom occur after age 45 and only rarely before puberty, although cases of schizophrenia in children as young as 5 have been reported. In adolescents, the first signs can include a change of friends, a drop in grades, sleep problems, and irritability. Because many normal adolescents exhibit these behaviors as well, a diagnosis can be difficult to make at this stage. In young people who go on to develop the disease, this is called the "prodromal" period.



Research has shown that schizophrenia affects men and women equally and occurs at similar rates in all ethnic groups around the world.

### **Are people with schizophrenia violent?**

People with schizophrenia are not especially prone to violence and often prefer to be left alone. Studies show that if people have no record of criminal violence before they develop schizophrenia and are not substance abusers, they are unlikely to commit crimes after they become ill. Most violent crimes are not committed by people with schizophrenia, and most people with schizophrenia do not commit violent crimes. Substance abuse always increases violent behavior, regardless of the presence of schizophrenia (see sidebar). If someone with paranoid schizophrenia becomes violent, the violence is most often directed at family members and takes place at home.

### **What about suicide?**

People with schizophrenia attempt suicide much more often than people in the general population. About 10 percent (especially young adult males) succeed. It is hard to predict which people with schizophrenia are prone to suicide, so if someone talks about or tries to commit suicide, professional help should be sought right away.

### **How is schizophrenia treated?**

Because the causes of schizophrenia are still unknown, current treatments focus on eliminating the symptoms of the disease.

#### Antipsychotic medications

Antipsychotic medications have been available since the mid-1950s. They effectively alleviate the positive symptoms of schizophrenia. While these drugs have greatly improved the lives of many patients, they do not cure schizophrenia.

Everyone responds differently to antipsychotic medication. Sometimes several different drugs must be tried before the right one is found. People with schizophrenia should work in partnership with their doctors to find the medications that control their symptoms best with the fewest side effects.

# IN-HOME SUPPORTIVE SERVICES PROGRAM

## Background

The In-Home Supportive Services (IHSS) Program provides services to approximately 448,000 low-income aged, blind, and disabled consumers. Over 372,000 providers allow them to remain safely in their homes as an alternative to out-of-home institutional care. Services include:

- Personal Care,
- Domestic and Related,
- Protective Supervision, and
- Paramedical

## History

In the 1950s, California established the Attendant Care Program to enable elderly and disabled consumers who needed assistance to remain safely in their own homes. This program provided grants to consumers so they could contract with providers to provide various domestic services and was funded jointly by the county and state governments. This program has evolved over the years to assist the most vulnerable population in California. For example, in the 1970s, the Homemaker Chore Program (also known as the Chore Program) was added to the Attendant Care Program to provide personal care services. This addition also enabled those consumers who could not hire or supervise their own providers the opportunity to receive services through county employees or contract with an outside agency. California established the Homemaker Chore Program (now the IHSS Program) which was funded by State General Funds, limited federal funds, and county share-of-cost.

In the 1980s, the IHSS Program went through a tremendous amount of caseload growth which led to statutory monthly caps placed on service hours (283 severely impaired and 195 non-severely impaired). In addition, the California Department of Social Services (CDSS) enhanced a payrolling system for individual providers to incorporate a management information feature which became known as the Case Management, Information, and Payrolling System (CMIPS). Counties were then able to access real-time consumer information, produce turn-around eligibility documents, and utilize the system to calculate a consumer's share-of-cost for services. Subsequently, legislation (Welfare and Institutions Code 12309) was enacted which required CDSS to develop and implement a standardized process to make authorization of supportive services equitable while at the same time continue to provide assessments that are individualized based on the needs of the consumer. Henceforth, the Uniformity System was implemented.

The 1990s also brought about changes to the IHSS Program. These changes included a state/local realignment which increased the county-share of funding; authorized CDSS to define the role of Public Authorities as the employer of record for collective bargaining; and established the Personal Care Services Program with 50 percent Medi-Cal funding while California maintained the IHSS Residual Program to fund services received by consumers ineligible for federal funding.

Many other changes came in the early 2000s. One significant change came about in 2004 when the CDSS enacted the IHSS/Quality Assurance (QA) Initiative as part of the Budget Trailer Bill Senate Bill 1104. The key features are ongoing social worker training, state/county QA monitoring, development of Hourly Task Guidelines with exceptions criteria, interagency collaboration to prevent/detect fraud and maximize overpayments recovery, and annual error-rate studies. In addition, the IHSS Plus Waiver (IPW) Program became effective in August 2004 utilizing Medi-Cal funding primarily for services provided by parents and spouses. In August 2009, the IPW Program was replaced by the IHSS Plus Option (IPO) Program with no change in program eligibility requirements.

In March 2010, the Affordable Care Act (ACA) was enacted allowing for the establishment of a new Medi-Cal state plan option, Community First Choice Option (CFCO). This option enhanced the ability of IHSS to provide community-based personal attendant care services to certain enrollees who would otherwise require institutional care. It also provided a six percent increase in federal funding for CFCO services and supports effective December 1, 2012. Approximately 41 percent of IHSS consumers were transitioned into this program. All PCSP and IPO consumers with an assessed need of 195 hours per month or more were automatically transitioned to CFCO and additional PCSP and IPO consumers who met specific criteria based on Functional Index rankings in designated task categories became eligible. A new Medi-Cal secondary aid code, 2K, was established for CFCO cases.

CMIPS II, a significantly enhanced payroll and case management system, was rolled out to counties during calendar years 2012 and 2013. The updated system allows for more user-friendly methods of input and access of system data, a more efficient and centralized payroll system, as well as new tools for managing cases and tracking case activities.

**CALIFORNIA DEPARTMENT OF SOCIAL SERVICES  
ADULT PROGRAMS POLICY & OPERATIONS BUREAU  
POLICY INTERPRETATION REQUEST**

**PHONE:** (916) 651-5350

**FAX:** (916) 653-2220

<b>COUNTY:</b>	<b>DATE:</b>
<b>NAME:</b>	<b>TITLE:</b>
<b>TELEPHONE:</b>	<b>EMAIL:</b>
<b>SUBJECT:</b>	
<b>QUESTION(S)</b>	
<b>RESPONSE</b>	
<i>This response is based on the particular facts and circumstances presented here, applicable to this case only, and is not intended to serve as a precedent for any other case. This response is not intended to apply generally or to constitute a declaration of the manner in which any class of cases shall be decided.</i>	
<b>ANALYST:</b>	<b>DATE:</b>
<b>MANAGEMENT APPROVAL:</b>	<b>DATE:</b>

**ATTACHMENTS:**



## Senate Bill No. 1104

### CHAPTER 229

An act to amend Section 8263 of, to add Section 8263.4 to, and to add Article 16.5 (commencing with Section 8385) to Chapter 2 of Part 6 of, the Education Code, to amend Section 11796 of the Government Code, to amend Sections 1522, 1523.1, 1523.2, 1568.05, 1569.185, 1596.803, 1596.816, 1596.871, 1596.872a, 1596.872b, and 11970.2 of, and to add Section 128241 to, the Health and Safety Code, to amend Section 273d of the Penal Code, to amend Section 1611.5 of the Unemployment Insurance Code, and to amend Sections 10531, 10532, 11320.1, 11322.8, 11322.9, 11325.21, 11325.22, 11325.23, 11325.7, 11326, 11403.1, 11403.3, 11453, 11454, 11454.5, 11454.6, 11462, 11462.06, 11466.21, 12201, 12300, 12301.1, 14132.95, 15204.2, 17021, 18939, and 19806 of, to amend and renumber Section 10553.2 of, to add Sections 9404, 11401.5, 11486.3, 12301.21, 12305.7, 12305.71, 12305.72, 12305.8, 12305.81, 12305.82, 12305.83, 12317, 12317.1, 12317.2, 14132.951, and 16521.3 to, to repeal and add Section 12301.2 of, and to repeal Chapter 2.4 (commencing with Section 16145) of Part 4 of Division 9 of, the Welfare and Institutions Code, relating to human services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor August 16, 2004. Filed with  
Secretary of State August 16, 2004.]

#### LEGISLATIVE COUNSEL'S DIGEST

SB 1104, Committee on Budget and Fiscal Review. Budget Act of 2004: human services.

(1) Existing law provides for a system of priority for state and federally subsidized child development services and provides that first priority is given to neglected or abused children, or children who are at risk of being neglected or abused.

This bill would provide that a family receiving child care services on the basis of a child being at risk of abuse is eligible to receive services for up to 3 months, unless the county child welfare agency certifies that child care services continue to be necessary, or the child is receiving child protection services, requires child care, and remains otherwise eligible for services, in which case the family may receive child care services for up to 12 months.

(2) The department, in consultation with the county welfare departments and the State Department of Health Services, shall determine, define, and issue instructions to the counties describing the roles and responsibilities of the department, the State Department of Health Services, and counties for resolving data match discrepancies requiring followup, defining the necessary actions that will be taken to resolve them, and the process for exchange of information pertaining to the findings and disposition of data match discrepancies.

(c) The department shall develop methods for verifying the receipt of supportive services by program recipients. In developing the specified methods the department shall obtain input from program stakeholders as provided in Section 12305.72. The department shall, in consultation with the county welfare departments, also determine, define, and issue instructions describing the roles and responsibilities of the department and the county welfare departments for evaluating and responding to identified problems and discrepancies.

(d) The department shall make available on its Internet Web site the regulations, all-county letters, approved forms, and training curricula developed and officially issued by the department to implement the items described in Section 12305.72. The department shall inform supportive services providers, recipients, and the general public about the availability of these items and of the Medi-Cal toll free fraud hotline and Web site for reporting suspected fraud or abuse in the provision or receipt of supportive services.

(e) The department shall, in consultation with counties and in accordance with Section 12305.72, develop a standardized curriculum, training materials, and work aids, and operate an ongoing, statewide training program on the supportive services uniformity system for county workers, managers, quality assurance staff, state hearing officers, and public authority or nonprofit consortium staff, to the extent a county operates a public authority or nonprofit consortium. The training shall be expanded to include variable assessment intervals, statewide hourly task guidelines, and use of the protective supervision medical certification form as the development of each of these components is completed. Training shall be scheduled and provided at sites throughout the state. The department may obtain a qualified vendor to assist in the development of the training and to conduct the training program. The design of the training program shall provide reasonable flexibility to allow counties to use their preferred training modalities to educate their supportive services staff in this subject matter.

(f) The department shall, in conjunction with the counties, develop protocols and procedures for monitoring county quality assurance programs. The monitoring may include onsite reviews of county quality



## DEPARTMENT OF SOCIAL SERVICES

744 P Street, MS 19-96, Sacramento, CA 95814



September 30, 2004

ALL-COUNTY INFORMATION NOTICE NO. I-69-04

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

Reason For This Transmittal

- ☒ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order or Settlement Agreement
- ☐ Clarification Requested by one or More Counties
- ☐ Initiated by CDSS

SUBJECT: IN-HOME SUPPORTIVE SERVICES/PERSONAL CARE SERVICES PROGRAM (IHSS/PCSP) QUALITY ASSURANCE (QA) AND PROGRAM INTEGRITY PROVISIONS OF THE FISCAL YEAR (FY) 2004/05 HEALTH AND HUMAN SERVICES' BUDGET TRAILER BILL SENATE BILL (SB) 1104

This All-County Information Notice (ACIN) provides information regarding the In-Home Supportive Services/Personal Care Services Program (IHSS/PCSP) Quality Assurance (QA) and program integrity provisions of the Fiscal Year (FY) 2004/05 health and human services' budget trailer bill Senate Bill (SB) 1104.

**BACKGROUND**

The California Department of Social Services (CDSS) proposed an IHSS/PCSP QA Initiative as an element of the Governor's 2004/05 State Budget. The proposal outlined a number of enhanced activities to be performed by CDSS, the counties, and the California Department of Health Services (DHS) to improve the quality of IHSS/PCSP service need assessments, enhance program integrity, and detect and prevent program fraud and abuse. The proposal requested: (1) State and county staffing augmentations specifically for QA activities, (2) funding to establish an ongoing State training component for IHSS/PCSP workers, and (3) funding for specified systems changes tied to QA and program integrity improvements.

The CDSS QA proposal was adopted by the Administration. Funding for new State and county QA staff, the IHSS/PCSP training program, and systems changes was included in the FY 2004/05 Budget Act along with projected program savings expected as a result of the program improvements.





### **3. WIC Section 12305.7**

**Summary:** Establishes requirements for State-level IHSS/PCSP QA and program integrity functions.

- Requires CDSS, in consultation with DHS and the counties, to design and conduct an annual IHSS/PCSP payment error rate study beginning in the 04/05 FY to provide baseline data for prioritizing and directing QA and program integrity efforts at the State and county levels.
- Requires CDSS and DHS to conduct automated data matches between IHSS/PCSP paid hours data and Medi-Cal claims payment data to identify potential service overlap, duplication, and third-party liability among other things.
  - Requires CDSS to work with the counties to determine, define, and issue instructions to the counties describing the roles and responsibilities of the CDSS, the DHS, and the counties for resolving data match discrepancies requiring follow-up, defining the necessary actions that will be taken to resolve them, and the process for exchange of information pertaining to the findings and disposition of data match discrepancies.
- Requires CDSS to develop methods for verifying recipient receipt of services and work with the counties to determine, define, and issue instructions describing the roles and responsibilities of the Department and the county welfare departments for evaluating and responding to identified problems and discrepancies.
  - Requires CDSS to get input from counties and other stakeholders when developing the methods for verifying recipient receipt of services.
- Requires CDSS to make available on its website specified information regarding IHSS/PCSP including IHSS/PCSP QA and program integrity regulations, ACLs, program forms, IHSS/PCSP training and materials developed to implement the Trailer Bill's IHSS/PCSP program QA and program integrity provisions. Requires CDSS to notify program stakeholders of the availability of the information on the CDSS website.
- Requires CDSS to notify IHSS/PCSP providers, recipients, and the general public about the toll-free Medi-Cal hotline and website for reporting suspected fraud and abuse.
- Requires CDSS to work in consultation with the counties to develop a statewide training program for county IHSS/PCSP workers, managers, QA staff, State hearing officers, and Public Authority or Non-Profit Consortium

## Example of a Statute that has become Regulation

From ACIN I -69-04 pages 5-7

staff on the IHSS/PCSP Uniformity System and other elements of IHSS/PCSP QA and program integrity as they are developed. Requires CDSS to obtain input from program stakeholders while developing the training. Specifically:

- Authorizes CDSS to obtain a contractor to assist in developing and to conduct the training.
  - Requires that the design of the training afford reasonable flexibility to counties to use their preferred modalities arranging the training.
- Requires CDSS to monitor county IHSS/PCSP QA programs. This may include on-site visits.
  - Requires CDSS to work with the counties to develop protocols and procedures for monitoring county QA programs and protocols and procedures under which the Department will report its monitoring findings to a county, disagreements over the findings will be resolved, to the extent possible, and the county, DHS and CDSS will follow-up on the findings.
- Requires CDSS to conduct a review of IHSS/PCSP regulations in effect on the date of enactment of this section and revise the regulations as necessary to conform to the changes in statute that have occurred since the regulations were initially promulgated and to conform to federally authorized program changes, such as the federal waiver.

### 4. WIC Section 12305.71

**Summary:** Requires each county to establish a dedicated, specialized IHSS/PCSP QA function or unit and specifies activities the function is to perform.

- Requires the counties to perform routine, scheduled reviews of supportive services cases to ensure that caseworkers appropriately apply the IHSS/PCSP uniformity system and other IHSS/PCSP rules and policies for assessing recipients' need for services to the end that there are accurate assessments of needs and hours. Authorizes counties to consult with State QA staff for technical assistance.
- Requires CDSS and the counties to develop policies, procedures, implementation timelines, and instructions under which the county QA function will perform the following specified QA activities:
  - Receive, resolve, and respond appropriately to claims data matches discrepancies or other State-level QA and program integrity information that indicates potential overpayments to providers or recipients or third

**Example of a Statute that has become Regulation**  
**From ACIN I -69-04 pages 5-7**

party liability for supportive services.

- Implement procedures to identify potential sources of third party liability for IHSS/PCSP services.
- Monitor the delivery of supportive services in the county to detect and prevent potential fraud by providers, recipients, and others and maximize the recovery of overpayments from providers or recipients.
- Inform IHSS/PCSP providers and recipients and the general public that suspected fraud in the provision or receipt of supportive services can be reported using of the toll-free Medi-Cal fraud hotline and website.
- Requires each county to develop a schedule beginning with July 1, 2005, under which county QA staff will periodically perform targeted IHSS/PCSP QA studies.
- Provides that, in accordance with protocols developed by the CDSS and county welfare departments, county QA staff will conduct joint case review activities with State QA staff, including random post-payment paid claims reviews to ensure that payments to providers were valid and were associated with existing program recipients; identify, refer to, and work with appropriate agencies in investigation, administrative action, or prosecution of instances of fraud in the provision of supportive services.
- Requires that protocols take into account the relative priority of the activities required of county IHSS/PCSP QA functions and available resources.

## IHSS ELIGIBILITY

### Financial

- **Receives SSI/SSP (called Status Eligible)**

- Potentially eligible for all IHSS programs without a share of cost.
- Social Security Administration (SSA) determines eligibility and issues monthly checks. Aged (over 65 years old), or Blind, or Disabled (unable to work because of an impairment that is expected to last at least a year or end in death. This determination is done by CDSS Disability and Evaluation Division staff who evaluates medical information and the person's work history
- Low income – The SSA evaluates net nonexempt monthly income within the following:

2014 Total Monthly Payment			
Category	Aged	Disabled	Blind
<b>Single people</b> Independent living status	\$877.40	\$877.40	\$932.40
<b>Aged person and disabled spouse</b> Independent living status	\$1,478.20		
<b>Blind couples</b> Independent living status			\$1,625.20
<b>Blind person with an aged or disabled spouse</b> Independent living status			\$1,569.20
<b>Disabled minor child</b>		\$784.40	
<b>Disabled minor child in the household of another</b>		\$547.50.	

- Countable Resources under \$2,000 for an individual or \$3,000 for a couple. Resources are things like savings, checking, stocks, and bonds. A home where the client lives is not counted as a resource.
- Is a U.S. citizen or a legal immigrant with certain other requirements.
- A resident of California.
- **Income Eligible: Does not receive SSI/SSP but received unrestricted Medi-Cal**
  - County Medi-Cal Eligibility Workers evaluate income, resources and other criteria to determine eligibility.
  - An Aid Code chart (provided in this binder) will help to determine which Medi-Cal beneficiaries have unrestricted Medi-Cal and potentially may qualify for the various IHSS programs.
  - Recipients may or may not have a Share of Cost (SOC). A SOC is the amount a Medi-Cal recipient must pay towards their own medical expenses each month before the Medi-Cal benefit becomes available to them.
  - If there is a SOC the total monthly amount must be obligated before the IHSS service provider can be paid. The Share of Cost is obligated either to a health care provider such as a doctor or a pharmacy or to the IHSS provider whose net pay check will be reduced by the amount of the unpaid Share of Cost.

### Threshold of Need

- MPP §30-700.1 states, “The In-Home Supportive Services (IHSS) Program provides assistance to those eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without this assistance. IHSS is an alternative to out-of-home care.”  
People who are not at risk without the provision of paid or unpaid assistance from another are not eligible for IHSS.
- Health Care Certification: Effective August 1, 2011 State Law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual requesting IHSS services unable to perform some activity of daily living independently and without IHSS would be at risk of placement in out-of-home care.

### **Own Home**

- To qualify for IHSS, the person must be living in his/her “own home.”
  - MPP §30-701(o)(2) defines own home as, “...the place in which the individual chooses to reside. An individual’s “own home” does not include an acute care hospital, skilled nursing facility, intermediate care facility, or a board and care facility. A person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement is not considered to be living in his/her home.
  - A person can be living with family members or others and still be living in his/her “own home.”
  - A person living in a homeless shelter is living in his/her “own home,” but specific IHSS tasks which are provided by the shelter (such as meal preparation) cannot be authorized.
  - Must be a California Resident

### **IHSS Programs**

- *PCSP* – For Status Eligible or Income Eligible people who are not disqualified from the Program because of one of the conditions listed in IPO or Residual.
- *IHSS Plus Option (IPO)* – For individuals who are Full Scope FFP Medi-Cal, and have their services provided by a Spouse or Parent of a minor child, or are receiving Restaurant Meal Allowance or Advance Pay.
- *Residual* – Not Federally funded Medi-Cal but meets the eligibility requirements found in MPP §30-755.
  - This is unusual.
  - The consumer’s Share of Cost is the difference between the SSI/SSP payment level and the consumer’s net nonexempt income.
  - Because there is no federal funding for the Residual Program the cost of care is funded entirely by the state and county
- *CFCO* – All CFCO participants must be eligible for Full-Scope, Federal Financial Participation (FS FFP) Medi-Cal [as in the Personal Care Services Program (PCSP) and IHSS Plus Option (IPO) programs], and meet CFCO Nursing Facility Level Of Care (NF LOC) eligibility.

## IHSS PROGRAM CATEGORIES

Program Title	Characteristics	Payment Source
<b>CFCO 2K</b>	All CFCO participants must be eligible for Full-Scope, Federal Financial Participation (FS FFP) Medi-Cal [as in the Personal Care Services Program (PCSP) and IHSS Plus Option (IPO) programs], <u>and</u> meet CFCO Nursing Facility Level Of Care (NF LOC) eligibility.	Federal, State, and County  Hours max 283
<b>IHSS Plus Option (IPO) 2L</b>	Covers consumers who are eligible for Full Scope Federal Financial Participation (FFP) Medi-Cal, but not eligible for Personal Care Services (PCSP) due to one or more of the following: <ul style="list-style-type: none"> <li>• Consumer has a spouse for a provider; <b>or</b></li> <li>• Consumer is a minor child with a parent for a provider; <b>or</b></li> <li>• Consumer receives Advance Pay; <b>or</b></li> <li>• Consumer receives Restaurant Meal Allowance.</li> </ul>	Federal, State, and County  Hours max 195 for NSI  <b>Note:</b> IPO services are eligible for FFP as a Section 1915(j) State Plan Option.
<b>Personal Care Services Program (PCSP) 2M</b>	Covers consumers who are eligible for Full Scope FFP Medi-Cal. Services include: Domestic and Related Services, Personal Care Services, Protective Supervision, Heavy Cleaning, Transportation, Yard Hazard Abatement, and Paramedical.  <b>Note:</b> If one of the four IPO conditions listed above exists, the case would be an IPO case rather than PCSP. If the consumer is not eligible for FFP Medi-Cal, the consumer would be in the Residual Program.	Federal, State, and County  Hours max 283  <b>Note:</b> Cases with Protective Supervision and cases with only Domestic and Related Services were added to the PCSP Program in 2004.
<b>Residual Program 2N</b>	Covers consumers who are not eligible for Full Scope FFP Medi-Cal and who meet the IHSS eligibility criteria (MPP 30-755).	State and County  Hours max 195 for NSI and 283 for SI

## **COMMUNITY FIRST CHOICE OPTION (CFCO) ELIGIBILITY CRITERIA**

All CFCO participants must be eligible for Full-Scope, Federal Financial Participation (FS FFP) Medi-Cal [as in the Personal Care Services Program (PCSP) and IHSS Plus Option (IPO) programs], and meet CFCO Nursing Facility Level Of Care (NF LOC) eligibility based on one of the following criteria:

1. Have a total assessed need (excluding heavy cleaning and yard hazard abatement) of 195 or more IHSS hours per month.
2. Have a total assessed need (excluding heavy cleaning and yard hazard abatement) under 195 IHSS hours per month and:
  - Have 3 or more of the following services with the designated Functional Index (FI) Ranks:
    - Eating, FI Rank of 3-6
    - Bowel and bladder, FI Rank of 3-6
    - Menstrual care, FI Rank of 3-6
    - Bathing/grooming, FI Rank of 4-5
    - Dressing, FI Rank of 4-5
    - Mobility inside, FI Rank of 4-5
    - Transferring, FI Rank of 4-5
    - Respiration, FI Rank of 5-6
    - Paramedical, (FI Rank not applicable)
  - OR
  - Have a combined FI Rank of 6 or higher in mental functioning (memory, orientation, and judgment)
3. Have an impairment level of “Severely Impaired” (SI). A recipient is deemed SI when he/she has a combined “Individual Assessed Need” of 20 hours or more per week in one or more of the following services:
  - Preparation of meals
  - Meal clean-up (if preparation of meals and feeding are assessed needs)
  - Respiration
  - Bowel and bladder care
  - Feeding
  - Routine bed baths
  - Dressing
  - Menstrual care
  - Ambulation
  - Transfer
  - Bathing, oral hygiene, grooming
  - Repositioning and rubbing skin
  - Care and assistance with prosthesis
  - Paramedical services

The above criteria were developed by the Department of Health Care Services (DHCS) in consultation with the California Department of Social Services (CDSS).





## Short-Doyle Medi-Cal (SDMC) Aid Code Master Chart May 14, 2014

The following chart organizes Medi-Cal aid codes into six groups based on the percent of federal financial participation (FFP) that will be paid for Medi-Cal eligibles within that group, provided FFP is available:

- Refugee (100% FFP)
- Managed Risk Medical Insurance Board (MRMIB) at Title XXI 65%
- Aid codes (Regular FFP) at Title XIX 50%
- Title XXI of the Social Security Act (Enhanced FFP) at 65%
- Breast and Cervical Cancer Treatment Program (BCCTP) Aid Codes (Enhanced FFP) at 65%
- Mixed Funding based on diagnostic and/or procedure codes. Emergency (Regular FFP) at Title XIX 50%, and/or Pregnancy (Enhanced FFP) at Title XXI 65%

**Please note all Affordable Care Act (ACA) Aid Codes will not be effective until January 1, 2014 (see listing of Aid Codes on Change Log page 4).**

### ACA Aid Codes:

The new aid codes identify those individuals eligible for benefits in the ACA new adult group, expansion children, pregnant women and parents/caretaker relatives.

**Aid Codes L1, N0 and N9 will be at 100% FFP until 2016.**

**For Aid Codes M1, M2, N5, N6, N7 and N8 please refer to the following table:**

FFP	Dates
100%	2014-2016
95%	2017
94%	2018
93%	2019
90%	2020 and thereafter

Benefit	Definition
• Full	• No restrictions
• Restricted	• Special Condition: e.g. Undocumented or non-satisfactory immigration status; Pregnancy; Emergency, etc
• Restricted Limited	• A restriction based upon time (e.g. IP off the grounds of the prison for <24H)

The chart columns identify Mental Health Services (MHS), Medicaid Eligibility Group (MEG)<sup>1</sup>, Drug Medi-Cal Program (DMC), Effective Dates and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The MHS and DMC column indicate a “yes” if the aid code is appropriate for use by MHS and/or DMC; and “no” if it is not. The SD/MC column indicates the effective date of the aid code for Medi-Cal eligibility. The Inactive in MEDS

<sup>1</sup> The Centers for Medicare and Medicaid Services (CMS) requires that the State (DHCS) submit quarterly actual member month enrollment statistics by MEG in conjunction with the State’s submitted CMS-64 forms for the Specialty Mental Health Waiver. The method used to develop the trends historical data is compiled by quarter by MEG which are: Disabled, Foster Care, MCHIP and Other. PLEASE NOTE: MEGs DO NOT APPLY TO DMC.

column indicates the date for which FFP is no longer available for an aid code. The EPSDT column identifies aid codes that may include beneficiaries under age 21 who are eligible for expanded Medi-Cal benefits under the EPSDT program.

#### **Historical FFP Rates (As of Date Payment)**

<b>Federal Fiscal Year (October 1 through September 30)</b>	<b>Regular FFP</b>	<b>Enhanced FFP<sup>2</sup></b>
2005 - 2012	50.00%	65.00%
July 1, 2004 - September 30, 2005	50.00%	65.00%
October 1, 2003 - June 30, 2004	52.95%	65.00%
April 1, 2003 - September 30, 2003	54.35%	65.00%
October 1, 2002 - March 31, 2003	50.00%	65.00%
2001 – 2002	51.40%	65.98%
2000 – 2001	51.25%	65.88%
1999 – 2000	51.67%	66.17%

Effective October 1, 2008, Beneficiary Services received a stimulus of 11.59% FMAP rate for FY 08/09 with a date of service from October 1, 2008 through December 31, 2010. On August 10, 2010 the American Recovery and Reinvestment Act (ARRA) of 2009 was extended to continue the additional Federal assistance for six months, ending June 30, 2011, but would phase down the level of assistance. Therefore, the ARRA FMAPs for QTR 2 of FY 2011 are 3 percent less than the QTR 1 levels (6.2 percent minus 3.2 percent) and the ARRA FMAPs for QTR 3 of FY 2011 are 2 percent less than those for QTR 2 (3.2 percent minus 1.2 percent). Please see chart below:

#### **Historical Stimulus Rates for Beneficiary Services Only**

<b>Federal Fiscal Year</b>	<b>Regular FFP</b>
April 1, 2011 - June 30, 2011	56.88%
January 1, 2011 - March 31, 2011	58.77%
October 1, 2010 - December 31, 2010	61.59%
October 1, 2009 - September 30, 2010	61.59%
October 1, 2008 - September 30, 2009	61.59%

#### **SD/MC Aid Codes Change Log**

<b>New Revision</b>	<b>Previous Revision</b>	<b>Added Codes</b>	<b>Removed Codes</b>	<b>Comments</b>
9/10/2008	10/17/2003	3D, 3W, 65, 06, 46, 0W	5X, 5Y (discontinued in MEDS 10/1/03)	
2/11/2010	9/10/2008	C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, 2H, 5E, 8U, 8V, E1		8X, 0M, 0N, 0P, 1X, 1Y, 47, 8W, Changed from restricted to Full Benefits
8/9/2010	2/11/2010	None		All BCCTP aid codes updated Enhanced FFP – page 6
8/25/2010	8/9/2010	None		Updated '0U' benefits to be 'FFP Funds for Emergency & Pregnancy only'

<sup>2</sup> FFP of more than 50% is not applicable for DMC.

New Revision	Previous Revision	Added Codes	Removed Codes	Comments
9/13/2010	8/25/2010			Aid Codes E1, C3, C4, C5, C6, C7, C8, C9, D1, D4, D5, D6 and D7 changed to indicate "N" in the EPSDT column
10/7/2010	9/13/2010	4H, 4L – active in MEDS on 12/13/2010		Changed table deleted EDS and SD/MC- added effective dates and inactive dates
1/13/11	1/7/11	4T	4G, 53, 0R, 0T, 8Y, 81 = not eligible for FFP effective 1/10/11	Removed from Chart
1/21/11	1/13/11			7M, 7N, 7P, changed to "No" for MHS. These aid codes are not eligible for FFP.
1/27/11	1/21/11	4G on 1/25/11 (previously removed in error)		
2/11/11	1/27/11	74 for ADP (pending ITSD deployment)		Listed 8U and 8V under Title 19.
2/28/11	2/11/11	74 activated for ADP on 2/25/11		Added footnotes for aid codes 5E, 8E & 8W.
5/6/11	2/28/11			Changed ARRA language and added 7/1/11 -9/30/11 at 50% to chart.  Organized aid codes according to funding.  7X, 8X now listed under Title 21 and "Yes" EPSDT.
9/13/11	2/28/11		7R = not eligible for FFP	Removed from Chart
12/02/11	9/13/11	07, 4N, 4S, 4W, 43, 49		Updated description for aid codes 3G, 3H, 3N, 3P, 3R, 30, 32, 33, 35, 39 and 59
6/5/12	12/2/11			0U, 0V are now listed under BCCTP.  0W is transitional aid code only.  48 is pregnancy only
8/29/12	6/5/12			Generally, enhanced aid codes are categorized as either SCHIP and MCHIP

New Revision	Previous Revision	Added Codes	Removed Codes	Comments
1/28/13	8/29/12	53, 65, 0R, 0T, 8Y, 81, R1  5C, 5D, H1, H2, H3, H4, H5  G0, G1, G2, G5, G6, G7, G8		State Only Aid Codes  Effective Date 1/1/13  Effective Date 1/1/12
	1/28/13	3F, K1		Effective Date 4/1/13
10/28/13	1/28/13	E2, E4, E5, E7  H6, H7, H8, H9, H0, 4E, P1, P2, P3, P4,  J1, J2, J3, J4, J5, J6, J7, J8, G9  L1, N9, N0,  M1, M2, M3, M4, M7, M5, M6 M8, M9, M0  N5, N6, N7, N8,  P5, P6, P7, P8, P9, P0  T1, T2, T3, T4, T5, T6, T7 T8, T9, T0,		Effective 1/1/14

**New Format for SD/MC Aid Codes Change Log**

New Revision	Previous Revision	Aid Codes	Effective Dates	Comments of Changes
3/18/14	10/28/13	13, 23, 63	3/11/14	DMC Only Restrict NTP (dosing and individual group counseling) services for LTC Aid Codes.
		8E	1/1/14	Expanded the age up to 65 years of age.
4/10/14	3/18/14	3F & K1	4/3/14	Changed to "Yes" for EPDST
		D2, D3, D4, D5, D6, D7, 69 and 74	3/11/14	Changed DMC column to indicate "Yes"
5/14/14	4/10/14	E6	1/1/14	New Aid Code
		7U, 7W	2/1/14	New Aid Code

New Revision	Previous Revision	Aid Codes	Effective Dates	Comments of Changes
5/14/14	4/10/14	7S	4/1/14	New Aid Code
		G0, J1, J2, J7, M3, M7, P2, P3, L1 & M1	N/A	Changed to “yes” for EPSDT services
		03, 04, 06, 07	N/A	Changed MEG to “Other”

**Aid Codes Master Chart Contact Information**

<http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx#MasterAidCodeChart> [MedCCC Home Page](#)

MHS email: [MedCCC@dhcs.ca.gov](mailto:MedCCC@dhcs.ca.gov)

DMC email: [Anthony.Ortiz@dhcs.ca.gov](mailto:Anthony.Ortiz@dhcs.ca.gov); [Jim.Jacobson@dhcs.ca.gov](mailto:Jim.Jacobson@dhcs.ca.gov)

Refugee Aid Codes (100% FFP through-Refugee Resettlement Program) These aid codes are funded by the Refugee Resettlement Program (not Title XIX or XXI)							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
0A	Full	No	Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.	Yes	N/A	Yes			Yes
01	Full	No	Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision.	Yes	N/A	Yes			Yes
02	Full	Y/N	Refugee Medical Assistance/Entrant Medical Assistance (FFP). Covers refugees and entrants who need Medi-Cal and who do not qualify for or want cash assistance.	Yes	N/A	Yes			Yes
08	Full	No	Entrant Cash Assistance (ECA) (FFP). Provides ECA benefits to Cuban/Haitian entrants, including unaccompanied children who are eligible, during their first eight months in the United States. (For entrants, the month begins with their date of parole.) Unaccompanied children are not subject to the eighth-month limitation provision.	Yes	N/A	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
G0	Full	No	Title XIX, Medi-Cal no SOC for State Medical Parolees. Full Scope Medical parolees who are Medi-Cal eligible in aid code G0 will be entitled to all Medi-Cal covered services because they are not considered to be incarcerated. To the extent possible, former state inmates on Medical Parole with an OHC code of "G" will be moved into aid code G0 once it is implemented. Aid code G0 will be a secondary aid code.	Yes	Other	No	1/1/12		Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
G1	Restricted; Limited	No	Title XIX, Medi-Cal no share-of-cost (SOC) for state juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital and inpatient mental health services only, for juvenile inmates in state correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/12		No
G5	Restricted; Limited	No	Title XIX, Medi-Cal no SOC for county juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital or inpatient mental health services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility	Yes	Other	No	1/1/12		No
G7	Restricted; Limited	No	Title XIX, Medi-Cal SOC for county juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital or inpatient mental health services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/12		No
H7	Full	No	Hospital Presumptive Eligibility for Children age 1-6 (FPL at or below 142 percent FPL)	Yes	Other	Yes	1/1/14		Yes
H8	Full	No	Hospital Presumptive Eligibility for Children age 6-19 (FPL at or below 108 percent FPL)	Yes	Other	Yes	1/1/14		Yes
J1	Full	No	Title XIX, Medi-Cal no share-of-cost (SOC) for Compassionately released/Medical Probation County Inmates. Individuals who are Medi-Cal eligible in aid code J1 will be entitled to all Medi-Cal covered services because they are not considered to be incarcerated. The county is responsible for the non-federal share.	Yes	Other	Yes	1/1/14		Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
J2	Full	Yes	Title XIX, Medi-Cal SOC for Compassionately released/Medical Probation County Inmates. Individuals who are Medi-Cal eligible in aid code J2 will be entitled to all Medi-Cal covered services because they are not considered to be incarcerated. The county is responsible for the non-federal share.	Yes	Other	Yes	1/1/14		Yes
J5	Full	No	Title XIX, Medi-Cal no SOC/SOC for aged (>65 years old) Compassionately released/Medical Probation County Inmates who reside in long-term care (LTC) facilities. Individuals who are Medi-Cal eligible in aid code J5 will be entitled to all Medi-Cal covered LTC services because they are not considered to be incarcerated. The county is responsible for the non-federal share.	Yes	Other	No	1/1/14		No
J7	Full	No	Title XIX, Medi-Cal no SOC/SOC for disabled Compassionately released/Medical Probation County Inmates who reside in LTC facilities. Individuals who are Medi-Cal eligible in aid code J7 will be entitled to all Medi-Cal covered LTC services because they are not considered to be incarcerated. The county is responsible for the non-federal share.	Yes	Other	No	1/1/14		Yes
K1	Full	No	Two Parent Safety Net & Drug/Fleeing Felon Family	Yes	Other	Yes	4/1/13		Yes
M3	Full	No	Parent/Caretaker Relative at or below 125% FPL: Citizen/Lawfully Present	Yes	Other	Yes	1/1/14		Yes
M7	Full	No	Pregnant Women 0% through 125% FPL: Citizen/Lawfully Present	Yes	Other	Yes	1/1/14		Yes
M9	Limited Scope: Pregnancy Services	No	Pregnant Women 125% - 200% FPL: Citizen/Lawfully Present	Yes	Other	Yes	1/1/14		No
P0	Restricted	No	Infant up to 1 year of age with 0 percent - 208 percent Federal Poverty Level, Undocumented, restricted to emergency services and long term care services.	Yes	Other	No	1/1/14		No



Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
P1	Full	No	Hospital PE Children 0-1 (at or below 208 percent FPL)	Yes	Other	Yes	1/1/14		Yes
P2	Full	No	Hospital PE Parent/Caretaker Relative (at or below 125 percent FPL)	Yes	Other	Yes	1/1/14		Yes
P3	Full	No	Hospital PE Adults (19-64) (at or below 138 percent FPL)	Yes	Other	Yes	1/1/14		Yes
P4	Limited	No	Hospital PE Pregnant Women (at or below 213 percent FPL). Limited to Ambulatory prenatal services.	Yes	Other	Yes	1/1/14		No
P5	Full	No	Children 6 to 19 years of age with 0 percent – 108 percent Federal Poverty Level, Citizen/Lawfully present, full scope no cost Medi-Cal.	Yes	Other	Yes	1/1/14		Yes
P7	Full	No	Children 1 to 6 years of age with 0 percent – 142 percent Federal Poverty Level, Citizen/Lawfully present, full scope, no cost Medi-Cal.	Yes	Other	Yes	1/1/14		Yes
P8	Restricted	No	Children 1 to 6 years of age with 0 percent - 142 percent Federal Poverty Level, Undocumented, restricted to emergency services and long term care services.	Yes	Other	No	1/1/14		No
P9	Full	No	Infant up to 1 year of age with 0 percent - 208 percent Federal Poverty Level, Citizen/Lawfully present, full scope, no cost Medi-Cal.	Yes	Other	Yes	1/1/14		Yes
03	Full	No	Adoption Assistance Program (AAP) (FFP). A cash grant program to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance.	Yes	Other	Yes			Yes
04	Full	No	Adoption Assistance Program/Aid for Adoption of Children (AAP/AAC). Covers cash grant children receiving Medi-Cal by virtue of eligibility to AAP/AAC benefits.	Yes	Other	Yes			Yes
06	Full	No	Adoption Assistance Program (AAP) Child. Covers children receiving federal AAP cash subsidies from out of state. Provides eligibility for Continued Eligibility for Children (CEC) if for some reason the child is no longer eligible under AAP prior to his/her 18th birthday.	Yes	Other	No			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
07	Full	No	AAP Title IV-E Federal Cash and Medi-Cal.	Yes	Other	Yes	1/1/12		Yes
0W	Full	No	BCCTP transitional Medi-Cal coverage: Provides transitional no cost-full scope Medi-Cal coverage while county makes determination of eligibility under any other Medi-Cal program to beneficiaries formerly in aid code OP who no longer meet federal BCCTP requirements due to turning 65, obtaining creditable health insurance or who no longer need treatment for breast and/or cervical cancer.	Yes	Other	Yes			Yes
1E	Full	No	Continued eligibility for the Aged (FFP), Covers former SSI beneficiaries who are Aged (with exception of persons who are deceased or incarcerated in a correctional facility) until the county predetermines their eligibility.	Yes	Other	Yes			No
1H	Full	No	Federal poverty level – Aged (FPL-Aged) Provides full scope (no share of cost) Medi-Cal to qualified aged individuals/couples.	Yes	Other	Yes			No
1X	Full	No	Multipurpose Senior Services Program Medi-Cal Qualified, Eligible due to application of spousal impoverishment rules. Covers persons 65 years and older who meet the Medi-Cal criteria for inpatient care in a nursing facility.	Yes	Other	Yes			No
1Y	Full	Yes	Multipurpose Senior Services Program Medi-Cal Qualified, Eligible due to application of spousal impoverishment rules. Covers persons 65 yrs and older who meet the Medi-Cal criteria for inpatient care in a nursing facility.	Yes	Other	Yes			No
10	Full	No	SSI/SSP Aid to the Aged (FFP). A cash assistance program administered by the SSA which pays a cash grant to needy persons 65 years of age or older.	Yes	Other	Yes			No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
13	Full	Y/N	Aid to the Aged – LTC (FFP) Covers persons 65 years of age or older who are medically needy and in LTC status <b>For DMC only: Restricted to Narcotic Treatment Program Individual/Group Counseling and NTP dosing.</b>	Yes	Other	Yes			No
14	Full	No	Aid to the Aged – Medically Needy (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.	Yes	Other	Yes			No
16	Full	No	Aid to the Aged – Pickle Eligibles (FFP). Covers persons 65 years of age or older who were eligible for and receiving SSI/SSP and Title II benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions in the <u>Lynch v. Rank</u> lawsuit.	Yes	Other	Yes			No
17	Full	Yes	Aid to the Aged – Medically Needy, SOC (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required.	Yes	Other	Yes			No
18	Full	No	Aid to the Aged – IHSS (FFP). Covers aged IHSS cash recipients, 65 years of age or older, who are not eligible for SSI/SSP cash benefits.	No	Other	Yes		Phased out from 9/05 to 1/06	No
2A	Full	No	Abandoned baby program. Provides full scope benefits to children up to 3 months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act	Yes	Other	No			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
2E	Full	No	Continued eligibility for the Blind (FFP), Covers former SSI beneficiaries who are Blind (with exception of persons who are deceased or incarcerated in a correctional facility) until the county determines their eligibility.	Yes	Other	Yes			Yes
2H	Full	No	Blind – Federal Poverty Level – covers blind individuals in the FPL for the Blind Program.	Yes	Disabled	Yes			Yes
20	Full	No	SSI/SSP Aid to the Blind (FFP). A cash assistance program administered by the SSA, which pays a cash grant to needy blind persons of any age.	Yes	Other	Yes			Yes
23	Full	Y/N	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status. <b>For DMC only: Restricted to Narcotic Treatment Program Individual/Group Counseling and NTP dosing.</b>	Yes	Other	Yes			Yes
24	Full	No	Aid to the Blind – Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.	Yes	Other	Yes			Yes
26	Full	No	Aid to the Blind – Pickle Eligibles (FFP). Covers persons who meet the federal criteria for blindness and are covered by the provisions of the <u>Lynch v. Rank</u> lawsuit. (See aid code 16 for definition of Pickle eligibles.)	Yes	Other	Yes			Yes
27	Full	Yes	Aid to the Blind – Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC is required of the beneficiaries.	Yes	Other	Yes			Yes
28	Full	No	Aid to Blind – IHSS (FFP). Covers persons who meet the federal definition of blindness and are eligible for IHSS. (See aid code 18 for definition of eligibility for IHSS.)	No	Other	Yes		Phased out from 9/05 to 1/06	Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
3A	Full	No	Safety Net – All other Families, CalWORKs Timed-Out, Child-Only Case. (FFP) Provides for continued cash and Medi-Cal coverage of children whose parents have been discontinued from cash aid and removed from assistance unit (AU) due to reaching the CalWORKs 60 month time limit without meeting a time extender exception.	Yes	Other	Yes			Yes
3C	Full	No	Safety Net – Two Parent, CalWORKs Timed-Out, Child-Only Case. (FFP) Provides for continued cash and Medi-Cal coverage of children whose parents have been discontinued from cash aid and removed from AU due to reaching the CalWORKs 60 month time limit without meeting a time extender exception.	Yes	Other	Yes			Yes
3D	Full	No	Not on cash aid, but cash-linked Medi-Cal eligible because the individual has been determined to be eligible for CalWORKs.	Yes	Other	Yes			Yes
3E	Full	No	CalWORKs Legal Immigrant-Family Group (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.	Yes	Other	Yes			Yes
3G	Full	No	CalWORKs – Zero Parent Exempt.	Yes	Other	Yes			Yes
3F	Full	No	Two Parent Safety Net & Drug/Fleeing Felon Family	Yes	Other	Yes	4/1/13		Yes
3H	Full	No	CalWORKs – Zero Parent Mixed.	Yes	Other	Yes			Yes
3L	Full	No	CalWORKs Legal Immigrant-Family Group – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.	Yes	Other	Yes			Yes
3M	Full	No	CalWORKs Legal Immigrant-Family Group – Unemployed (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.	Yes	Other	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
3N	Full	No	Aid to Families with Dependent Children (AFDC) – 1931(b) Non-CalWORKs	Yes	Other	Yes			Yes
3P	Full	No	CalWORKs – All Families – Exempt.	Yes	Other	Yes			Yes
3R	Full	No	CalWORKs – Zero Parent – Exempt.	Yes	Other	Yes			Yes
3U	Full	No	CalWORKs Legal Immigrant-Family Group – Unemployed (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.	Yes	Other	Yes			Yes
3W	Full	No	Temporary Assistance to needy Families (TANF) Timed-Out Mixed Case	Yes	Other	No			Yes
30	Full	No	CalWORKs – All Families	Yes	Other	Yes			Yes
32	Full	No	TANF Timed out.	Yes	Other	Yes			Yes
33	Full	No	CalWORKs – Zero Parent	Yes	Other	Yes			Yes
34	Full	No	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.	Yes	Other	Yes			Yes
35	Full	No	CalWORKs – Two Parent	Yes	Other	Yes			Yes
36	Full	No	Aid to Disabled Widow/ers (FFP). Covers persons who began receiving Title II SSA before age 60 who were eligible for and receiving SSI/SSP and Title II benefits concurrently and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II disabled widow/ers reduction factor and subsequent COLAs were disregarded.	Yes	Disabled	Yes			Yes
37	Full	Yes	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required of the beneficiaries.	Yes	Other	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
38	Full	No	Continuing Medi-Cal Eligibility (FFP). <u>Edwards v. Kizer</u> court order provides for uninterrupted, no SOC Medi-Cal benefits for families discontinued from AFDC until the family's eligibility or ineligibility for Medi-Cal only has been determined and an appropriate <i>Notice of Action</i> sent.	Yes	Other	Yes			Yes
39	Full	No	Initial Transitional Medi-Cal (TMC) (6 months). Provides six months of coverage for those discontinued from CalWORKs or the Section 1931(b) program due to increased earnings or increased hours of employment.	Yes	Other	Yes			Yes
4A	Full	No	Adoption Assistance Program (AAP). Program for AAP children for whom there is a state-only AAP agreement between any state other than California and adoptive parent(s).	Yes	Other	Yes			Yes
4E	Full	No	Hospital Presumptive Eligibility for Former Foster Care Children up to age 26 No income screening	Yes	Other	Yes	1/1/14		Yes
4F	Full	No	Kinship Guardianship Assistance Payment (Kin-GAP). Federal program for children in relative placement receiving cash assistance.	Yes	Foster Care	Yes			Yes
4G	Full	No	Kin-GAP. State-only program for children in relative placement receiving cash assistance.	Yes	Foster Care	Yes			Yes
4H	Full	No	Foster Care children in CalWORKs	Yes	Foster Care	Yes	12/13/10		Yes
4K	Full	No	Emergency Assistance (EA) Program (FFP). Covers juvenile probation cases placed in foster care.	Yes	Foster Care	Yes		Termed on 6/96	Yes
4L	Full	No	Foster care children in Social Security Act Title XIX, Section 1931 (b) program	Yes	Foster Care	Yes	12/13/10		Yes
4M	Full	No	This program covers former foster care youth who were in foster care on their eighteenth birthday. Coverage extends until the 21st birthday and provides full-scope, no-cost benefits.	Yes	Other	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
4N	Full	No	CalWORKs FC State Cash Aid/ FFP Medi-Cal.	Yes	Foster Care	Yes	1/1/12		Yes
4P	Full	No	CalWORKs Family reunification – All Families (FFP) Provides for the continuance of CalWORKs services (includes Medi-Cal) to all families except two parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.	No	Other	No	10/1/01		Yes
4R	Full	No	CalWORKs Family reunification – Two Parent (FFP) Provides for the continuance of CalWORKs services (includes Medi-Cal) to two parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.	No	Other	No	10/1/01		Yes
4S	Full	No	Kin-GAP Title IV-E Federal Cash and Medi-Cal.	Yes	Foster Care	Yes	1/1/12		Yes
4T	Full	No	Children in IV-E Kin-GAP Program.	Yes	Foster Care	Yes	1/1/11		Yes
4W	Full	No	Kin-GAP State Cash Aid/FFP Medi-Cal after full Medi-Cal determination.	Yes	Foster Care	Yes	1/1/12		Yes
40	Full	No	AFDC-FC/Non-Fed (State FC). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.	Yes	Foster Care	Yes			Yes
42	Full	No	AFDC-FC/Fed (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.	Yes	Foster Care	Yes			Yes
43	Full	No	AFDC-FC State Cash Aid/FFP Medi-Cal.	Yes	Foster Care	Yes	1/1/12		Yes
44	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnant (FFP) United States Citizen/Permanent Resident Alien/PRUCOL Alien. Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level.	Yes	Other	Yes			No



Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
45	Full	No	Children Supported by Public Funds (FFP). Children whose needs are met in whole or in part by public funds other than AFDC-FC.	Yes	Other	Yes			Yes
46	Full	No	Out of State Interstate Compact Foster Care children from out of state placed in CA	Yes	Foster Care	No			Yes
47	Full	No	Income Disregard Program (FFP). Infant – United States Citizen, Permanent Resident Alien/PRUCOL Alien. Provides full Medi-Cal benefits to infants up to one year old and continues beyond one year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the federal poverty level.	Yes	Other	Yes			Yes
49	Full	No	AFDC-FC Title IV-E/Federal Cash and Medi-Cal	Yes	Foster Care	Yes	1/1/12		Yes
5E	Full	No	Healthy Families to the Medi-Cal Presumptive Eligibility (PE) program. Provides immediate, temporary, fee-for-service, full-scope Medi-Cal benefits to certain children under the age of 19. T21 effective through 3/31/09; T19 effective 4/1/09.	Yes	Other	Yes	10/25/10		Yes
5K	Full	No	Emergency Assistance (EA) Program (FFP). Covers child welfare cases placed in EA foster care.	Yes	Foster Care	Yes			Yes
54	Full	No	Four-Month Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the increased collection of child/spousal support payments but eligible for Medi-Cal only.	Yes	Other	Yes			Yes
59	Full	No	Continuing TMC (6 months). Provides an additional six months of TMC for beneficiaries who had six months of initial TMC coverage under aid code 39	Yes	Other	Yes			Yes
6A	Full	No	Disabled Adult Children (DAC)/Blindness (FFP).	Yes	Other	Yes			Yes
6C	Full	No	Disabled Adult Children (DAC)/Disabled (FFP).	Yes	Disabled	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
6E	Full	No	Continued eligibility for the Disabled (FFP), Covers former SSI beneficiaries who are Disabled (with exception of persons who are deceased or incarcerated in a correctional facility) until the county determines their eligibility.	Yes	Disabled	Yes			Yes
6G	Full	No	250 Percent Program Working Disabled. Provides full-scope Medi-Cal benefits to working disabled recipients who meet the requirements of the 250 Percent Program.	Yes	Disabled	Yes	3/16/09		Yes
6H	Full	No	Federal Poverty Level – Disabled (FPL Disabled). Provides full-scope Medi-Cal (No share of cost) to qualified disabled individuals/couples	Yes	Disabled	Yes			Yes
6J	Full	No	SB87 Pending Disability Program. Provides full scope (no share of cost) benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and are claiming disability. Medi-Cal coverage continues uninterrupted during the determination period.	Yes	Other	Yes			No
6N	Full	No	Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)/No Longer Disabled Recipients (FFP). Former SSI disabled recipients (adults and children not in aid code 6P) who are appealing their cessation of SSI disability.	Yes	Disabled	Yes			Yes
6P	Full	No	PRWORA/No Longer Disabled Children (FFP). Covers children under age 18 who lost SSI cash benefits on or after July 1, 1997, due to PRWORA of 1996, which provides a stricter definition of disability for children.	Yes	Disabled	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
6R	Full	Yes	SB87 Pending Disability Program. Provides full scope (no share of cost) benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and are claiming disability. Medi-Cal coverage continues uninterrupted during the determination period.	Yes	Disabled	Yes			No
6V	Full	No	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.	Yes	Disabled	Yes			Yes
6W	Full	Yes	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.	Yes	Disabled	Yes			Yes
6X	Full	No	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.	Yes	Disabled	Yes			Yes
6Y	Full	Yes	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.	Yes	Disabled	Yes			Yes
60	Full	No	SSI/SSP Aid to the Disabled (FFP). A cash assistance program administered by the SSA that pays a cash grant to needy persons who meet the federal definition of disability.	Yes	Disabled	Yes			Yes
63	Full	Y/N	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status. For DMC only: Restricted to Narcotic Treatment Program Individual/Group Counseling and NTP dosing.	Yes	Disabled	Yes			Yes
64	Full	No	Aid to the Disabled – Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant, but are eligible for Medi-Cal only.	Yes	Disabled	Yes			Yes
66	Full	No	Aid to the Disabled Pickle Eligibles (FFP). Covers persons who meet the federal definition of disability and are covered by the provisions of the Lynch v. Rank lawsuit. No age limit for this aid code.	Yes	Disabled	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
67	Full	Yes	Aid to the Disabled – Medically Needy, SOC (FFP). (See aid code 64 for definition of Disabled – MN.) SOC is required of the beneficiaries.	Yes	Disabled	Yes			Yes
68	Full	No	Aid to the Disabled IHSS (FFP). Covers persons who meet the federal definition of disability and are eligible for IHSS. (See aid codes 18 and 65 for definition of eligibility for IHSS).	Yes	Disabled	Yes		Phased out from 9/05 to 1/06	Yes
69	Restricted to emergency services only	No	Income Disregard Program. Infant (FFP) – Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides Emergency services only for infants under 1 year of age and beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is at or below 200 percent of the federal poverty level.	Yes	Other	Yes			No
7A	Full	No	100 Percent Program. Child (FFP) – United States Citizen, Lawful Permanent Resident/PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides full benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the federal poverty level.	Yes	Other	Yes			Yes
7J	Full	No	Continuous Eligibility for Children (CEC) program. Provides full-scope benefits to children up to the 19 years of age who would otherwise lose their share of cost	Yes	Other	Yes			Yes
7M	Restricted Valid for Minor Consent Services	Y/N	Minor consent Program. Covers minors age 12 and under 21. Limited services related to sexually transmitted diseases, sexual assault, drug and alcohol abuse, and family planning. Funded 100% through county realigned funds	No	N/A	Yes			No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
7N	Restricted Valid for Minor Consent Services	No	Minor consent Program (FFP). Covers pregnant female minors under age 21. Limited to services related to pregnancy and family planning. Funded 100% through county realigned funds	No	N/A	Yes			No
7P	Restricted Valid for Minor Consent Services	Y/N	Minor consent Program. Covers minors age 12 and under 21. Limited services related to sexually transmitted diseases, sexual assault, drug and alcohol abuse, family planning, and outpatient mental health treatment. Funded 100% through county realigned funds	No	N/A	Yes			No
7S	Full	No	Express Lane Enrollment. CalFRESH parents from 19 through 64 years of age who are neither blind nor disabled.	Yes	Other	Yes	4/1/14		Yes
7W	Full	No	Express Lane Enrollment For Children.	Yes	Other	Yes	2/1/14		Yes
72	Full	No	133 Percent Program. Child-United States Citizen, Permanent Resident Alien/PRUCOL Alien (FFP). Provides full Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.	Yes	Other	Yes			Yes
74	Restricted to emergency services only	No	133 Percent Program (OBRA). Child Undocumented/ Nonimmigrant Alien (but otherwise eligible) (FFP). Provides Emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.	Yes	Other	Yes			No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
76	Restricted to 60-day postpartum services	No	60-Day Postpartum Program (FFP). Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for, and received Medi-Cal benefits. They may continue to be eligible for all-postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.	Yes	Other	Yes			No
8E	Full	No	Accelerated Enrollment. Provides immediate, temporary, fee-for-service, full scope Medi-Cal benefits up to the age of 65. T21 effective through 3/31/09; T19 effective 4/1/09.	Yes	Other	Yes			Yes
8G	Full	No	Qualified Severely Impaired Working Individual Program Aid Code. Allows recipients of the Qualified Severely Impaired Working Individual Program to continue their Medi-Cal eligibility.	Yes	Other	Yes			Yes
8U	Full	No	CHDP Gateway Deemed Infant. Provides full-scope, no Share of Cost (SOC) Medi-Cal benefits for infants born to mothers who were enrolled in Medi-Cal with no SOC in the month of the infant's birth.	Yes	Other	Yes	10/11/10		Yes
8V	Full	Yes	CHDP Gateway Deemed Infant SOC. Provides full-scope Medi-Cal benefits with a Share of Cost (SOC) for infants born to mothers who were enrolled in Medi-Cal with a SOC in the month of the infant's birth and SOC was met.	Yes	Other	Yes	10/11/10		Yes
8W	Full	No	Medically Indigent (MI)-Accelerated Enrollment (AE)-CHDP Gateway for Medi-Cal. Provides for the pre-enrollment of CHILDREN into the Medi-Cal program that are Screened as No Cost Medi-Cal Eligibles. Provides Temporary, full scope Medi-Cal benefits with no SOC. Please note: T21 through 3/31/09; however T19 effective 4/1/09.	Yes	Other	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
80	Restricted to Medicare expenses	No	Qualified Medicare Beneficiary (QMB). Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind, or disabled individuals.	Yes	Other	Yes			No
82	Full	No	MI-Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.	Yes	Other	Yes			Yes
83	Full	Yes	MI-Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.	Yes	Other	Yes			Yes
86	Full	No	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meets the eligibility requirements of medically indigent.	Yes	Other	Yes			No
87	Full	Yes	MI-Confirmed Pregnancy (FFP). Covers person's aged 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.	Yes	Other	Yes			No

**Department of Health Care Services - Short Doyle Aid Code Master Chart for MHS and DMC**

Title XIX 100% FFP- Please note: The FFP will be at 100 % from 2014 through 2016. All of the individuals in these aid codes should be placed into the appropriate ACA aid code for ongoing eligibility by March 2015.							Effective Dates		
Code	Benefits	SOC	Program / Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
7U	Full	No	Express Lane Enrollment For Adults.	Yes	Medicaid Expansion	Yes	2/1/14		Yes
L1	Full	No	Adults aged 19 through 64 years of age, enrolled in LIHP MCE program on December 31, 2013 with 0 percent – 138 percent Federal Poverty Level	Yes	Medicaid Expansion	Yes	1/1/14		Yes
N0	Limited	No	Adults aged 19 through 64 years of age, inmates in county jail enrolled in LIHP MCE program on December 31, 2013, with 0 percent – 138 percent Federal Poverty Level (FPL), limited to covered inpatient hospital services provided off the grounds of the correctional facility.	Yes	Medicaid Expansion	No	1/1/14		No
N9	Limited	No	Adults aged 19 through 64 years of age, inmates in State prison enrolled in LIHP MCE program on December 31, 2013 with 0 percent – 138 percent FPL, limited to covered inpatient hospital services provided off the grounds of the correctional facility, no SOC.	Yes	Medicaid Expansion	No	1/1/14		No



Department of Health Care Services - Short Doyle Aid Code Master Chart for MHS and DMC

Title XIX 100% FFP - Enhanced Title XIX federal funding is available for those who are “newly eligible” in the adults group. Please note the FFP category will decrease to the following: 100 % for 2014-2016; 95% for 2017; 94% for 2018; 93% 2019; 90% for 2020 and thereafter.							Effective Dates		
Code	Benefits	SOC	Program / Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
M1	Full	No	Adult 19 to 65 Yrs at or below 138% FPL: Citizen/Lawfully Present	Yes	Medicaid Expansion	Yes	1/1/14		Yes
M2	Restricted	No	Adult 19 to 65 Yrs at or below 138% FPL: Undocumented-Restricted to emergency and pregnancy related services.	Yes	Medicaid Expansion	Yes	1/1/14		No
N5	Limited	No	Medi-Cal benefits limited to covered inpatient hospital only, for adult inmates aged 19 through 64 years of age in state correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Medicaid Expansion	No	1/1/14		No
N6	Restricted	No	This aid code will reflect the new ACA adult group aged 19-64. Aid code provides restricted Medi-Cal benefits, without a share of cost, limited to inpatient hospital emergency related services only, to eligible undocumented adult state inmates who receive those services off the grounds of the correctional facility.	Yes	Medicaid Expansion	No	1/1/14		No
N7	Limited	No	Medi-Cal no SOC for County Adult Inmates. Medi-Cal benefits limited to covered inpatient hospital services only, for adult inmates aged 19 through 64 years of age in county correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Medicaid Expansion	No	1/1/14		No
N8	Restricted	No	This Aid code will reflect the new ACA adult group aged 19-64. Aid code provides restricted Medi-Cal benefits, without a share of cost, limited to inpatient hospital emergency related services only, who receive those services off the grounds of the correctional facility.	Yes	Medicaid Expansion	No	1/1/14		No

Breast and Cervical Cancer Treatment Program (BCCTP) Aid Codes (Enhanced FFP 65%)Title XIX							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
0M	Full	No	BCCTP-Accelerated Enrollment (AE). Provides AE for temporary full-scope, no SOC Medi-Cal for females under 65 years of age who are diagnosed with breast and/or cervical cancer. Eligibility limited to 2 months	Yes	Other	Yes			Yes
0N	Full	No	BCCTP-AE, Provides AE for temporary full-scope, no SOC Medi-Cal for females under 65 years of age who have diagnosed with breast and/or cervical cancer and are without creditable insurance coverage. No time limit	Yes	Other	Yes			Yes
0P	Full	No	BCCTP-Federal, Provides full-scope, no SOC Medi-Cal for females under 65 years of age who have diagnosed with breast and/or cervical cancer and are without creditable insurance coverage	Yes	Other	Yes			Yes
0U	Restricted to pregnancy and/or emergency services	No	BCCTP Provides services for females with unsatisfactory immigration status, who are under 65 years of age, who have been diagnosed with breast and/or cervical cancer and are found in need of treatment. They are eligible for Federal BCCTP for Emergency services for the duration of treatment. Does not cover individuals with creditable health insurance. State-only cancer treatment payments are 18 months (breast) and 24 months (cervical).	Yes	Other	No			No
0V	Restricted to pregnancy and/or emergency services	No	Post 0U eligibility for federal Medi-Cal Emergency services only and who continue to meet Federal BCCTP criteria. State-only pregnancy-related and LTC; for individuals whose 0U eligibility has expired and who are determined to be still in need of breast or cervical cancer treatment.	Yes	Other	No			No

**SCHIP**

The State Children's Health Insurance Program (SCHIP) was established by the federal government in the late 1990's to provide health insurance to children in families at or below 200 percent of the federal poverty level. SCHIP allowed states to create new programs to serve these children and families and/or expand their existing Medicaid programs. California elected to create the Healthy Families Program, serving children with family incomes below 250% of the federal poverty level and expand Medi-Cal programs to serve lower income children that would not previously qualify for Medi-Cal.

The HFP was established to provide a basic health, vision, and dental benefit package (provided by HFP health plans) that includes a mental health benefit for children assessed with serious emotional disturbances (SED). Mental health services for children meeting the SED criteria are provided by the county mental health departments. The enhanced Federal Medicaid Assistance Percentage (FMAP) of 65% under Title XXI is provided for HFP health and mental health service expenditures

<b>Healthy Families - MRMIB Title XXI (Enhanced FFP 65%) - SCHIP</b>							<b>Effective Dates</b>		
<b>Code</b>	<b>Benefits</b>	<b>SOC</b>	<b>Program / Description</b>	<b>MHS</b>	<b>MEG</b>	<b>DMC</b>	<b>SD/MC</b>	<b>Inactive in MEDS</b>	<b>EPSDT</b>
9H	HF services only (no Medi-Cal)	No	The Healthy Families (HF) Program provides a comprehensive health insurance plan for uninsured children from 1 to 19 years of age whose family's income is at or below 200 percent of the federal poverty level. HF covers medical, dental and vision services to enrolled children.	Yes	N/A	No			No
9R	CCS Services only (no Medi-Cal)	No	CCS-eligible Healthy Families Child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management)	Yes	N/A	No			No

**MCHIP**

California expanded Medicaid (Medi-Cal) eligibility for certain populations of children for the provision of health and mental health services. Known in California as MCHIP, services are reimbursed for “optional targeted low-income children” using the enhanced FMAP of 65% under Title XXI. These children are defined in federal law as targeted low-income children who would not otherwise qualify for Medicaid.

Title XXI Aid Codes (Enhanced FFP 65%) –MCHIP							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
E1	Restricted to pregnancy and/or emergency services	No	Unverified citizens. Covers eligible unverified citizen children. One Month Medi-Cal to Healthy Families Bridge. Prenatal and Emergency Services Only. Covers services only to eligible children ages 0-19, who are unverified citizens	Yes	MCHIP	Yes	8/1/08		No
E2	Full	No	CHIP 2101(f) Citizen/Lawfully Present (Age 0-19, No premiums)	Yes	MCHIP	Yes	1/1/14		Yes
E4	Restricted	No	CHIP 2101(f) Undocumented (Age 0-19, No premiums) Restricted to emergency and pregnancy related services, and state-funded long term care services.	Yes	MCHIP	Yes	1/1/14		No
E5	Full	No	CHIP 2101(f) Citizen/Lawfully Present (Age 1-19, With premiums)	Yes	MCHIP	Yes	1/1/14		Yes
E6	Full	No	AIM infant above 213% to 266%	Yes	MCHIP	No	1/1/14		Yes
E7	Full	No	AIM infant above 250% to 300%	Yes	MCHIP	No	1/1/14		Yes
H0	Full	No	Hospital Presumptive Eligibility for Children age 6-19 (FPL above 108 percent up to and including 266 percent FPL).	Yes	MCHIP	Yes	1/1/14		Yes
H1	Full	No	Targeted Low Income FPL for infants. Provides full scope, no-cost Medi-Cal for infants who are U.S. citizens, have satisfactory immigration status, or unverified citizenship**. Coverage is up to the month of their first birthday or continues beyond one year, when in an inpatient status that began before the first birthday. Family income is above 200 percent up to 250 percent of the FPL.	Yes	MCHIP	Yes	1/1/13		Yes
H2	Full	No	Medi-Cal Targeted Low-Income FPL for Children Program. Provides full scope, no-cost Medi-Cal coverage to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages one through the month of the 6 <sup>th</sup> birthday or continues when in an inpatient status which began before the 6 <sup>th</sup> birthday for family income at or below 133 up to 150 percent of federal poverty level.	Yes	MCHIP	Yes	1/1/13		Yes

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	Benefits	SOC	Program / Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
H3	Full	No	Medi-Cal Targeted Low-Income FPL for Children Program. Provides full scope, Medi-Cal coverage with a premium payment to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages one through the month of their 6 <sup>th</sup> birthday or continues when in an inpatient status which began before the 6 <sup>th</sup> birthday, with family income above 150 percent up to 250 percent of the FPL.	Yes	MCHIP	Yes	1/1/13		Yes
H4	Full	No	Medi-Cal Targeted Low-Income FPL for Children Program. Provides full scope, no-cost Medi-Cal coverage to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages six through the month of the 19th birthday or continues when in an inpatient status which began before the 19th birthday for family income above 100 up to 150 percent of federal poverty level.	Yes	MCHIP	Yes	1/1/13		Yes
H5	Full	No	Medi-Cal Targeted Low-Income FPL for Children Program. Provides full scope, Medi-Cal coverage with premium payment to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages six through the month of the 19th birthday or continues when in an inpatient status which began before the 19th birthday, with family income above 150 percent up to 250 percent of FPL.	Yes	MCHIP	Yes	1/1/13		Yes
H6	Full	No	Hospital Presumptive Eligibility for infants (FPL above 208 percent up to and including 266 percent FPL).	Yes	MCHIP	Yes	1/1/14		Yes
H9	Full	No	Hospital Presumptive Eligibility for Children age 1-6 (FPL above 142 percent up to and including 266 percent FPL).	Yes	MCHIP	Yes	1/1/14		Yes
M5	Full	No	Expansion Child from 6 to 19 Yrs 101% through 133% FPL: Citizen/Lawfully Present.	Yes	MCHIP	Yes	1/1/14		Yes
M6	Restricted	No	Expansion Child from 6 to 19 Yrs 101% through 133% FPL: Undocumented Restricted to pregnancy related, emergency, and long term care.	Yes	MCHIP	Yes	1/1/14		No

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
T0	Restricted	No	Infant up to 1 Yr. Undoc 201%-250% FPL (TLIC). Restricted to emergency and state funded long term care services.	Yes	MCHIP	No	1/1/14		No
T1	Full	No	Child from 6 to 19 Yrs: Citizen 151%-250% FPL (TLIC Premiums).	Yes	MCHIP	Yes	1/1/14		Yes
T2	Full	No	Child from 6 to 19 Yrs: Citizen 134%-150% FPL (TLIC).	Yes	MCHIP	Yes	1/1/14		Yes
T3	Full	No	Child from 1 to 6 Yrs: Citizen 151%-250% FPL (TLIC Premiums).	Yes	MCHIP	Yes	1/1/14		Yes
T4	Full	No	Child from 1 to 6 Yrs: Citizen 134%-150% FPL (TLIC).	Yes	MCHIP	Yes	1/1/14		Yes
T5	Full	No	Infant up to 1 Yr. Citizen 201%-250% FPL (TLIC).	Yes	MCHIP	Yes	1/1/14		Yes
T6	Restricted	No	Child from 6 to 19 Yrs: Undoc 151%-250% FPL (TLIC Premiums). Restricted to emergency and pregnancy related services, and state funded long term care services.	Yes	MCHIP	Yes	1/1/14		No
T7	Restricted	No	Child from 6 to 19 Yrs: Undoc 134%-150% FPL (TLIC). Restricted to emergency and pregnancy related services, and state funded long term care services.	Yes	MCHIP	Yes	1/1/14		No
T8	Restricted	No	Child from 1 to 6 Yrs: Undoc 151%-250% FPL (TLIC Premiums). Restricted to emergency and state funded long term care services.	Yes	MCHIP	No	1/1/14		No
T9	Restricted	No	Child from 6 to 19 Yrs: Undoc 134%-150% FPL (TLIC). ). Restricted to emergency services and state funded long term care services.	Yes	MCHIP	No	1/1/14		No
5C	Full	No	Medi-Cal Presumptive Eligibility, Title XXI, HFP Transitional Children Provides no-cost, full scope, Medi-Cal coverage with no premium payment, to children with family income at or below 150 percent of the federal poverty level during the transition period until the annual eligibility review.	Yes	MCHIP	Yes	1/1/13		Yes

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
5D	Full	No	Medi-Cal Presumptive Eligibility, Title XXI, HFP Transitional Children Provides full scope Medi-Cal coverage with a premium payment, to children with family income above 150 percent and up to 250 percent of the federal poverty level during the transition period.	Yes	MCHIP	Yes	1/1/13		Yes
7X	Full	No	One-Month Healthy Families (HF) Bridge (FFP). Provides one additional calendar month of health care benefits with no Share of Cost, through the same health care delivery system, to Medi-Cal-eligible children meeting the criteria of the HF Bridging Program.	Yes	MCHIP	Yes			Yes
8X	Full	No	Medically Indigent (MI)-Accelerated Enrollment (AE)-CHDP Gateway for Healthy Families. Provides for the pre-enrollment of CHILDREN into the Medi-Cal program that are Screened as Probable Healthy Families Eligibles. Provides Temporary, full scope Medi-Cal benefits with no SOC.	Yes	MCHIP	Yes			Yes
8N	Restricted to emergency services only	No	133 Percent Program (OBRA). Child Undocumented / Nonimmigrant Alien (but otherwise eligible except for excess property) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.	Yes	MCHIP	No			No
8P	Full	No	133 Percent Program. Child – United States Citizen (with excess property), Permanent Resident Alien/PRUCOL Alien (FFP). Provides full-scope Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.	Yes	MCHIP	Yes			Yes

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
8R	Full	No	100 Percent Program. Child (FFP) – United States Citizen (with excess property), Lawful Permanent Resident / PRUCOL / (IRCA Amnesty Alien [ABD or Under 18]). Provides full-scope benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19 <sup>th</sup> birthday and family income is at or below 100 percent of the federal poverty level.	Yes	MCHIP	Yes	1/1/12		Yes
8T	Restricted to pregnancy and/or emergency services	No	100 Percent Program. Child-Undocumented / Nonimmigrant Status / (IRCA Amnesty Alien [with excess property]). Covers emergency and pregnancy-related services only to otherwise eligible children ages 6 to 19 and beyond 19 when in patient status begins before the 19 <sup>th</sup> birthday and family income is at or below 100 percent of the federal poverty level.	Yes	MCHIP	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
1U	Restricted to pregnancy and/or emergency services	No	Restricted Federal poverty level – Aged (Restricted FPL – Aged) Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified aged individuals/couples who do not have satisfactory immigration status	Yes	Other	Yes			No
3T	Restricted to pregnancy and/or emergency services	No	Initial Transitional Medi-Cal (TMC) (FFP). Provides six months of emergency and pregnancy-related initial TMC benefits (no SOC) for aliens who do not have satisfactory immigration status (SIS) and have been discontinued from Section 1931(b) due to increased earnings from employment.	Yes	Other	Yes			No
3V	Restricted to pregnancy and/or emergency services	No	Section 1931(b) (FFP). Provides emergency and pregnancy-related benefits (no SOC) for aliens without SIS who meet the income, resources and deprivation requirements of the AFDC State Plan in effect July 16, 1996.	Yes	Other	Yes			No



Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
48	Restricted to pregnancy services only	No	Income Disregard Program. Pregnant – Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level. Routine prenatal care is non-FFP. Labor, delivery and emergency prenatal care are FFP.	Yes	Other	Yes			No
5F	Restricted to pregnancy and/or emergency services	Y/N	OBRA Aliens. Covers non-immigrant and undocumented aliens who do not have proof of permanent resident alien, PRUCOL or amnesty alien status, but who are otherwise eligible for Medi-Cal.	Yes	Other	Yes			No
5J	Restricted to pregnancy and/or emergency services	No	Pending disability Program. Covers recipients whose linkage has to be re-determined under Senate Bill 87 (SB87) requirements. Services restricted due to unsatisfactory immigration status. Recipients have a potential new linkage of disability with no SOC.	Yes	Other	No			No
5R	Restricted to pregnancy and/or emergency services	Yes	Pending disability Program. Covers recipients whose linkage has to be re-determined under Senate Bill 87 (SB87) requirements. Services restricted due to unsatisfactory immigration status. Recipients have a potential new linkage of disability with a SOC.	Yes	Other	No			No
5T	Restricted to pregnancy and/or emergency services	No	Continuing TMC (FFP). Provides an additional six months of continuing emergency and pregnancy-related TMC benefits (no SOC) to qualifying aid code 3T recipients.	Yes	Other	Yes			No
5W	Restricted to pregnancy and/or emergency services	No	Four Month Continuing (FFP). Provides four months of emergency and pregnancy-related benefits (no SOC) for aliens without SIS who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
55	Restricted to pregnancy and/or emergency services	No	Aid to Undocumented Aliens in LTC Not PRUCOL. Covers undocumented aliens in LTC not Permanently Residing Under Color Of Law (PRUCOL). LTC services: State-only funds; Emergency and pregnancy-related services: State and federal funds. Recipients will remain in this aid code even if they leave LTC.	Yes	Other	Yes			No
58	Restricted to pregnancy and/or emergency services	Y/N	OBRA Aliens. Covers nonimmigrant and undocumented aliens who do not have proof of permanent resident alien, PRUCOL or amnesty alien status, but who are otherwise eligible for Medi-Cal.	Yes	Other	Yes			No
6U	Restricted to pregnancy and/or emergency services	No	Restricted Federal Poverty Level – Disabled (Restricted FPL-Disabled) Provides emergency and pregnancy-related benefits (no share of cost) to qualified disabled individuals/couples who do not have satisfactory immigration status.	Yes	Disabled	Yes			No
7C	Restricted to pregnancy and/or emergency services	No	100 Percent Program. Child – Undocumented / Nonimmigrant Status / [IRCA Amnesty Alien (Not ABD or Under 18)]. Covers emergency and pregnancy related services to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19 <sup>th</sup> birthday and family income is at or below 100 percent of the federal poverty level.	Yes	Other	Yes			No
7K	Restricted to pregnancy and/or emergency services	No	Continuous Eligibility for Children (CEC) program. Provides emergency and pregnancy-related benefits (no share of cost) to children up to 19 years of age who would otherwise lose their no share of cost Medi-Cal	Yes	Other	Yes			No
C1	Restricted to pregnancy and/or emergency services	No	Aid to the Aged – Medically Needy (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.	Yes	Other	Yes			No
C2	Restricted to pregnancy and/or emergency services	Yes	Aid to the Aged – Medically Needy, SOC (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
C3	Restricted to pregnancy and/or emergency services	No	Aid to the Blind – Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.	Yes	Disabled	Yes			No
C4	Restricted to pregnancy and/or emergency services	Yes	Aid to the Blind – Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC is required of the beneficiaries.	Yes	Disabled	Yes			No
C5	Restricted to pregnancy and/or emergency services	No	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.	Yes	Other	Yes			No
C6	Restricted to pregnancy and/or emergency services	Yes	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required of the beneficiaries.	Yes	Other	Yes			No
C7	Restricted to pregnancy and/or emergency services	No	Aid to the Disabled – Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant, but are eligible for Medi-Cal only.	Yes	Disabled	Yes			No
C8	Restricted to pregnancy and/or emergency services	Yes	Aid to the Disabled – Medically Needy, SOC (FFP). (See aid code 64 for definition of Disabled – MN.) SOC is required of the beneficiaries.	Yes	Disabled	Yes			No
C9	Restricted to pregnancy and/or emergency services	No	MI-Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.	Yes	Other	Yes			No
D1	Restricted to pregnancy and/or emergency services	Yes	MI-Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
D2	Restricted to pregnancy and/or emergency services	No	Aid to the Aged – LTC (FFP) Covers persons 65 years of age or older who are medically needy and in LTC status	Yes	Other	Yes			No
D3	Restricted to pregnancy and/or emergency services	Yes	Aid to the Aged – LTC (FFP) Covers persons 65 years of age or older who are medically needy and in LTC status	Yes	Other	Yes			No
D4	Restricted to pregnancy and/or emergency services	No	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.	Yes	Disabled	Yes			No
D5	Restricted to pregnancy and/or emergency services	Yes	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.	Yes	Disabled	Yes			No
D6	Restricted to pregnancy and/or emergency services	No	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.	Yes	Disabled	Yes			No
D7	Restricted to pregnancy and/or emergency services	Yes	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.	Yes	Disabled	Yes			No
D8	Restricted to pregnancy and/or emergency services	No	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meets the eligibility requirements of medically indigent.	Yes	Other	Yes			No
D9	Restricted to pregnancy and/or emergency services	Yes	MI-Confirmed Pregnancy (FFP). Covers person's aged 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
G2	Restricted; Limited	No	Title XIX/Title XXI, Medi-Cal no SOC for undocumented state juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital emergency and inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in state correctional facilities who receive those services off the grounds of the correctional facility	Yes	Other	No	1/1/12		No
G6	Restricted; Limited	No	Title XIX/Title XXI, Medi-Cal no SOC for undocumented county juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital emergency, inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/12		No
G8	Restricted; Limited	Yes	Title XIX/Title XXI, Medi-Cal SOC for undocumented county juvenile inmates. Restricted/Limited- Medi-Cal limited to covered inpatient hospital emergency, inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/12		No
G9	Restricted	No	Undocumented State Medical Parolees. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. Aid code G9 will be in the secondary segment in MEDS	Yes	Other	No	1/1/14		No
J3	Restricted	No	Compassionately released/Medical Probation County Inmates. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. The county is responsible for the non-federal share.	Yes	Other	Yes	1/1/14		No
J4	Restricted	Yes	Compassionately released/Medical Probation County Inmates. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. The county is responsible for the non-federal share.	Yes	Other	Yes	1/1/14		No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
J6	Restricted	No	Compassionately released/Medical Probation County Inmates who reside in LTC facilities. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. The county is responsible for the non-federal share.	Yes	Other	No	1/1/14		No
J8	Restricted	No	Compassionately released/Medical Probation County Inmates who reside in LTC facilities. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. The county is responsible for the non-federal share.	Yes	Other	No	1/1/14		No
M0	Limited Scope -- Pregnancy Services/ Emergency Services	No	Pregnant Women 126% - 200%: FPL - Undocumented CHDP Funding: Baby using Mom's ID only 50/50 Final FPL 60% - 213% FPL	Yes	Other	Yes	1/1/14		No
M4	Restricted	No	Parent/Caretaker Relative at or below 125% FPL: Undocumented- Restricted to emergency, pregnancy related and long term care services.	Yes	Other	Yes	1/1/14		No
M8	Limited Scope: Pregnancy Services/ Emergency Services	No	Pregnant Women 0% through 125% FPL: Undocumented	Yes	Other	Yes	1/1/14		No
P6	Restricted	No	Children 6 to 19 years of age with 0 percent - 108 percent Federal Poverty Level, Undocumented, restricted to emergency services, pregnancy and long term care services.	Yes	Other	Yes	1/1/14		No

STATE ONLY AID CODES – NO FFP AVAILABLE							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
53	Restricted to LTC and related services	Y/N	Medically Indigent-LTC (Non-FFP). Covers persons age 21 or older and under 65 years of age who are residing in a Skilled Nursing or Intermediate Care Facility (SNF or ICF) and meet all other eligibility requirements of medically indigent, with or without SOC.	No	Other	No			No
65	Full	Y/N	1115 Waiver five months of eligibility for Evacuees of Hurricane Katrina. Applications 8/24/05 to 1/31/06. Final date of any waiver eligibility 5/31/06.	No	Other	No			Yes
0R	Restricted	No	BCCTP-State. Provides payment of premiums, co-payments, deductibles and coverage for non-covered cancer-related services for all-age males and females (regardless of age or immigration status). These individuals must have a high cost-sharing insurance (over \$750/year); have a diagnosis of breast (payment limited to 18 months) and/or cervical (payment limited to for 24 months) cancer.	No	Other	No			No
0T	Restricted	No	BCCTP-State. Provides 18 months of breast cancer treatments and 24 months of cervical cancer treatments for all-age males and females who are not eligible under aid codes 0P, 0R, or 0U regardless of citizenship, that are diagnosed with breast and/or cervical cancer. Does not cover individuals with other creditable insurance.	No	Other	No			No
8Y	Restricted CHDP services only	No	Covers CHDP eligible children who are also eligible for Medi-Cal emergency, pregnancy-related and Long Term Care (LTC) services.	No	Other	No			No
81	Full	Y/N	Medically Indigent Adult (MIA)–Adults Aid Paid Pending.	No	Other	No			No
R1	Full	Yes	CalWORKs TCVAP Trafficking Victims  Funded 100% through county realigned funds.	No	N/A	Yes			Yes

## County Number Table

01	Alameda	30	Orange
02	Alpine	31	Placer
03	Amador	32	Plumas
04	Butte	33	Riverside
05	Calaveras	34	Sacramento
06	Colusa	35	San Benito
07	Contra Costa	36	San Bernardino
08	Del Norte	37	San Diego
09	El Dorado	38	San Francisco
10	Fresno	39	San Joaquin
11	Glenn	40	San Luis Obispo
12	Humboldt	41	San Mateo
13	Imperial	42	Santa Barbara
14	Inyo	43	Santa Clara
15	Kern	44	Santa Cruz
16	Kings	45	Shasta
17	Lake	46	Sierra
18	Lassen	47	Siskiyou
19	Los Angeles	48	Solano
20	Madera	49	Sonoma
21	Marin	50	Stanislaus
22	Mariposa	51	Sutter
23	Mendocino	52	Tehama
24	Merced	53	Trinity
25	Modoc	54	Tulare
26	Mono	55	Tuolumne
27	Monterey	56	Ventura
28	Napa	57	Yolo
29	Nevada	58	Yuba





**CDSS**

**WILL LIGHTBOURNE**  
DIRECTOR

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**EDMUND G. BROWN JR.**  
GOVERNOR

July 24, 2012

ALL-COUNTY LETTER NO.: 12-36

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: PROGRAM POLICY FOR THE CASE MANAGEMENT  
INFORMATION AND PAYROLLING SYSTEM II (CMIPS II)

- INQUIRY, REFERRAL AND APPLICATION
- PERSON NOTES/CASE NOTES/CASE (ASSESSMENT)  
NARRATIVE
- PERSONAL CARE SERVICES PROGRAM/IHSS PLUS  
OPTION/IHSS RESIDUAL
- SOCIAL SECURITY NUMBER REQUIREMENTS
- IHSS RECIPIENT RESIDENCE
- USE OF RANK 6
- INTER-COUNTY TRANSFER

REFERENCE: All County Letter No. 88-118  
All County Letters Nos. 06-34 and 06-34E2  
All County Letter No. 09-30

This All-County Letter (ACL) explains the difference between an inquiry, a referral and an application for In-Home Supportive Services (IHSS) and provides policy direction related to Medi-Cal eligibility, pending Disability Evaluation Determinations (DEDs), loss of Medi-Cal eligibility and eligibility for IHSS Residual (IHSS-R). In addition, it will define the use for the following in CMIPS II: Use of new Person Note/Case Note/Narrative functionality; Social Security Number (SSN) requirements; Recipient Primary Residence; Rank 6 and Inter-County Transfer (ICT) process. In this letter, all references to IHSS shall be recognized to include the Personal Care Services Program (PCSP), IHSS Plus Option (IPO), and IHSS-R unless specified otherwise.

**INQUIRY, REFERRAL AND APPLICATION**

With the impending transition to CMIPS II, this ACL will explain the enhanced referral and application functionality that counties will be required to complete in CMIPS II as

**REASON FOR THIS TRANSMITTAL**

- ☐ State Law Change
- ☐ Federal Law or Regulation  
Change
- ☐ Court Order
- ☒ Clarification Requested by  
One or More Counties
- ☒ Initiated by CDSS

the system is implemented in each county. It will also clarify the differences between an inquiry, a referral and an application that exist today, as well as describe the required county actions related to these activities in both Legacy CMIPS and CMIPS II. In the case of CMIPS II activities, this letter will direct counties to the appropriate CMIPS II screens, but will not provide directions for screen entry; those step-by-step directions will be covered in CMIPS II training. When a county receives an initial contact regarding the IHSS program, the county may determine the nature of the contact based on the direction provided in this ACL.

Inquiry:

If a county receives a call from an individual making an informational inquiry regarding the IHSS program only, e.g., what kinds of services does IHSS provide, it is considered an inquiry and does not merit a referral or qualify as an application. During an inquiry, the county will generally not receive or respond to any person-specific information. The county is not required to take any further action.

Referral:

A referral is a contact about the IHSS program received by the county from a third party who does not have legal authority to make decisions on behalf of the potential applicant, e.g., a health care professional, neighbor, friend or religious affiliate, or a person who is not the authorized representative of the individual they are referring. The county must record the contact as a Referral until the county has contacted the individual or their authorized representative to determine whether the referred individual or their authorized representative is interested in applying for IHSS.

**Legacy CMIPS:** For the time that a county remains on Legacy CMIPS, the county is encouraged to enter the referral information in Record (R) status; however, counties using external tools to record and track referrals may continue to do so.

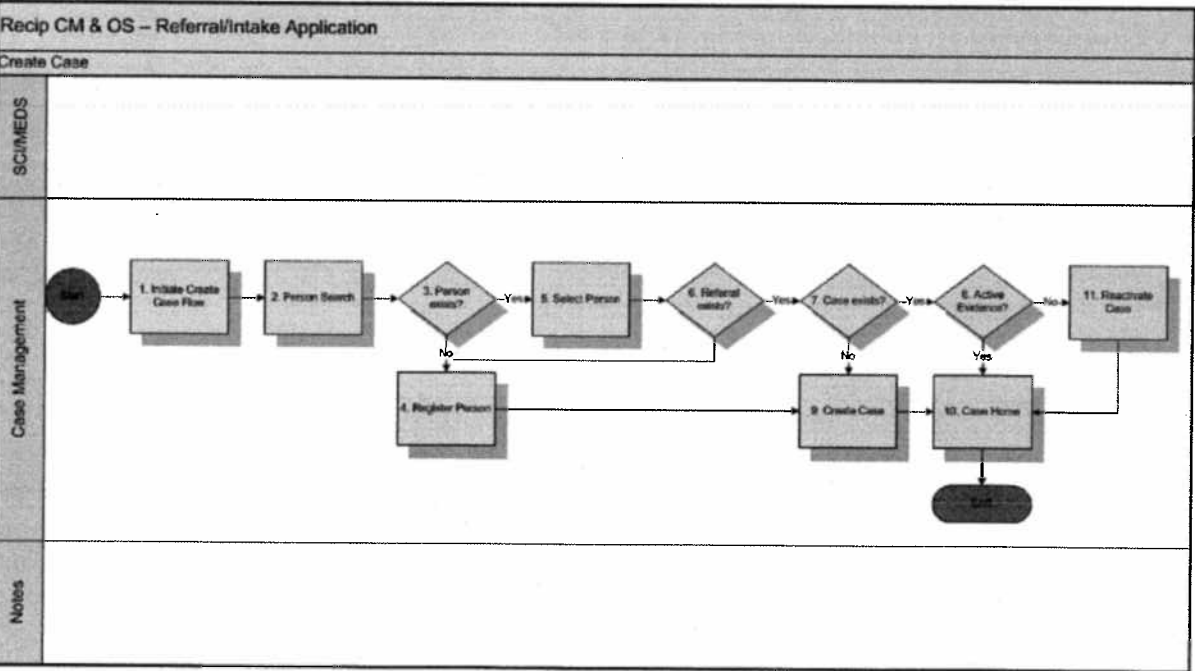
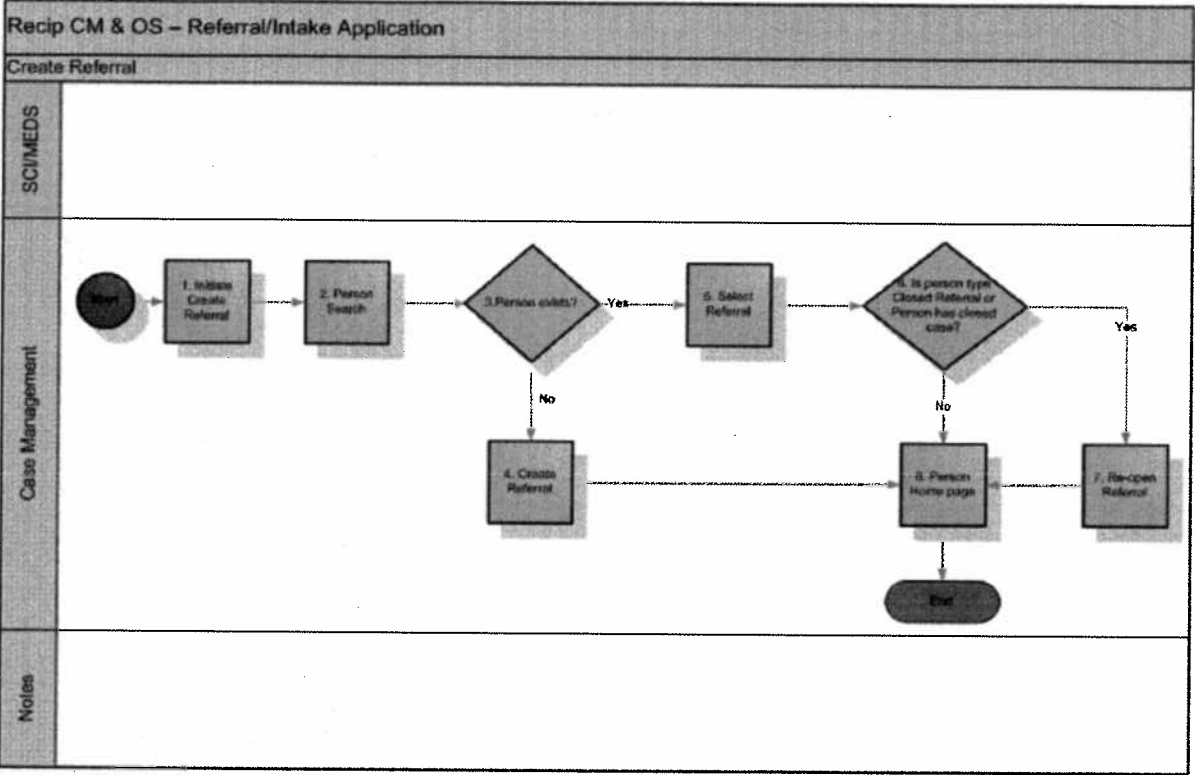
**CMIPS II:**

- The county shall initiate a Person Search to determine if the individual calling or being referred to IHSS is already known to CMIPS II. An individual shall exist only once in CMIPS II.
- If the person calling is the individual seeking services or their authorized representative, the county shall proceed to the Create Application screen and initiate the application process. (See Create Application Flowchart below.)
- If the person calling is a third party not authorized to open an application on the referred individual's behalf, the county must initiate the Referral using the Create Referral screen. (See Create Referral Flowchart below.) The Create Referral screen allows the entry of minimal referral data regarding the individual being referred. These data include the first and last names, the referral source, and either the person's address or telephone number. When the record is saved, the Person Type is indicated as Referral.

The outcome of either the Create Referral or Create Application process in CMIPS II is the creation of a single Person Record in CMIPS II. All persons are registered and are identified with one of the following Person Type Indicators: Referral, Applicant, Recipient, or Provider. An individual may have more than one Person Type, i.e., a person can be both a Recipient and a Provider.

CMIPS II uses a new case number configuration for both Applicants/Recipients and Providers. An Applicant will be assigned a random Case Number consisting of seven (7) digits, e.g., 1234567. This number is part of the Person Record and will remain as the Case Number for an Applicant/Recipient for the life of the case record, even if the Recipient moves to another county. The county numeric identifier is no longer directly associated with the Recipient Case Number. The county that owns the Recipient case can be found on the Case Home page using the same numeric county identifiers as were used in Legacy CMIPS.

Providers will be assigned random Provider numbers consisting of nine (9) digits, e.g., 123456789. These numbers will be random and not associated in any way with the Providers SSN as they were in Legacy. Like Recipient Case Numbers, this assigned Provider identifier will be the same regardless of the number of Recipients for whom the Provider works or the number of counties in which the Provider works. This number will remain associated to the Provider for the duration of their CMIPS II record.



Application:

Manual of Policies and Procedures (MPP) section 30-009.221 states "Any person shall have the right to apply for services or to make application through another person on his behalf." Once an individual or their authorized representative indicates that they wish to apply for IHSS, an application shall be taken immediately (MPP section 30-009.222). The county shall not deny or in any way dissuade the individual or their representative from making an application for IHSS based on information communicated during a phone call or face-to-face visit. The individual must be afforded due process by being allowed to make an application for IHSS if they are so inclined, and have that application assessed for eligibility based on program rules. The applicant shall receive a Notice of Action detailing the outcome of the county's determination.

An application for IHSS may be made over the phone or in writing by submitting an Application for Social Services (SOC 295). The following data about the applicant is required to complete the Create Applicant process:

- Name;
- SSN or verification that the applicant has applied for an SSN;
- Date of Birth;
- Applicant's preferred spoken and written languages;
- Gender;
- Ethnicity;
- County of Residence;
- Residence and mailing addresses; and
- Applicant's primary phone number.

At the time the application information is entered in either Legacy CMIPS or CMIPS II, a case number will be assigned to the applicant. Legacy counties, to the extent that current business practice allows, and all CMIPS II counties shall provide the case number to the applicant or their authorized representative before the end of the telephone call during which the application is taken, or before they leave the IHSS office so the applicant or their authorized representative will be able to refer to the case number in any communications with the county. For counties still using Legacy CMIPS where current county practice is for key data entry of the application information by a person other than the person taking the application, the county shall enter the application into CMIPS as expeditiously as possible and if the case number is requested, the county will provide it to the applicant as soon as possible.

Applications always require a signature. However, social services staff or the applicant's authorized representative can sign on the applicant's behalf to preserve the application date (MPP section 30-009.224). For those individuals who apply by phone, the SOC 295 may be signed at the IHSS face-to-face assessment.

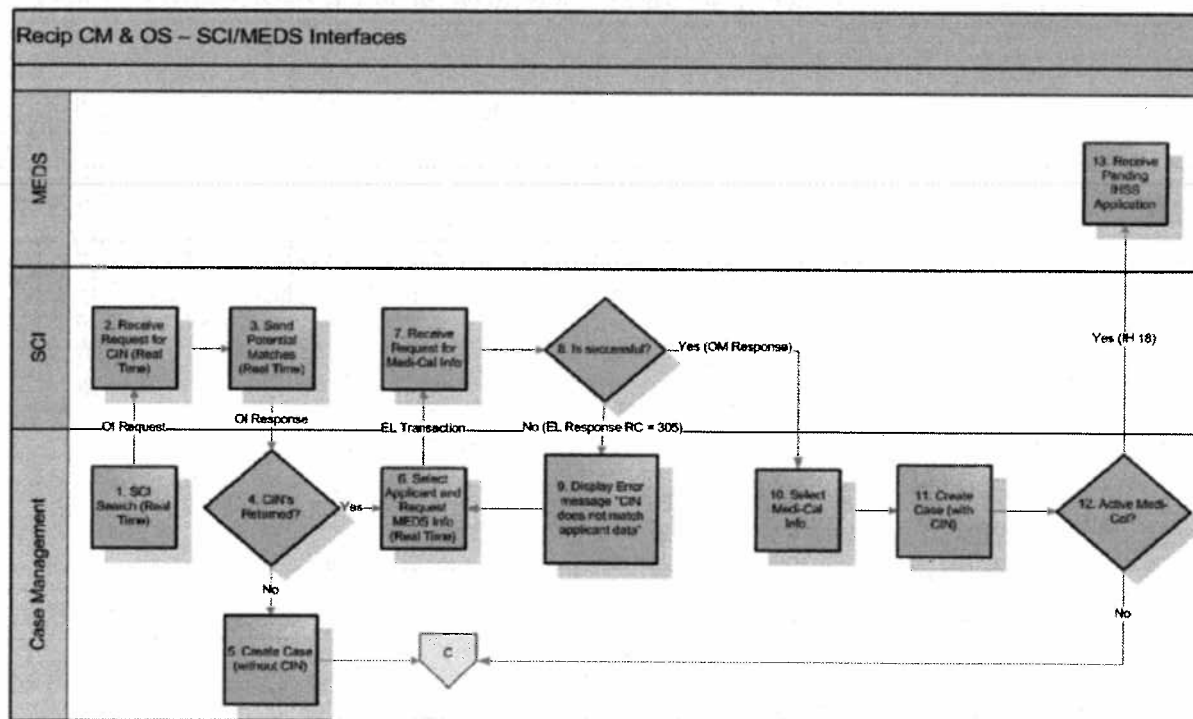
The date the services are requested either by phone or submission of the SOC 295, whichever is earlier, shall be the applicant's "protected date of eligibility". If the applicant is not already a Medi-Cal beneficiary, the county must create the IHSS application to establish the "protected date of eligibility". While counties are still on Legacy CMIPS, non-Medi-Cal applicants should be referred to the local Medi-Cal office to apply for Medi-Cal. At the point a county goes live on CMIPS II, the system will automatically check for Medi-Cal eligibility and generate a referral if no eligibility exists. If the applicant is ultimately determined to be eligible for IHSS, the applicant may be authorized services back to the "protected date of eligibility".

**LEGACY CMIPS:**

- The county shall initiate a name or social security number search to determine if the individual calling or being referred to IHSS is already known to CMIPS.
- The county shall determine if the potential applicant is currently a Medi-Cal beneficiary. If not, the county shall take the application for IHSS and refer the applicant to the local Medi-Cal office to apply for Medi-Cal.
- The county shall enter into CMIPS the information necessary to establish an application and provide the assigned case number to the applicant for use in future communication with the county.

### CMIPS II:

- The county shall initiate a Person Search to determine if the individual calling or being referred to IHSS is already known to CMIPS II. An individual shall exist only once in CMIPS II.
- From the Person Search, if the person does not exist, the user will access the Create Application screen and proceed with the application to the Create Case screen.
- The county shall provide the assigned case number to the applicant for use in future communications with the county,
- When an application is opened in CMIPS II, the system will check to see if the applicant has active Medi-Cal. If none exists, CMIPS II will generate a referral through an interface with the SAWS system requesting a Medi-Cal eligibility determination be completed. When the Medi-Cal eligibility determination is completed, the information will be sent back to CMIPS II through the interface. (See SCI/MEDS Flowchart below..)



## **PERSON NOTES/CASE NOTES/CASE (AUTHORIZATION) NARRATIVE**

CMIPS II will provide counties with several areas to enter electronic notes and case narratives related to referrals, applicants, recipients and providers that were not available to counties in Legacy CMIPS. The following paragraphs will explain the use of each of these functions as they relate to IHSS case management. The technical aspects of accessing and using each of the functions will be addressed during CMIPS II Training.

CMIPS II has 2 types of notes for an individual – Person and Case. Person Notes should be used when only a referral exists for the individual. Once an application has been taken and a case created all notes regarding the individual shall be entered in Case Notes.

Person Notes and Case Notes entries are displayed in chronological order with the most recent entry displayed first. Counties are advised to instruct their staff to carefully review their entries before saving the entries in either Person Notes or Case Notes. Once an entry is saved, the system will not allow the entry to be edited and a new Person or Case Note must be initiated. CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

### **PERSON NOTES**

Person Notes are entries made in association with a Person Record. Person Notes are specific to an individual before they apply for IHSS services, meaning that Person Notes should only be entered during the "Referral" process. Once an individual moves from being a referral to an applicant or a case, all notes entries should be made in Case Notes.

Person Notes entries are also used when the entry relates specifically to a provider and should be entered on the Notes page attached to that provider's Person Record. Notes related to the provider should only be entered in Person Notes on the provider's Person Record, not in Case Notes.

Examples of Person Notes are:

*Received call from daughter inquiring about possible services for mother. Daughter didn't have sufficient information to open application and wasn't sure her mother will accept services. Daughter requested IHSS application and other appropriate paperwork be mailed to her. Mailed SOC 295 and Health Cert 12/12/12.*

Or



*Daughter wants to be a provider for her father who is an IHSS recipient. Explained provider enrollment requirements and mailed required documents 11/12/13.*

CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

### **CASE NOTES**

The Case Notes function allows users to enter information that is related to a case but not related to a specific assessment. Once the case is created, notes should be entered in Case Notes and no longer entered in Person Notes.

An example of a case note is:

*Received a call from recipient's son stating recipient may be leaving to live with her daughter in Michigan and asking what steps needed to be taken to terminate her case if she decides to move. The move is still uncertain. Advised son to call when plans are firm.*

CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

### **CASE (OR ASSESSMENT) NARRATIVE**

The Case (or Assessment) Narrative is used to record information relating to an initial assessment or reassessment. Each time New Evidence is added to CMIPS II a new Assessment Narrative is created. Assessment Narratives are associated with Evidence and once evidence is authorized that Assessment Narrative is no longer editable

An example of an abridged Assessment Narrative is:

*Reassessment home visit to the 75-year-old female recipient: The recipient lives with her husband in a small 2-BR ground floor apartment. She suffers from severe osteoporosis, but is ambulatory. She is unable to independently perform most domestic and related activities and needs minimal assistance with bathing and dressing; however, her condition has deteriorated since my last visit and I anticipate her need for service will increase over the next year. Her husband is currently able and available, but is also having more difficulty functioning and may need assistance soon himself."*

Generally, the information in the Assessment Narrative will be similar to the narratives created by social workers today. The Assessment Narrative may include observations about the recipient, the recipient's functional abilities, living arrangements, others in the

household and any other information the social worker deems pertinent to the case. The Assessment Narrative is also the area in CMIPS II where information about the recipient's diagnoses may be recorded. The Assessment Narrative is limited to 13,500 characters.

### **PCSP/IPO/IHSS-R**

Welfare and Institutions Code (WIC) section 12300 (g) states that an individual who is eligible to receive services under PCSP or IPO shall not be eligible to receive services under IHSS-R. Therefore, all applicants for IHSS must complete a Medi-Cal eligibility determination prior to being authorized PCSP/IPO/IHSS-R. The only exception to this requirement is if an applicant is complying with all Medi-Cal requirements, but the determination of their eligibility for Medi-Cal is pending a DED, and completion of the DED will require longer than the 45-day statutory maximum for processing a Medi-Cal application. These individuals may be evaluated for potential IHSS-R presumptive eligibility in accordance with MPP section 30-759.3. If eligible, the applicant may be authorized IHSS-R services prior to Medi-Cal completing the eligibility determination. If the Medi-Cal application is denied because the applicant's DED is turned down, IHSS-R services must be discontinued. No other applicants can be served in the IHSS-R program prior to completion of a Medi-Cal eligibility determination. An applicant who does not cooperate or fails to comply with Medi-Cal requirements during the application process is not eligible for IHSS-R.

Individuals who are eligible for Medi-Cal with full Federal Financial Participation (FFP) and who are currently linked to Medi-Cal as aged, blind or disabled; or who meet the MPP section 30-780.2 (b) criteria of a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or result in death within 12 months; and who are determined through an in-home assessment to be unable to remain safely at home without IHSS, may be authorized PCSP or IPO services. Those individuals are not required to have a DED.

IHSS applicants who are not eligible for FFP Medi-Cal or have been denied Medi-Cal eligibility for a reason other than failure to comply with Medi-Cal requirements, or failure to complete the Medi-Cal eligibility process, shall be considered for IHSS-R eligibility. These individuals shall complete a Statement of Facts for In-Home Supportive Services (SOC 310). The IHSS program staff may utilize resource and income information from the State Automated Welfare Systems (SAWS) eligibility system when determining IHSS-R financial eligibility and share of cost calculation so long as the non-FFP Medi-Cal case is active and the most current information in SAWS is used. All IHSS-R rules must be applied and any additional income and resource information required under IHSS-R rules must be collected and entered in CMIPS II. The CMIPS II system

will calculate the IHSS-R financial eligibility and share of cost based on IHSS-R rules. If services are authorized, the recipient is required to pay any IHSS-R share of cost (SOC) to their provider in accordance with MPP section 30-755.233. An IHSS-R recipient who receives non-FFP full scope Medi-Cal and has a Medi-Cal SOC may submit receipts for their IHSS-R SOC payments to Medi-Cal where they will be applied toward meeting their Medi-Cal SOC obligation.

If an IHSS recipient's Medi-Cal eligibility is discontinued, CMIPS II shall generate a task to the social worker/case owner notifying them of the reason for the discontinuance. If the reason for discontinuance is failure to comply with Medi-Cal eligibility, including the annual renewal, the social worker/case owner shall terminate IHSS services. If the Medi-Cal discontinuance is due to change in circumstance the recipient should be considered for IHSS-R eligibility.

### **SOCIAL SECURITY NUMBER (SSN) REQUIREMENTS**

Title 22 of the California Code of Regulations (CCR) section 50187 (22 CCR 50187(a) and (b)), requires that all beneficiaries of Medicaid services, which for purposes of this letter means PCSP or IPO recipients and non-FFP Full-Scope Medi-Cal (State-only Medi-Cal) beneficiaries who meet the eligibility requirements for IHSS-R, must have a valid SSN in order to receive services or show proof of an application for an SSN (form SSA 5028 Evidence of Application for SSN).

In order to be eligible for IHSS-R, applicants/recipients must meet the requirements for Supplemental Security Income (SSI) eligibility except for income. One requirement for SSI eligibility is that the applicant/recipient must have a valid SSN or must have submitted an application for an SSN before or at the same time they submit an application for SSI.

Counties must take an application from an individual requesting to apply who can provide the application criteria described above. However, in the event an applicant does not have a SSN, at the time of application the applicant must provide proof of having applied for an SSN by providing the county with a copy of an SSA 5028 form completed by the Social Security Administration (SSA). Thus, an application cannot be accepted unless it includes an SSN or proof of an application for an SSN (form SSA 5028 Evidence of Application for SSN).

SSA will issue SSN cards clearly marked "NOT VALID FOR EMPLOYMENT" to individuals who are lawfully admitted to the United States without work authorization from the Department of Homeland Security, but who have a valid non-work reason for

needing an SSN, such as a federal law requiring an SSN to get a benefit or service (<http://www.socialsecurity.gov/ssnumber/cards.htm>). Medicaid and SSI each require an SSN for an individual to be eligible.

Qualified aliens are eligible for SSNs that include the designation "NOT VALID FOR EMPLOYMENT" based on the law requiring an SSN to receive a benefit or service. Aliens who are not in a satisfactory immigration status, and who do not have an SSN, can still receive State-Only Medi-Cal, and potentially IHSS-R, if they meet all eligibility requirements. Please see All-County Information Notice Number I-18-08 for more information on IHSS-R Eligibility for Non-Citizens.

Although DHCS has historically assigned pseudo SSNs to Medi-Cal eligible adoptees, this practice is largely out-of-date due to the current strict confidentiality laws. Neither Legacy CMIPS nor CMIPS II will accept pseudo SSNs that include an alpha character as valid entries. Adoptive parents should be directed to use the valid SSN previously assigned to their child or to apply for a new SSN for the child under his/her adopted name.

After taking the IHSS application, counties still using Legacy CMIPS should refer applicants without an SSN or an active Medi-Cal record in the Medi-Cal Eligibility Data System (MEDS) to Medi-Cal to complete a Medi-Cal eligibility determination and to the Social Security Administration (SSA) to apply for an SSN.

In CMIPS II, the county must enter the applicant's information into CMIPS II and conduct a Person Search to see if the applicant is already known to CMIPS II and perform a State Client Index (SCI) look-up to see if the applicant already has a Client Index Number (CIN) and active Medi-Cal. The CMIPS II user will be prompted to either select the correct CIN from any possible matches that are returned or send a Medi-Cal referral via interface to the local SAWS to initiate a Medi-Cal eligibility determination. If there is no CIN match, the user must select the option to send the referral to SAWS. When the Medi-Cal eligibility determination is completed, CMIPS II will receive notification through the interface of the outcome and, if approved, the aid codes assigned to the beneficiary and a notification will be sent to the case owner.

The response from MEDS will include both the MEDS Primary Aid Code and the FFP status indicator. The appropriate secondary Medi-Cal Aid Code (2L IHSS Plus Option – IPO; 2M Personal Care Services Program – PCSP; or 2N IHSS Residual Program – IHSS-R) will be determined by CMIPS II based on programmed eligibility criteria. Applicants cannot be approved for PCSP/IPO services until the individual has been

granted FFP Full-Scope Medi-Cal. Counties should be aware that although the CMIPS II case record may indicate a full-scope FFP primary Medi-Cal Aid Code when compared to the list of current Medi-Cal aid codes, it does not necessarily mean the Recipient has been granted full-scope FFP Medi-Cal. For IHSS program eligibility purposes, the county should rely on the FFP status indicator and the secondary Medi-Cal Aid Code determined by CMIPS II. If CMIPS II displays a secondary aid code of 2N (IHSS-R) it means the recipient/beneficiary has been authorized full-scope, State-only (non-FFP) Medi-Cal and must be evaluated for IHSS-R eligibility using IHSS-R rules before services can be authorized.

If an applicant for IHSS submits as their own an SSN that is already associated with a Person Record in CMIPS II and which has been provided by a different individual, the county must follow the system processes that will be described in detail as part of CMIPS II user training to take the application and potentially authorize services while the issue is researched and resolved. County staff should contact their Medi-Cal program staff to determine if Medi-Cal has completed a Social Security Administration Referral Notice (MC 194) form a copy of which is attached to this letter. This form is a request to SSA to research and resolve the conflict in SSN numbers. If Medi-Cal program staff has not initiated this process, IHSS program staff should request that it be initiated. When SSA has completed its research, it will return the MC 194 with the outcome to Medi-Cal. The IHSS program should take actions consistent with the outcome SSA provides to Medi-Cal, and deny or terminate services as appropriate to the applicant/recipient determined by SSA to have provided an SSN not issued to that person.

#### **RECIPIENTS RESIDING IN MORE THAN ONE COUNTY**

An IHSS recipient may reside and receive services in more than one county. As an example, a child recipient may live a portion of the time with their mother in one county and the remainder of the time with their father in a separate county. Similarly, an elderly parent who receives IHSS may divide their time between three adult children who live in separate counties and receive services in all three counties.

In Legacy CMIPS, the recipient would likely have had a case in each county in which they received services. However, in CMIPS II, a recipient will have one Person Record and thereby one case record regardless of the number of counties in which they receive services.

If an IHSS recipient has residence in more than one county a "primary county of residence" must be designated. The primary county of residence will be the county that carries the case. In general, the primary county of residence for the IHSS case should

be the same county where the recipient has active Medi-Cal. There may be exceptions to this, such as when the Medi-Cal case is carried by the county in which eligibility was initially determined regardless of the recipient's county of residence. In these types of circumstances, the recipient may choose the county they want to designate as the IHSS primary county of residence. Please note that it is perfectly acceptable for the Medi-Cal case and the IHSS case to be in different counties; it will not impact Medi-Cal eligibility or FFP for the IHSS case.

The primary county of residence is responsible for all aspects of the case including: conducting the needs assessment; authorizing services; enrolling providers; issuing timesheets; and funding the case. Other counties of residence should be viewed as "alternate service sites" similar to services received in the work place. The services received at the alternate service sites are limited to those currently authorized in the primary county of residence.

The case owner in the primary county of residence should work with the recipient to identify and designate a specific number of the authorized hours available for each alternate service site based on the time the recipient spends at that site. If the recipient chooses, the designated hours may be assigned to the provider at each alternate service site and the recipient should complete and sign an IHSS Recipient Request For Assignment Of Authorized Hours To Providers (SOC 838). The place of residence in each county must also meet the IHSS "own home" criteria. All Individual Providers for the recipient must complete the provider enrollment criteria in order to be enrolled on the case and will receive the wages of the primary county of residence and any benefits offered by that county for which they are eligible.

#### **REINSTATEMENT OF RANK 6**

In ACL 88-118 (issued September 6, 1988), the Assessment Standards specified the use of Rank 6 in the following service categories: Meal Preparation & Clean-up, Feeding and Respiration. ACL 88-118 directed counties to assess Rank 6 for these service categories when all services were exclusively paramedical. Legacy CMIPS has been programmed according to this direction since 1988. Design and development of CMIPS II has also incorporated the use of Rank 6 as described in this paragraph.

Manual of Policies and Procedures (MPP) section 30-756.41 currently states that county staff shall assess Rank 1 when all services are exclusively paramedical. It is unclear whether the MPP section has been written this way as far back as 1988, when the ACL was issued. It is uncertain if the need for Rank 6 was realized only after the regulations were promulgated and the regulations were never amended to include Rank 6, or if the MPP section was erroneously amended at some time subsequent to

the 1988 ACL. Regardless, the intent of the direction in ACL 88-118 has always been clear that Rank 6 was to be used when all Meal Preparation and Clean-up, Feeding and/or Respiration services are provided under Paramedical Services.

Please note that the instructions in this ACL supersede the instructions given in ACL 88-118 and ACLs 06-34 and 06-34E2. ACL 06-34 (issued August 31, 2006) included Rank 6 in the Annotated Assessment Criteria. However, ACL Errata 06-34E2 (issued May 4, 2007) eliminated Rank 6 for Meal Preparation & Clean-up, Feeding and Respiration in the Annotated Assessment Criteria. As a result, some counties discontinued using Rank 6 to identify Paramedical needs in these service categories. The elimination of Rank 6 precluded counties from accurately reflecting recipients' needs for Paramedical Services in cases where such services were authorized in addition to human assistance.

Upon receipt of this ACL, counties shall begin using Rank 6 for the following service categories, when applicable, during initial assessments and all reassessments:

- Meal Preparation & Clean-up
- Feeding
- Respiration
- Bowel, Bladder and Menstrual Care

In ACL 09-30, Question #12 asks if there is a Rank 6 for Bowel and Bladder care. The answer stated, "No, Rank 6 is not used for Bowel and Bladder. The recipient should be ranked from one to five based on level of function, irrespective of any related Paramedical Services."

CDSS has reconsidered its position and determined it is appropriate in certain instances for Bowel, Bladder and Menstrual Care to be provided only in the form of Paramedical Services. For instance, you have a recipient who does not need assistance toileting because he is able to get to the bathroom and urinate independently. However, he does need assistance maintaining his colostomy site (a paramedical service). He should be ranked a 6 in Bowel, Bladder and Menstrual Care because all his Bowel, Bladder and Menstrual needs are being met through a Paramedical Service. Therefore, the category of Bowel, Bladder & Menstrual Care has been added to the list of service categories where Rank 6 may be assessed if the need is met only by Paramedical Services. Please note this ACL supersedes the response provided to Question #12 in ACL 09-30.

Rank 6 will be added to the regulation sections for Meal Preparation & Clean-up, Feeding, Respiration and Bowel, Bladder & Menstrual Care in the next amendment to the MPPs. Until that time, ACL 88-118 and this ACL will serve as the authorities for including Rank 6 as part of the assessment criteria when conducting assessments and reassessments. Additionally, the Annotated Assessment Criteria will be modified to reflect these changes.

Functionality for the use of Rank 6 in Legacy CMIPS Rank 6 has not changed since the issuance of ACL 88-118. Counties should resume using Rank 6 based on the instructions in that ACL. Bowel, Bladder and Menstrual has just been added to the categories that are eligible for an assignment of Rank 6 and due to the imminent conversion to CMIPS II, Legacy CMIPS has not been modified to accept a Rank 6 for this service category.

CMIPS II expands the functionality of Rank 6 so social workers may assess and assign Rank 6, as needed, for the authorization of Paramedical Services in Meal Preparation/Clean-up, Feeding, Respiration and Bowel, Bladder and Menstrual Care.

Similar to Legacy CMIPS, CMIPS II will continue to display error messages when there are discrepancies between services authorized and its assigned functional rankings (i.e., Rank 6 has been assigned to a Service Type but there are no Paramedical Services authorized). These validation edits will appear on the screens and documents the error messages that will be displayed for each edit.

- When an attempt is made to save Create or Modify Service Type Feeding and the Functional Rank for Feeding is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Feeding is indicated as Paramedical.
- When an attempt is made to save a Service Type associated with Meal Prep & Clean-up and the Functional Rank for Meal Prep & Clean-up is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Meal Prep & Clean-up is indicated as Paramedical.
- When an attempt is made to save a Respiration Service Type and the Functional Rank for Respiration is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Respiration is indicated as Paramedical.
- When an attempt is made to save a Service Type associated with Bowel & Bladder Care and the Functional Rank for Bowel & Bladder Care is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Bowel & Bladder is indicated as Paramedical.



To resolve these error messages, the social worker will need to check the functional ranking for the Service Types and confirm a Rank 6 is needed and/or to reassess the functional ranking, if needed. Additionally, the social worker will need to determine why Paramedical Services have not been authorized on the Service Evidence screen if a Service Type has been assigned a Rank 6.

### **INTER-COUNTY TRANSFER (ICT) PROCESS IN CMIPS II**

Conversion to CMIPS II will not create a need for changes to the existing regulatory requirements related to ICTs (MPP sections 30-759.9 to .972). An ICT occurs when an IHSS recipient moves from one county to another and the originating county that has been responsible for the management of the recipient case transfers management of that case to the receiving county.

When an ICT is completed in Legacy CMIPS, the recipient is terminated in the transferring county and a new case is opened and a new case number assigned in the receiving county. The process is primarily a manual exchange between the sending and receiving counties.

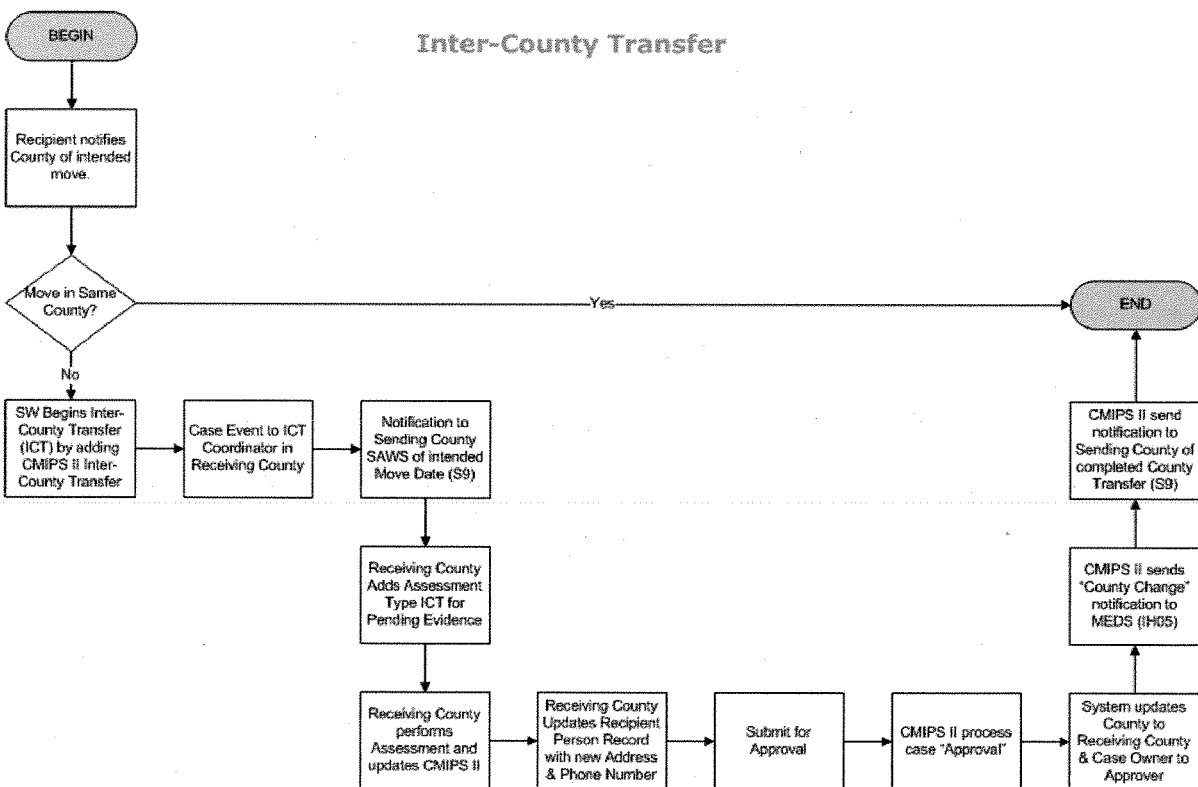
In CMIPS II, the ICT process is much more automated providing a more efficient process. For example, a recipient will have a single Person Record and case number for the life of the IHSS case that will follow the recipient during an ICT, rather than terminating the case in the sending county and creating a new case in the receiving county. In CMIPS II, when the receiving county accepts the ICT, the only change to the case number will be the numeric county indicator at the beginning of the case number. For example, in Fresno County the case number might be 10-123456; the 10 at the beginning representing the Fresno County code. After an ICT to Sacramento County, the 10 would change to 34, Sacramento County's code. The second portion of the case number, 123456, remains the same. Thus, the case number would change to 34-123456.

CMIPS II has functionality to support the ICT process including:

- Generating a referral from the transferring to receiving county;
- An assessment specific to ICT;
- Updating county and case owner upon receiving county authorization;
- Notifications to transferring county SAWS system;
- Not allowing an ICT when the case has an open state hearing record in the system; and
- Allowing an ICT to be canceled when necessary.

Although most ICT activities will be conducted within CMIPS II, the transferring county will still be required to fax or mail to the receiving county all completed forms/documents that are retained outside of CMIPS II, such as the Request for Order and Consent – Paramedical Services (SOC 321) form.

If the recipient moves from the receiving county to a third county during the transfer period, the original transferring county is responsible for canceling the transfer to the first receiving county and initiating the transfer to the second receiving county (MPP 30-759.922). The flow chart below documents the steps of the ICT process in CMIPS II. The CMIPS II ICT process is displayed in the flow chart below.



### **Inter-County Transfer (ICT) Process during CMIPS II Implementation Phase**

During the period of statewide rollout of CMIPS II, ICTs may occur between two Legacy CMIPS counties, two CMIPS II counties or a Legacy CMIPS county and a CMIPS II county. The following chart provides the possible scenarios and the action to be taken in each scenario.

SCENARIO	ACTION TO BE TAKEN
Legacy CMIPS county is receiving an ICT from a Legacy CMIPS county	Follow current (pre-CMIPS II) procedure
Legacy CMIPS county is receiving an ICT from a CMIPS II county	Follow current (pre-CMIPS II) procedure
CMIPS II county is receiving an ICT from a Legacy CMIPS county	Open new application in CMIPS II
CMIPS II county is receiving an ICT from a CMIPS II county	Follow CMIPS II process to review ICT in CMIPS II and assign to worker (See flow chart above.)
CMIPS II county is sending an ICT to a Legacy CMIPS county	Terminate the case in CMIPS II and follow current (pre-CMIPS II) procedure
Legacy CMIPS county is sending ICT to a CMIPS II county	Follow current (pre-CMIPS II) procedure

**Funding of the Case during Inter-County Transfer (ICT)**

In accordance with existing regulations, the transferring county is responsible for the county share of the case funding until the effective date of authorization in the receiving county. MPP section 30-759.921 states, "The transferring county is responsible for authorizing and funding services until the transfer period expires, at which time the receiving county becomes responsible." Which county maintains the Medi-Cal case is irrelevant to which county pays the county share of funding for the IHSS case. Communication between counties to ensure timely transfer of case responsibility is essential. CMIPS II produces a "Monthly Inter-County Transfer Report" to support communication between counties regarding ICT cases to help ensure ICTs are being completed timely.

If you have questions regarding this letter, contact Adult Programs at (916) 651-1069.

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

c: CWDA

**SOCIAL SECURITY ADMINISTRATION REFERRAL NOTICE****Instructions:**

- To CWD: Please complete Part I. Retain original for your records, copy for recipient/SSA. Client must take this form to SSA.
- To Recipients: Read the back of this form. Take the necessary documentation to the Social Security Administration Office listed below in Part I.B.
- To SSA: This form is a request for the action noted in Part I.C. Please complete Part II of this form and distribute as noted in Part I.A. If you have any questions, the eligibility worker's name and phone number are provided.

**PART I: TO BE COMPLETED BY THE COUNTY WELFARE DEPARTMENT**

A. Please enter the complete county welfare office name and address within the brackets provided.

[

]

**SSA, after completion:**

- ☐ Mail this form to the county welfare office.
- ☐ Return this form to the recipient to be returned to CWD.

L

]

**B. Social Security Office Information**

Name of SSA District/Regional Office

Address (number and street)

City

State

ZIP code

**D. Applicant/Recipient Information**

Recipient's name (last, first, middle initial)

Date of birth (month/day/year)

Sex (M or F)

County ID per MEDS

			X																
--	--	--	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Recipient's SSN (if applicable)

Case name

**E. CWO Information**

Name of Eligibility Worker

Date form completed

E.W. Worker

E.W. phone number

C. The bearer of this form is an applicant for, or recipient of, Food Stamps, Cash Aid, or Medi-Cal. The following service is required:

- ☐ Original SSN card
- ☐ Duplicate SSN card      SSN: \_\_\_\_\_
- ☐ Info on SSA's Numident File needs to be verified.  
☐ Name      ☐ DOB      ☐ Sex
- ☐ Info on SSA's Numident File needs to be corrected.  
☐ Name      ☐ DOB      ☐ Sex
- Note: Recipient must provide verification of change.*
- ☐ Recipient has been assigned two SSNs. Please take action to delete all but one.
- ☐ Two recipients appear to have been assigned the same SSN. Please verify correct number for recipient from Numident File.

**F. Comments****PART II. TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION DISTRICT/REGIONAL OFFICE**

A. Date received

C. Comments

**B. Result of Referral**

- ☐ 1. Recipient has completed an SSN application (including Form SS-5 and other proof) and application is being processed.
- ☐ 2. Insufficient ID.
- ☐ 3. SSN application is not being processed. (Explain.)  
 \_\_\_\_\_
- ☐ 4. Other. (Explain.)  
 \_\_\_\_\_

D. SSA Representative—print name

Signature

Telephone number

**SSA REFERRAL INFORMATION SHEET**  
**(For Medi-Cal, Food Stamp, and CalWORKs Recipients)**

**YOU MUST CONTACT SOCIAL SECURITY**

Public Law requires that each person who applies for or receives full-scope Medi-Cal, Food Stamps, or California Work Opportunity and Responsibility to Kids must have or apply for a social security number. For the applicant/ recipient noted on the reverse side, either (1) the Social Security Administration does not have a social security number on file, or (2) the information provided by the Social Security Administration and the information provided to the eligibility worker do not agree. To correct this situation, you must contact the Social Security Office indicated on the reverse side of this referral form. **DO NOT MAIL THESE FORMS TO THEM.**

**NOTE:** *Age, citizenship or alien status, and identity must all be documented.* One of the identification documents must be a **birth or baptismal certificate established BEFORE age 5**. If one is not obtainable, refer to **Column A** for acceptable substitutes. In addition, if the applicant/recipient is a U.S. citizen born outside of the U.S. or an alien, one of the items listed in **Column B** must be presented.

**Column A**

1. Evidence of Age/Citizenship
  - School records
  - Church records
  - Census records (state or federal)
  - Insurance policy
  - Marriage records
  - Draft card
  - U.S. passport
  - Other records indicating applicant's age or date and place of birth
2. Evidence of Identity
  - Driver's license
  - State identification card
  - Voter's registration
  - School records
  - Health records (doctor's, hospital's, etc.)
  - Any other document which shows applicant's signature, photograph, or description

**Column B**

1. If you are now a U.S. citizen born outside the U.S., take one of the following items in addition to the item(s) required in Column A:
  - U.S. citizen identity card
  - U.S. passport
  - Naturalization certificate
  - Certificate of citizenship
  - Consular report of birth
  - Form I-179 (U.S. citizen card)
  - Form I-197 (U.S. citizen resident card)
2. If you are an alien, take one of the following items in addition to the item(s) listed in Column A:
  - Form I-151 or I-551 (Alien Registration Receipt Card)
  - Form AR3a, I-94, I-95a, I-84, I-85, I-86, or SW-434
  - Letters from Immigration and Naturalization Service showing alien status

If you have a question concerning the two identification documents which you must take to the Social Security Office, please contact the Social Security Office.



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](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

February 23, 2011

ALL-COUNTY LETTER (ACL) NO. 11-19

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY IHSS PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS OPTION (IPO)

REASON FOR THIS TRANSMITTAL

- ☒ State Law Change
- ☒ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS

REFERENCES: All-County Information Notice (ACIN) I-33-10, dated April 21, 2010; ACL 05-05, dated June 2, 2005; ACL 05-05E, dated July 20, 2005; ACL 07-08, dated January 26, 2007; All-County Welfare Director's Letter (ACWDL) 06-04, dated February 3, 2006; and Welfare and Institutions Code (WIC) section 14132.952

This All-County Letter provides counties with further information regarding implementation of the In-Home Supportive Services Plus Option (IPO) program.

**Background**

In 2004, California implemented a Social Security Act section 1115 Demonstration Waiver, the IHSS Plus Waiver (IPW) program. This Waiver allowed California to move almost all of the IHSS-Residual (IHSS-R) recipients into either the IPW or Personal Care Services Program (PCSP), and receive Federal Financial Participation (FFP) for services to these recipients. The IPW was limited to five years with a possibility of renewal; however, during that time, the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) initiated new options to allow recipients in the IPW to be served in the Medicaid State Plan.

CMS approved a Social Security Act section 1915(j) Self-Directed Personal Assistance Services (PAS) State Plan Option (SPO) program for California. Effective October 1, 2009, this SPO replaced the IPW program and, per WIC section 14132.952, is known as the IHSS Plus Option (IPO). FFP continues for the IPO program.

### **Transition of the IPW Population to the IPO**

Effective October 1, 2009, the IPW population was moved into the new IPO program. The transition to the IPO was seamless for IPO recipients and no notices were issued. The Medi-Cal secondary aid code for this population will continue to be 2L.

IPW and IPO program expenditures will be differentiated in the Case Management, Information and Payrolling System (CMIPS) Legacy and CMIPS II systems based upon service date (i.e., service dates through September 30, 2009 are IPW expenditures, and service dates beginning October 1, 2009 are IPO expenditures).

Individuals who are eligible for full scope FFP Medi-Cal, and have their services provided by a spouse or parent (if the individual is a minor child under 18), or receive Restaurant Meal Allowance or Advance Pay are eligible for the IPO program.

### **Medi-Cal Exemptions**

In accordance with ACWDL #06-04, under the new IPO program, IHSS provider wages paid to a spouse or the parent of a minor child under 18 will continue to be exempt as income for Medi-Cal eligibility as under the IPW program.

### **IPO Program Hours**

Non-Severely Impaired (NSI)/Severely Impaired (SI) Cases

- IPO recipients will continue, as in IPW, to receive a maximum of 195 hours for NSI cases and 283 hours for SI cases [WIC section 14132.952(b)].

### **Differences Between the IPW and IPO**

Unlike the Demonstration Waiver IPW, the IPO is a State Plan Option, and therefore follows the State Plan PCSP regarding program eligibility and services.

### **Program Eligibility**

Under IPW eligibility, a recipient must have had a disability determination completed when the linkage to Medi-Cal was not based on the individual being disabled according to Medi-Cal definitions [Manual of Policies and Procedures (MPP) section 30-785(b)(1)].

Under the IPO program, eligibility is the same as for PCSP, i.e., a recipient is eligible when she/he is a categorically or medically needy Medi-Cal beneficiary as defined in WIC section 14050.1, section 14051, and section 14051.5, who has a disabling condition that causes functional impairment that is expected to last at least twelve consecutive months, or that is expected to result in death within twelve months and who is unable to remain safely at home without the services.

- IPO eligibility, therefore, does not require a disability determination in accordance with Medi-Cal definitions.

### **Program Services**

While IPW services included Teaching and Demonstration, services for the IPO program are the same as for the PCSP and will not include Teaching and Demonstration. Please note, however, there are different rules for recipient services when provided by a spouse or parent(s) (of a minor child under 18) based on program regulations.

### **New Program Requirements for IPO Cases**

The following are new program components required by 42 Code of Federal Regulations (CFR) Part 441:

#### **Enhanced Assessment Process**

42 CFR Part 441.464 requires social workers to complete the following enhanced assessment processes during assessments/reassessments (many of which are already standard practice in most counties):

- Inform recipients of the transition from IPW to IPO beginning March 1, 2011
- Inform recipients they will receive a Notice of Action (NOA) indicating each of their services and the hours allotted for each service
- Inform recipients they may request changes to their authorized hours due to a change in their condition
- Inform recipients of their right to request a state hearing if a request for change has been denied or the amount of their authorized hours has been reduced
- Inform recipients of the voluntary disenrollment process
  - If a recipient chooses to voluntarily change one of the IPO program elements (spouse provider, parent of a minor child under 18 provider, Restaurant Meal Allowance and/or Advance Payment), they would then be moved into the traditional State Plan program known as PCSP



- Social Workers will verbally provide notification of the ability to voluntarily disenroll.

### **Social Worker Training**

Social workers shall receive mandatory training on the following:

- Utilizing a person-centered planning philosophy for assessments;
- The risk management process; and
- Completing the Individualized Back-Up Plan and Risk Assessment Form (SOC 864).

### **Risk Management**

The IPW requirement for completion of an Individual Emergency Back-Up Plan (SOC 827) was applied to all IHSS recipients. The IPO also requires an additional risk management process be completed. Thus, a new form was developed for IPO cases, the SOC 864, to help facilitate this new risk management process. Please see detailed instructions on the attached form for completing this process.

This process must be completed every year, but in the event there have been no changes to the Plan from the prior year, the recipient and social worker may sign in the space provided on page three of the form confirming no changes. However, every IPO recipient must have a new form completed every other year.

Social workers will attend training through the Social Worker Training Academy on the risk management process and completing the new form for IPO recipients. All elements of the form will be discussed. Please see the Training section below for more information.

### **Individualized Back-Up Plan and Risk Assessment Form (SOC 864)**

#### **Pilot**

The California Department of Social Services (CDSS) developed the SOC 864 with input from counties and stakeholders. The form was piloted in five counties: San Diego, San Joaquin, Lassen, Mariposa and Tuolumne. Time study data, county averages and operational issues were compiled from all five counties and this information, as well as stakeholders' input, was utilized in finalizing the form.

### **Use of the Form**

Effective March 1, 2011, all recipients in the IPO program shall be required to complete the new SOC 864. Counties are instructed to continue using the existing SOC 827 for all recipients in the IPO program through February 28, 2011. Counties shall continue using the SOC 827 for all recipients in the PCSP and IHSS-R programs.

### **Translation of the New Form**

The SOC 864 will be available in the state threshold languages for the IPO population, English and Spanish, as required by section 7295.2 of the Government Code.

You will find the SOC 864 on the CDSS website at:  
<http://www.cdss.ca.gov/cdssweb/PG168.htm#s>

### **Time Study Code**

Counties are instructed to continue using the same IPW time-study code PC 1034 (PCSP/IPO-Case Management) for all IPO activities including completing the new SOC 864.

### **What to Expect in the Future**

#### **Training**

CDSS and California State University, Sacramento (CSUS) are currently developing an IPO training curriculum to include utilizing a person-centered planning philosophy for assessments; the risk management process; and completing the SOC 864. The IPO training will begin as a pilot and is tentatively scheduled to commence in the spring of 2011. After the pilots and possible regional trainings, CSUS will offer this mandatory training in various counties throughout the State. More information will follow specifying the training details for each county. The IPO training will ultimately be incorporated into the IHSS Training Academy, *IHSS 101 Training*.

#### **Regulations**

CDSS is in the process of developing regulations for the IPO and an ACL regarding IPO regulations will be issued in the near future.

All County Letter No. 11-19  
Page Six

**CMIPS II**

Legacy CMIPS currently does not have the capacity to generate the new SOC 864; however, the form will be generated and auto populated in CMIPS II.

If you have questions regarding any of this information, please call the Waiver and Policy Development Unit, at (916) 651-5350 or email to [APBpolicy@dss.ca.gov](mailto:APBpolicy@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Attachment

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

### SECTION 1 – RECIPIENT'S INFORMATION

RECIPIENT'S NAME:

CASE NUMBER:

### INDIVIDUALIZED BACK-UP PLAN

### SECTION 2 – SUPPORT CONTACTS

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

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

#### Other important numbers available to you, if needed:

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

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

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

**If you have an emergency, call: 911**

An emergency is an immediate threat to your health, welfare and/or safety.

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Page 1 of 4

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

RECIPIENT'S NAME:	CASE NUMBER:
-------------------	--------------

## RISK ASSESSMENT

### SECTION 3 – GENERAL RISK ASSESSMENT

#### A. IHSS Assessment

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

#### B. Additional Risk Areas

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

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

### SECTION 4 – DISASTER PREPAREDNESS

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

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

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

RECIPIENT'S NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

**AGREEMENT AND SIGNATURES**

**SECTION 5 – AGREEMENT AND SIGNATURES**

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

**Recipient**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

**Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

**Other**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

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

**Recipient /Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

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

---

RECIPIENT'S NAME:

CASE NUMBER:

---

### INSTRUCTIONS

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

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

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

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

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

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

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

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

**Comments/Notes:**

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Page 4 of 4

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CDSS

WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

May 16, 2011

ALL-COUNTY INFORMATION NOTICE: I-27-11

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY IHSS PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS OPTION (IPO)  
COUNTY WELFARE DIRECTOR'S ASSOCIATION OF  
CALIFORNIA (CWDA) REGIONAL MEETING  
QUESTIONS/COMMENTS AND ANSWERS

REFERENCES: All-County Letter (ACL) 11-19, dated February 23, 2011

This All-County Information Notice (ACIN) provides clarification to questions and comments (Attachment A) raised during the County Welfare Directors Association of California (CWDA) Regional Meetings that took place in February 2011. A chart (Attachment B) is also included to show the maximum hours for each IHSS program.

If you have questions regarding any of this information, please call the Waiver and Policy Development Unit, at (916) 651-5350 or email [APBpolicy@dss.ca.gov](mailto:APBpolicy@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Attachments

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☒ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS



## ATTACHMENT A

### CWDA REGIONAL MEETINGS FEBRUARY 2011 ANSWERS TO QUESTIONS/COMMENTS

1. **Q: Clarification was requested regarding the maximum hours for each IHSS program, including IPO and especially protective supervision cases. Can CDSS provide some information on maximum hours for each program?**

A: Attached is a chart that shows the maximum hours for each IHSS program (see Attachment B).

2. **Q: Unlike IPW, the IPO disability requirement is the same as for PCSP. Can APB provide counties with the ACL reference that discussed PCSP disability determinations?**

A: ACL 93-21 provides information on PCSP disability determinations. This ACL may be found at:

<http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acl93/93-21.PDF>.

3. **Q: Will CDSS send a mass mailing of Notices of Action (NOAs) to IPO recipients to inform them of the transition from IPW to IPO?**

A: No, a notice is not required and would likely cause confusion for recipients.

#### SOC 827 vs. SOC 864

4. **Q: Who will be required to use the SOC 827 and the SOC 864? ACL 11-19 states that counties shall use the new SOC 864 for all IPO cases, and shall continue using the SOC 827 (Individual Emergency Back-Up Plan) for all PCSP and IHSS-R cases. Some counties would like to use the new SOC 864 for all cases and would like assurance from APB that APB QA will not cite the counties for using the SOC 864 for PCSP/IHSS-R cases.**

A: The SOC 864 must be used for all IPO recipients. Counties may use the SOC 827 or the SOC 864 for PCSP & IHSS-R recipients. APB QA staff will inform county QA staff that the SOC 864 is acceptable for all IHSS cases.

5. **Q: Should social workers fill out both forms (i.e., SOC 827 & SOC 864) for intake assessments if the case cannot be identified as IPO during the initial application process? Or should an SOC 827 be completed and if it turns out the case is IPO eligible, the SOC 864 can be completed at the next reassessment?**

A: Social workers can bring the SOC 864 to all intake assessments when the applicant has a spouse who may potentially be the IHSS provider or if the applicant is a child with a potential parent-provider. If the social worker determines the case is not IPO eligible and is PCSP or IHSS-R eligible during or after the initial assessment, the completed SOC 864 is sufficient as it includes the individualized back-up plan. An SOC 827 may be completed at the next reassessment for those IHSS-R/PCSP recipients. Counties also have the option of using the SOC 864 for all cases.

6. **Q: If a recipient has a change of address that does not require a new face-to-face (i.e., a phone reassessment is adequate), can the SW update the existing SOC 864, mail recipient a new 864 to complete, or not worry about it until the next face-to-face assessment?**

A: Update the existing SOC 864 if necessary. It is not necessary to mail the recipient a new SOC 864 to complete. A new SOC 864 does not need to be completed until the next face-to-face assessment.

#### **From IPO to PCSP**

7. **Q: What if a PCSP case changes to an IPO case before the next reassessment is due?**

A: Counties can wait until the next reassessment to complete an SOC 864.

8. **Q: If a recipient voluntarily disenrolls from IPO and is now PCSP, is the SOC 864 an acceptable substitute for the SOC 827? What if he/she moves from PCSP to IPO? Can he/she wait until the next face-to-face to complete an 864?**

A: The SOC 864 is an acceptable substitute for the SOC 827 under all circumstances. If a recipient moves from PCSP to IPO, the social worker can wait until the next face-to-face to complete an SOC 864.

**9. Q: If a recipient chooses to no longer have one of the IPO options (parent or spouse provider, Restaurant Meal Allowance or Advance Pay), and moves into PCSP, how will this change be reflected in CMIPS?**

A: Once a recipient informs the county of his/her requested change and county staff makes the appropriate change in CMIPS, the recipient's aid code (2L) will automatically update to 2M (PCSP).

#### **Use of Form**

**10. Q: Will the SOC 864 need to be completed for all IPO recipients by 3/1/11?**

A: No, counties should start using the form for all IPO assessments and reassessments beginning in March 2011.

**11. Q: CDSS' forms are password protected. Can CDSS provide an unlocked version of the SOC 864 so that counties may fill in the fields and save the document for future use?**

A: The online version of the SOC 864 is an Adobe PDF, and can be filled in and saved. You can fill in the information for individual recipients and save the document for future use. You can also fill in a county specific template with information to speed up the process, or both. This information can be saved on the form for future use.

**12. Q: A copy needs to be given to the recipient. Will the form have to be filled out twice?**

A: Social workers may complete two forms during the assessment, or bring the completed form back to the office to photocopy and then mail a copy to the recipient. Counties can also have this form reproduced on NCR paper.

**13. Q: Should the information collected in Sections B1-B3 of the SOC 864, pg. 2, be consistent with the SOC 293, D (2) Disaster Preparedness and the Functional Impairment (FI) rankings on the H-line?**

A: Although there is no direct correlation between the information, this form should be consistent with the Assessment information captured on the SOC 293.

**14. Q: Some counties distribute CMIPS print-outs to emergency responders (county disaster preparedness is part of the IPO Risk Assessment form). Is a recipient release form/signature needed before counties can distribute these print-outs with recipient's information?**

A: No, a recipient release form or recipient signature is not needed in order for authorized county staff to release IHSS recipients' names and addresses to emergency agencies in the event of a public safety emergency. [Welfare & Institutions Code (WIC) 10850.9; ACIN I-54-00]

**15. Q: If a recipient participates in completing the Risk Assessment form (SOC 864) but refuses to sign it, should he/she be taken off the IPO program?**

A: Not as long as the recipient participates in the process and agrees with the information on the form. The federal IPO statute does not require that a signature be obtained on the Risk Assessment form, but the statute does require the recipient to participate in the Risk Assessment process in order to be eligible for IPO. If the recipient refuses to participate in the Risk Assessment process, he/she will not be eligible for IPO (i.e., the recipient will not have the option to have a parent or spouse provider, Advance Pay or Restaurant Meal Allowance). A recipient is not required to participate in the Risk Assessment process to be eligible for IHSS/PCSP, as the Risk Assessment is a requirement only for IPO.

## **CMIPS**

**16. Q: Will the SOC 864 be tracked in CMIPS?**

A: No.

**17. Q: Is there a systematic way to identify IPO recipients in CMIPS so that county social workers may highlight these cases to identify that an SOC 864 is needed for the reassessment?**

A: Counties can use the Adhoc Tool to run a report of all 2L cases each month. We encourage each county to set up a process that best suits their needs.

**ATTACHMENT B**  
**Maximum Hours for In-Home Supportive Services (IHSS) Programs**

Type of Case	In-Home Support Services-Residual (IHSS-R)	Personal Care Services Program (PCSP)	In-Home Supportive Services Plus Waiver (IPW)	In-Home Supportive Services Plus Option (IPO)***
Non-Severely Impaired (NSI)	195 hours [WIC 12303.4(a); MPP 30-765.12] <ul style="list-style-type: none"> <li>The entire 195 hours can be for protective supervision.</li> </ul>	283 hours [WIC 12303.4(b); MPP 30-765.11] <ul style="list-style-type: none"> <li>Only up to 195 hours can be for protective supervision.**</li> <li>Additional service-hours, up to a maximum of 283, can be used for other PCSP services.</li> </ul>	195 hours [IPW Application Utilization Controls] <ul style="list-style-type: none"> <li>The entire 195 hours can be for protective supervision.</li> </ul>	195 hours [IPW Application Utilization Controls] <ul style="list-style-type: none"> <li>The entire 195 hours can be for protective supervision.</li> </ul>
Severely Impaired (SI)	283 hours [WIC 12303.4(b); MPP 30-765.11] <ul style="list-style-type: none"> <li>The entire 283 hours can be for protective supervision.*</li> </ul>	283 hours [WIC 14132.95(g)] <ul style="list-style-type: none"> <li>The entire 283 hours can be for protective supervision.*</li> </ul>	283 hours [IPW Application Utilization Controls] <ul style="list-style-type: none"> <li>The entire 283 hours can be for protective supervision.*</li> </ul>	283 hours [IPW Application Utilization Controls] <ul style="list-style-type: none"> <li>The entire 283 hours can be for protective supervision.*</li> </ul>

\*Although unlikely, this can occur; the 20 hours or more per week assessed in specific areas as required in the SI definition [MPP 30-701(s)(1); WIC 12303.4(b)], could be provided as an alternate resource.

\*\*In the IPW application, CDSS requested to provide all services, including protective supervision, in the IPW with the same NSI/SI hours-restrictions that are in IHSS-R. Per DHCS, CMS informed California that protective supervision can now be considered a State-Plan service under the PCSP. CMS further stated that a State Plan Amendment was not necessary, and that we could provide protective supervision in the PCSP "as described in the Waiver application." Under Utilization Controls in the Waiver application, the maximum hours for NSI recipients for Protective Supervision are 195 (the same as for IHSS-R).

\*\*\*Maximum hours for IPO are the same as for the IPW, and for IHSS-R [WIC 14132.952(b) states "the IPO shall incorporate the ...benefits...of the IHSS program pursuant to Article 7 (commencing with Section 12300) of Chapter 3."]



CDSS

WILL LIGHTBOURNE  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

August 29, 2014

ALL-COUNTY LETTER NO. 14-60

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: IMPLEMENTATION OF THE COMMUNITY FIRST CHOICE OPTION  
(CFCO) PROGRAM

REFERENCES: SOCIAL SECURITY ACT (SSA) Section 1915(k) (42 United States  
Code Section 1396n); WELFARE and INSTITUTIONS CODE (WIC)  
Section 14132.956; IHSS PROGRAM MANAGERS' LETTER  
(DECEMBER 2, 2011); COUNTY FISCAL LETTER (CFL) No. 12/13-  
28 (JANUARY 24, 2013)

This In-Home Supportive Services (IHSS) All-County Letter (ACL) provides counties with additional information regarding implementation of California's CFCO Program.

### Background

The federal Patient Protection and Affordable Care Act (ACA) of 2010 (Public Law 111-148) was enacted March 23, 2010 and established CFCO as a new State Plan Option, which allows States to provide Home and Community-Based Attendant Services and Supports.

In December 2011, the California Department of Social Services (CDSS) and the California Department of Health Care Services (DHCS) submitted a State Plan Amendment (SPA) for the CFCO Program to the Centers for Medicare & Medicaid Services (CMS). This SPA allowed California to receive an additional 6% in federal funding for services for CFCO-eligible Personal Care Services Program (PCSP) and IHSS Plus Option (IPO) program recipients, who were moved into CFCO, and for new CFCO-eligible applicants. This initial CFCO SPA was approved by CMS on August 31, 2012, retroactive to December 1, 2011.

The initial SPA was based on the *draft* CFCO federal regulations and was approved with the understanding that a new SPA would be submitted for approval to include

### REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☒ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS

Nursing Facility Level of Care (NF LOC) eligibility criteria as required, per the final CFCO regulations. The new CFCO SPA was approved by CMS on July 31, 2013, with an effective date of July 1, 2013.

California was the first state in the nation to receive approval for implementing the CFCO Program. With this addition, California now operates four IHSS programs: IHSS-Residual (IHSS-R), PCSP, IPO and CFCO.

### **Development and Implementation Council**

As required by 42 Code of Federal Regulations (CFR) Section 441.575 and WIC Section 14132.956, CDSS established a Development and Implementation Council (Council) to collaborate on the implementation of CFCO. The Council is composed of elders and individuals with disabilities, their representatives, and other stakeholders. CDSS, DHCS, and the Council worked together to develop both CFCO SPAs to implement CFCO services and supports. The counties will be notified of any further Council meetings necessary to provide updates on the status of CFCO implementation.

### **CFCO Eligibility**

All CFCO participants must be eligible for Full-Scope, Federal Financial Participation (FS FFP) Medi-Cal (as in the PCSP and the IPO programs), and meet CFCO NF LOC eligibility based on one of the following criteria:

1. Have a total assessed need (excluding heavy cleaning and yard hazard abatement) of 195 or more IHSS hours per month.
2. Have a total assessed need (excluding heavy cleaning and yard hazard abatement) under 195 IHSS hours per month and:
  - Have 3 or more of the following services with the designated Functional Index (FI) Ranks:
    - Eating, FI Rank of 3-6
    - Bowel and bladder/menstrual care, FI Rank of 3-6
    - Bathing/grooming, FI Rank of 4-5
    - Dressing, FI Rank of 4-5
    - Mobility inside, FI Rank of 4-5
    - Transfer, FI Rank of 4-5
    - Respiration, FI Rank of 5-6
    - Paramedical, (FI Rank not applicable)

OR

- Have a combined FI Rank of 6 or higher in mental functioning (memory, orientation, and judgment). FI Ranks for mental functioning can be either 1, 2, or 5.
3. Have a combined “Individual Assessed Need” total of 20 hours or more per week in one or more of the following services:
- Preparation of meals
  - Meal clean-up (if preparation of meals and feeding are assessed needs)
  - Respiration
  - Bowel and bladder care
  - Feeding
  - Routine bed baths
  - Dressing
  - Menstrual care
  - Ambulation
  - Transfer
  - Bathing, oral hygiene, grooming
  - Repositioning and rubbing skin
  - Care and assistance with prosthesis
  - Paramedical services

The above NF LOC criteria were developed by DHCS in consultation with CDSS.

The new CFCO eligibility requirements are more stringent than those in effect from December 1, 2011 through June 30, 2013; therefore, individuals with FS FFP Medi-Cal eligibility who were, but are no longer, eligible for CFCO, due to the NF LOC criteria, will be served in the PCSP or IPO programs, effective July 1, 2013.

Please note that, as in the IPO program, recipients in CFCO may also receive Restaurant Meal Allowance, Advance Pay, service(s) provided by a recipient's spouse, and service(s) provided by a minor recipient's parent.

### **Required Services in CFCO**

The four required services in CFCO are:

1. Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks, which currently include:
  - Personal Care Services
  - Protective Supervision
  - Domestic and Related Services



- Paramedical Services
  - Medical Accompaniment
  - Heavy Cleaning
  - Yard Hazard Abatement
2. Acquisition, maintenance, and enhancement of skills necessary for recipients to perform ADLs, IADLs, and health-related tasks:
- This service is provided via the IHSS Teaching and Demonstration Service, as described in Manual of Policies and Procedures (MPP) Section 30-757.18. This regulation section contains all the information regarding the Teaching and Demonstration service currently available. (Previously, only IHSS-R recipients were eligible for the Teaching and Demonstration Service.)
  - A recipient training handbook addressing “Teaching and Demonstration” is available online at the IHSS Consumer/Recipient Resources webpage at: [http://www.cdss.ca.gov/agedblinddisabled/res/FactSheets/IHSS\\_Teaching\\_and\\_Demonstration\\_Color.pdf](http://www.cdss.ca.gov/agedblinddisabled/res/FactSheets/IHSS_Teaching_and_Demonstration_Color.pdf)
3. Back-up Systems to ensure continuity of services and supports:
- The back-up system requirements are being met through the use of the Individualized Back-up Plan and Risk Assessment process for all CFCO recipients.
- Effective December 1, 2011, form SOC 864 (IHSS Program Individualized Back-up Plan and Risk Assessment) is a required form for use during assessments and reassessments. Please refer to the IHSS Program Managers’ Letter, dated December 2, 2011, at: [http://www.cdss.ca.gov/agedblinddisabled/res/pdf/CFCO-FINAL%20PM's%20Letter%20\(12-2-11\).pdf](http://www.cdss.ca.gov/agedblinddisabled/res/pdf/CFCO-FINAL%20PM's%20Letter%20(12-2-11).pdf)
    - Please note form SOC 864 is now automated in the Case Management, Information and Payrolling System (CMIPS) II.
4. Voluntary Recipient Training on Managing Care Providers:
- Recipients may choose to receive training on how to manage their care providers. Training options include:

- A recipient training handbook available online at the IHSS Consumer/Recipient Resources webpage:  
[http://www.cdss.ca.gov/agedblinddisabled/res/2011\\_IHSS\\_Consumer\\_Training\\_HB\\_v2.pdf](http://www.cdss.ca.gov/agedblinddisabled/res/2011_IHSS_Consumer_Training_HB_v2.pdf)
- Recipient education videos located at the link below. These videos address how an IHSS consumer/recipient may hire a care provider and includes tips on how to find, interview, and select a care provider.  
<http://www.cdss.ca.gov/agedblinddisabled/PG3154.htm>

Although CFCO regulations allow States to provide permissible services and supports, such as expenditures for transition costs, California did not elect to include permissible services.

### **6% in Federal Medical Assistance Percentage (FMAP)**

As previously stated in this ACL, the federal ACA provides an additional 6% in FMAP for CFCO Home and Community-Based Attendant Services and Supports. The required CFCO services eligible for the enhanced FMAP are: (1) assistance with ADLs, IADLs, and health-related tasks and (2) acquisition, maintenance, and enhancement of skills necessary for recipients to perform ADLs, IADLs, and health-related tasks.

The 6% in FMAP was retroactive to December 1, 2011. Counties received their portion of the enhanced FMAP for the period December 1, 2011 through June 30, 2012. After June 30, 2012, the counties' portion of the additional 6% in FMAP was factored into the calculation of the County Maintenance of Effort (MOE). Please see CFL No. 12/13-28 for additional details.

[http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/cfl/2012-13/12-13\\_28.pdf](http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/cfl/2012-13/12-13_28.pdf)

### **Systems and New Aid Code**

As a newly established IHSS program, CFCO was assigned the Medi-Cal Secondary Aid Code of 2K in CMIPS II. CMIPS II programming of this Aid Code is expected to be completed by September 1, 2014. Prior to that, CFCO recipients will receive services under CFCO, but will continue to be identified in the system as either a PCSP (Aid Code 2M) or IPO (Aid Code 2L) case.

Effective September 1, 2014, as the movement of IPO recipients into CFCO is completed, those recipients who are considered Non-Severely Impaired (NSI) and receive protective supervision, will be eligible for 195 hours of protective supervision, plus hours for other services, up to a maximum of 283 hours per month.

### **Quality Assurance (QA)**

The CFCO SPA resulted in two notable changes to existing QA requirements for all IHSS programs:

County Annual Quality Assurance/Quality Improvement (QA/QI) Plans:

- The static (i.e. unchanged) data formerly reported in the QA/QI Plans will instead now only be included in county Policies and Procedures (P&P). The CFCO SPA reflects the requirement to review county P&P for that information, in addition to reviewing the QA/QI Plan. Please refer to ACL No. 13-105 (Updated Guidance on County Submission of Annual QA/QI Improvement Plans) for further details.

QA Sample Size

- Previously, county QA was required to conduct 250 desk reviews per allocated QA position every year, with a subset of 50 also receiving home visits. The new methodology results in significantly reduced workloads for counties, while still providing for the review of a representative sample of each county's IHSS caseload, statistically valid to within appropriate parameters.

### **SOC 824**

On a quarterly basis, counties report IHSS program-specific data on form SOC 824 (IHSS QA/QI Quarterly Activities Report), which now includes fields for CFCO program data. Prior to the September 1, 2014 implementation of the CFCO 2K Aid Code, we request that counties enter "0" in the CFCO data columns, as there is no other automated means to capture this data. Beginning September 1, 2014, counties will enter CFCO data on form SOC 824 based on cases with a 2K Aid Code.

For questions regarding this ACL, please contact the Adult Programs Policy and Operations Bureau at (916) 651-5350.

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

c: CWDA  
Department of Health Care Services

**COMPLETING THE SOC 864  
IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

- ☐ The Individualized Back-Up Plan and Risk Assessment form (SOC 864) is required for all HSS cases. This individualized Back –UP and Risk Assessment process identifies risks and mitigates these potential issues through program services, referrals to other available programs and services, identified individuals person to the recipient, emergency contacts, and disaster preparedness and is agreed upon by the recipient and social worker completing this process.
- ☐ The SOC 864 is designed to facilitate a discussion between the social worker and recipient and any others whom the recipient wants involved in order to ensure the recipient is making informed decisions about risk and their options. During the discussion, individuals in the recipient's life that may be called upon when a provider has not arrived as scheduled, or another issue arises that could potentially put the recipient at risk, should be discussed and identified. These individual's contact information (telephone, pager, etc.) must be included in the Individual Back-Up Plan, along with entities (Police, Fire Department, Adult Protective Services, etc.) and their contact numbers, plus 9-1-1, that are provided to assist the recipient, if needed.
- ☐ When working with recipients, there are needs that the IHSS program cannot meet because the program does not provide for that service.
- ☐ When filling out the SOC 864 Section 2, help the recipient to look for all available resources to support them for non-emergency and emergency needs. Section 3 of the form is the General Risk Assessment, Section 4 is the Disaster Preparedness section and section 5 contains areas for recipient/authorized representative and social worker signatures. If necessary, you may need to help them identify resources that aren't obvious. Make sure you reinforce how to contact other resources that are available to them.
- ☐ When discussing risk, you should be mindful of the following:
  - What risks you are aware that exist.
  - The factors that are influencing the recipient's decisions.
  - Influences on decisions by other involved persons such as family and providers.
  - Available resources that can be considered to augment the recipient's options.
- ☐ Even though you may not be able to provide a solution, you can help the recipient see risk and its potential concerns, and refer them to services that may be able to help them mitigate these risks and meet their needs.
- ☐ The discussion that occurs should be well documented by using the SOC 864, and if necessary, documenting further information in the recipient's CMIPS file either in the narrative note or case note.

SAMPLE A

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

## SECTION 1 – RECIPIENT'S INFORMATION

RECIPIENT'S NAME:

CASE NUMBER:

## INDIVIDUALIZED BACK-UP PLAN

## SECTION 2 – SUPPORT CONTACTS

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

	Name	Phone
Family Member:	██████████ (spouse)	(916) ██████████
Friend/Neighbor:	██████████ (friend)	(916) ██████████
County Social Services Worker:	██████████	(916) ██████████
County IHSS Social Services Office:	In-Home Supportive Services	(916) 874-2357
Public Authority:	Public Authority	(916) 874-4131
Other:	██████████ (adult son)/██████████ (adult dtr)	(916) ██████████

### Other important numbers available to you, if needed:

Doctor's Office:	Dr. ██████████	(916) ██████████
Advocacy Group(s):	Alta Regional - ██████████	(916) 929-8145
Police Department:	Sacramento Police Department	(916) 320-1651
Fire Department:	Sacramento Fire Department	(916) 920-1475
Other:	Sacramento Sheriff's Department	(916) 578-1542

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

Adult Protective Services:	(916) 245-2684
Child Protective Services:	(916) 354-1598
Deaf or Hard of Hearing Resource Hotline:	(916) 558-5670
Fraud & Elder Abuse Hotline:	(800) 722-0432
Medi-Cal Fraud Hotline:	(800) 822-6222
Social Security Administration Fraud Hotline:	(800) 269-0271

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

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

SAMPLE A

RECIPIENT'S NAME:

CASE NUMBER:

**RISK ASSESSMENT**

**SECTION 3 – GENERAL RISK ASSESSMENT**

**A. IHSS Assessment**

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

**B. Additional Risk Areas**

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

**Comments**

**B1. Living Arrangements**

- ☒ Lives with others who may assist
- ☐ Lives alone, relatives/friends nearby who may assist
- ☐ Lives alone, no relatives/friends nearby

■■■■■ lives with her spouse and two adult children in the home.

**B2. Evacuation/Environmental Factors**

- ☐ Can evacuate independently
- ☐ Can evacuate, but only with supervision/verbal direction
- ☒ Needs physical assistance to evacuate home in an emergency
- ☐ Able to access food/water independently
- ☐ Aware of emergency or crisis numbers/contacts
- ☐ Able to control lights, heat, cooling or other utilities

■■■■■ uses a walker and needs help from spouse to get out of the house during an emergency. Spouse stated he is usually available and if he is not there, one of his two adult children will be available: ■■■■■. Contact information on page 1.

**B3. Communication**

- ☐ Communicates without difficulty
- ☒ Hearing impairment, communication limited
- ☒ Speech impairment, communication limited
- ☒ Can speak or hear with the use of assistive device(s)  
Assistive device(s): video relay & ASL
- ☐ Able to place and receive calls independently
- ☒ Can use telephone only with assistive device(s)  
Assistive device(s): video relay

■■■■■ phone is connected to a video relay service so when SW dials phone number, relay service will connect to client's video relay phone. ■■■■■ requires an ASL interpreter.

**SECTION 4 – DISASTER PREPAREDNESS**

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

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

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

SAMPLE A

RECIPIENT'S NAME:

CASE NUMBER:

**AGREEMENT AND SIGNATURES**

**SECTION 5 – AGREEMENT AND SIGNATURES**

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

**Recipient**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: 3/11/11

Print Name and Title: \_\_\_\_\_ Human Services Social Worker

**Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

**Other**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

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

**Recipient /Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

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SOC 864 (3/11)

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

SAMPLE A

RECIPIENT'S NAME:

CASE NUMBER:

**INSTRUCTIONS**

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

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

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

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

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

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

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

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

**Comments/Notes:**

SW discussed risk assessment with [REDACTED]. [REDACTED] and spouse stated they understood the risks involved with [REDACTED]'s need to use a walker in case of an emergency. Spouse stated he or his two children will assist [REDACTED], if needed. SW informed [REDACTED] and spouse to post page one of this form in an easily accessible area such as the refrigerator or by the telephone. [REDACTED] has several throw rugs in the home which may be hazardous as she uses a walker to ambulate safely in the home. SW suggested to [REDACTED] and spouse that removing the throw rugs or taping them down may reduce the risk of [REDACTED] tripping on the rugs. [REDACTED] and spouse declined suggestion, stating they prefer the rugs to be in their home and did not want to remove the rugs or tape them down.

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SAMPLE B

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

## SECTION 1 – RECIPIENT'S INFORMATION

RECIPIENT'S NAME:

CASE NUMBER:

## INDIVIDUALIZED BACK-UP PLAN

## SECTION 2 – SUPPORT CONTACTS

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

	Name	Phone
Family Member:	██████████ (mom)	(916) ██████████
Friend/Neighbor:	██████████ (grandma)	(916) ██████████
County Social Services Worker:	██████████	(916) ██████████
County IHSS Social Services Office:	In-Home Supportive Services	(916) 874-1125
Public Authority:	Public Authority	(916) 874-7854
Other:	██████████ (sister)/ ██████████ (sister)	(916) ██████████

### Other important numbers available to you, if needed:

Doctor's Office:	Dr. ██████████	(916) ██████████
Advocacy Group(s):	Alta Regional - ██████████	(916) ██████████
Police Department:	Sacramento Police Department	(916) 320-1651
Fire Department:	Sacramento Fire Department	(916) 920-1475
Other:	Sacramento Sheriff's Department	(916) 578-1542

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

Adult Protective Services:	(916) 245-2684
Child Protective Services:	(916) 354-1598
Deaf or Hard of Hearing Resource Hotline:	(916) 558-5670
Fraud & Elder Abuse Hotline:	(800) 722-0432
Medi-Cal Fraud Hotline:	(800) 822-6222
Social Security Administration Fraud Hotline:	(800) 269-0271

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

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

SAMPLE B

RECIPIENT'S NAME:

CASE NUMBER:

## RISK ASSESSMENT

### SECTION 3 – GENERAL RISK ASSESSMENT

#### A. IHSS Assessment

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

#### B. Additional Risk Areas

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

#### Comments

##### B1. Living Arrangements

- ☒ Lives with others who may assist
- ☐ Lives alone, relatives/friends nearby who may assist
- ☐ Lives alone, no relatives/friends nearby

██████████ (12-year-old child) lives with his mom and two adult sisters.

##### B2. Evacuation/Environmental Factors

- ☐ Can evacuate independently
- ☐ Can evacuate, but only with supervision/verbal direction
- ☒ Needs physical assistance to evacuate home in an emergency
- ☐ Able to access food/water independently
- ☐ Aware of emergency or crisis numbers/contacts
- ☐ Able to control lights, heat, cooling or other utilities

██████████ is wheelchair bound and needs help from his mom to get out of the house during an emergency. Mom stated she is available and if she is not there, one of her adult daughters can help ██████████. Mom also stated ██████████'s grandma comes over a few times a week and may be available too. Contact information listed on page 1.

##### B3. Communication

- ☐ Communicates without difficulty
- ☐ Hearing impairment, communication limited
- ☒ Speech impairment, communication limited
- ☒ Can speak or hear with the use of assistive device(s)  
Assistive device(s): American Sign Language (ASL)
- ☐ Able to place and receive calls independently
- ☐ Can use telephone only with assistive device(s)  
Assistive device(s): \_\_\_\_\_

██████████ is non-verbal. He communicates using ASL. His mom and two sisters are verbal but also can communicate using ASL. ██████████ needs an ASL interpreter.

### SECTION 4 – DISASTER PREPAREDNESS

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

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

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

**SAMPLE B**

RECIPIENT'S NAME:

CASE NUMBER:

**AGREEMENT AND SIGNATURES**

**SECTION 5 – AGREEMENT AND SIGNATURES**

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

**Recipient**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: 5/25/11

Print Name and Title: \_\_\_\_\_ Social Worker I

**Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

**Other**

Signature: \_\_\_\_\_ Date: 5/25/11

Print Name and Relationship: \_\_\_\_\_ mother/provider

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

**Recipient /Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

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SOC 864 (3/11)

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

**SAMPLE B**

RECIPIENT'S NAME:

CASE NUMBER:

**INSTRUCTIONS**

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

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

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

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

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

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

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

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

**Comments/Notes:**

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## THINGS TO CONSIDER WHEN ASSESSING

### **Domestic Services** [MPP 30-757.11]

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

- What is the living arrangement? How many people live in the home? Does the consumer have a separate bedroom and bathroom? How many people use the rooms used in common? Are there any rooms not being used by the consumer? What are the proration rules that apply?
- What is the consumer's mental status? Is he/she alert? Are there cognitive issues that prevent the consumer from completing tasks?
- Avoid judging the suitability of the living situation based on your own standards versus the safety of the situation. The social worker may not believe this is the best condition, but the check is if it is SAFE?
- What physical or mental limitations exist that contribute to the consumer's need for assistance?
- Look at the number and size of rooms to be cleaned. The assessed need for a studio apartment should usually be less than for a larger dwelling.
- If the consumer suffers from incontinence, frequent changes of bed linen may be necessary if the consumer does not have protective pads that protect linens. Extra changing of the sheets should be assessed as domestic services but the washing of them is assessed as laundry.

#### **Common Authorization Mistakes:**

- *Everyone is assessed 6.00 hours per month regardless of FI score.*
- *Size of residence or lifestyle choices are not taken into consideration.*
- *Service is authorized when the consumer resides with Able/Available spouse or is a minor child with parent provider.*
- *The total need is divided by the number of persons living in the household without taking into consideration shared living regulations.*
- *Social workers are sometimes not familiar with how to document "refused services".*

## THINGS TO CONSIDER WHEN ASSESSING

### **Meal Preparation and Clean-Up** [MPP 30-757.131 and .132]

Meal Prep: Planning menus; removing food from the refrigerator or pantry; washing/drying hands before and after meal preparations; washing, peeling, and slicing vegetables; opening packages, cans and bags; measuring and mixing ingredients; lifting pots and pans; trimming meat; reheating food; cooking and safely operating the stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-sized pieces.

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

- Are there health or safety issues that prevent the consumer from preparing their own meals?
- What is the living arrangement? In shared living situations, are the meals prepared together with other family members? Some meals may be prepared separately and others may be shared.
- What are the consumer's specific medical dietary requirements? Are they requirements that preclude the housemates from sharing meals? For example, a diabetic diet or heart diet are healthy diets that can be shared by housemates.
- What types of meals does the consumer typically eat?
- Can the consumer chew? Do they need pureed foods?
- Does the consumer need help cutting up food?
- What alternative resources are available? Do they get Meals on Wheels or go to a day care center that provides meals? Are there voluntary resources such as family or neighbors who bring food to the consumer?
- Is the consumer able to use the kitchen?
- How often is meal preparation needed? How often does the consumer eat?
- What is their Functional Index rank for Meal Preparation?
- Observe if the consumer's movements are impaired. Do they have poor strength and endurance? Can they lift pots/pans? Can they bend or stoop? Can they reach stored food or utensils?
- Ask if they can stand long enough to prepare a meal, help with clean up, wash the dishes or load the dishwasher.
- Is the consumer safe around a stove? Do they use oxygen?
- Does the consumer have a microwave? Can s/he use it? A consumer who is otherwise unable to use the stove to prepare a meal may be able to reheat meals in the microwave.
- Authorization of Restaurant Meals Allowance may be appropriate for some consumers.

### **Common Authorization Mistakes:**

- *Needs are assessed for meals that consumers are able to prepare/clean-up without any assistance.*
- *Consumers are assessed the same amount of time regardless of what type of meals they eat (frozen dinner vs. full meal).*
- *Everyone gets the same amount of time for meal prep/clean-up regardless of what they eat or their FI score.*
- *Alternative resources such as Meals on Wheels or meals received at ADHCs are not taken into consideration in the authorized hours.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Laundry** [MPP 30-757.134]

Washing and drying laundry, mending, ironing, folding, and storing clothes on shelves or in drawers.

- Provider should accomplish other tasks while clothes are washing and drying if done in the home.
- If the consumer has a washer and the capability to dry clothes on the premises, laundry facilities are considered to be in the home. Per CDSS policy “on the premises” means available within an apartment complex or mobile home park.
- If the consumer is able to do some laundry, their assessed need may be less than the 1 or 1.5 hours per week guideline.
- If the consumer has incontinence or other issues which creates extra laundry, justification for the extra hours is required in the case file. (Not everyone who is incontinent requires extra laundry as some consumers wear pads or underwear to prevent soiling clothing and bedding and use protective pads on beds.)
- Does the consumer have the capability to hand wash some items? If so, the need for laundry may be decreased.
- Is the consumer’s laundry washed separately? What is the living arrangement? If the consumer’s laundry is done with laundry of other household members, proration rules apply.

#### **Common Authorization Mistakes:**

- *Consumers routinely are assessed at the guideline of 1.00 or 1.50 hours per week without taking into consideration things that the consumer is able to do, such as gathering clothes, folding clothes, etc.*
- *Consumers are assessed extra hours for out of home laundry facilities when laundry facilities exist on the premises of apartment buildings, mobile home parks, etc.*

### **Shopping for Food** [MPP 30-757.135(b)]

Making a grocery list, travel to/from the store, shopping, loading, unloading, and storing food.

- What is the living arrangement? Is shopping for groceries for the entire household? Is there a reason the shopping must be done separately?
- Observe the consumer’s ability to move around the home. Observe the consumer’s ability to reach, grasp, and lift.
- Are they physically/mentally able to perform all tasks related to shopping?
- If the consumer “prefers” items from a particular distant store but there are comparable items at a nearby store, extra time is not allowed for the provider to shop at the preferred store. An exception would be if the nearby store is not consistent with the consumer’s economic needs.
- Although the consumer may want to accompany the provider shopping, extra time should not be approved.

#### **Common Authorization Mistakes:**

- *A need is assessed for services the consumer is able to perform independently, such as going to a nearby store for small items.*
- *Consumers are assessed extra time to go to distant stores when there is a nearby store that is consistent with their economic needs.*
- *Extra time is allowed for the consumer to accompany the provider shopping.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Other Shopping and Errands** [MPP 30-757.135(c)]

Making a shopping list, travel to/from store, shopping, loading, unloading, and storing supplies purchased, and/or performing reasonable errands such as delivering a delinquent payment to avert an imminent utility shut-off or picking up a prescription, etc.

- What is the living arrangement? Is other shopping and errands done for the entire household?
- In some cases, the other errands may be completed when the food shopping is done, e.g. superstore which has a pharmacy, clothing, etc., and additional time for shopping and errands may not be needed.
- Purpose of other shopping and errands is for picking up prescriptions, going to the bank, shopping for clothing, getting a haircut, etc.
- What alternative resources are available or could be obtained to help with shopping and errands?
- Although the consumer may want to accompany the provider shopping, extra time should not be approved.

### **Heavy Cleaning** [MPP 30-757.12]

Involves thorough cleaning of the home to remove hazardous debris or dirt.

- Heavy cleaning can be authorized at the time IHSS is initially granted to enable the provider to perform continuous maintenance; or if a lapse in eligibility occurs, eligibility is re-established, and IHSS has not been provided within the previous 12 months. Can also be authorized when living conditions are a threat to his/her safety or when the consumer is at risk for eviction for failure to prepare his/her home for fumigation as required by statute or ordinance.
- An APS referral might be appropriate to develop a corrective plan so that the heavy cleaning service can occur (so that the hoarder doesn't take things back out of the dumpster during the cleanup process). This may increase the potential that a provider can maintain the home after heavy cleaning.
- Health factors should be considered when authorizing this service. Is there human or animal waste, garbage lying around, clutter that prevents the consumer from moving around the house safely, etc.? Referral to APS or Public Health may be indicated in some cases.
- Are the extreme conditions the result of lifestyle choice or the consumer's disability? Referral for a new provider might be needed if the current provider is not performing authorized services. If this is a lifestyle choice, this service would not benefit the consumer because it would not make a difference in his/her future living conditions.

#### **Common Authorization Mistakes:**

- *Justification for allowing the service is not documented in the case file.*
- *A plan has not been developed to assure that the housing unit can be maintained after heavy cleaning has been completed.*
- *A need is assessed for reasons that are not consistent with regulations which specify when the service can be authorized.*



## THINGS TO CONSIDER WHEN ASSESSING

### **Respiration** [MPP 30-757.14(b)]

Limited to non-medical services such as assistance with self-administration of oxygen and cleaning IPPB machines.

- Observe the home for breathing equipment. Does the consumer cough or wheeze excessively during the interview? Is their breathing labored? Always ask regarding the need for breathing equipment. May be used intermittently and not in plain sight.
- What type of apparatus does the consumer use? Is the consumer physically and mentally able to hold a nebulizer or inhaler without assistance for the required time?
- Ask if they have been instructed on how to use their equipment and if they are able to manage cleaning it.
- If the consumer has an oxygen machine but can hook it up and clean it themselves, they should be considered independent with respiration.
- If the provider or others assist with the administration of oxygen and/or cleaning of the equipment, how often is the assistance provided and how long does it take?
- Is there a service that does maintenance? If the consumer has a service that assists them with the cleaning of their equipment, those needs should be assessed and shown as being met through an alternative resource in CMIPS.
- Does the consumer have a portable tank?
- Does the consumer need help putting the apparatus on? How often is this needed and how long does it take?

#### **Common Authorization Mistakes:**

- *Alternative resources that the consumer receives (such as cleaning equipment by vendor) are often not identified.*
- *Consumer is capable of performing the services for which a need is assessed.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Bowel and Bladder** [MPP 30-757.14(a)]

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

- Does the consumer have difficulty getting to the bathroom in time?
- Can you smell urine/feces in the home?
- Are there other signs of bowel/bladder incontinence, such as supplies of diapers in the bedroom/bathroom or pads on the bed to prevent soiling bedding?
- Observe for signs that the consumer is not making it to the bathroom in time or missing the toilet.
- Does the consumer have a medical condition or take medications which contribute to the need for assistance with bowel and bladder care?
- Is the need expected to be ongoing or time limited? Example: Consumer normally can get to the bathroom and does not require assistance, but due to a recent injury/surgery, cannot get into the bathroom.
- What assistive devices does the consumer have? What devices would help minimize the need for assistance? Examples: Elevated toilet seat or bars that can assist on/off the toilet.
- Does the consumer use a urinal or bedside commode?
- Can the consumer complete cleaning and maintenance of the commode? If the consumer uses a bedside commode or urinal but can empty or clean it by themselves, they should be assessed as Rank 1 (independent).
- Can the consumer stay on the commode/toilet once assisted to get on?
- Is the consumer able to change diapers/pads?
- Is the consumer able to wipe himself?
- Is the consumer incontinent? How many times a day? Some cleaning will need to occur after each episode of incontinence. Can the consumer manage that cleaning?
- How many times a day does the consumer use toilet/commode if they need an assist, and how long for each assist? (Separate answers for bowel movement and for urination.)
- What impact does bowel and bladder issues have on needs for extra laundry and/or an increased need for Domestic services? Also consider need to have laundry done separately.
- If the consumer has ostomy bag, and the provider is only emptying the bag, services are assessed as bowel/bladder.

### **Common Authorization Mistakes:**

- *Service is assessed when the consumer experiences some difficulty performing task, however, it does not put them at risk for injury, hazard or accident.*
- *A need is assessed for consumers who wear diapers but are able to manage without assistance from another person.*
- *Consumer needs assistance but is too embarrassed to discuss the need and the social worker does not ask.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Feeding** [MPP 30-757.14(c)]

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

- Does the consumer have physical conditions that prevent him/her from grasping/holding utensils, cups, etc.? Is it difficult or impossible? Look for paralysis, tremors, weakness, arthritis, pain, or physical deformity.
- A consumer's hands may be deformed and they may have restricted ability to grasp but if they are able to feed themselves, they would still be considered independent.
- Does the consumer have a special device or brace on his hand or available for feeding?
- Is the consumer's condition consistent throughout the day? Does it improve after medication? Is their independence better for some meals?
- Look for cognitive issues that may interfere with focus during eating, i.e., psychotic disorder, severe depression, mental confusion, or dementia. If such disorders exist, does the consumer eat if reminded? Does the provider need to sit with the consumer, encouraging him/her throughout the meal?
- Does the provider need to feed the consumer?
- How many times a day does the consumer eat and how much time does it take for each meal?
- Are there some meals that the consumer can eat independently while others require more hands on help? Example: Consumer can eat toast or sandwich independently, but requires hands on help for dinner.
- How willing is the consumer to eat? Will they eat once you've set food in front of them, or do they need constant attention?
- When the consumer greets you, how do they shake hands with you? Do they appear extremely frail? Shaky?
- Does the consumer appear undernourished? Observe if their clothes appear too large, possibly indicating a recent weight loss. Ask them what they have eaten that day. If the consumer didn't eat that day, ask follow-up questions to determine the reason.
- If the consumer is able to feed themselves and does not need the provider's constant presence, the provider can often remind them to eat while they are doing other IHSS tasks such as meal cleanup or housework.
- If the consumer feeds self, do they spill food on clothing, table, etc. which results in increased need for dressing, laundry, meal cleanup?

### **Common Authorization Mistakes:**

- *Often services are assessed for reminding the consumer to eat, which in many cases can be done while the provider is accomplishing other tasks.*
- *A need is assessed for cutting food, which should be assessed as part of meal preparation.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Bed Baths** [MPP 30-757.14(d)]

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

- Is the shower or tub too narrow for the consumer to access?
- Are there steps or other barriers leading to the bathroom that prevent the consumer from going into the bathroom?
- Is the consumer recovering from an injury or surgery? If so, their needs will probably be different than the long-term bed bound consumer. Consider a time-limited assessment, or flag the case for follow-up at time of expected recovery.
- Does the consumer need to be bathed daily to prevent skin breakdown and pressure sores?
- How many times a week does a consumer need to be bathed to maintain safety?
- Can the consumer assist with the process at all? If so, this should be encouraged to maximize independence and promote self-esteem.
- The assessed need for consumers who are unable to assist in changing positions or participate in washing their body, etc. will be greater than that of consumers who can change positions and assist.
- How long does it take to bathe the consumer?

#### **Common Authorization Mistakes:**

- *A need is assessed for bed baths when the consumer is able to safely bathe in the bathroom.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Dressing** [MPP 30-757.14(f)]

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

- If the consumer dresses self, observe if he/she is appropriately dressed for their environment.
- Consider lifestyle choices. Do they prefer to spend the day in pajamas or sweats? Consider that even if they prefer to spend the day in pajamas or sweats, they will probably dress in other clothing when they leave the house for medical appointments, etc.
- Is the consumer bed bound?
- Does the consumer use specialized garments, braces, splints, etc.?
- Do they frequently soil their clothing causing frequent changes?
- Does the consumer have uncontrollable tremors in extremities or medical problems such as arthritis that affect the hands/fingers making fastening or lacing garments difficult?
- Does the consumer have devices that assist with dressing? Could they use devices that would assist them in dressing? If not, suggest these items to the consumer/family/provider. These may lessen the need for assistance.
- Remember that one of the goals should be to foster independence so the consumer should be encouraged to do whatever they are capable of doing to dress self or assist in dressing.
- Do they look and appear comfortably dressed?
- Are all buttons buttoned correctly? Zippers zipped? Shoes tied or fastened?
- If the consumer only changes clothing in the morning and evening or only requires occasional assistance, the assessed time should reflect that.
- If the consumer only requires assistance on “bad days” such as after dialysis treatments, the need should reflect this.

### **Common Authorization Mistakes:**

- *Consumer changes clothes only once a day, however, assessed need reflects numerous clothing changes.*
- *Consumer has minor need, however, assessed need reflects full clothing changes.*
- *Consumer needs only occasional assistance, however, need reflects daily assistance.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Menstrual Care** [MPP 30-757.14(j)]

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

- Limited to external application of sanitary napkin and cleaning.
- Does the consumer menstruate? Regardless of the consumer's age, it is vital to ask questions as spotting might indicate a possible serious medical condition. Is her period regular? What is the duration?
- Ask what kinds of personal assistance she requires.
- Are there any mental/physical issues? Why does the consumer require assistance?
- Determine whether the task is still needed at each reassessment. Stop authorization when the consumer has gone through menopause or has had a hysterectomy.
- Determine amount of daily time assistance is required by asking about the number of times pad is changed daily and how long it takes each time. Determine weekly time by multiplying daily time by number of days the period lasts. Divide weekly time by 4.33, as time entered on the SOC 293 is weekly.

#### **Common Authorization Mistakes:**

- *A need is assessed when the consumer is able to perform the task without assistance.*
- *Need is typically monthly, however assessed need does not reflect it as such (menstrual cycles are normally only once a month, however, time is sometimes assessed as a weekly need).*
- *Authorization continues even after the consumer goes through menopause.*
- *The social worker is too embarrassed to discuss menstrual care so there is no discussion about the reason assistance is needed, the frequency changes are needed, or the duration of the period.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Ambulation** [MPP 30-757.14(k)]

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

- How much difficulty does the consumer have in moving around the house or from the front door to the car (and in and out of car for medical appointments or travel to alternative resources)? Ask the consumer to show you around the house and observe their mobility.
- Does the consumer need help maneuvering the wheelchair from one room to another?
- Ask if they feel safe walking around their home and if they have a history of falls when ambulating.
- Can the person move around more safely using a walker/cane? Do they know how to use them properly? Do they remember to use the assistive device or leave it next to the chair when they get up and walk?
- If the consumer does not have assistive devices and it appears they are needed to make the consumer safer and more independent, suggest that the consumer or his/her representative discuss this with their physician.
- Will the consumer use assistive devices?
- If they use a wheelchair, walker or cane but can do so safely without assistance, they should be considered independent.
- Is the consumer at risk if they are unassisted? Consider the amount of assistance needed to keep the consumer safe – stand-by versus hands-on.
- How often does the consumer move around the home? How long does it take them to get from place to place?
- Are there stairs the consumer must maneuver?
- Consider whether the consumer needs someone to bring assistive devices to them and put them away. If so, time should be assessed under ambulation.

### **Common Authorization Mistakes:**

- *A need is assessed for assistance moving around outside of the home – time should be related to daily activities which the consumer needs to walk (or use a wheelchair/walker) to perform, such as walking to and from the bathroom, bedroom, and kitchen. Ambulation is not authorized for general exercise purposes or for assistance walking outside of the home.*
- *Need is often based solely on the fact that the consumer uses an assistive device. Assistive devices often make the consumer independent or less dependent on the need for human assistance.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Moving In/Out of Bed (Transfers)** [MPP 30-757.14(h)]

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

- Assess the consumer's strength, balance, flexibility, and stability on their feet.
- Does the consumer use any assistive devices to assist in transfer or would such devices increase safety and improve independence?
- Does the consumer need the assistance of a Hoyer or other type of lift to transfer them from the bed to the wheelchair?
- Does the provider need to do a pivot transfer? Does the consumer have an appropriate belt to assist in this process?
- Can the consumer use furniture safely to get in and out of a position for transfer?
- Ask the consumer if s/he gets dizzy upon standing up and if s/he has ever fainted or fallen when that happens. Ask if this was reported to the consumer's physician and if not, suggest they report this at the next visit.
- Do they nap during the day? Do they need help every time they get in and out of bed?
- Does the consumer have trouble getting out of a chair? If so, getting out of bed would probably be even more difficult.
- Ask them if they need help getting out of bed in the morning or back in at night. It may be more difficult for the consumer to get out of bed in the morning due to joint stiffness, etc., but may be able to get back into bed without assistance.

#### **Common Authorization Mistakes:**

- *Assessed need reflects more time than is actually required.*
- *Consumer is allowed time daily, however, only requires assistance on bad days.*
- *Need is assessed when assistive device allows the consumer to move in and out of bed without assistance.*



## THINGS TO CONSIDER WHEN ASSESSING

### **Bathing, Oral Hygiene, Grooming** [MPP 30-757.14(e)]

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

Oral hygiene: Applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

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

- Consider a medical condition that would increase the need for frequent bathing, i.e., diabetes (sweating), incontinence, skin allergies, or lesions which need to be kept clean. Note that the care of open lesions would be a paramedical service.
- What is the consumer’s activity level? The more active they are, the more frequent the need for bathing.
- How often is the consumer currently being bathed? Does the consumer look clean?
- Does the consumer resist bathing (frequently with people with Alzheimer’s disease)?
- How much assistance does the consumer need? What can they do to maximize their independence?
- Does the consumer need assistance to get in/out of tub for safety, but able to bathe himself once in the tub or on a shower stool?
- Assess the need for a grab bar or shower chair to maximize safety and promote independence.
- Frequent bathing of the elderly can cause dry skin leading to itchiness, lesions, or skin breakdown.
- Elderly people who are not active frequently do not bathe on a daily basis.
- Time for application of lotion/powder to the skin after bathing can be included here.
- Does the consumer need shaving? How often and how long does it take? Can the consumer shave with an electric shaver?
- How often does the consumer need hair washing?
- Can the consumer brush their own teeth? Floss?
- Can the consumer do their own denture care?
- Can the consumer do their own hair (comb/brush)? Check out range of motion of their arms.
- If toenail care is medically contraindicated, it is evaluated as a paramedical service.

#### **Common Authorization Mistakes:**

- *A need is assessed for services that the consumer is able to perform without assistance.*
- *Services are assessed daily and it is apparent that they are not being performed (consumer is not clean).*
- *Services are assessed daily, however, the provider provides services less frequently.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Repositioning and Rubbing of Skin** [MPP 30-757(g)(1) & (2)]

Repositioning and Rubbing of Skin: Rubbing skin to promote circulation and/or prevent skin breakdown; turning in bed and other types of repositioning; and limited range of motion exercises.

- Is the consumer's movement unimpaired?
- Are they able to get out of a chair unassisted?
- Are they able to reposition themselves as necessary in a wheelchair or in bed?
- How often does the consumer move around? If bed bound, medical repositioning standard is every 2-3 hours. Discuss with consumer/responsible person what physician has indicated is needed. If necessary, get clarification from physician's office.
- Does the consumer need skin rubbing to promote circulation and prevent skin breakdown?
- Range of motion exercises must have been taught to the consumer by a licensed health care professional.
- If pressure sores have developed, the need for care of them is evaluated as a paramedical service.
- Range of motion must be needed to restore mobility restricted because of injury, disuse, or disease, not for comfort or esthetic reasons.
- A need for maintenance therapy which is consistent with the consumer's capacity and tolerance may be authorized. This consists of carrying out the performance of repetitive exercises required to maintain function, improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

#### **Common Authorization Mistakes:**

- *A need is assessed when the consumer can safely perform transfers without assistance from another person.*
- *Assessed need does not accurately reflect number of times assistance is required.*

## THINGS TO CONSIDER WHEN ASSESSING

### Care and Assistance with Prosthesis [MPP 30-757.14(i)]

Assistance with taking off/putting on and maintaining and cleaning prosthetic devices, vision/hearing aids and washing/drying hands before and after performing these tasks. Reminding the recipient to take prescribed and/or over-the-counter medications when they are to be taken and setting up medi-sets.

- How long does it take to set up a mediset? How many times a week? Consider packaging of pills from the pharmacy.
- Does the consumer's cognitive impairment make it unsafe to do self-meds setup? Can the consumer remember to take meds from the filled medi-set? Is the consumer mentally competent to manage their own meds?
- If assistance with medication is more complicated, for example administering injections, the time should be assessed as a paramedical service.
- If the consumer requires prosthetic devices, ask what types of assistance they require. May be assessed as "dressing" versus "care & assistance with prosthesis". For example, if the consumer uses a leg brace, putting it on would be "Dressing" rather than "Care and Assistance with Prosthesis."
- When a provider must physically put the medication into a consumer's mouth or orifice, this should be assessed as a paramedical service rather than assistance with prosthesis.

#### Common Authorization Mistakes:

- *Assessed need reflects daily set up of medications; however provider sets up medications one time weekly.*
- *Time is authorized when consumer requires only "reminding" to take meds which is done while provider is performing other tasks.*

### Accompaniment to Medical Appointments [MPP 30-757.15]

Transportation to and from appointments with physicians, dentists, and other health practitioners. Transportation necessary for fitting health related appliances/devices and special clothing. Authorized only after social service staff have determined that Medi-Cal will not provide transportation in the specific case.

- Accompaniment is only authorized when the consumer needs the help of a provider because of mobility problems or because the consumer gets disoriented. It is not just to fill the consumer's need for transportation. It is not to act as an interpreter because the consumer does not speak or understand English.
- Does not include time waiting for an appointment to finish.
- If the consumer takes a bus to appointments, time should be authorized only if the consumer cannot ambulate **outside** of the home without assistance.
- If the consumer uses taxi scripts or is driven to appointments, time should be authorized only if the consumer cannot ambulate **inside** the home without assistance.
- Consumers using medi-vans should not be authorized accompaniment time unless they are confused or disoriented.
- Transportation should be authorized only after it is determined that Medi-Cal will not provide transportation in the specific case. Suggest that the consumer be asked if they ever use Medi-vans that use their Medi-Cal card for.

#### Common Authorization Mistakes:

- *Assessed need includes time waiting for the consumer while they are in the appointment.*
- *Assessed need does not reflect the total time needed during the month because the monthly need was not converted to a weekly need when completing the SOC 293.*
- *Assessed need includes accompaniment to locations not consistent with regulations.*
- *Assessed need is authorized on a weekly or monthly basis when the consumer only goes to the physician twice a year.*

## THINGS TO CONSIDER WHEN ASSESSING

### **Accompaniment to Alternative Resources** [MPP 30-757.15]

Transportation to the site when alternative resources provide in-home supportive services to the recipient in lieu of IHSS.

- Accompaniment to alternative resources should only be authorized if the alternative resource does not provide its own transportation (most adult one-day health centers provide their own transportation) and when the consumer is going to receive some service at the alternative resource site that is an alternative to IHSS.
- Also see SS above.

#### **Common Authorization Mistakes:**

- *Need is assessed for transportation to a location which provides services which are not an alternative to IHSS.*
- *Need is assessed for transportation to practitioners other than physicians, such as chiropractors, dentists, and podiatrists. Transportation to physicians, dentists, and other health practitioners should be assessed as Accompaniment to Medical Appointments.*

### **Remove Grass, Weeds, Rubbish** [MPP 30-757.16]

Removal of high grass or weeds, and rubbish when this constitutes a fire hazard.

- This is not gardening. Need for the service must constitute a fire or safety hazard.
- Has the consumer received a citation from the fire department or other agency?
- How long will it reasonably take to eliminate the yard hazard? Consider the size of the yard, amount of weed growth, and time of year.

#### **Common Authorization Mistakes:**

- *Services are allowed for merely enhancing the appearance of the yard.*
- *Type of living arrangement has not been taken into consideration.*

### **Remove Ice, Snow** [MPP 30-757.16]

Removal of ice, snow from entrances and essential walkways when access to the home is hazardous.

- Must constitute a safety hazard.
- Must be from entrances and essential walkways.
- Must be stopped when the season changes.

#### **Common Authorization Mistakes:**

- *Calendar controls are not set.*
  - *Service allowed during summer months.*

## THINGS TO CONSIDER WHEN ASSESSING

### Protective Supervision [MPP 30-757.17]

Observing recipient behavior and intervening as appropriate in order to safeguard nonself-directing recipients who are confused, mentally impaired or mentally ill against injury, hazard or accident.

- Protective supervision consists of observing the consumer's behavior in order to safeguard them against injury, hazard or accident.
- This service is available for monitoring the behavior of non-self-directing, confused, mentally impaired or mentally ill persons.
- Not in anticipation of a medical emergency (seizure, heart attack, there might be a fire and the consumer couldn't get out of the house if this were to happen) or to control anti-social or aggressive behavior (consumer might break neighbor's windows, has a tendency of smearing feces, may take drugs). Not to prevent suicide.
- A 24-hour need must exist which can be met through IHSS and alternative resources.
- Ask for a description of incident(s) that have occurred during which the consumer placed him/herself at risk for injury, hazard and accident and date(s) of the incidents. Do they wander? Do they attempt to turn on the stove or operate appliances?
- What does the consumer do when confronted with danger, crisis or hazard?
- Has the provider voluntarily instituted measures such as taking knobs off stoves, putting locks/alarms on doors which have eliminated the ability of consumer to put him/herself at risk? (Cannot require this, but should be considered if this was done voluntarily.)
- Do they know how to act in a way that is appropriate to the situation?
- Never having an "accident" is not cause to deny services.
- Even if the consumer says that they know what to do, can they act on it?
- Is the consumer physically capable of placing themselves at risk for injury, hazard or accident? Are they bed or wheelchair bound?
- What is their mental functioning? How alert are they? Consider progression of dementia may lesson need. Need must be reassessed yearly.
- Is the consumer ever left alone? If so, how long are they able to be alone?
- Not being able to get self out of the home in case of fire or other emergency is, in itself, not a basis for authorizing protective supervision.

### Common Authorization Mistakes:

- *Hours are not calculated correctly.*
- *Documentation in the case file does not indicate how the consumer places themselves in danger for injury, hazard or accident.*
- *Protective supervision is assessed when the primary purpose is one of the following:*
  - *Friendly visiting.*
  - *The need is caused by a medical condition and the form of supervision required is medical.*
  - *In anticipation of a medical emergency or to prevent or control anti-social or aggressive consumer behavior.*
- *The need is not reassessed when a reassessment is conducted.*
- *The authorized hours are not removed when the consumer's condition changes and they are no longer able to physically put themselves at risk for injury, hazard or accident.*

## THINGS TO CONSIDER WHEN ASSESSING

### Teaching & Demonstration [MPP 30-757.18]

- Limited to instruction in domestic tasks, related services, non-medical personal care services and yard hazard abatement.
- Provider must possess skills to effectively and safely train the consumer.
- There must be a reasonable expectation that the consumer will no longer require IHSS assistance with the task after the training, or assistance will be at a reduced level.

#### Common Authorization Mistakes:

- *Services authorized longer than three months.*
- *Results of service not sent to CDSS.*

### Paramedical [MPP 30-757.19]

Activities which include the administration of medications, puncturing the skin, or inserting a medical device into a body orifice, activities requiring sterile procedures or other activities requiring judgment based on training given by a licensed health care professional.

- Does the consumer require injections? Are they able to safely self-administer them?
- Do they require a bowel program or other invasive medical type procedure?
- Is the consumer physically or mentally able to perform the function?
- Life support is usually not paramedical because it doesn't meet the definition of "...are activities which persons would normally perform for themselves but for their functional limitations." Consider a referral for In Home Medical Care through DHS' In Home Operations. Perhaps the doctor should be referring for Home Health Agency care and/or hospice, if indicated.
- Paramedical services cannot be authorized prior to obtaining a medical order (SOC 321) from the consumer's physician confirming the provider has been trained in the required procedures.

#### Common Authorization Mistakes:

- *Paramedical services are authorized before SOC 321 has been obtained.*
  - *Services should not be authorized until SOC 321 is correctly completed and in the case file.*
- *Services approved are not always paramedical in nature.*
- *The time period for which the services are ordered by the physician has expired.*
- *The authorization for services continue indefinitely without reassessment. The need for services should be reassessed at each assessment.*

## THE HOME VISIT CHECKLIST

### Before the Visit:

- Set up appointment by letter or phone.
- Check for current Medi-Cal eligibility in CMIPS.
- Prepare paperwork packet including CMIPS printout. Have forms semi-completed before you arrive at the appointment. Bring additional forms that may be needed.
- Make sure you have the Health Care Certification Form (SOC 873) for the consumer to complete as it is a requirement for obtaining IHSS services.
- Arrange for an interpreter if needed.
- Familiarize yourself with the person's illness or diagnosis – check for contagious diseases.
- Familiarize yourself with case. Review narrative notes from last home visit and any notes documenting phone calls to identify any potential issues that will need to be addressed during the home visit. Make notes to take with you or copy information, if necessary.
- Pay special attention to safety alerts, i.e., dogs, illegal activity expected, mental health issues.
- Make any contacts (i.e., APS, etc.) that you feel will help you do a thorough assessment or answer questions that you may have.
- If indicated, get input or discuss concerns with supervisor or peers.
- If possible, review timesheets or CMIPS screens to determine if the provider has been submitting timesheets for all authorized hours.
- Prepare a map.

### During the Visit:

- Introduce yourself, show your ID.
- On entry into the home, be sure to inquire as to who is currently present in the home.
- Ask for permission to be seated. This gives them control early on and helps with rapport building.
- Explain the purpose of the visit.
- Observe consumer's abilities. This should begin with observing how the consumer greets you and continue until the interview is concluded.
- Observe environmental safety issues (i.e., throw rugs, lack of handrails, availability of DME, etc.).
- Conduct needs interview:
  - Give civil rights pamphlet (pub 13).
  - Complete Emergency Back-up plan.
  - Review medications.
  - Explain rights and responsibilities.
  - All other county and state forms, if applicable.
- If the consumer is new to IHSS, inform him/her regarding the steps required to hire a provider and how they get paid. If this is a reassessment, check with the consumer about how well things are going with the provider. Make appropriate referrals to the Public Authority if the provider needs training or if the consumer wants to change the provider.
- Before leaving, tell the consumer what to expect next:
  - S/he will receive a NOA.
  - Discuss significant changes in authorization, but do not commit to a new service plan while at the home visit.

**Best Practices (not in regs):**

- View all rooms in the home utilized by the consumer (if reassessing, check that assessed chores are being completed).
- Note DMEs that will improve the safety of the client.
- Suggest/make referrals as needed.
- Assess the need to make referrals.

Cleanse your hands immediately following every visit.

Take precautions while transporting forms that contain consumer information per your county's policy.



## **PERSONAL SAFETY TIPS FOR HOME VISITING**

### **General Tips:**

- Pay attention to intuitive feelings.
- Be alert to your surroundings.
- Anticipate potential problems.
- Keep a list of your credit card numbers in a safe place.
- Carry only enough money to get through the day.
- Maintain your car;. Make sure you have enough gas.
- Carry a cell phone.
- Obtain any history of clients to be visited (i.e., chemical abuse, history of violence, criminal activity, non-compliance with medication, violent or criminal family members, etc.)

### **Appearance is Everything:**

- Dress practically. Wear clothing that allows you to move freely and wear comfortable walking shoes.
- Avoid wearing expensive jewelry or accessories.
- Walk with confidence and purpose – head up, eyes forward.
- Keep your purse or wallet out of sight or lock them in the trunk. Keep car keys handy at all times.

### **Protect Your Health:**

- Learn about any situations that might jeopardize your health. Use universal health precautions.
- Carry sanitary wipes or antibacterial lotion.

### **Know Where You Are Going:**

- Plan your route and carry maps.
- Learn about the neighborhood you will be visiting.
- Go with assistance if you're concerned (law enforcement or another social worker).
- Consider asking law enforcement to do a "Welfare Check".
- Visit areas of high-risk early in the day.
- Let people know where you are going: Give location, name of consumer, license plate of your vehicle, and time you are expected to leave location with a supervisor or co worker.
- Don't carry any weapons. (In case of emergency, pens, clipboards, keys, etc. could be used for protection.)
- Have supervisor or co-worker make a safety check phone call every 10-15 minutes.

### **Before You Get Out of the Car:**

- Check out the neighborhood as you drive in.
- Drive around the block, try and see what is happening behind the house.
- If you don't feel safe, don't get out of the car. Leave.
- Park in a visible area as close to the consumer's residence as possible.
- Think about an escape route.

### **Getting to the Door:**

- Lock your car.
- Be prepared to drop items you are carrying.
- Do not stop to speak to strangers. If you must respond, keep walking.

Before entering a fenced yard, make noise to see if any animals are present.

Don't enter the home if an animal threatens your safety (ask the consumer to secure the animal). After knocking, stand away from the door and to one side if possible – hinge side is best for providing protection.

In an elevator, stand near the control panel. Leave the area if your instincts tell you to.

#### **Entering the Consumer's Home:**

Follow consumers up the stairs. Do not let them behind you. Scan the inside of the consumer's home before entering.

Once in the home, look around for signs of dog. Ask if the dog is safe/friendly if it is locked up. Don't enter the home if you suspect that the consumer is under a chemical influence.

Try to make eye contact with anyone present.

Sit near an exit door and be prepared to leave at any sign of danger. Do not allow anyone between you and the door.

#### **Acknowledge Anger if it Exists:**

People may escalate their anger if they aren't sure you know it exists. Remain calm, objective and in control.

Avoid interviewing hostile people in the kitchen (knives).

Use a problem-solving approach.

#### **After the Visit:**

When returning to your car, have a co-worker or supervisor on the phone until you are in the car and on the road.

Have your keys in your hand when returning to your car.

Check the inside of your car before getting in.

Document any unusual or unsafe conditions.

Discuss concerns with your supervisor.

Develop strategies to address concerns for future visits.

#### **Vehicle Safety:**

Always check your tires and gas gauge before setting out on a visit.

Park in a well lit area.

Keep doors and windows locked.

Do not leave anything on the seat of the car. Put all items in a trunk prior to arriving at your destination.

#### **If a Crisis Arises:**

Talk softly.

Try to keep calm.

Tell the person you are expected elsewhere or a co-worker has been instructed to call for help if you are not out at an agreed time.

## SOME SUGGESTIONS ABOUT DOGS

### What to do when approached by or you approach a strange dog:

- Treat all breeds the same – all dogs bite.
- NEVER look the dog in the eye.
- NEVER pat the dog on top of its head.
- Don't give the dog undue attention.
- Be aware of your body language and voice tone
  - (do/say nothing threatening).
- Older dogs are more likely to bite.
- NEVER turn your back on a dog or run away (walk slowly).



### What to do when approached by an apparently vicious dog:

- Don't get out of your car if you're already in it.
- Do nothing that seems threatening to the dog. This includes spraying with pepper spray.
- Throw dog treats and/or tennis balls to distract the dog.
- Protect your face and neck. Do not play dead.
- Larger breeds have larger mouths.
- If bitten, go to your doctor. Bites must be reported to the Humane Society.





## INTERVIEW SKILLS

### **Establishing Rapport – Warmth, Empathy and Genuineness**

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

### **General Interviewing Skills**

**Before the Interview** – review the case and think about the possible things you will need to assess with this consumer. Are there any cues from the initial information that help you to come up with an approach

to the interview? For example: Is the consumer a native English speaker, blind, mentally-impaired?

### **Pre-interview Planning – Be Prepared**

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

### **Meeting the Consumer – Establish Rapport**

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

### **Begin Assessment Interview – Explain Process**

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

### **Concluding the Interview**

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

## CHOOSING THE RIGHT QUESTIONS

### **Direct or Closed-ended Questions –**

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

### **Open-ended Questions –**

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

### **Indirect Questions –**

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

## OPEN-ENDED QUESTIONS FOR INTERVIEWS

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

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

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

## OTHER ASSESSMENT CUES

### Non-verbal Assessment Cues:

#### Your Body Speaks Your Mind

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

#### Eye Contact

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

#### Facial Expressions

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

#### Body Positioning

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

### Environmental Cues:

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

### Sensory Cues:

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



## CLARIFYING INFORMATION

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

### 1. Conflicting information.

- What is observed is not consistent with information given  
For example, consumer says she can't feed herself but she has been knitting, an activity that demonstrates manual dexterity. Perhaps the consumer's difficulty is in lack of strength; probing questions would be needed to tease out the basis of the statement that she cannot feed herself. Also, consider good days versus bad days. You may be seeing the consumer whose condition and abilities fluctuate.
- What the consumer says is inconsistent  
For example, he says that he has no trouble bathing himself and he tells you that he is unable to walk without someone's constant assistance because he can't hold onto the handrails of a walker or a cane and he's unsteady on his feet. Perhaps the consumer who is at risk of falling is extremely modest and doesn't want anyone to see his naked body.
- What the consumer says and the family says are in conflict.  
For example, the consumer says that he needs no help in dressing. The daughter with whom he lives and who is also his primary caretaker says that she dresses him every day. Probing questions are needed to determine whether the daughter is dressing her father because it's faster than to let him do it himself or if he is unable to dress himself. Issues to be considered would include his ability to reach, balance when standing, and perform tasks that require manual dexterity such as buttoning and zipping.

### 2. Unrealistic expectations of the program.

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

### 3. Safety issues.

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

## **How to Probe to Clarify Information**

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

1. Paraphrasing – Feedback the consumer's ideas in your own words. For example, the consumer says that he doesn't go to church anymore because he can't be far from a toilet after taking his diuretic. You say, "I see, you take a diuretic in the morning and have to be close to the toilet. How long does that last?"
2. Stating your observations – Tell the consumer your observations about his behavior, actions and environment to find out if they are on target. For example, if you see that he can't get out of the chair without help, say so.
3. Demonstration – Have the consumer to show you an activity. For example, you wonder how well the consumer transfers. You ask the consumer to show you the apartment. That gives you the opportunity to see the consumer transfer without specifically asking the consumer to demonstrate.
4. Asking clarifying questions – These questions are questions that get to details. For example:
  - "What do you mean by that? You said that you were tired a lot; tell me what the mean to you." If the consumer doesn't explain what they mean it is open to interpretation.
  - "Could you explain that, tell me more about that?"
  - "I'm not sure I understand." The simply directs the consumer's comments by letting him know you do not understand.

## HANDLING DIFFICULT SITUATIONS

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

1. The angry consumer – It is best to try to handle the anger at the beginning of the interview. This shows the consumer you care, and aren't there just to get your agenda accomplished. It never helps to ignore the anger; it will be a constant barrier to getting useful information.
  - Acknowledge the anger by gently confronting the consumer by saying something like, "You seem very upset and I am not sure why. Could we talk about what is upsetting you before we start?"
  - To get an angry person to open up explain (or re-explain) your purpose and that you need them to help you so you can best understand their needs and how the program can help them.
2. The consumer who is very sad / grieving – If the consumer is overcome by sadness and starts to cry.
  - Don't ignore or pretend they are not upset, crying. In some cases, it may not be obvious about the reasons for the sadness/grief, which may not become apparent until you ask a specific question that triggers the grief/sadness. Be direct but polite and sensitive. Let them talk briefly about the reason for the sadness/grief. You may say something like, "I'm sure that is very difficult for you", or "I'm sorry."
  - Try to be reassuring and let them know it is safe to express their feelings. A comment like, "It is OK to cry; we all cry," or, "I understand," can be effective.
  - Validate the situation by saying something like, "I have had other consumers who have the same reaction. It is hard." or, "These are difficult issues you're dealing with, it is very normal."
  - If the consumer is too distraught about a recent death or other stressful event to focus on the issues you need to discuss for your assessment, it might be most appropriate to offer to reschedule the interview.
3. The consumer who rambles without focus – These consumers often want to tell long stories and often have a difficult time getting to 'the point'.
  - Remind the consumer of the goal of the interview. "That is very interesting Mrs. Jones, I really need to find out the details of how you get along each day so that I can help you get the services that you need. Can you tell me specifically how you prepare your meals?"
  - Rephrase the question in a more closed ended question, "I understand there have been many issues with your personal care. Do you need help with bathing?", if so you can then probe for specifics.
4. The consumer who answers with only a word or two – This can be very difficult because without information it is hard to get a good picture of the consumer's need.
  - Use open ended questions to try to get the consumer to give you a better picture.
  - Ask the consumer to paint you a picture of their day, "tell me what your day normally looks like." It is difficult to answer a question like this with one or two words and may get them to open up, or will allow you opportunities to probe for further information.

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

Communication blocks:

- Hearing difficulties –
  - o Ask the consumer if they have a hearing aide. If they do check to see if it is in and if it is on. If the consumer cups his/her hand over the ear, the hearing aid will whistle if it is turned on.
  - o Talk slowly without jargon.
  - o If the person doesn’t seem to understand, paraphrase yourself.
  - o Ask if one ear is better than another and position yourself on that side.
  - o You may need to follow up with a family member to get clarification of information.
- Language barriers –
  - o If they understand and speak some English make sure you go slowly, give them plenty of time to think of their answers and do not compound your questions.
  - o Follow State regulations (MPP 21-115) and county procedures to arrange for an interpreter if the consumer does not speak English and you do not speak his/her language.

## COMMUNICATING IN DIFFICULT SITUATIONS

1. Listen for full understanding of the person's perspective. Allow them the opportunity to give you a clear picture of what they are trying to say.
2. Put the person at ease using non-verbal cues that show interest and concern.
3. Take the time you need to really understand the situation. In the long run, spending a few more minutes now will save time in avoiding conflict.
4. Respond to concerns the consumer may have in an affirming manner. Restate their concerns in a way that shows you have heard their issues.
5. Focus on the overall goal of the situation. Avoid personalization of the issues. Keep the conversation professional.
6. Understand what you do Today will have an Effect on Tomorrow. The more effective you are in dealing with the issue at hand, the less the issue will grow and consume your energies.

## HANDLING HOSTILITY

The following are suggestions for handling consumer hostility:

1. Don't get angry or defensive. Recognize your own reactions. Remember that this is a professional, not personal, issue.
2. Don't patronize or lecture. Saying things such as, "why don't you just calm down" will only escalate the problem and is disrespectful to the consumer.
3. Allow the consumer to voice his/her concerns. Respond with acceptance and understanding. Be empathetic. Listen to understand the situation from the consumer's perspective.
4. Be positive – don't attack them. Show them respect for their discomfort.
5. Greet anger with calmness – set the mood for calm discussion and resolution.
6. Understand the facts regarding the situation that is upsetting the consumer. If you don't have the facts, state what you will need to find out and when you will get back to them.
7. Focus on present and future. Avoid allowing the consumer to get stuck in the past. Emphasize what can be done positively in the future, not what has happened in the past.
8. Ask questions – "How can I help?" Often the consumer knows what they want from you. If you understand their wants you will be able to discuss future possibilities with that in mind.
9. Summarize for clarification and understanding.
10. Be honest about your next steps. If you can't fix the problem outright, don't make promises that you cannot keep. If there are consequences to the behavior, let the consumer know.

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

## **THINGS TO CONSIDER WHEN DEALING WITH SOMEONE WHO IS HOSTILE**

1. Try to evaluate as honestly as you can by reasoning with yourself whether his/her anger is justified.
2. Put hostile people in perspective. You are probably nothing but an afterthought to them, so don't take their antics personally. They're not concerned about you because they're too busy worrying about themselves.
3. Take your pick – positive or negative. You cannot concentrate on constructive, creative alternatives or solutions while you cling to negative feelings. Vent your emotions to a fellow worker or your supervisor and cool off. Think about the result you really want, the consequences or outcome that will benefit the consumer the most.
4. Don't expect hostile people to change. They will not, and in a way that is good because their behavior is predictable. They may not change but by choosing a better approach you can change the outcome.
5. Learn to respond as well as listen. Ask questions instead of making accusations. If you let others save face, you give them room to change their minds.
6. Request feedback. Use open-ended questions to let emotional people vent their feelings before you try to reason with them and explore options.
7. Be straightforward and unemotional. The more you remain calm and matter-of-fact, the sooner you gain another's confidence. People want to feel you are leveling with them, that they can trust you. Remember that respect from other begins with self-respect.
8. Be gracious. Someone else's rudeness does not give us the right to be rude. Treat the other with the kindness you would like to be shown and allow them to feel important. When our own egos are healthy, we are rich; we can afford to be generous.

## SHARED LIVING PRORATION CHART

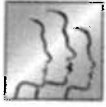
Living Arrangement	Related Services				
	Domestic/Heavy Cleaning	Meal Preparation/ Meal Cleanup	Laundry	Food Shopping	Other Shopping/ Errands
<b>Lives only with A/A Spouse</b>	<b>Not prorated - MPP 30-701(s)(2) provides that a shared living arrangement does not exist if consumer resides only with A/A Spouse</b>				
<b>Lives with A/A Spouse and Others, or Spouse not A/A</b>	Follow Shared Living rules <b>MPP 30-763.31</b>	Follow Shared Living rules <b>MPP 30-763.32</b>	Follow Shared Living rules <b>MPP 30-763.32</b>	Follow Shared Living rules <b>MPP 30-763.32</b>	Follow Shared Living rules <b>MPP 30-763.32</b>
<b>Shared</b>	<ul style="list-style-type: none"> <li>Assess need in room(s) used exclusively by consumer.</li> <li>No need assessed in rooms used exclusively by others.</li> <li>Determine consumer's share of rooms used in common.</li> </ul> <b>MPP 30-763.31</b>	When need is met in common, divide household need by all housemates involved. <b>MPP 30-763.32</b>	When need is met in common, divide household need by all housemates involved. <b>MPP 30-763.32</b>	When need is met in common, divide household need by all housemates involved. <b>MPP 30-763.32</b>	When need is met in common, divide household need by all housemates involved. <b>MPP 30-763.32</b>
<b>Live-in Provider</b>	<ul style="list-style-type: none"> <li>No need assessed in rooms used solely by provider.</li> <li>Assess need in rooms used by consumer.</li> <li>Determine consumer's share of rooms used in common.</li> </ul> <b>MPP 30-763.471</b>	Prorate if provider and consumer agree and need met in common. <b>MPP 30-763.471</b>	Prorate if provider and consumer agree and need met in common. <b>MPP 30-763.471</b>	Prorate if provider and consumer agree and need met in common. <b>MPP 30-763.471</b>	Prorate if provider and consumer agree and need met in common. <b>MPP 30-763.471</b>
<b>Consumer moves in with relative to receive IHSS</b>	Need is assessed only in room used solely by consumer. <b>MPP 30-763.43</b>	Follow Shared Living rules <b>MPP 30-763.32</b>	Follow Shared Living rules <b>MPP 30-763.32</b>	Follow Shared Living rules <b>MPP 30-763.32</b>	Follow Shared Living rules <b>MPP 30-763.32</b>
<b>Landlord/Tenant (Consumer is Tenant)</b>	Need is assessed only on the living area used solely by the consumer. <b>MPP 30-763.421</b>	Follow Shared Living rules taking into account any services landlord is obligated to perform under the rental agreement <b>MPP 30-763.32; 30-763.421</b>			
<b>Landlord/Tenant (Consumer is Landlord)</b>	Need is assessed for all living areas not used solely by the tenant. <b>MPP 30-763.422</b>	Follow Shared Living rules taking into account any services tenant is obligated to perform under rental agreement. <b>MPP 30-763.32; 30-763.422</b>			

**Note:** When prorating services, the natural or adoptive children of the consumer who are under 14 are not considered (MPP 30- 763.46). Other children in the household (i.e., grandchildren, nieces, nephews, etc.) under 14 are considered.



## SHARED LIVING PRORATION CHART

Living Arrangement	Personal Care Services/ Paramedical Services	Accompaniment to Medical Appts./ Alt. Resources	Teaching/Demonstration	Yard Hazard Abatement/ Removal of Ice/Snow	Protective Supervision
Lives only with A/A Spouse	Not prorated - MPP 30-701(s)(2) provides that a Shared living arrangement does not exist if consumer resides only with A/A Spouse				
Lives with A/A Spouse and Others, or Spouse not A/A	Not prorated <b>MPP 30-763.351</b>	Not prorated <b>MPP 30-763.351</b>	Prorate, if feasible, if consumers live together and have a common need which is met in common. <b>MPP 30-763.34</b>	Not assessed unless one or more of following apply to all housemates: <ul style="list-style-type: none"> <li>Other IHSS recipients unable to provide</li> <li>Other persons physically or mentally unable</li> <li>Children under age 14</li> </ul> <b>MPP 30-763.34</b>	<b>MPP 30-763.33</b>
Shared	Not prorated <b>MPP 30-763.351</b>	Not prorated <b>MPP 30-763.351</b>	Prorate, if feasible, if consumers live together and have a common need which is met in common. <b>MPP 30-763.34</b>	Not assessed unless one or more of following apply to all housemates: <ul style="list-style-type: none"> <li>Other IHSS recipients unable to provide</li> <li>Other persons physically or mentally unable</li> <li>Children under age 14</li> </ul> <b>MPP 30-763.34</b>	<b>MPP 30-763.33</b>
Live-in Provider	Not prorated <b>MPP 30-763.351</b>	Not prorated <b>MPP 30-763.351</b>	Prorate, if feasible, if consumers live together and have a common need which is met in common. <b>MPP 30-763.34 &amp; 30-763.471</b>	Not prorated <b>MPP 30-763.471</b>	<b>MPP 30-763.33</b>
Consumer moves in with relative to receive IHSS	Not prorated <b>MPP 30-763.351</b>	Not prorated <b>MPP 30-763.351</b>	Prorate, if feasible, if consumers live together and have a common need which is met in common. <b>MPP 30-763.34</b>	No need assessed <b>MPP 30-763.43</b>	<b>MPP 30-763.33</b>
Landlord/Tenant (Consumer is Tenant)	Not prorated <b>MPP 30-763.351</b>	Not prorated <b>MPP 30-763.351</b>	Prorate, if feasible, if consumers live together and have a common need which is met in common. <b>MPP 30-763.34</b>	No need assessed <b>MPP 30-763.421</b>	<b>MPP 30-763.33</b>
Landlord/Tenant (Consumer is Landlord)	Not prorated <b>MPP 30-763.351</b>	Not prorated <b>MPP 30-763.351</b>	Prorate, if feasible, if consumers live together and have a common need which is met in common. <b>MPP 30-763.34</b>	Not prorated unless tenant agrees to provide as part of rental agreement. <b>MPP 30-763.422</b>	<b>MPP 30-763.33</b>



**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](http://www.cdss.ca.gov)



**ARNOLD SCHWARZENEGGER**  
GOVERNOR

June 30, 2009

ALL-COUNTY LETTER NO.: 09-30

REASON FOR THIS TRANSMITTAL

- ☐ 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 CAPI PROGRAM MANAGERS

SUBJECT: PHASE ONE IN-HOME SUPPORTIVE SERVICES (IHSS) SOCIAL  
WORKER TRAINING QUESTIONS/COMMENTS AND ANSWERS

REFERENCE: ALL-COUNTY LETTER (ACL) NO. 08-18, ISSUED APRIL 23, 2008

The purpose of this All County Letter (ACL) is to clarify or correct some of the answers provided in the referenced ACL. Since the release of ACL 08-18 in April of 2008, we have received several questions concerning services, assessments, and the definition of marriage. Some answers previously provided have been reexamined and are presented in the attached pages, either clarified or corrected. For those responses that are corrected, this current ACL is to be considered the current guideline. Please disregard any conflicting answers provided in ACL 08-18.

These responses are an attempt to answer general questions in very broad terms; specific situations will vary from case to case. For specific guidance on cases, or if you have any questions concerning these answers, please contact the Adult Programs Branch, at (916) 229-3494, or via e-mail at [IHSS-QA@dss.ca.gov](mailto:IHSS-QA@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

EVA L. LOPEZ  
Deputy Director  
Adult Programs Division

Attachment

c: CWDA

## **ATTACHMENT**

### **Question 5: Are Common Law Spouses considered spouses for the purposes of IHSS?**

**Clarified:** The IHSS program has two parts to its definition for spouse found in the California Department of Social Services (CDSS) Manual of Policies and Procedures (MPP) Section 30-701(s)(4). The second part of the definition, "legally married under the laws of the state of the couple's permanent home at the time they lived together" (legally married criteria), is intended only to determine whether or not services are provided by a spouse. This determines which program is appropriate, the Personal Care Services Program (PCSP), which prohibits a recipient's spouse from acting as the provider, or the IHSS Plus Waiver (IPW), which does not.

For *all* other purposes, including the assessment of hours for services, especially when assessing hours for Domestic and Related services, all three sub-programs apply the IHSS Residual (IHSS-R) definition. The IHSS-R definition is the first part of MPP Section 30-701(s) (4), and defines a spouse as a "member of a married couple, or considered to be a member of a married couple for SSI/SSP purposes." The SSI/SSP definition can be found in Title 20 of the Code of Federal Regulations (20 CFR) 416.1806. It includes the holding out criteria, which is created when two unrelated people of the opposite sex are living together in the same household, and present themselves to the community (hold themselves out) as a married couple. When authorizing hours for services, an individual will be considered a spouse for the purposes of MPP Section 30-763.41 (Able and Available Spouse) whether the couple is legally married under the laws of the State, entitled to each other's Social Security insurance benefits as spouses, or a holding-out spousal relationship exists according to SSI/SSP rules.

This is based in part on Welfare and Institutions Code Sections 14132.95(f), (i) and 14132.951(e), which indicate that determination of need and authorization for services for PCSP and IPW cases shall be performed in accordance with IHSS-R rules.

#### **Example:**

A social worker is evaluating an IHSS application for an FFP Medi-Cal recipient who will receive services from his "Common Law Spouse" who meets the holding out criteria. The applicant does not meet the legally married definition, and thus is eligible for services under PCSP instead of IPW. The social worker then begins assessing hours for services. The assessment will show that the need for Domestic and Related services is met by an alternative resource because the couple meets the holding out criteria and the Able and Available Spouse exceptions listed in MPP Section 30-763.41 are applicable.

**Question 10: Can Meal Preparation and Meal Clean-up be performed outside of the recipient's home?**

**Corrected:** To the extent feasible, services shall be provided in the recipient's home, per MPP Sections 30-700.1, 30-701 (o) (2), 30-755.11, and 30-780.2 (b). There are unusual circumstances which could occasionally arise, necessitating that Meal Preparation and Meal Clean-Up services temporarily take place outside of the recipient's home. Should such circumstances arise, measures should be adopted as necessary to ensure that authorized services are provided without interruption. It is assumed that Meal Preparation and Meal Clean-Up services provided outside the recipient's home, if required at all, would be a temporary solution to a situation such as a broken stove or clogged sink in the recipient's home, and not the regular means of providing those services. No time can be added for delivering meals prepared elsewhere.

**Question 12: Is there a Rank 6 for Bowel and Bladder?**

**Clarified:** No, rank 6 is not used for Bowel and Bladder. The recipient should be ranked from one to five based on level of function, irrespective of any related Paramedical services.

**Question 20: Can the maintenance exercise of assistive walking (MPP 30-757.14(g) (2) (A)) be performed outside of the recipient's home?**

**Corrected:** Yes, assistive walking as part of a maintenance program can be performed outside the home; however no time can be authorized for travel or assistance into or out of a vehicle for this service.

**Question 24: How do we assess people with seizures who are unable to do anything after they have one?**

**Clarified:** Time assessed in that scenario would be based on the frequency of seizures; severity of seizures, as well as the need for IHSS covered services during the seizures and seizure recovery periods. Thorough and accurate case documentation is crucial. A recipient may experience seizures and have varying degrees of need for IHSS covered services, and it is expected that, though hours are authorized based on a realistic worst case scenario, the provider's timesheet will accurately reflect hours for services actually provided.

**Question 25: How do we assess stand-by time?**

**Clarified:** We do not assess stand-by time. A recipient should be assessed and authorized that amount of time which is needed to provide the level of assistance required for authorized services.

**Question 30: Can the provider provide services to the recipient while the recipient is temporarily absent from the home?**

**Clarified:** Under some circumstances, yes. There are services which are necessarily provided outside the home, such as Accompany to Medical Appointments and Alternative Resources, Laundry when no laundry facilities are available in the home, Food Shopping, and Other Shopping and Errands. If, in the course of accompaniment to a medical appointment, the recipient needs assistance with Dressing, or Bowel and Bladder, it is conceivable that personal care services could be performed outside the home. Common sense and clear case documentation will be important in answering this question on a case by case basis.

**Question 36: Can we accept a mental health diagnoses from other medical professionals or should the diagnoses be provided by mental health professionals only?**

**Corrected:** We can accept a diagnosis from any medical professional who is acting within the scope of his or her license. Service hours are authorized based on assessed need, never solely based on a diagnosis. Mental function shall be assessed in accordance with MPP Section 30-756.37. While any diagnosis may be accepted and considered in the course of the process, the diagnosis would only be considered as a part of the whole, in conjunction with the social worker's observations.

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, Sacramento, CA 95814



April 23, 2008

ALL-COUNTY LETTER NO. 08-18

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

**REASON FOR THIS TRANSMITTAL**

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☒ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS

**SUBJECT: PHASE ONE IN-HOME SUPPORTIVE SERVICES SOCIAL WORKER TRAINING QUESTIONS/COMMENTS AND ANSWERS**

The purpose of this All-County Letter (ACL) is to provide policy clarification to the attached questions/comments that were raised throughout the course of Phase One training of the In-Home Supportive Services (IHSS), Social Worker Training Academy (SWTA) conducted by the California State University, Sacramento (CSUS), College of Continuing Education (CCE). The California Department of Social Services (CDSS) contracted with CSUS to develop and deliver training curricula, materials, and work aids as mandated by Welfare and Institutions Code (WIC) Section 12305.72, enacted by Senate Bill 1104 (Chapter 229, Statutes of 2004) that requires ongoing statewide training pertaining to IHSS activities.

The SWTA was established in the summer of 2005. Phase One training was held September through December of 2005. Subsequently, Hourly Task Guidelines regulations were implemented as of September 2006, and some of the questions and answers have been updated for consistency with these regulations. Attached are updated additional questions/comments and answers resulting from the Phase One segment of the SWTA.

If you have any questions regarding this ACL, please contact the Adult Programs Branch, at (916) 229-4000 or via e-mail at [IHSS-QA@dss.ca.gov](mailto:IHSS-QA@dss.ca.gov).

Sincerely,

**Original Signed By****Eva L. Lopez****EVA L. LOPEZ**

Deputy Director

Adult Programs Division

Attachment

c: CWDA

## **ATTACHMENT A**

### **SOCIAL WORKER TRAINING ACADEMY PHASE ONE ANSWERS TO QUESTIONS/COMMENTS**

**1. Q: Are there plans to implement an open flow of information regarding the State's Quality Assurance (QA) activities and the counties?**

A: Yes. Currently the In-Home Supportive Services (IHSS) QA website contains meeting notes from all of the QA workgroups which were utilized in developing QA policies and implementation strategies. It also contains links to forms and other pertinent resources, tools, and program information. The website can be accessed at: <http://www.cdss.ca.gov/agedblinddisabled/>. The California Department of Social Services (CDSS) will continue to provide information regarding the State's QA activities on the website.

**2. Q: Is there a minimum number of assessed hours required in order to receive IHSS?**

A: There is no minimum number of hours required to authorize a case for IHSS. The regulations at the Manual of Policies and Procedures (MPP) Section 30-761.1 specify the conditions to be eligible for services which include meeting specific eligibility requirements and having a needs assessment to determine the services that would enable an individual to remain safely in his/her home without regard to any minimum standard of time.

**3. Q: Can hours be increased for services which have time per task guidelines if a social worker believes the recipient will not be safe with the hours assessed under the time guideline?**

A: Yes. The social workers have the responsibility to assess hours based on the recipient's needs. In accordance with Welfare and Institutions Code (WIC) Section 12301.2, time per task guidelines can be used only if appropriate in meeting the individual's particular circumstances. Exceptions to time per task guidelines shall be made when necessary to enable the recipient to establish/maintain an independent living arrangement and/or remain safely in his/her home or abode of his/her own choosing. When an exception to a time per task guideline is made in an individual case, the reason for the exception shall be documented in the case file. Hourly task guidelines regulations, which include exception criteria, were implemented September 1, 2006. These regulations are located at MPP Section 30-757 and were transmitted to counties by All-County Letter (ACL) 06-34 which included implementing instructions and subsequent Errata.

**4. Q: What is the ranking for a recipient with an “able and available spouse”? Do social workers rank as usual based on the recipient’s functional ability? In the past, some have been ranked as a Rank 1 because no hours were authorized for Domestic and Related chores.**

A: Functional Index (FI) scores should always be ranked based on the recipient’s functional ability (MPP Section 30-756.1) regardless of whether the spouse is “able and available.” The assessed time is listed under “Total Need” on the SOC 293. If the recipient lives with an “able and available spouse,” Domestic and Related Services are shown as being met under an “Alternative Resource” and no time is listed under “Authorized to Be Purchased.”

**5. Q: Are Common Law Spouses considered spouses for purposes of IHSS?**

A: In accordance with MPP Section 30-701(s) (4), a spouse is defined in accordance with the Supplemental Security Income/State Supplementary Program (SSI/SSP) definition (42 USC Section 1382c (d)). For purposes of SSI, a spouse is someone: (1) legally married under the laws of the state where the permanent home is located; (2) entitled to husband or wife’s Social Security Insurance benefits as the spouse of the other; or (3) persons of the opposite sex living together in the same household holding themselves out to their community as husband and wife. Therefore, if any of the above circumstances apply, the person would be considered a spouse for purposes of IHSS. However, for purposes of determining Personal Care Services Program (PCSP) and Independence Plus Waiver (IPW) eligibility, MPP Section 30-701(s)(4) defines a spouse more narrowly as a person legally married under the laws of the state of the couple’s permanent home at the time they lived together.

**6. Q: If SSI still shows a couple as married, yet the recipient has divorce documents in hand, are they considered an “able and available spouse” for IHSS purposes until they show up divorced in SSI system?**

A: Consult with county counsel to determine if the Divorce Decree is a valid final Decree. If so, the recipient should not be considered married for IHSS purposes. Additionally, the recipient should be referred to Social Security Administration (SSA) for the SSA to make the appropriate change.

**7. Q: We have a recipient who is legally married. His spouse moved out of the house, yet continues to be his IHSS provider. Do the “able and available spouse” regulations apply in this case?**

A: No. Per MPP Section 30-763.4, the “able and available spouse” regulations under MPP Section 30-763.41 only apply in a shared-living situation where the spouses live together. If a spouse is living outside the home and still desires to be the IHSS



provider, the “able and available spouse” regulations do not apply. (See MPP Sections 30-763.3 and 30-763.4.)

**8. Q: Would children who are not the recipient’s children living in the home that are under the age of 14 be counted in household composition?**

A: Children who are not the recipient’s children living in the home (regardless of age) would be counted in the household composition for purposes of proration for Domestic and Related services. Only children of the recipient (not grandchildren, foster children or other minor relatives for whom the recipient may have guardianship) are excluded (MPP Section 30-763.46). The CMIPS Manual, Page V-A-12, Field G2 defines Number in Household as “The total number of people living in the recipient’s household, including other IHSS recipients. Exclude recipient’s non-IHSS children under 14 years of age.”

**9. Q: Is there a written regulation addressing the issue of a parent provider signing time sheets for the minor child?**

A: The MPP regulations do not address this particular issue. However, the CMIPS Users Manual, Section VII, Page H-2, Section D reads: “A parent provider of a minor child may sign the time sheet.”

**10. Q: Can Meal Preparation and Meal Cleanup be performed outside of the recipient’s home?**

A: Meal preparation and cleanup must be done in the recipient’s home. It is inferred from the language of the statute and regulations that the intent is to provide these services in the home of the recipient.

**11. Q: If an IHSS recipient chooses to eat meals separately from other family members residing in the home, must the IHSS recipient’s needs be prorated unless the recipient has a health and safety need requiring his/her meals to be prepared separately?**

A: No, these services do not have to be prorated. MPP Section 30-763.32 discusses when it is appropriate to prorate related services, which includes meal preparation. The regulation states that meal preparation should not be prorated, “when the service is not being provided by a housemate and is being provided separately to the recipient.” This regulation does not speak to the issue of a housemate preparing separate meals. However, the intent of the regulation is to prorate hours when the needs of multiple persons are being met. When a housemate prepares food it does not automatically follow that the food prepared is meeting the needs of multiple individuals. Therefore, when a housemate prepares food separately for a recipient, the hours are not prorated because they are not meeting multiple needs. The

regulation does not require that there be a health and safety reason for the recipient to eat meals separately. Consequently, the recipient may have meals provided separately in this situation solely because he/she chooses to eat separately.

**12. Q: Is there a Rank 6 for Bowel and Bladder?**

A: No. Bowel, Bladder and Menstrual Care are Ranks 1 through 5, with Rank 1 being "independent" and able to manage Bowel, Bladder and Menstrual Care with no assistance from another person. Rank 5 requires physical assistance in all areas of care (MPP Section 30-756.35). If the recipient's Bowel and Bladder needs include catheter insertion, ostomy irrigation, or a bowel program; they are assessed as Paramedical Services (MPP Section 30-757.191(c)).

**13. Q: The Paramedical form (SOC 321) needs revision, as it is unclear and many doctors do not understand the IHSS definition of Paramedical services. Can the county fill out the form for the physician to sign for completion if he/she concurs?**

A: The CDSS has modified the Paramedical form (SOC 321) for clarity. The new version was released in April 2006. Counties may have social workers identify the IHSS Paramedical services by filling out the form and then having the physician sign for completion. Additionally, some counties with Public Health Nurses (PHNs) have their PHNs contact the recipient's physician's office and speak with his/her nurse to explain the SOC 321 form and suggest timeframes for the Paramedical Services being requested. The PHN then faxes a partially completed SOC 321 to the doctor's office where she/he can review and sign it for completion. The fact the physician signs as the appropriate licensed health care professional complies with the requirements of MPP Section 30-757.19.

**14. Q: Do we need a Paramedical form annually even if the recipient has no change in Paramedical needs?**

A: At this time, renewing the Paramedical form (SOC 321) is not required annually. However, it should be a county "best practice" to insure that the Paramedical form is reviewed at each reassessment for any health changes (improvements or deteriorations). The ending dates (if any) of authorized Paramedical Services should also be noted.

**15. Q: Is toenail clipping for the recipient an eligible task in the IHSS program?**

A: No, toenail clipping is not a covered service by IHSS. According to the California Code of Regulations regulation Section 51183 (a) (2) and Section 51350 (f), grooming includes fingernail and toenail care, but excludes cutting with scissors or clipping toenails. Therefore, for consistency, the toenail care specified at MPP

Section 30-757.14 (e), does not include cutting with scissors or clipping toenails. Toenail cutting or clipping is covered under Medi-Cal when performed by a Podiatrist and if it is a medical necessity.

**16. Q: Is brushing teeth considered a Paramedical Service?**

A: No, brushing teeth is considered "oral hygiene" and would be assessed under Bathing, Oral Hygiene and Grooming (MPP Section 30-780.1(a) (2)). Paramedical Services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional (MPP Section 30-757.191 (c)).

**17. Q: Is crushing pills into food/liquid due to dysphasia considered Paramedical?**

A: Yes. Paramedical Services are activities which due to the recipient's physical or mental condition, are necessary to maintain the recipient's health (MPP Section 30-757.191). The services may include administration of medications, puncturing the skin, inserting a medical device into a body orifice, activities requiring sterile procedures or other activities requiring judgment based on training given by a licensed health care professional.

**18. Q: Where on the SOC 293 is time for catheter insertion authorized?**

A: Time for catheter insertion is authorized as a Paramedical Service (MPP Section 30-757.19). The recipient's FI score would be ranked on the H Line under Bowel, Bladder and Menstrual Care. If the recipient is "independent" in bowel movements and all urination is done with the catheter, the recipient would rank a "1" in Bowel, Bladder and Menstrual Care. However, if the recipient uses intermittent catheterization and urinates between those catheterizations (number of times a day), the recipient's dependence with urination and with bowel movements would affect the recipient's FI ranking in Bowel, Bladder, and Menstrual Care.

**19. Q: Can time be authorized for a provider to "shadow/follow" the recipient for ambulation if they have an unsteady gait or experience dizziness?**

A: Yes. County staff would determine the recipient's level of ability and dependence upon verbal or physical assistance by another (MPP Section 30-756.1). If a recipient has an unsteady gait or experiences dizziness, the social worker would not assess him/her as "independent" in these tasks and time for assistance with ambulating. Per ACL 06-34, the regulations at MPP Section 30-757.14 (k), as well as the Annotated Assessment Criteria, describe "Ambulation inside" as assisting a recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or

descending stairs; moving and retrieving assistive devices such as a cane, walker, or wheelchair, etc; and washing/drying hands before and after performing these tasks. Ambulation also includes assistance to/from the front door to the car (including getting in and out of the car) for medical accompaniment and/or alternative resource travel. As taught in Phase One of the training, county practices should be followed in communicating with the recipient's doctor about prescribing Durable Medical Equipment (DME).

**20. Q: Can the maintenance exercise of assistive walking (MPP 30-757.14(g)(2) (A)) be performed outside of the recipients home?**

A: Yes, the maintenance exercise of assistive walking can be provided outside the recipient's home if necessary to meet the needs of the recipient. In accordance with MPP Section 30-757.14 (g) (2) (A) and MPP Section 30-780.1(a) (5) (B) "such exercises shall include the carrying out of maintenance programs, i.e., the performance of repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking." Usually, the carrying out of maintenance programs including assistive walking can be accomplished on the recipient's premises. If not, then other locations may be utilized if they are necessary and reasonable. However, if the maintenance therapy/exercise takes place away from the home, no travel time may be authorized, although time for assistance into and out of a vehicle may be authorized under MPP Section 30-757.15.

**21. Q: When doctors request exercise, is it authorized under Ambulation or Paramedical?**

A: It would depend on the type of health care professional providing the supervision of the exercise. If the exercise is assistive walking around inside the home, the services would be assessed as Range of Motion (MPP Section 30-757.14 (g) (2) (A)). However, if the provider is performing an exercise that requires the provider to receive training by a medical doctor or other medical professional authorized to do so, the service would be assessed under Paramedical. The controlling issue is the level of skill involved (MPP Section 30-757.19).

**22. Q: Is time allowed to accompany recipients to medical appointments that are not local?**

A: If the appointment is medically necessary and the health care professional is not local, the time to drive the recipient to the appointment and home would be allowed. The social worker needs to document the case file with the frequency and distance of the appointment (MPP Section 30-757.15). Providers may only claim this time when the services are actually performed.

**23. Q: Are translation services for medical appointments covered under the program?**

A: No. This service is not covered under IHSS.

**24. Q: How do we assess people with seizures who are unable to do anything after they have one?**

A: Assessing time for this service would be based on the severity and frequency of the seizures. Although the recipient is unable to do anything during and immediately after a seizure, the amount of time for recuperation varies. This is why accurate case documentation is crucial. Social workers should document the frequency of seizures, as well as the severity and duration of functional impairment following seizures. The amount of assistance required by the provider should also be documented. It is also important to note that the providers may only claim time for the service when it is actually performed.

**25. Q: How and where do we assess stand-by time?**

A: Stand-by is not allowed. For those recipients with a Functional Index rank of 2, which requires encouragement and reminding only, time to encourage and remind the recipient is allowed under the specific task where the recipient has this need (MPP Section 30-756.12). For example, if the recipient is ranked 2 in Feeding due to needing verbal assistance, such as reminding; the time would be assessed under Feeding. Remember when assessing time for encouragement and reminding, the provider can often be performing another task. Therefore, the assessed time may be minimal.

**26. Q: For Teaching & Demonstration, is the provider paid by IHSS to teach the recipient skills to live independently?**

A: The provider is paid to teach a particular task to the recipient so that once the recipient is trained IHSS assistance for that particular task will no longer be needed. Tasks are limited to instruction in Domestic and Related Services, non-medical personal care services, and Yard Hazard Abatement (MPP Section 30-757.18). Please note, Teaching and Demonstration is not an allowable task under the PCSP.

**27. Q: How should the counties handle recipients who are living on the riverbanks and request IHSS? They claim this is their cultural right, but they are living in the open with no shelter.**

A: The purpose of IHSS is to enable recipients to remain safely in their own "home." In accordance with MPP Section 30-755.11, "a person is eligible for IHSS who is a California resident living in his/her own home." Living in the

open with no shelter would not be considered "living safely," and the riverbank would not be considered a "home."

**28. Q: How do we deal with non-compliance (i.e., applicant/recipient will not make information available) when attempting to conduct needs assessments to determine IHSS service authorizations?**

A: If the social worker is unable to obtain the required information, the case should be closed for non-compliance, and the applicant/recipient must be sent a Notice of Action. The applicants/ recipients must provide all pertinent information to enable the county to determine eligibility and need for services (MPP Sections 30-760.1, 30-763.11 and .12).

**29. Q: When can the county close cases when there has been no provider for months?**

A: There are no regulations that allow termination or discontinuance of IHSS/PCSP services when a recipient fails to hire a provider or there is no payroll activity. The county should determine why the recipient does not have a provider and refer the recipient to the Public Authority since the recipient has been determined to have a need for services. The key is determining if the recipient has a need for services, not whether there is a provider available. In accordance with MPP Section 30-761.219, needs assessments are performed when the county has "pertinent information which indicates a change in circumstances affecting the recipient's need for supportive services." If the recipient does not hire a provider, that may be an indication that the recipient's physical/mental condition or living/social situation has changed and the county may conduct a reassessment. The reassessment will establish the need for continued services.

**30. Q: Can the provider provide services to the recipient while the recipient is temporarily absent from the home?**

A: Yes, provided the service has been authorized, the provider is in the accompaniment of the recipient, and/or the absence is not precluded by the out-of-state absence requirements at MPP Sections 30-770.444 and .461.

**31. Q: Is there a limit to the number of providers a recipient can have?**

A: There are no regulations that limit the number of providers that a recipient can have. Time is authorized based on the recipient's needs without regard to the number of providers, and for this same reason, no additional time can be authorized on the basis of multiple providers.

**32. Q: Can an individual who is not the parent of a minor have a full-time job and still work as a full-time IHSS provider?**

A: The regulations do not prohibit a provider from working another job. However, the provider must complete and submit a timesheet (SOC 361) verifying that all of the reported service hours claimed were performed. There may be a reason to question whether hours are actually provided or are provided appropriately to meet the needs of the recipient. It may be appropriate to evaluate the adequacy of the plan or to make appropriate referrals related to possible fraud or client neglect.

**33. Q: Can counties require a yearly medical form if a recipient's condition is not likely to change?**

A: Although some counties may request that their social workers obtain a yearly medical form, it is not a State requirement. However, as part of the reassessment, the social worker should assess whether the medical information beyond a year is sufficient to determine the recipient's condition has not changed (improvements or deteriorations) and whether or not the recipient can still remain safely in his/her home with or without specific IHSS service needs. Pursuant to MPP Section 30-761.13, social services staff must have face-to-face contact with the recipient in the recipient's home at least once every 12 months to determine the recipient's level of need which would enable the recipient to remain safely in his/her own home.

**(Note: The face-to-face may be beyond 12 months if the county has opted to extend the reassessment up to six months based on the requirements of MPP Section 30-761.215 through .217.)** Additionally, MPP Section 30-761.263 specifies the need for services shall be based on the "available medical information."

**34. Q: How do we prorate when meals are prepared for a large group (i.e., living in a temple)?**

A: If the recipient is living with a large group, there needs to be a determination of whether the recipient is living in a community care facility or a board and care facility and, therefore, she/he might not be eligible for IHSS. In accordance with MPP Section 30-701 (o) (2), "own home" is defined as the place in which an individual chooses to reside. An individual's "own home" does not include an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or a board and care facility. However, if this is not the case and the individual is determined to be living in his/her "own home," normal proration procedures would apply as specified in MPP Section 30-763.321: "When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the recipient's need is his/her prorated share."

**35. Q: What happens when the provider claims hours after recipient's death? (Example; recipient passes away on 27th of the month and the provider claims hours up until the 30<sup>th</sup>).**

A: No services can be claimed after a recipient has passed away, as the purpose of the program is to allow recipients to remain safely in their own home. If payment for services is received after the death of the recipient, overpaid compensation is to be collected from the provider in accordance with MPP Section 30-769.9.

**36. Q: Can we accept mental health diagnoses from other medical professionals or should it be diagnoses provided by mental health professionals only?**

A: A mental health diagnosis can only be made by a mental health professional. To be eligible for Social Security Disability on the basis of a mental disorder, a variety of documentation consisting of symptoms, signs, and laboratory findings (including psychological test findings) is analyzed.



# Case Home

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
- Medi-Cal Eligibility
- Contacts
- Disaster Preparedness
- Blind or Visually Impaired
- Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Travel Claim
- Payroll
- Case Maintenance
- Administration
- Quality Assurance
- Unannounced Home Visit
- Forms/Correspondence
- Recent Changes
- Notes
- Tasks

**MY WORKSPACE**

PERSON

**CASES**

SEARCH

WAGE RATE

COUNTY CONTRACTOR

HOMEMAKER

RECENT ITEMS

**Case Home:** [REDACTED] [Edit](#)

**Manage**

[Leave](#) [Terminate](#)

**Details**

<b>Case Number:</b>	[REDACTED]	<b>Status:</b>	Eligible
<b>Recipient Name:</b>	[REDACTED]	<b>Status Date:</b>	9/1/2013
<b>IHSS Referral Date:</b>	9/12/1989	<b>Resource Suspension End Date:</b>	
<b>IHSS Application Date:</b>	9/12/1989	<b>County:</b>	[REDACTED]
<b>Medi-Cal Eligibility Referral Date:</b>		<b>District Office:</b>	03 District Office
<b>Medi-Cal Initial Eligibility Notification Date:</b>	11/1/2013	<b>Case Owner:</b>	[REDACTED]
<b>In-Home Visit Date:</b>	9/23/2015	<b>Companion Case:</b>	No
<b>Interpreter Available:</b>	No	<b>State Hearing:</b>	No
<b>Number of Household Members:</b>	2	<b>Mail Designee:</b>	[REDACTED]
<b>Number of Active Providers:</b>	1		

**County Use Comments**

**Contact Information**

<b>Residence Address:</b>	[REDACTED]	<b>Primary Phone Number:</b>	[REDACTED]
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# Person Home

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**PERSON**

- Home
- Cases
- Provider
- Background
- Contact
- Payroll
- Timesheet
- Travel Claim
- Identity
- Notes
- CDPH Death Match

**MY WORKSPACE**

- PERSON
- CASES
- SEARCH
- WAGE RATE
- COUNTY CONTRACTOR
- HOMEMAKER
- RECENT ITEMS

**Person Home:** [REDACTED] [Edit](#)

**Manage**

[Create Provider](#)

**Name**

<b>Title:</b> Ms.	<b>Effective Date:</b> 8/25/2015
<b>First Name:</b> [REDACTED]	<b>Middle Name:</b>
<b>Last Name:</b> [REDACTED]	<b>Suffix:</b>

**Contact Information**

<b>Residence Address:</b> [REDACTED]	<b>Email Address:</b>
	<b>Primary Phone Number:</b> [REDACTED]

**Details**

<b>Case Number:</b> [REDACTED]	<b>Blank SSN Reason:</b>
<b>Duplicates:</b>	<b>SSN:</b> [REDACTED]
<b>Person Type:</b> Recipient	<b>County:</b> [REDACTED]
<b>Meets Residency Requirements:</b> Met	<b>Referral Source:</b> Other Relative
<b>Date of Birth:</b> [REDACTED]	<b>Medi-Cal Pseudo:</b> No
<b>Gender:</b> [REDACTED]	<b>Ethnicity:</b> [REDACTED]
<b>Spoken Language:</b> [REDACTED]	<b>Written Language:</b> English
<b>Reported Date of Death :</b>	<b>Date of Death:</b>
<b>Death Notification Source:</b>	<b>Death Outcome:</b>

# Household Evidence

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
- Medi-Cal Eligibility
- Contacts
- Disaster Preparedness
- Blind or Visually Impaired
- Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Travel Claim
- Payroll
- Case Maintenance
- Administration
- Quality Assurance
- Unannounced Home Visit
- Forms/Correspondence

**MY WORKSPACE**

PERSON

**CASES**

SEARCH

WAGE RATE

**Household Evidence:** [REDACTED]

[Evidence Home](#) [Next](#)

**Residence Information**

<b>Stove:</b>	Yes	<b>Living Arrangement:</b>	Shared
<b>Refrigerator:</b>	Yes	<b>Residence Type:</b>	House
<b>Washer:</b>	Yes	<b>Number of Recipient only Rooms:</b>	2
<b>Dryer:</b>	Yes	<b>Number of Shared Rooms:</b>	4
<b>Yard:</b>	Yes	<b>Number of Rooms not Used:</b>	6

**Household Members**

Action	Last Name	First Name	Date of Birth	Relationship	Age	Case Owner	Companion Case Number	Protective Supervision Status
<a href="#">View</a>	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	No

[Evidence Home](#) [Next](#)

# Household Member

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
- Medi-Cal Eligibility
- Contacts
- Disaster Preparedness
- Blind or Visually Impaired
- Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Travel Claim

**View Household Member:** [REDACTED] [Close](#)

**Companion Case Details**

<b>Companion Case Number:</b>	<b>Protective Supervision Status:</b> No
-------------------------------	--

**Household Member Details**

<b>Relationship:</b> Spouse	<b>Date of Birth:</b> [REDACTED]
<b>Last Name:</b> [REDACTED]	<b>First Name:</b> [REDACTED]
<b>Spouse / Parent:</b> Spouse - available/not able	<b>Protective Supervision Proration:</b> No

[Close](#)

# Household Member - Parent

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
- Medi-Cal Eligibility
- Contacts
- Disaster Preparedness
- Blind or Visually Impaired
- Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Travel Claim

**View Household Member:** [REDACTED] [Close](#)

**Companion Case Details**

<b>Companion Case Number:</b>		<b>Protective Supervision Status:</b>	No
-------------------------------	--	---------------------------------------	----

**Household Member Details**

<b>Relationship:</b>	Parent	<b>Date of Birth:</b>	[REDACTED]
<b>Last Name:</b>	[REDACTED]	<b>First Name:</b>	[REDACTED]
<b>Spouse / Parent:</b>	Parent - provides no services	<b>Protective Supervision Proration:</b>	No

[Close](#)

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
- Medi-Cal Eligibility
- Contacts
- Disaster Preparedness
- Blind or Visually Impaired
- Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Travel Claim

**View Household Member:** [REDACTED] [Close](#)

**Companion Case Details**

<b>Companion Case Number:</b>		<b>Protective Supervision Status:</b>	No
-------------------------------	--	---------------------------------------	----

**Household Member Details**

<b>Relationship:</b>	Parent	<b>Date of Birth:</b>	[REDACTED]
<b>Last Name:</b>	[REDACTED]	<b>First Name:</b>	[REDACTED]
<b>Spouse / Parent:</b>	Parent - provides all services	<b>Protective Supervision Proration:</b>	No

[Close](#)

# Service Evidence

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
  - Medi-Cal Eligibility
  - Contacts
  - Disaster Preparedness
  - Blind or Visually Impaired
  - Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Travel Claim
- Payroll
- Case Maintenance
- Administration
- Quality Assurance
- Unannounced Home Visit
- Forms/Correspondence

**MY WORKSPACE**

- PERSON
- CASES**
- SEARCH
- WAGE RATE
- COUNTY CONTRACTOR
- HOMEMAKER

**Service Evidence:** [REDACTED] [Evidence Home](#) [Next](#)

[View Assessment Narrative](#)

**Functional Ranks**

<b>Housework :</b>	4	<b>Laundry:</b>	5
<b>Shopping &amp; Errands:</b>	5	<b>Meal Prep &amp; Clean-up:</b>	4
<b>Ambulation:</b>	3	<b>Bathing &amp; Grooming:</b>	4
<b>Dressing:</b>	4	<b>Bowel, Bladder &amp; Menstrual Care:</b>	4
<b>Transfer :</b>	3	<b>Feeding:</b>	1
<b>Respiration:</b>	1	<b>Memory:</b>	2
<b>Orientation:</b>	1	<b>Judgment:</b>	1

**Functional Index:** 3.277

**Service Type Details**

Action	Service Type	W/M	HTG	Total Assessed Need	Adj	Ind Assessed Need	Alt+Ref+Vol	Net Adj Need
<a href="#">View</a>	Domestic Services	M		01:15	00:00	01:15	00:00	01:15
<a href="#">View</a>	Preparation of Meals	W	☐	05:15	03:13	02:02	00:00	02:02
<a href="#">View</a>	Meal Clean-up	W	☐	02:34	01:36	00:58	00:00	00:58
<a href="#">View</a>	Laundry	W		01:00	00:00	01:00	00:00	01:00
<a href="#">View</a>	Shopping for Food	W		01:00	00:55	00:05	00:00	00:05

# Service Type Details

## Extraordinary Need for Laundry

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
- Medi-Cal Eligibility
- Contacts
- Disaster Preparedness
- Blind or Visually Impaired
- Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Travel Claim
- Payroll
- Case Maintenance
- Administration
- Quality Assurance

**View Service Type Details:** [REDACTED] [Close](#)

**Service Type:** Laundry

**Task Details:**

<u>Service Task</u>	<u>Frequency</u>	<u>Quantity</u>	<u>Duration</u>	<u>Proration</u>
Laundry	Weekly	7	00:15	1

<b>Total Assessed Need (HH:MM):</b> 01:45	<b>Refused Services (HH:MM):</b> 00:00
<b>Adjustments (HH:MM):</b> 00:00	<b>Voluntary Services (HH:MM):</b> 00:00
<b>Alternative Resources (HH:MM):</b> 00:00	

**Comments:** C walks with a walker and has ataxia and shakes, Cannot carry a laundry basket, tremors prevent her from folding, C is incontinent and creates additional laundry

[Close](#)

## Service Type: Protective Supervision

**CASE WORKER APPLICATION** 1.6.2.0001 CMIPS II

**CASES**

- Home
- Evidence
- Medi-Cal Eligibility
- Contacts
- Disaster Preparedness
- Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Payroll

**MY WORKSPACE**

**PERSON**

**CASES**

**SEARCH**

**WAGE RATE**

**COUNTY CONTRACTOR**

**HOMEMAKER**

**RECENT ITEMS**

**View Service Type Details:** Close

Service Type: Protective Supervision	
<b>Protective Supervision Form Sent Date:</b> 8/1/2012	<b>Protective Supervision Form Received Date:</b> 8/1/2012
<b>Total Assessed Need (HH:MM):</b> 168:00	<b>Alternative Resources (HH:MM):</b> 15:00
<b>Adjustments (HH:MM):</b> 99:55	<b>Voluntary Services (HH:MM):</b> 00:00
<b>Companion Case Protective Supervision Adjustment (HH:MM):</b> 84:00	<b>24 Hour Care Plan Need (HH:MM):</b> 03:39
<b>Pending Receipt of Additional Information:</b> No	

**Comments:** CT continues to try and eat non-food items (socks, toys, chews on wood/styrofoam), continues to try and get out doors leading to outside. Severely impaired judgment per physician.

[Close](#)

Field Name*	Description*
Protective Supervision Form Sent Date	The date when the Protective Supervision Form (SOC 821) was sent to the physician.
Total Assessed Need	Displays the system-generated total assessed need for Protective Supervision (168 hours). (HH:MM)
Adjustments	System-generated hours of service prorated between the recipient and other members of the household. (HH:MM)
Companion Case Protective Supervision Adjustment	Calculated during Final Determination. (HH:MM)
Pending Receipt of Additional Information	User-entered answer.
Protective Supervision Form Received Date	The date when the Protective Supervision Form (SOC 821) was received from the physician.
Alternative Resources	User-entered Alternative Resources for Protective Supervision. (HH:MM)
Voluntary Services	User-entered voluntary service for Protective Supervision. (HH:MM)
24 Hour Care Plan Need	Calculated during Final Determination. (HH:MM)

\*(HH:MM) indicates that the data is displayed in an hours and minutes, rather than a decimal, format.



# Authorization Summary

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**Authorization Summary:** [REDACTED] [Close](#)

[View Assessment Narrative](#) [Print SOC 293 Form](#)

**Authorization Summary**

<b>Authorization Segment Start Date:</b>	1/1/2016	<b>Application Date:</b>	4/1/1998
<b>Authorization Segment End Date:</b>	7/31/2016	<b>IHSS Determination Date:</b>	12/19/2015
<b>Total Auth to Purchase Before LMA (HH:MM):</b>	283:00	<b>Impairment Level:</b>	SI
<b>Unmet Need Before LMA (HH:MM):</b>	00:00	<b>Functional Index Score:</b>	5
<b>LMA (HH:MM):</b>	00:00	<b>Restaurant Meals Allowance:</b>	No
<b>Unmet Need After LMA (HH:MM):</b>	00:00	<b>Advance Pay:</b>	No
<b>Total Auth to Purchase After LMA (HH:MM):</b>	283:00	<b>IHSS SOC:</b>	0.00
<b>Adjusted Hours (HH:MM):</b>	00:00	<b>SOC Compare Cost:</b>	2,830.00
<b>Unmet Need After Adjusted Hours (HH:MM):</b>	00:00	<b>Funding Source Aid Code:</b>	2K - CFCO
<b>Total Auth to Purchase After Adjusted Hours (HH:MM):</b>	283:00	<b>24 Hour Protective Supervision Care Plan Need (HH:MM):</b>	102:39
<b>Weekly Authorized Hours (HH:MM):</b>	70:45	<b>Monthly Overtime Maximum (HH:MM):</b>	123:00

**Service Type Details**

Service Type	W/M	HTG	Total Assessed Need	Adj	Ind Assessed Need	Alt+Ref+Vol	Net Adj Need	Unmet Need	Auth to Purchase
Domestic Services	M		06:00	00:00	06:00	02:40	03:20	00:00	03:20
Preparation of Meals	W		07:00	00:00	07:00	00:00	07:00	00:00	07:00
Meal Clean-up	W	☐	01:45	00:00	01:45	00:00	01:45	00:00	01:45

# Program Evidence

**CASE WORKER APPLICATION** 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
  - Medi-Cal Eligibility
  - Contacts
  - Disaster Preparedness
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  - Authorization
- Modes & Hours
- Providers
- Overtime
- Timesheet
- Travel Claim
- Payroll
- Case Maintenance
- Administration
- Quality Assurance
  - Unannounced Home Visit
  - Forms/Correspondence

**MY WORKSPACE**

- PERSON
- CASES**
- SEARCH
- WAGE RATE
- COUNTY CONTRACTOR
- HOMEMAKER
- RECENT ITEMS

**Program Evidence:** [REDACTED] [Evidence Home](#) [Next](#)

**Program Information**

<b>Authorization Start Date:</b> 1/1/2016	<b>Authorization End Date:</b> 7/31/2016
<b>Home Visit Date:</b> 5/18/2015	<b>Re-Assessment Due Date:</b> 5/18/2016
<b>Health Care Certification Date:</b> 5/30/2012	<b>Health Care Certification Reason:</b> Health Care Certification
<b>Presumptive Eligibility:</b> No	<b>Waiver Program:</b> No

**IHSS Program**

<b>IHSS AID Code:</b> 68 Disabled, IHSS	<b>Advance Pay:</b> No
<b>Restaurant Meals Allowance:</b> No	<b>Advance Pay Rate:</b> 0.00

**Modes Of Service**

<b>Individual Provider:</b> Yes	<b>Homemaker:</b> No	<b>County Contractor:</b> No
---------------------------------	----------------------	------------------------------

**Manual NOAs**

NOA Code	NOA Text

**Freeform Text:**

[Evidence Home](#) [Next](#)

# Medi-Cal Eligibility

CASE WORKER APPLICATION 1.10.0141 CMIPS II

**View Medi-Cal Eligibility:** [REDACTED] [Share of Cost Details](#) [Close](#)

**Medi-Cal Eligibility Information**

<b>Eligibility Month:</b>	04/2016	<b>Last Updated:</b>	3/29/2016 20:09
<b>Medi-Cal Eligibility Status:</b>	001	<b>Record Type:</b>	MEDS Monthly Renewal Eligibility Record
<b>Medi-Cal Aid Code:</b>	10	<b>FFP:</b>	Yes
<b>Medi-Cal Share Of Cost:</b>	0.00	<b>BIC Issue Date:</b>	3/25/2005
<b>Medi-Cal County ID:</b>	[REDACTED]	<b>Medi-Cal County Serial:</b>	[REDACTED]
<b>County FBU:</b>	[REDACTED]	<b>County Person Number:</b>	[REDACTED]
<b>MEDS ID:</b>	[REDACTED]	<b>Medi-Cal Date of Birth:</b>	[REDACTED]
<b>SSN Verification Code:</b>	SSN verified via SSA NUMIDENT data match - SSA birthdate exactly matches MEDS	<b>Medi-Cal Denial Reason:</b>	
<b>SSI Living Arrangement:</b>	Own Household	<b>Medi-Cal Denial Date:</b>	
<b>Optional Living Arrangement:</b>	Independent living with cooking facilities	<b>Refugee Alien Status:</b>	Proven US citizen
<b>Date of Death:</b>		<b>INS Date Of Entry:</b>	
<b>Death Source:</b>		<b>Identity Document Type:</b>	SSA confirmed U.S. Citizenship/Identity consistent with SSA data via the State Verification Exchange System (SVES)
<b>CIN:</b>	[REDACTED]	<b>Citizenship Document Type:</b>	SSA confirmed U.S. Citizenship consistent with SSA data via State Verification Exchange System (SVES)
<b>Disability Onset Date:</b>		<b>RV Due Month:</b>	
<b>Application Date:</b>	2/26/2016	<b>Last RV Completed Date:</b>	12/2015

[Share of Cost Details](#) [Close](#)

# Provider Details

CASE WORKER APPLICATION 1.10.0141 CMIPS II

**CASES**

- Home
- Evidence
  - Medi-Cal Eligibility
  - Contacts
  - Disaster Preparedness
  - Blind or Visually Impaired
  - Authorization
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  - Unannounced Home Visit
  - Forms/Correspondence
  - Recent Changes
  - Notes
  - Tasks

**MY WORKSPACE**

PERSON

**CASES**

SEARCH

WAGE RATE

COUNTY CONTRACTOR

HOMEMAKER

RECENT ITEMS

**View Case Provider:** [REDACTED]

View Case Provider View WPCS Details View IHSS Provider Hours History View WPCS Provider Hours History

**Details**

<b>Provider Name:</b>	[REDACTED]	<b>Provider Assigned Hours Form:</b>	No
<b>Provider Status:</b>	Active	<b>Relationship Status Date:</b>	6/1/2014
<b>Timesheet Review:</b>	No	<b>End Date:</b>	12/31/9999
<b>Relationship to Recipient:</b>	Other	<b>Termination Comment:</b>	
<b>Begin Date:</b>	6/1/2014	<b>Updated By:</b>	superuser
<b>Termination Reason:</b>		<b>History Created:</b>	12/19/2015 23:30
<b>Provider Number:</b>	[REDACTED]	<b>Recipient Waiver Begin Date:</b>	

**County Use Comments:**

**Financial**

<b>W-4 Status:</b>	Single	<b>DE-4 Status:</b>	Single	<b>Elective SDI:</b>	No
<b>W-4 Allowance:</b>	3	<b>DE-4 Allowance:</b>	3	<b>SDI Begin Date:</b>	
<b>W-4 Amount:</b>	0.00	<b>DE-4 Amount:</b>	0.00	<b>SDI End Date:</b>	
<b>W-4 Last Updated:</b>	5/28/2015	<b>DE-4 Last Updated:</b>	5/28/2015		
<b>W-2 Issued:</b>	1/9/2016	<b>W-2C Issued:</b>			
<b>W-2 Reprinted:</b>		<b>W-2C Reprinted:</b>			

[Edit](#) [Close](#)

[New](#) [Leave/Terminate](#)

**Provider Hours**

Action	Begin Date	End Date	Assigned Hours	Pay Rate	Status	Updated By	History Created
<a href="#">Edit</a>	1/1/2016	12/31/9999	283:00	[REDACTED]	Active	superuser	12/19/2015 23:30
<a href="#">Edit</a>	10/1/2015	12/31/2015	283:00	[REDACTED]	Active	superuser	12/19/2015 23:30
<a href="#">Edit</a>	7/1/2015	9/30/2015	283:00	[REDACTED]	Active	dneves001	8/20/2015 07:48

**NEEDS ASSESSMENT FORM**

Social Worker Number

Assessment Type <input type="checkbox"/> Initial <input type="checkbox"/> Reassessment <input type="checkbox"/> Change <input type="checkbox"/> ICT		Application Date		Home Visit Date	
Recipient Number		CIN		SSN	
Name (Last, First, M.I.)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB	Age
Residence Address - Street		City		State	Zip Code
Mailing Address - Street		City		State	Zip Code
Home Phone		Cell Phone		Other Phone	
Medi-Cal Aid Code		Funding Source Aid Code		IHSS Aid Code Federal Funding Participation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Does the Recipient Speak and Understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the Recipient Request a Translator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnic Origin (Enter Code)		Primary Spoken Language	
		Primary Written Language	

<b><u>Ethnic Codes</u></b>	<b><u>Spoken Language</u></b>	<b><u>Written Languages</u></b>
01 – White	00 – American Sign Language	01 – Spanish
02 – Hispanic	01 – Spanish	02 – Cantonese
03 – Black	02 – Cantonese	03 – Japanese
04 – Asian or Pacific Islander	03 – Japanese	04 – Korean
05 – Alaskan Native or American Indian	04 – Korean	05 – Tagalog
07 – Filipino	05 – Tagalog	06 – Other Non-English
08 – No Valid Data Reported	06 – Other Non-English	07 – English
09 – No Response, Client Declined to State	07 – English	08 – No Valid Response Reported
A – Amerasian	08 – No Valid Response Reported	09 – No Response, Client Declined to State
C – Chinese	09 – No Response, Client Declined to State	B – Mandarin
H – Cambodian	A – Other Sign Language	C – Other Chinese Languages
J – Japanese	B – Mandarin	D – Cambodian
K – Korean	C – Other Chinese Languages	E – Armenian
M – Samoan	D – Cambodian	F – Ilocano
N – Asian Indian	E – Armenian	G – Mien
P – Hawaiian	F – Ilocano	H – Hmong
R – Guamanian	G – Mien	I – Lao
T – Laotian	H – Hmong	J – Turkish
V – Vietnamese	I – Lao	K – Hebrew
Z – Other	J – Turkish	L – French
	K – Hebrew	M – Polish
	L – French	N – Russian
	M – Polish	P – Portuguese
	N – Russian	Q – Italian
	P – Portuguese	R – Arabic
	Q – Italian	S – Samoan
	R – Arabic	T – Thai
	S – Samoan	U – Farsi
	T – Thai	V – Vietnamese
	U – Farsi	
	V – Vietnamese	

[illegible]

2

Type	Name	Address	Primary Phone	Message Phone	Language
Message					
Emergency					
Conservator					
Guardian					
Past Guardian					
Timesheet Signatory					
Authorized Representative					
Power of Attorney					

SOC 293 (6/09)

RESIDENCE INFORMATION			LIVING ARRANGEMENT	
Stove	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Living Alone	
Refrigerator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Living With Spouse	
Washer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Shared	
Dryer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Live-In Provider	
Yard	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Tenant	
			<input type="checkbox"/> Landlord	
			<input type="checkbox"/> Board and Room	

RESIDENCE TYPE	
<input type="checkbox"/> House	Number of Recipient Only Rooms _____
<input type="checkbox"/> Apartment	Number of Shared Rooms _____
<input type="checkbox"/> Mobile Home	Number of Rooms _____
<input type="checkbox"/> Hotel	Not In Use By Recipient _____
<input type="checkbox"/> Other _____	

DISASTER PREPAREDNESS	
<b>Degree of Contact</b> <input type="checkbox"/> Critical <input type="checkbox"/> Urgent <input type="checkbox"/> Moderate <input type="checkbox"/> Critical but Consumer Declines <input type="checkbox"/> Urgent but Consumer Declines <input type="checkbox"/> Moderate but Consumer Declines <input type="checkbox"/> Not Needed	<b>Extreme Weather</b> <input type="checkbox"/> Extreme Heat <input type="checkbox"/> Extreme Cold <input type="checkbox"/> Extreme Heat and Cold <input type="checkbox"/> No Contact Required
<b>Life Support</b> <input type="checkbox"/> Respirator <input type="checkbox"/> Oxygen <input type="checkbox"/> Insulin <input type="checkbox"/> Life Support Medications <input type="checkbox"/> Dialysis <input type="checkbox"/> Paramedical Services <input type="checkbox"/> None Listed	<b>Special Impairment</b> <input type="checkbox"/> Severely Disabled or Bedfast <input type="checkbox"/> Relies on IHSS for Needs <input type="checkbox"/> Functional Rank 4 <input type="checkbox"/> Functional Rank 5 <input type="checkbox"/> Heavy Medication <input type="checkbox"/> Blind <input type="checkbox"/> Deaf <input type="checkbox"/> Lacks Transportation <input type="checkbox"/> Lives in Isolated Area <input type="checkbox"/> Receives Protective Supervision <input type="checkbox"/> Independent Low Hours <input type="checkbox"/> No Mental Functional Ranks of 5 <input type="checkbox"/> Functional Index Below 2.75 <input type="checkbox"/> Functional Index Over 2.75 with Assistance Available <input type="checkbox"/> Home Accessible by Emergency Services <input type="checkbox"/> No Special Impairments

Parent / Spouse
<input type="checkbox"/> Parent – Provides All Services
<input type="checkbox"/> Parent – Provides Some Services
<input type="checkbox"/> Parent – Provides No Services
<input type="checkbox"/> Parent – IHSS Recipient
<input type="checkbox"/> Spouse – Able And Available
<input type="checkbox"/> Spouse – Able/Partially Available
<input type="checkbox"/> Spouse – Able /Not Available
<input type="checkbox"/> Spouse – Available/Not Able
<input type="checkbox"/> Spouse – IHSS Recipient

Functional Ranks			
	Housework		Bowel, Bladder & Menstrual
	Laundry		Transfer
	Shopping and Errands		Feeding
	Meal Prep & Clean-up		Respiration
	Ambulation		Memory
	Bathing & Grooming		Orientation
	Dressing		Judgment

IHSS Training Academy

Recipient Number

**SERVICE EVIDENCE**

Rank	Activities of Daily Living	Frequency (Daily, Weekly, Monthly)	Quantity	Duration	Proration	Alternative Resources	Comments	Total Assessed Need
4	<b>Domestic</b> <input type="checkbox"/> Lives Alone <input type="checkbox"/> Wheelchair Maintenance <input type="checkbox"/> A&A Spouse <input type="checkbox"/> Roommate <input type="checkbox"/> Relative Home <input type="checkbox"/> Landlord/Tenant <input type="checkbox"/> Minor Children <input type="checkbox"/> Live-In Provider							
	<b>Meal Preparation</b> <input type="checkbox"/> Separate From Household <input type="checkbox"/> Home Delivered <input type="checkbox"/> Meals/Dining Site <input type="checkbox"/> Special Diet (describe) <input type="checkbox"/> Paramedical on File <input type="checkbox"/> Reheat							
	<b>Meal Cleanup</b> <input type="checkbox"/> Separate From Household							
June 2015	<b>Laundry</b> <input type="checkbox"/> 1.0 hr/wk-With Facilities <input type="checkbox"/> 1.5 hr/wk-W/o Facilities <input type="checkbox"/> Separate From Household <input type="checkbox"/> Incontinence/ Extra Soiled Laundry							



Service Evidence							Recipient Number	
Rank	Activities of Daily Living	Frequency (Daily, Weekly, Monthly)	Quantity	Duration	Proration	Alternative Resources	Comments	Total Assessed Need
1	<b>Shopping for Food</b> <input type="checkbox"/> Separate From Household <input type="checkbox"/> Remote Location							
	<b>Other Shopping &amp; Errands</b> <input type="checkbox"/> Separate From Household <input type="checkbox"/> Remote Location							
	<b>Respiration</b> <input type="checkbox"/> Oxygen <input type="checkbox"/> Nebulizer							
5	<b>Bowel &amp; Bladder Care</b> <input type="checkbox"/> Assistance on/off Toilet <input type="checkbox"/> Pads/Diapers <input type="checkbox"/> Empty Bed <input type="checkbox"/> Pan/Urine bag <input type="checkbox"/> Bedside Commode							
	<b>Feeding</b> <input type="checkbox"/> Needs Full/Partial Assistance							
	<b>Bed Baths</b>							
June 2015	<b>Dressing</b> <input type="checkbox"/> Zipper, Buttons, Shoes, etc. <input type="checkbox"/> Full Human Assistance							

Service Evidence							Recipient Number	
Rank	Activities of Daily Living	Frequency (Daily, Weekly, Monthly)	Quantity	Duration	Proration	Alternative Resources	Comments	Total Assessed Need
1	Menstrual Care							
	<b>Ambulation</b> <input type="checkbox"/> Some Human Assistance <input type="checkbox"/> Total Human Assistance <input type="checkbox"/> Walker/Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Needs Some Help w/ Stairs							
6	<b>Transfers</b> <input type="checkbox"/> Some Human Assistance <input type="checkbox"/> Total Human Assistance <input type="checkbox"/> Assistance Getting on/off Seats and Wheelchairs							
	<b>Bathing, Grooming, Oral Hygiene</b> <input type="checkbox"/> Bathing <input type="checkbox"/> Hair Care/Shampoo <input type="checkbox"/> Foot/Hand/Nail Care <input type="checkbox"/> Shaving <input type="checkbox"/> Oral Hygiene							
June 2015	<b>Rubbing Skin, Repositioning</b> <input type="checkbox"/> Rubbing of Skin <input type="checkbox"/> Repositioning <input type="checkbox"/> Range of Motion <input type="checkbox"/> Apply Lotion							

Service Evidence								Recipient Number	
Rank	Activities of Daily Living	Frequency (Daily, Weekly, Monthly)	Quantity	Duration	Proration	Alternative Resources	Comments	Total Assessed Need	
1	<b>Care &amp; Assistance with Prosthesis (Meds)</b> <input type="checkbox"/> Care/Assistance w/ Prosthesis <input type="checkbox"/> Medication (set up reminders) <input type="checkbox"/> Crushing Meds/Pills								
	<b>Accompaniment to Medical Appointments</b>								
7	<b>Accompaniment to Alternative Resource</b>								
	<b>Protective Supervision</b> <input type="checkbox"/> 24 hour Care Plan								
	<b>Paramedical</b> <input type="checkbox"/> G-tube Feeding <input type="checkbox"/> Finger Prick / Blood Sugar Check <input type="checkbox"/> Injection of Insulin <input type="checkbox"/> Enema <input type="checkbox"/> Suctioning								

June 2015

Service Evidence		Recipient Number						Total Assessed Need
Rank	Activities of Daily Living	Frequency (Daily, Weekly, Monthly)	Quantity	Duration	Proration	Alternative Resources	Comments	
IHSS Training Academy	Heavy Cleaning <input type="checkbox"/> IHSS not Provided in Last 12 Months							
	Yard Hazard Abatement							
	Remove Ice, Snow							
	Teaching and Demonstration							

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Light Grey – Will Be Populated by System

Dark Grey – Not Applicable

June 2015

		Recipient Number	
Authorization Begin Date	Authorization End Date	Reassessment Due Date	
Total Auth to Purchase		Presumptive Eligibility <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mode of Service <input type="checkbox"/> Individual Provider <input type="checkbox"/> County Contractor <input type="checkbox"/> Homemaker		Does the Recipient Need Assistance Finding a Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Pay <input type="checkbox"/> Yes <input type="checkbox"/> No		Restaurant Meals Allowance <input type="checkbox"/> Yes <input type="checkbox"/> No	

Social Worker Name	Social Worker Number	Social Worker Phone Number
County	District Office	

Notes
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## Task List Job Aid

The table below lists the tasks generated by Case Management.

**Note:** Table sorted by Recipient, Topic and Task Priority.

Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[case name] [case number] No Initial Medi-Cal Eligibility Received	Case Maintenance	If no initial Medi-Cal eligibility is received in 45 days from MEDS eligibility referral, case should be denied because applicant did not complete Medi-Cal application.	Case owner	Issue manual NOA and process determination to deny case or close the task with a comment.	High
[case name] [case number] Para-medical Service Authorization Expiring	Case Maintenance	Recipient Event: Fifteen days prior to a para-medical services authorization expiration.	Case owner	Assessment must be updated or close task with a comment.	High
[case name] [case number] Disability Determination received from Medi-Cal	Case Maintenance	When a Medi-Cal disability determination is received, CMIPS II shall produce a task to the case owner. Update from MEDS to the disability onset date for cases with presumptive eligibility.	Case owner	Assessment must be updated to remove the presumptive eligibility indicator or close task with a comment.	High
[case name] [case number] Assigned IP Hours are not equal to IP Mode of Service Hours. Provider Assigned Hours Form Update Required	Case Maintenance	When a change in the recipient case authorized to purchase hours are not equal to the aggregated provider assigned hours, produce a notification to the case owner.  When a case has hours associated only with the individual provider mode of service and the total recipient case authorized hours have not been assigned to single or multiple individual providers, CMIPS II shall produce an online notification indicating unassigned hours.	Case owner	Provider assigned hours must be updated to be equal to the recipient authorized hours.	High

Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[case name] [case number] Change in Recipient Auth Hours; Verify Modes of Service	Case Maintenance	When a change in a recipient's authorized hours occurs and the case has multiple modes of service assigned, CMIPS II shall produce a case notification to the case owner to modify the assignment of hours by modes of service.	Case owner	Assigned modes of services hours equals the total authorized hours.	High
[case name] [case number] SAWS discontinuance of IHSS Recipient effective [discontinuance date] for reason [discontinuance reason]	Case Maintenance	SAWS issues discontinuance from MEDS notice and transaction is sent to CMIPS II. Notification is sent to the case owner. Depending upon the reason, the case owner may need to terminate the case for non-compliance or do an IHSS-R determination.	Case owner	Re-determine residual eligibility, or if case is already terminated, add a task comment and close task with a comment.	High
[case name] [case number] Advance Pay Timesheets not Received in 75 Days	Case Maintenance	CMIPS II shall produce a case event for the case owner when no reconciling timesheets have been received within 75 days of an Advance Payment issuance.	Case owner	Remove from Advance Pay or close task with a comment.	High
[case name] [case number] Recipient Death Notification - Source [MEDS, CDPH]	Case Maintenance	CMIPS II shall produce a case event when a death notification is received from MEDS through the daily batch interface.	Case owner	Case is terminated or task is closed with a comment.	High
[case name] [case number] Recipient Address Changed to Out of State	Case Maintenance	A recipient's address change from California to any other state shall trigger a notification for the user to verify eligibility, pursuant to MPP 30-770.42 and 30-770.452.	Case owner	Task is closed with a comment or case is terminated.	High
[case name] [case number] Recipient Turns Eighteen (18)	Case Maintenance	Recipient Event: when the Recipient turns eighteen (18).	Case owner	Assessment must be updated or close task with a comment.	Medium
[case name] [case number] Recipient's Child Turns 14	Case Maintenance	CMIPS II shall produce a case event to the case owner at the beginning of the month in which the "child" of a recipient turns 14.	Case owner	Assessment must be updated or close task with a comment.	Medium



Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[case name] [case number] Change in Medi-Cal Share of Cost	Case Maintenance	Upon receipt of a change to the Medi-Cal share of cost for the current service month, CMIPS II shall create a task to the case owner indicating "MEDS SOC change."	Case owner	Trigger request for SAWS income information or close task with a comment. Create change assessment and update income evidence and authorize the evidence or close task with a comment.	Medium
[case name] [case number] State Hearing Compliance Form Due	Case Maintenance	When a state hearing with an outcome of grant or partial grant/partial denial is indicated and the Compliance Form Sent Date field is blank, notify the case owner with "Compliance Form Required." The Task due is 30 days from outcome date.	Case owner	Compliance Form Sent Date must be completed.	Medium
[case name] [case number] Recipient SSN pending 60 Days	Case Maintenance	Recipient SSN is not provided after 60 days.	Case owner	SSN must be updated to valid SSN or close task with a comment.	Medium
[case name] [case number] Recipient SSN pending for 120 days	Case Maintenance	When an applicant or recipient person type record has had a "Blank SSN Reason" other than "Blank" for 120 days from the application date and the case status is pending, eligible, presumptive eligible or leave	Case owner	Create Alternative ID – Type SSN for the person record or close with comment.	Medium

Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[case number] CIN Re-Clearance needed to sync Medi-Cal Eligibility	Case Maintenance	CMIPS II shall trigger a Task to the Case Owner when a Person Type Recipient or Applicant has had a change to any of the following fields <ul style="list-style-type: none"> <li>• First Name</li> <li>• And/or Middle Name</li> <li>• And/or Last Name</li> <li>• And/or Date of Birth</li> <li>• And/or Gender</li> </ul> and three (3) business days have passed since the change occurred.	Case owner	Create Alternate ID Type Client Index Number. Manual closure not allowed.	Medium
[case number] CIN Re-Clearance needed to sync Medi-Cal Eligibility	Case Maintenance	CMIPS II shall trigger a Task to the Case Owner when a Person Type Recipient or Applicant has had a change to Alternate ID Type Social Security Number and three (3) business days have passed.	Case owner	Create Alternate ID Type Client Index Number. Manual closure not allowed.	Medium
[case number] Name update received update from SCI [SCI Name First; Middle Name; or Last Name]. Update person name and then process CIN Re-Clearance to sync with Medi-Cal Eligibility	Case Maintenance	CMIPS II shall trigger a Task to the Case Owner when an SCI Daily Update is received and Field Codes 411, 412 or 413 (First Name Middle Name Last Name) are indicated when the CMIPS II Case Status is Pending, Eligible, Presumptive Eligible or Leave.	Case owner	Create Alternate ID Type Client Index Number. Manual closure not allowed.	Medium
[case number] Date of Birth Update received from SCI [Date of Birth]. Update case Date of Birth and then process CIN Re-Clearance to sync with Medi-Cal Eligibility	Case Maintenance	CMIPS II shall trigger a Task to the Case Owner when an SCI Daily Update is received and the Field Code indication of 408 (Date of Birth) is indicated when the CMIPS II Case Status is Pending, Eligible, Presumptive Eligible or Leave.	Case owner	Create Alternate ID Type Client Index Number. Manual closure not allowed.	Medium

Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[case number] Gender Update received from SCI [Gender]. Update case Gender and then process CIN Re-Clearance to sync with Medi-Cal Eligibility	Case Maintenance	CMIPS II shall trigger a Task to the Case Owner when an SCI Daily Update is received and the Field Code indication of 410 (Sex) is indicated when the CMIPS II Case Status is Pending, Eligible, Presumptive Eligible or Leave.	Case owner	Create Alternate ID Type Client Index Number. Manual closure not allowed.	Medium
[case number] Social Security Number Update received from SCI [Social Security Number]. Update case Social Security Number and then process CIN Re-Clearance to sync with Medi-Cal Eligibility	Case Maintenance	CMIPS II shall trigger a Task to the Case Owner when an SCI Daily Update is received and the Field Code indication of 405 (Social Security Number) is indicated when the CMIPS II Case Status is Pending, Eligible, Presumptive Eligible or Leave.	Case owner	Create Alternate ID Type Client Index Number. Manual closure not allowed.	Medium
[case number] Case Review Rejection - [reason]	Final Determination	CMIPS II shall trigger a Task to the Case Owner when an SCI Daily Update is received and Field Codes 411, 412 or 413 (First Name Middle Name Last Name) are indicated when the CMIPS II Case Status is Pending, Eligible, Presumptive Eligible or Leave.	Case owner	Resubmit case for approval.	High
[case name] [case number] Authorized Hours Less than Hours Paid	Final Determination	From the payroll GSD session, if the recipient's authorized hours are reduced to less than what has already been paid for a service period (due to leave or terminated status), send task to the case owner.	Case owner	Establish overpayment or close task with a comment.	Medium
[case name] [case number] Treatment Authorization Request (TAR) Approval for [claim type] units [units] effective [start date] to [end date]	Fraud Prevention	CMIPS II shall produce a notification to a designated county worker when a recipient is identified through a DHCS interface as having been approved for admission to inpatient services or Adult Day Health Care.	Case owner	Update the recipient case assessment or close task with a comment.	High

Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[person name] [case number] [provider number] Death Confirmed	Initial Contact-Receive Referral	When a death match record is confirmed for a provider.	Case owner	The case owner must terminate the recipient-provider relationship.	High
[case name] [case number] Provider [provider number] Death Notification - Source [source] (SSA, CDPH, etc)	Provider Mgt	CMIPS II shall produce a task to the case owner for each case where a provider is assigned when the SSN verification for the provider's SSN is indicated as deceased.	Case owner	Provider terminated or close task with a comment.	High
[case name] [case number] Provider [provider number] is Terminated due to updated Enrollment information	Provider Mgt	When provider is updated to ineligible and the provider is assigned and active on an existing case.	Case owner	Case owner must add a new provider to the case or close task with a comment.	High
[provider name] [provider number] Ineligible Provider for Reinstatement Rejected [Reject comments]	Provider Mgt	When the supervisor rejects the request for provider reinstatement.	Case owner	Send task to the user who made the request for reinstatement. The user must close this task with a comment.	Medium
[case name] [case number] Inter-County Transfer - State Hearing Added	Case Maintenance	State hearing added to a case pending inter-county transfer.	Case owner and ICT Coordinator queue (if no ICT Assigned Worker) or Assigned ICT worker	N/A	High
[case name] [case number] Inter-County Transfer Cancelled	Case Maintenance	When an ICT is cancelled: 1) Send a notification to the current case owner if user is other than the current case owner. 2) Send a notification to the ICT coordinator in the receiving county.	Caseworker and ICT Coordinator Queue or Assigned ICT worker	N/A	Medium
[case name] [case number] Request for Homemaker Service	Assign Modes of Service	When a recipient case is assigned hours to the homemaker mode of service, CMIPS II shall produce a case event to the homemaker supervisor.	Homemaker Supervisor work queue	Close task with a comment.	Low

Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[case name][case number] Inter-County Transfer Referral from[sending county]	Case Maintenance	When the Create Inter-County Transfer screen is saved, CMIPS II sends a task associated to the recipient case to the ICT Coordinator in the receiving county.	ICT Coordinator (receiving county) Queue	Assign an ICT worker within five business days. Deleted actions to complete ICT assessment.	Medium
Provider [provider name] [provider number] is Medi-Cal Suspended or Ineligible	Provider Mgt	For any CMIPS II provider who is indicated as included on the public authority registry and is terminated as Medi-Cal suspended or ineligible, CMIPS II shall produce a notification to the public authority work queue for any county where the provider is a member of the provider registry, at which time it is expected that the terminated provider should be removed from the provider registry.	PA work queue	Close task with a comment.	High
[case name] [case number] Review Payment Correction Request - Cross County	Payroll within CM	When a payment correction is submitted for approval for a case associated to the user's county location.	Payments Pending Approval work queue	Transaction is approved or rejected.	High

Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[case name] [case number] Review Special Transaction Request	Payroll within CM	When a Special Transaction is submitted for approval for a case associated to the user's county location	Payments Pending Approval Queue (IHSS)  Notes: (1) Tasks related to WPCS transactions are routed to the WPCS work queue and are not subject to escalation. (2) Tasks related to Buyout Reimbursement, Writ of Administrative Mandamus, or Legislative Change Special Transactions are routed to the CDSS Payment Pending Approval work queue and are not subject to escalation.	The Payroll Approver should approve or reject the pending request.	High
[case name] [case number] Review Payment Correction Request	Payroll within CM	When a payment correction is submitted for approval.	Payments Pending Approval work queue	Transaction is approved or rejected.	High
[case name] [case number] Review Special Transaction Request - Cross County	Payroll within CM	When a special transaction is submitted for approval cross-county.	Payments Pending Approval work queue	Transaction is approved or rejected.	High

Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[error code] [error text] Timesheet Exception for Case Number [case number] Provider Number [provider number]	Time and Attendance	For timesheets that could be imaged but cannot complete processing due to errors or inconsistencies, CMIPS II shall notify the applicable county or state staff of all timesheet errors and provide the image of the problem timesheet within four (4) business hours of discovery. Examples of this type of error include, but are not limited to, the following: a. No provider signature on timesheet b. No recipient signature on timesheet c. Timesheet hours worked are over authorized hours	Payroll work queue(s) or WPCS	Timesheet for pay period is regenerated or a payment correction is submitted.	Low
[case name] [case number] Paid Claim Match for [mm/yy] month not reserved	Program Mgt	Updated to a task to the QA supervisor work queue in case the QA supervisor serves multiple positions within the county.	QA Supervisor work queue	Close task with a comment.	Low
[case name] [case number] Recipient Death Notification - Source SCO	Case Maintenance	CMIPS II shall produce a case event when a death notification is received from MEDS through the daily batch interface.	QA work queue	Case is terminated or task is closed with a comment.	High
[case name] [case number] Paid Claim Match for [mm/yy] month	Program Mgt	Upon receipt of the monthly Medi-Cal Service Match file.	QA work queue	Task to the QA queue in the county indicated on the Medi-Cal service match record for each case and each service month. Update the outcome on the Modify Paid Claim screen or close the task with comment.	High
[case name] [case number] Provider [provider number] Death Notification - Source SCO	Provider Mgt	CMIPS II shall produce a task to the case owner for each case where a provider is assigned when the SSN verification for the provider's SSN is indicated as deceased.	QA work queue	Provider terminated or close task with a comment.	High

<b>Name (Subject)</b>	<b>Topic</b>	<b>Description/Comment</b>	<b>Recipient</b>	<b>Required Action (for closure)</b>	<b>Task Priority</b>
case name] [case number] Special Transaction Request Rejection - See Task History for Rejection Comments	Payroll within CM	When a special transaction request is rejected.	Requester	Resubmit for approval or cancel the request.	High
[case name] [case number] Payment Correction Request Rejection - See Task History for Rejection Comments	Payroll within CM	When a payment correction request is rejected.	Requester	Resubmit for approval or cancel the request.	High
Homemaker Time Ready for Review	Case Maintenance	CMIPS II shall produce a case event to the homemaker supervisor when homemaker time is entered by a user other than the homemaker supervisor.	Supervisor (for the submitter)	Timesheet is approved or rejected.	Medium
[case name] [case number] Case Ready for Review	Final Determination	When a user submits a case for supervisor for review, CMIPS II shall produce a case event to the supervisor.	SW Supervisor	Case is approved or rejected.	Medium
[provider name] [provider number] Ineligible Provider for Reinstatement Approval	Provider Mgt	When a previously ineligible provider is indicated as eligible to serve IHSS on the Provider Enrollment screen.	SW Supervisor	Send task to the user's supervisor for approval. The supervisor must approve the update to the provider's status.	Medium
[case name] [case number] IHSS Recipient on Leave - Verify WPCS Hours	Case Maintenance	When a recipient case with WPCS hours is placed in leave status, CMIPS II shall produce a notification to the WPCS worker of the case leave status.	WPCS work queue	Close task with a comment.	High
[case name] [case number] WPCS hours terminated because the IHSS recipient is Terminated	Case Maintenance	When a recipient case with WPCS hours is terminated, CMIPS II shall notify the WPCS worker of the case and WPCS hours' termination.	WPCS work queue	Close task with a comment.	High



Name (Subject)	Topic	Description/Comment	Recipient	Required Action (for closure)	Task Priority
[case name] [case number] WPCS recipient case back from Leave	Case Maintenance	When the recipient case status changes from leave to eligible or presumptive eligible and WPCS hours were associated with the previous eligibility, CMIPS II shall produce a notification to the WPCS worker.	WPCS work queue	Close task with a comment.	Medium
[case name] [case number] [provider number] Provider Terminated due to Confirmed Death	Program Mgt	When a death is confirmed on the Person screen and the active WPCS provider has been terminated by the system.	WPCS work queue	Close task with a comment.	High
[case name] [case number] Provider [provider number] is Medi-Cal Suspended or Ineligible	Provider Mgt	For any CMIPS II WPCS provider terminated as Medi-Cal suspended or ineligible, CMIPS II shall produce a notification to the WPCS work queue.	WPCS work queue	Close task with a comment.	High



## Notifications List Job Aid

The table below lists the notifications generated by Case Management.

**Note:** Table sorted by recipient and topic.

Name (Subject)	Topic	Description/Comment	Recipient
[case name] [case number] Recipient SSN pending for 90 days	Case Maintenance	When an applicant or recipient person type record has had a "Blank SSN Reason" other than "Blank" for 90 days from the application date and the case status is pending, eligible, presumptive eligible or leave.	Case owner
Provider [provider number] converted without SSN	Case Maintenance	When a provider record exists With an alternative ID type – conversion duplicate And there is no alternative ID type – SSN record	Case owner
[case name] [case number] converted without SSN	Case Maintenance	When a person type applicant, or recipient person has a "Blank SSN Reason" of "Conversion Duplicate."	Case owner
[case name] [case number] Recipient SSN pending for 60 days	Case Maintenance	When the person record associated with a case in pending, eligible, presumptive eligible or leave status does not have an "Alternative ID Type Social Security Number" and 60 days have passed since the application date.	Case owner
[case name] [case number] Overpayment Recovery Complete	Payroll within CM	When a collection is made that fully satisfies the overpayment (balance is drawn down to zero). <b>Note:</b> WPCS overpayments are not subject to notification.	Case owner
[case name] [case number] Treatment Authorization Request (TAR) Pending for [claim type] units [units] effective [start date] to [end date]	Program Mgt	Upon receipt of a TAR for a case through the DHCS TAR Interface. Notification sent to case owner for any case with a pending in-patient, long term care or Adult Day Health Care TAR.	Case owner
[case name] [case number] Initial Medi-Cal Eligibility Received	Case Maintenance	Receipt of initial Medi-Cal eligibility from MEDS for a SAWS referral. MEDS daily indicates eligibility and CMIPS II has no active eligibility for the period.	Case owner
[case name] [case number] Time Limit Service Expired	Case Maintenance	Recipient Event: When a time-limited (one-time-only) service, except para-medical, has expired.	Case owner
[case name] [case number] Case Has No Assigned Provider	Case Maintenance	CMIPS II shall produce a case event to the case owner upon a change (e.g., provider termination, change in recipient assigned hours) until a provider assignment occurs, when no active status individual provider is associated to a recipient case with individual provider mode of service assignment.	Case owner
[case name] [case number] SAWS Rescission of discontinuance (S4 transaction from SAWS)	Case Maintenance	SAWS rescinds discontinuance, case owner should determine appropriate action.	Case owner

Name (Subject)	Topic	Description/Comment	Recipient
[case name] [case number] Inter-County Transfer Requested - State Hearing Pending	Case Maintenance	<p>If/when a recipient requests an ICT and the recipient case has state hearing indication other than complete withdrawal, approved, denied or partial approval, CMIPS II shall:</p> <ul style="list-style-type: none"> <li>• Notify the user of the pending state hearing and not allow.</li> <li>• Send a case event to the assigned case owner indicating attempted ICT if the user is other than the case owner.</li> </ul>	Case owner
[case name] [case number] Advance Pay Timesheets are not Reconciled - 45 days	Case Maintenance	CMIPS II shall produce a case event for the case owner when no reconciling timesheets have been received within 45 day of an Advance Payment issuance.	Case owner
[case name] [case number] Recipient Address Matches Provider's Address	Case Maintenance	Recipient Event: When the recipient's address matches one of the recipient's provider's addresses.	Case owner
[case name] [case number] Inter-County Transfer Case Assigned	Case Maintenance	Notify the assigned ICT case owner of the case assignment in the receiving county.	Case owner
[case name] [case number] Pending Para-medical Authorization	Case Maintenance	Notify the case owner that there is a pending para-medical assessment 30 days following the determination date if the para-medical form has not yet been received.	Case owner
[case name] [case number] Pending Protective Supervision	Case Maintenance	Notify the case owner that there is a pending protective supervision assessment 30 days following the determination date.	Case owner
[case name] [case number] Recipient Address Changed	Case Maintenance	When a recipient address change is keyed by a worker other than the case owner, CMIPS II shall produce a notification to the case owner.	Case owner
[case name] [case number] Recipient's <Date of Birth, CIN, Name, Gender> has been changed	Case Maintenance	When a user other than the case owner keys a change to the recipient's Date of Birth, CIN, Name or Gender, CMIPS II shall produce a notification to the case owner.	Case owner
[case name] [case number] Recipient's SSN has been changed	Case Maintenance	When a user other than the case owner keys a change to the recipient's SSN or via an interface CMIPS II, shall produce a notification to the case owner.	Case owner
[case name] [case number] Share of Cost Exceeds Need	Final Determination	Notification sent to the case owner when an IHSS-R case has an IHSS SOC that exceeds the SOC compare cost.	Case owner
[case name] [case number] Case Review Approval	Final Determination	CMIPS II shall allow the supervisor to produce a case event indicating to the case owner either approval for authorization or corrective action is required on the case being reviewed.	Case owner
[case name] [case number] Inter-County Transfer Completed	Final Determination	Notify the case owner (sending county) when the ICT assessment has been completed in the receiving county and the ICT has been completed.	Case owner

Name (Subject)	Topic	Description/Comment	Recipient
[case name] [case number] Treatment Authorization Request (TAR) Approval for [claim type] units [units] effective [start date] to [end date]	Fraud Prevention	<p>Upon receipt of a TAR for a case through the DHCS TAR Interface:</p> <ul style="list-style-type: none"> <li>Task is sent to case owner for any case with approved in-patient or long term care TAR.</li> <li>Notification sent to case owner for any case with approved Adult Day Health Care TAR.</li> <li>Action required for task for in-patient or long term care.</li> <li>Update the recipient case assessment or close the task with comment.</li> </ul>	Case owner
[case name] [case number] Case Assignment	Initial Contact-Receive Referral	CMIPS II shall produce a case event notifying the case owner of the assignment.	Case owner
[case name] [case number] Cross County [Void/Reissue/Replacement or Copy of Cashed Warrant or Forged Endorsement Affidavit] [Request or Create or Cancel or Modify] Activity on Warrant Number [warrant number]	Payroll within CM	<p>When a payroll action is taken on a case associated to a county other than the user's county location.</p> <p><b>Note:</b> Actions taken by WPCS users are not subject to notification.</p>	Case owner
[case name] [case number] Cross County Special Transaction [Approve or Cancel] Activity	Payroll within CM	<p>When a payroll action is taken on a case associated to a county other than the user's county location.</p> <p><b>Note:</b> Actions taken by WPCS users are not subject to notification.</p>	Case owner
[case name] [case number] Cross County Payment Correction [Approve or Cancel] Activity	Payroll within CM	<p>When a payroll action is taken on a case associated to a county other than the user's county location.</p> <p><b>Note:</b> Actions taken by WPCS users are not subject to notification.</p>	Case owner
[case name] [case number] Cross County Overpayment Recovery [Submit or Cancel or Stop] Activity	Payroll within CM	<p>When a payroll action is taken on a case associated to a county other than the user's county location.</p> <p><b>Note:</b> Actions taken by WPCS users are not subject to notification.</p>	Case owner
[case name] [case number] Cross County Overpayment Collection [Create or Cancel] Activity on [Date Collected]	Payroll within CM	<p>When a payroll action is taken on a case associated to a county other than the user's county location.</p> <p><b>Note:</b> Actions taken by WPCS users are not subject to notification.</p>	Case owner
[case name] [case number] Cross County Advance Pay [No Further Action or Un-Reconcile] Activity for Service Month [Service Month From Date - Service Month To Date]	Payroll within CM	<p>When a payroll action is taken on a case associated to a county other than the user's county location.</p> <p><b>Note:</b> Actions taken by WPCS users are not subject to notification.</p>	Case owner
Multiple New Cases Assigned	Program Mgt	Notify case owner when cases have been reallocated to him/her using the bulk reassignment of cases.	Case owner

Name (Subject)	Topic	Description/Comment	Recipient
[case name] [case number] Case pending approval 5 days	Program Mgt	CMIPS II shall notify a user of all case approvals sent for supervisory review, which have not been acted upon after a specified number of days.	Case owner
[case name] [case number] [provider number] Provider Terminated due to Confirmed Death	Program Mgt	When a death is confirmed on the Person screen and the active provider has been terminated by the system.	Case owner
[case name] [case number] Provider [provider number] is Medi-Cal Suspended or Ineligible	Provider Mgt	CMIPS II shall create a case event to the recipient case owner for any "active" recipient case when an IHSS or WPCS provider is identified as Medi-Cal excluded, suspended, or ineligible.	Case owner
[case name] [case number] Provider [provider number] Address matches Recipient Address	Provider Mgt	Notification sent to the SW when the IP address changes to the address of one of his/her recipient addresses.	Case owner
[case name] [case number] Provider [provider number] moved out of State	Provider Mgt	Notification sent to the SW when the IP address changes to another county or state.	Case owner
[case name] [case number] [provider number] Active Provider [provider number] End Date Within 30 Days	Provider Mgt	An active provider has an end date within the next 30 days. Could indicate the end of a work authorization period.	Case owner
[provider name] [provider number] Ineligible Provider for Reinstatement Approved	Provider Mgt	When the supervisor approves the request for provider reinstatement.	Case owner
[case name] [case number] Cross County Timesheet Activity	Time and Attendance	Updated message to be more specific to type of cross-county payroll activities.	Case owner
[case name] [case number] Inter-County Transfer - State Hearing Added	Case Maintenance	State hearing added to a case pending inter-county transfer.	Case owner and ICT coordinator work queue (if no ICT assigned worker) or assigned ICT worker
[case name] [case number] Inter-County Transfer Cancelled	Case Maintenance	When an ICT is cancelled: 1) Send a notification to the current case owner if user is other than the current case owner. 2) Send a notification to the ICT coordinator in the receiving county.	Case owner and ICT coordinator work queue or assigned ICT worker
[case name] [case number] Medi-Cal Eligibility Terminated	Case Maintenance	Medi-Cal termination received on the monthly renewal	Case owner supervisor
[case name] [case number] Recipient Application Withdrawal	Case Maintenance	Upon the indication of recipient's withdrawal of application for IHSS services, CMIPS II shall generate a notification to the case owner supervisor for any case owner not requiring case owner supervisor approval.	Case owner supervisor

Name (Subject)	Topic	Description/Comment	Recipient
[case name] [case number] Recipient Case - Rescission	Case Maintenance	Upon the indication of a recipient case termination rescission, CMIPS II shall generate a notification to the case owner supervisor for any case owner not requiring case owner supervisor review or approval. Updated to reflect rescission in case of termination or denial.	Case owner supervisor
[case name] [case number] Provider [provider number] Added and Terminated for a Single Pay Period	Fraud Prevention	CMIPS II shall generate a notification to the case owner supervisor for any provider added and terminated within a single pay period.	Case owner supervisor
[case name] [case number] [provider number] has Multiple Forged Warrant Affidavits	Fraud Prevention	CMIPS II shall produce a case event to a designated user when more than one forged warrant affidavit is submitted in a rolling one- year period for the same provider and/or recipient.	Case owner supervisor
[case name] [case number] Authorization Updated Multiple Times for a Service Month	Fraud Prevention Final Determination	CMIPS II shall produce a case event to a designated user when there are more than two (2) address changes (physical or mailing) in a rolling six (6) month period for the same recipient. Updated to reflect recipient auth hours change more than one (1) time per month on a case.	Case owner supervisor
[case name] [case number] Provider [provider number] is Medi-Cal Suspended or Ineligible	Provider Mgt	For any CMIPS II provider terminated as Medi-Cal suspended or ineligible, CMIPS II shall, in addition to the case notification to the case owner(s), send a case notification to the supervisor of the case owner(s).	Case owner supervisor
County Contractor Billing Invoice Received	Case Maintenance	CMIPS II shall produce a case event to the county contractor supervisor when CC billing invoices have been processed.	County contract coordinator
[case name] [case number] Special Transaction Request Approval	Payroll within CM	When a special transaction request is approved.	Requester
[case name] [case number] Payment Correction Request Approval	Payroll within CM	When a payment correction request is approved.	Requester

## IN-HOME SUPPORTIVE SERVICES (IHSS) RECIPIENT TIME SHEET SIGNATURE AUTHORIZATION

RECIPIENT NAME (FIRST	MIDDLE	LAST)	RECIPIENT CASE NUMBER
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This form gives the designated individual the authority to sign timesheets on behalf of the recipient for any provider who is working for the named recipient. The authority of the designated individual is limited to that of timesheet signatory and his/her authority can be terminated at any time at the request of the recipient.

INDIVIDUAL AUTHORIZED TO SIGN TIMESHEET (FIRST	MIDDLE	LAST)	RELATIONSHIP TO RECIPIENT	TELEPHONE NUMBER
AUTHORIZED SIGNATURE				DATE
RECIPIENT SIGNATURE				DATE
AUTHORIZED REPRESENTATIVE (IF RECIPIENT CANNOT SIGN ON THEIR OWN BEHALF)			RELATIONSHIP TO RECIPIENT	TELEPHONE NUMBER
SIGNATURE OF AUTHORIZED REPRESENTATIVE				DATE

### COUNTY USE ONLY

### COMMENTS

SOCIAL WORKER NAME (FIRST	MIDDLE	LAST)	SOCIAL WORKER IDENTIFICATION NUMBER
SOCIAL WORKER SUPERVISOR SIGNATURE			SUPERVISOR APPROVAL DATE





## IMPORTANT INFORMATION FOR PROSPECTIVE PROVIDERS ABOUT THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT PROCESS

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An IHSS provider is someone who gets paid to provide services to a person who receives in-home supportive services under the IHSS Program. If you want to become an IHSS provider, you must complete all of the steps outlined below before you can be enrolled as a provider and receive payment from the IHSS Program for providing services.

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### STEP 1. Complete and sign the IHSS Program Provider Enrollment Form (SOC 426), and return it in person to the County IHSS Office or IHSS Public Authority.

- Get a blank copy of the SOC 426 from the County IHSS Office or Public Authority. *Read the information carefully before you complete the form.*
- Complete the SOC 426 form and answer all questions completely and truthfully. You **must report** if you have been convicted of any crimes that would not allow you to provide services.
- Bring a U.S. government issued picture ID **AND** an original Social Security card. If you do not have a Social Security card you may show the original official letter from the Social Security Administration (SSA) showing your Social Security number (SSN).
- The information you provide on the Provider Enrollment Form (SOC 426) will be verified by a criminal background check by the California Department of Justice (DOJ). The criminal background check is required to be a provider (See Step 2).

### STEP 2. Be fingerprinted and go through a criminal background check by the California Department of Justice.

- The County IHSS Office or Public Authority will give you instructions on how to get fingerprinted when you turn in the completed and signed SOC 426. *Do not try to be fingerprinted until you have received instructions from the county.*
- You can get fingerprinted at some local law enforcement agencies (Police or Sheriff Department) or at a business that offers digitally scanned fingerprinting (Live Scan) services. The County IHSS Office or Public Authority can give you a list of nearby locations.
- State law requires that you pay the costs for fingerprinting and the criminal background check. Fees vary depending where you choose to get fingerprinted; the costs range from \$40 to \$90.
- If the background check verifies that you have **not** been convicted of any Tier 1 or Tier 2 crimes, **proceed to Step 3**.
- If the background check verifies that you **have been convicted** of any Tier 1 or Tier 2 crimes, please read the sections on the next pages.

If you **have been** convicted of, OR incarcerated following a conviction for, either a **Tier 1 or Tier 2** crime **WITHIN THE PAST 10 YEARS**, you are **NOT** eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing supportive services.

<p><b><u>Tier 1 crimes include:</u></b></p> <ul style="list-style-type: none"> <li>• Specified abuse of a child (Penal Code (PC) section 273a(a);</li> <li>• Abuse of an elder or dependent adult (PC section 368); or</li> <li>• Fraud against a government health care or supportive services program.</li> </ul>	<p>If you have a conviction for any of the <b>Tier 1 crimes</b> in the past 10 years, you are <b>NOT</b> eligible to be a provider.</p> <ul style="list-style-type: none"> <li>• You are <b>NOT</b> eligible even if you had a <b>Tier 1</b> crime that was expunged from your record.</li> </ul>
<p><b><u>Tier 2 crimes include:</u></b></p> <ul style="list-style-type: none"> <li>• A violent or serious felony, as specified in PC section 667.5(c), and PC section 1192.7(c),</li> <li>• A felony offense for which a person is required to register as a sex offender pursuant to PC section 290(c), and</li> <li>• A felony offense for fraud against a public social services program, as defined in W&amp;IC section 10980(c) (2) and (g) (2).</li> </ul> <p><i>You can ask the County IHSS Office or IHSS Public Authority for a list of the Tier 2 crimes.</i></p>	<p>If you have a conviction for any of the <b>Tier 2 crimes</b> in the past 10 years you may be eligible—</p> <ul style="list-style-type: none"> <li>• If your Tier 2 crime has been or can be expunged from your record.</li> <li>• If a recipient requests an individual waiver to hire you.</li> <li>• If you are approved for a general exception.</li> </ul> <p><i>Read sections below for more information.</i></p>

**Expungement for Tier 2 crime:**

- If you have a certificate of rehabilitation or an expungement for a Tier 2 crime, you may be eligible to be an IHSS provider. Provide copies of your certification of rehabilitation or documentation regarding the expungement with your completed SOC 426.
- If you are in the process of having a crime expunged, you should complete the expungement process before continuing the criminal background check.

**Individual Waiver of Exclusion for a Tier 2 crime:**

An individual waiver allows you to provide services **ONLY** to a specific recipient who chooses to hire you in spite of your criminal conviction (s) and he/she requests an individual waiver.

- A recipient must request and submit the Recipient Request for Provider Waiver (SOC 862) to the County IHSS Office to allow you to provide services.
- The IHSS recipient who wants to hire you must be told of your conviction; however, he/she will be directed to keep the conviction information confidential.

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**General Exception for a Tier 2 crime:**

An individual who has been found ineligible to be enrolled as a provider based on a conviction for a Tier 2 crime, but who wishes to be listed on a provider registry, may apply for a general exception of the exclusion.

- Apply for a General Exception by completing the IHSS Applicant Provider Request for General Exception (SOC 863) form.
- You will be required to provide backup documentation, e.g., employment history, personal references, etc., to support your request for a general exception.

If you have been disqualified based on a Tier 1 or Tier 2 conviction, you may request a copy of your criminal offender record information (CORI) from the county. Please be advised that the CORI can ONLY be used for this enrollment process.

**If the information on your criminal background is incorrect, you can dispute the information through the DOJ record review process.**

The DOJ record review process includes submitting fingerprints, paying a processing fee and following the instructions found on the DOJ website at <http://ag.ca.gov/fingerprints/security.php>. If there is criminal information on your record, a Claim of Alleged Inaccuracy or Incompleteness (FORM BCII 8706) will be included along with the response.

**STEP 3. Go to an IHSS Program Provider Orientation given by the county.**

- The County IHSS Office or Public Authority will tell you when and where you can attend an orientation session.
- The orientation will give you important information about the IHSS Program and the rules and requirements for you to follow as a provider.

**STEP 4. At the end of the Provider Orientation session, sign an IHSS Program Provider Enrollment Agreement (SOC 846).**

- By signing the SOC 846, you are saying that you understand and agree to the rules and requirements for being a provider in the IHSS Program.

You should maintain copies of all documents you submitted and any that you received from the county for your records.

Once you have successfully completed these four (4) steps and you have been approved by the county or Public Authority to be an IHSS provider, as long as you are an active provider and your criminal background check remains clear, you will continue to be eligible to provide services for any IHSS recipient.

If you have any questions about these provider enrollment requirements, contact your County IHSS Office or IHSS Public Authority.



## TIER 2 EXCLUSIONARY CRIMES

Violent or Serious Felonies, Offenses Requiring Registration as a Sex Offender  
and Felony Offenses for Fraud Against a Public Social Services Program  
Pursuant to Welfare and Institutions Code (WIC) Section 12305.87

- The statutes cited in WIC 12305.87 are Penal Code (PC) 290(c), PC 667.5(c), PC 1192.7(c), WIC 10980(c)(2) and WIC 10980(g)(2).
- The column "CODE SECTION" refers to PC sections referenced in the PC statutes listed above.
- If two or more PC sections list an offense, only the offense with the broader application is referenced in the "code section" column.

CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
PC 136.1	Intimidation of victims or witnesses.	Preventing or trying to convince a witness not to testify at any legal proceeding or not to make any reports or act in any way that leads to an arrest or prosecution of the person.	PC 1192.7(c)
PC 182 with any PC 290(c) crimes	Conspiracy to commit any of the crimes set forth in PC 290(c); PC 182 with: PC 220 (except assault to commit mayhem) ; PC 243.4; PC 261(a)(1), (2), (3), (4), or (6); PC 262(a)(1) involving force or violence for which the person is sentenced to state prison; PC 264.1; PC 266; PC 266c; PC 266h(b); PC 266i(b); PC 266j; PC 267; PC 269; PC 285; PC 286; PC 288; PC 288a; PC 288.3; PC 288.4; PC 288.5; PC288.7; PC 289; PC 311.1; PC 311.2(b), (c), or (d); PC 311.3; PC 311.4; PC 311.10; PC 311.11; PC 314(1) or (2); PC 647.6; former PC 647a; PC 653f(c); any offense involving lewd or lascivious conduct under PC 272; any felony violation of PC 288.2; any statutory predecessor that includes all of the elements of one of the above-listed offenses; or any person who, since that date, has been or is convicted of the attempt or conspiracy to commit any of the above-listed offenses.	Agreeing with one or more people to commit a crime that would require the person who commits the crime to register as a sex offender.	PC 290(c)
PC 182 with any PC 1192.7(c) crimes	Conspiracy to commit any of the crimes set forth in PC 1192.7(c); PC 182 with: PC 136.1; PC 186.22 (if a	Agreeing with one or more people to commit a specified violent or serious felony.	PC 1192.7(c)

CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
	felony); PC 187; PC 190-190.4; PC 192(a); PC 203; PC 205; PC 207; PC 208; PC 209; PC 209.5; PC 211; PC 212.5; PC 213; PC 215; PC 220 (with intent to commit PC 261 or PC 211); PC 220(a) (with intent to commit mayhem, rape, sodomy, or oral copulation); PC 244; PC 245(c) or (d); PC 245.2; PC 245.3; PC 245.5; PC 246; PC 261; PC 264.1; PC 286 (c)(2) or (3); PC 288; PC 288a(c)(2); PC 288.5; PC 289(a)(1); PC 422; PC 451; PC 460(a); PC 461; PC 487(d)(2); PC 4500 (only if on a non-inmate); PC 4501; PC 4503; PC 11418(b) or (c); PC 12022.53; PC 12034(c); PC 12308; PC 12309; or PC 12310.		
PC 186.22	Participation in a criminal street gang.	Any felony crime that is committed while a person is acting as part of a criminal street gang.	PC 1192.7(c)
PC 187, PC 190-190.4	Murder.	Murder is when one person kills another while acting recklessly or intending to kill the person, commit a felony crime or cause severe physical harm.	PC 667.5(c) PC 1192.7(c)
PC 192(a)	Voluntary Manslaughter.	When a person kills another person but has an excuse, such as "heat of passion."	PC 667.5(c) PC 1192.7(c)
PC 203 PC 205	Mayhem.	Removing, disabling, or disfiguring a body part of a person or cutting certain parts of a person's head.	PC 667.5(c) PC 1192.7(c)
PC 207 PC 208	Kidnapping.	Taking, holding, or keeping another person by force or fear and moving the person to a different place; or the person taken is under 14 years old; or when a person talks a child into going with them to another place.	PC 667.5(c) PC 1192.7(c)
PC 209	Kidnapping for Ransom.	Taking another person and intending to hold the victim for ransom, reward or to intimidate. If someone helps another person to commit this crime they are also guilty of kidnapping for ransom.	PC 667.5(c) PC 1192.7(c)

CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
PC 209.5	Kidnapping During a Carjacking.	Taking a person who is not involved in the carjacking and moving that person to a place away from the carjacking that causes an increased risk of harm to the victim.	PC 667.5(c) PC 1192.7(c)
PC 211 PC 212.5 PC 213	Robbery.	Taking property from someone by force or fear and against their will.	PC 667.5(c) PC 1192.7(c)
PC 214	Train Robbery.	Taking property from any passenger or person on a train; interfering with anything related to the train and railroad; placing dynamite on anything having to do with the train; or stopping or attempting to stop a train with the intent to rob a person on the train.	PC 667.5(c)
PC 215	Carjacking.	Taking a vehicle from another person against their will by force or fear intending to leave the person without the vehicle.	PC 1192.7(c)
PC 220	Assault with intent to commit mayhem, rape, sodomy, oral copulation, rape in concert, lewd or lascivious acts on a child under 14 and genital or anal penetration by a foreign object.	Intentionally causing violent injury to another person while intending to commit mayhem or certain sex offenses listed in PC 220.	PC 667.5(c)
PC 243.4	Sexual battery and attempted sexual battery.	Touching the private parts of a person for sexual purposes without permission while the victim is restrained; is a patient receiving medical care and is seriously disabled or seriously ill; or the perpetrator wrongly believes that the touching is for a professional purpose.	PC 290(c)
PC 244	Throwing acid or flammable substances at another person.	Intentionally trying to disfigure a person by throwing a specified chemical that could injure or disfigure the person.	PC 1192.7(c)
PC 245(c) or (d)	Assault with a deadly weapon or instrument against a peace officer or firefighter.	Intentionally using a deadly weapon to cause violent injury (assault) on a peace officer or firefighter.	PC 1192.7(c)
PC 245.2	Assault with a deadly weapon against a public transit employee.	Intentionally using a deadly weapon to cause violent injury to a person.	PC 1192.7(c)
PC 245.3	Assault with a deadly weapon against a custodial officer.	Intentionally using a deadly weapon to cause violent injury to a person employed by a law enforcement agency as a public officer who is not a peace officer.	PC 1192.7(c)



CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
PC 245.5	Assault with a deadly weapon against a school employee.	Intentionally using a deadly weapon to cause violent injury to a school employee.	PC 1192.7(c)
PC 246	Discharge of a firearm at an inhabited dwelling, vehicle, or aircraft.	Intentionally shooting at a building, vehicle or aircraft when a person or persons are inside.	PC 1192.7(c)
PC 261	Rape.	Sex with a person, not a spouse, without that person's consent and: against the person's will; the person is unconscious or unaware; or the person cannot consent because of a mental disorder or developmental or physical disability.	PC 667.5(c) PC 1192.7(c)
PC 262	Rape of a spouse.	When a person has sex with their spouse and it is either against the spouse's will, the spouse is unconscious or the spouse is prevented from resisting due to intoxication that the person should have known about.	PC 1192.7(c)
PC 264.1	Rape or penetration of genital or anal openings by a foreign object; acting in concert by force or violence.	When 2 or more people have sex with or sexually penetrate a person without that person's consent and against the person's will; when the person is unconscious or unaware; or when the person cannot consent because of a mental disorder or developmental or physical disability.	PC 290(c) PC 667.5(c) PC 1192.7(c)
PC 266	Enticing a minor into prostitution; aiding and abetting.	Convincing, or helping someone convince, a female younger than 18 years old to become a prostitute.	PC 290(c)
PC 266c	Inducing sexual intercourse by fear or consent through fraud.	Having sex, sexual penetration, oral sex or anal sex by misrepresentations to the person or through fear.	PC 290(c)
PC 266h(b)	Pimping a minor.	Sharing in or taking the money earned by a prostitute who is younger than 18 years old.	PC 290(c)
PC 266i(b)	Pandering a minor.	Convincing by threats, violence, or promises, a person younger than 18 years old to become or remain a prostitute.	PC 290(c)
PC 266j	Providing a minor under 16 for lewd or lascivious act.	Intentionally giving, providing, or making available a person younger than 16 years old for an obscene, indecent, or lustful act.	PC 290(c)
PC 267	Abduction of person under 18 for prostitution.	Taking a person younger than 18 years old from their parent or guardian without permission for prostitution.	PC 290(c)

CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
PC 269	Aggravated sexual assault of a child.	Raping, having anal sex, having oral sex, or sexually penetrating a person younger than 14 years old who is 7 or more years younger than the attacker.	PC 290(c)
PC 285	Incest.	Having sexual relations with family members or close relatives.	PC 290(c)
PC 286	Sodomy.	Anal-penile sexual contact (anal sex).	PC 290(c)
PC 288	Lewd or lascivious act upon a child under 14.	Intentionally doing, or trying to do, an obscene, indecent, or lustful act with a person younger than 14 years old.	PC 290(c) PC 1192.7(c)
PC 288a	Oral copulation.	Applying the mouth of one person to the genitals or anus of another person (oral sex).	PC 290(c)
PC 288.2	Felony distribution of lewd material to children.	Intentionally sending inappropriate material to seduce a person younger than 18 years old.	PC 290(c)
PC 288.3	Contact with a minor to commit sexual offense.	Contacting or communicating with a person younger than 18 years old for a specified sexual purpose.	PC 290(c)
PC 288.4	Meeting with a minor for a sexual purpose.	Arranging to meet with a minor younger than 18 years old to expose the genitals or anal area of the minor or the perpetrator; or to do obscene, indecent or lustful acts with the minor.	PC 290(c)
PC 288.5	Continuous sexual abuse of a child.	Abusing a child younger than 14 years old at least 3 times over a period of at least 3 months through sexual contact or obscene, indecent, or lustful acts.	PC 290(c) PC 667.5(c) PC 1192.7(c)
PC 288.7	Sexual conduct with a child 10 years old or younger.	Sexual intercourse, anal-penile sexual contact (anal sex), oral-genital or oral-anal contact (oral sex) with a person younger than 10 years old.	PC 290(c)
PC 289	Sexual penetration by foreign object.	Sexual penetrating against a victim's will by force, violence, or fear when the victim cannot consent because of a mental disorder or developmental or physical disability, or the victim is unconscious or unaware.	PC 290(c)
PC 311.1	Child-related pornography.	Having any connection to images showing a minor younger than 18 years old doing, or pretending to do, sexual acts.	PC 290(c)

CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
PC 311.2(b) PC 311.2(c) PC 311.2(d)	Child-related pornography.	Possessing or distributing images showing a person younger than 18 years old doing, or pretending to do sexual acts for profit.	PC 290(c)
PC 311.3	Sexual exploitation of a child.	Possessing any image showing a minor younger than 18 years old engaging in sexual acts.	PC 290(c)
PC 311.4	Using a minor to assist in making or distributing child pornography.	Knowingly employing a minor younger than 18 years old to make an image or video showing sexual acts.	PC 290(c)
PC 311.10	Advertising or distributing child pornography.	Knowingly advertising for sale or distributing obscene material that shows a minor younger than 18 years old doing, or pretending to do, sexual acts.	PC 290(c)
PC 311.11	Possessing child pornography.	Knowingly possessing or controlling any image showing a person younger than 18 years old doing, or pretending to do sexual acts.	PC 290(c)
PC 314 (1) PC 314 (2)	Lewd or obscene exposure of private parts.	Exposing or getting another minor to expose private parts in an obscene or indecent way in public or where others are present.	PC 290(c)
PC 422	Criminal threats.	Communicating a threat to commit a crime that causes death or serious physical harm to another person and intending this statement to be understood as a threat.	PC 1192.7(c)
PC 451	Arson.	Intentionally setting fire to or burning any structure, forest land or property.	PC 1192.7(c)
PC 460(a)	First Degree Burglary.	Entering a building or a vehicle occupied by people with the intent to steal.	PC 1192.7(c)
PC 487 with PC 664	Grand theft involving a firearm.	Using a firearm to take the property of a person that is worth a certain amount of money or more as listed in the PC 487.	PC 1192.7(c)
PC 518 only if committed as a felony violation of PC 186.22	Extortion when committed in participation with a criminal street gang.	Acting as part of a criminal street gang when taking property from a person by using force or fear or pretending that they have an official right to take the property.	PC 667.5(c)
PC 647.6	Annoy or molest a child under 18 years old.	Harassing or making indecent sexual offers to a minor younger than 18 years old.	PC 290(c)
PC 647a (Former)	Annoy or molest a child under 18 years old.	Harassing or making indecent sexual offers to a minor younger than 18 years old.	PC 290(c)

CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
PC 653f(c)	Solicit another to commit rape, sodomy.	Asking another person to commit rape, anal-penile sexual contact (anal sex), or oral-genital or oral-anal contact (oral sex) by force or violence or other specified sexual offenses.	PC 290(c)
PC 664 with PC 187	Attempted murder.	Trying and failing to kill a person while: acting recklessly; intending to kill a person; intending to commit a felony; or intending to cause bodily injury.	PC 667.5(c) PC 1192.7(c)
PC 664 with any PC 290(c) crime	Attempt to commit any of the PC 290(c) crimes; PC 664 with: PC 220 (except assault to commit mayhem) ; PC 243.4; PC 261(a)(1), (2), (3), (4), or (6); PC 262(a)(1) involving force or violence for which the person is sentenced to state prison; PC 264.1; PC 266; PC 266c; PC 266h(b); PC 266i(b); PC 266j; PC 267; PC 269; PC 285; PC 286; PC 288; PC 288a; PC 288.3; PC 288.4; PC 288.5; PC288.7; PC 289; PC 311.1; PC 311.2(b), (c), or (d); PC 311.3; PC 311.4; PC 311.10; PC 311.11; PC 314(1) or (2); PC 647.6; former PC 647a; PC 653f(c); any offense involving lewd or lascivious conduct under PC 272; any felony violation of PC 288.2; any statutory predecessor that includes all of the elements of one of the above-listed offenses; or any person who, since that date, has been or is convicted of the attempt or conspiracy to commit any of the above-listed offenses.	Trying and failing to commit a crime that would require a person to register as a sex offender if the crime has been committed.	PC 290(c)
PC 664 with any PC 1192.7(c) crime, except for assault	Attempt to commit any of the PC 1192.7(c) crimes except for assault; PC 664 with: PC 136.1; PC 186.22 (if a felony); PC 187; PC 190-190.4; PC 192(a); PC 203; PC 205; PC 207; PC 208; PC 209; PC 209.5; PC 211; PC 212.5; PC 213; PC 244; PC 246;	When a person tries and fails to commit any felony that is punishable by life in prison or death.	PC 1192.7(c)

CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
	PC 261; PC 264.1; PC 286 (c)(2) or (3); PC 288; PC 288a(c)(2); PC 288.5; PC 289(a)(1); PC 422; PC 451; PC 460(a); PC 461; PC 487(d)(2); PC 4503; PC 11418(b) or (c); PC 12022.53; PC 12034(c); PC 12308; PC 12309; or PC 12310.		
PC 4500 (only if on a non-inmate)	Assault on a non-inmate by a prisoner sentenced to life.	When a person who is in prison with a life sentence threatens violent injury to a person who is not an inmate.	PC 1192.7(c)
PC 4501	Assault with a deadly weapon by an inmate.	When a person who is confined in prison uses a deadly weapon to threaten violent injury (assault) on another person.	PC 1192.7(c)
PC 4503	Holding of a hostage by a person confined in a state prison.	When person in state prison holds another person against their will.	PC 1192.7(c)
PC 11418 (b) PC 11418 (c)	Weapons of mass destruction used: (b) against a person, drinking water, or animals, crop seed or seed stock; or (c) in a form causing damage to public natural resources.	When a person uses a weapon of mass destruction against a person, drinking water, or animals, crop seed or seed stock or in a form causing damage to public natural resources.	PC 667.5(c) PC 1192.7(c)
PC 12022.7 PC 12022.8 PC 12022.9  (Before July 1, 1977 PC 213, PC 264, and PC 461)	A felony crime wherein defendant inflicts great physical harm to someone other than an accomplice or where great physical harm is committed in attempted commission of certain sex offenses or injury occurs resulting in termination of a pregnancy.	PC 12022.7: When a person intentionally causes serious physical harm to a person while committing, or attempting to commit a felony. If the victim has certain characteristics or is injured in a certain way, the penalty may be higher.  PC 12022.8: When a person inflicts serious physical harm on a person while committing, or attempting to commit, certain sex offenses that are listed in PC 12022.8.  PC 12022.9: When a person, knowing that a woman is pregnant, personally injures the woman so that the pregnancy is terminated.	PC 667.5(c)
PC 12022.3(a) PC 12022.5 PC 12022.55	Firearm offenses, including PC 12022.5 the use of a firearm in the commission of any felony, 12022.3(a) use of a firearm in the commission of rape, rape of spouse, rape in concert, sodomy, lewd or	PC 12022.3(a): When a person uses a firearm or deadly weapon while committing: rape (PC 261), rape of a spouse ( 262), rape in concert and attempted rape in concert (PC 264.1), sodomy (PC 286), lewd or lascivious act	PC 667.5(c)

CODE SECTION	TITLE	PLAIN ENGLISH	STATUTE SOURCE
	lascivious acts upon a child under 14, oral copulation, or Genital or anal penetration by foreign object 12022.55 causing death by discharging firearm into a motor vehicle.	<p>upon a child under 14 and attempted lewd or lascivious act upon a child under 14 (PC 288), oral copulation (PC 288a) or Genital or anal penetration by foreign object and attempted genital or anal penetration by a foreign object (PC 289).</p> <p>PC 12022.5: When a person uses a firearm while committing, or trying to commit, a felony crime.</p> <p>PC 12022.55: When a person shoots a gun into another car while committing, or attempting to commit, a felony and causes injury or death to a person.</p>	
PC 12022.53	Use of firearm in the commission of a specified felony.	Personal use of a firearm while committing a felony that is listed in the statute.	PC 667.5(c) PC 1192.7(c)
PC 12034(c)	Shooting from a vehicle.	When someone shoots a gun from a vehicle at a person in a vehicle.	PC 1192.7(c)
PC 12308	Explosion with intent to commit murder.	When a person explodes, ignites or attempts to explode anything with the intent to kill another person while either acting recklessly or intending to either kill the person, commit a felony or cause bodily injury to a person.	PC 667.5(c)
PC 12309	Explosion that causes great physical harm.	When a person explodes or ignites anything which causes physical harm to a person.	PC 667.5(c)
PC 12310	Explosion causing death.	When a person explodes or ignites anything that causes death, mayhem or serious physical harm to a person.	PC 667.5(c)
WIC 10980(c)(2)	Felony Welfare Fraud.	Intentionally and wrongly receiving CalWORKS/welfare aid worth more than \$950.	PC 12305.87(b)(2)
WIC 10980(g)(2)	Felony Food Stamps Fraud.	Intentionally using food stamps or EBT worth more than \$950 in an illegal way.	PC 12305.87(b)(2)
Any felony punishable by death or life imprisonment.		The person has committed a felony that has a punishment of death or life in prison	PC 1192.7(c)

<b>CODE SECTION</b>	<b>TITLE</b>	<b>PLAIN ENGLISH</b>	<b>STATUTE SOURCE</b>
	Any felony in which the defendant personally inflicts GBI on another person other than an accomplice or any felony in which the defendant personally uses a firearm.	When a person has committed a felony and caused serious physical harm to a person who is not involved in the crime or the person uses a firearm while committing any felony.	PC 1192.7(c)
	Any felony in which the defendant personally used a dangerous or deadly weapon.	When the person used a dangerous or deadly weapon while committing a felony.	PC 1192.7(c)
	Selling, furnishing, administering, giving, or offering to sell, furnish, administer, or give to a minor any heroin, cocaine, phencyclidine, or any methamphetamine-related drug as specified in 11055(d) of the Health and Safety Code or any of the precursors of methamphetamines as described in Health and Safety Code Section 11055(f) or 11100(a).		PC 1192.7(c)



## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

### READ THE INFORMATION BELOW CAREFULLY BEFORE YOU BEGIN TO COMPLETE THIS FORM

Under state law, if you have been convicted of, or incarcerated following a conviction, for certain exclusionary crimes within the past 10 years, you are not eligible to be enrolled as a provider or to receive payment from the IHSS program for providing supportive services except as specified below. There are two categories of exclusionary crimes.

- **Tier 1 crimes, as set forth in Welfare and Institutions Code (W&IC) section 12305.81, are:**
  1. Specified abuse of a child (Penal Code [PC] section 273a[a]\*),
  2. Abuse of an elder or dependent adult (PC section 368\*), and
  3. Fraud against a government health care or supportive services program.
- **Tier 2 crimes, as set forth in W&IC section 12305.87, are:**
  1. A violent or serious felony, as specified in PC section 667.5(c)\*, and PC section 1192.7(c)\*,
  2. A felony offense for which a person is required to register as a sex offender pursuant to PC section 290(c)\*, and
  3. A felony offense for fraud against a public social services program, as defined in W&IC sections 10980(c)(2)\* and (g)(2)\*.

A complete listing of Tier 2 crimes is available upon request from the County IHSS Office or IHSS Public Authority.

\*See attached form SOC 426C for the text of these PC and W&IC sections.

- As part of the IHSS provider enrollment process, you must submit fingerprints and undergo a criminal background check conducted by the California Department of Justice.
- If your responses on this form or the results of the criminal background check show that you have been convicted of, or incarcerated following a conviction for, either a Tier 1 or Tier 2 crime within the last 10 years, you will not be eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing supportive services.
- For Tier 2 crimes, if you have obtained a certificate of rehabilitation or an expungement (dismissal pursuant to PC section 1203.4), the conviction will not disqualify you from working as an IHSS provider.
- If your conviction is for a Tier 2 crime, you may qualify for an individual waiver or a general exception under certain circumstances which are described below.
- ***There are no waivers or exceptions allowed for Tier 1 crimes.***

GO ON TO THE NEXT PAGE 



## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

**CONTINUE READING THE INFORMATION BELOW CAREFULLY BEFORE  
YOU BEGIN TO COMPLETE THIS FORM**

### **Individual Waiver of an Exclusion for Conviction for a Tier 2 Crime**

If you are found ineligible based on a conviction for a Tier 2 exclusionary crime but an IHSS recipient (or his/her authorized representative) wishes to hire you as his/her provider in spite of your criminal background, you may obtain a waiver as follows.

- The IHSS recipient who wishes to hire you (or his/her authorized representative) will be informed of your conviction and will be directed to keep the information confidential.
- The recipient who wishes to hire you as his/her provider (or his/her authorized representative) must submit an IHSS Recipient Request for Provider Waiver (SOC 862) to the County IHSS Office or IHSS Public Authority.
- The waiver will allow you to be enrolled to provide services only for the recipient who requested the waiver.
- If you, as the provider, are also the recipients' authorized representative, you are NOT allowed to sign the waiver on behalf of the recipient to waive crimes for which you have been convicted. In this case, the waiver must either be signed directly by the recipient or, if that is not possible, another individual must be declared an authorized representative for purposes of signing this waiver.
- For more information about requesting a waiver, the IHSS recipient who wishes to hire you as his/her provider should contact the County IHSS Office or IHSS Public Authority.

### **General Exception of an Exclusion for Conviction for a Tier 2 Crime**

If you are found ineligible based on a conviction for a Tier 2 exclusionary crime and you want to be listed on a provider registry or want to provide services for a recipient who has not requested an individual waiver –

- You may apply for a general exception of the exclusion by completing the IHSS Applicant Provider Request for General Exception (SOC 863).
  - You will be required to provide backup documentation, (e.g., employment history, personal references, etc.), to support your request for a general exception.
  - For more information about requesting a general exception, contact the County IHSS Office or IHSS Public Authority.
- 
- Completion of this form satisfies ONE of the IHSS provider enrollment requirements.
  - You must complete ALL of the provider enrollment requirements BEFORE you can be enrolled as an IHSS provider or get paid from the IHSS program for providing authorized services for an eligible IHSS recipient.

**GO ON TO THE NEXT PAGE** 

# IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

## INSTRUCTIONS:

- Use black or blue ink to fill out. Print information clearly.
- Fill out, sign and return this form in person to the office or location designated by the county. Bring original federal or state government-issued identification and your original Social Security card when returning this form.
- Complete all items in PART A, answer the questions in PART B, and read and sign the declaration in PART C.
- The county will: 1) Review the form to make sure it is complete; 2) Make photocopies of your identification and Social Security card; and 3) Provide you with a copy of the completed form for your records.
- You must let the county know if anything you report on this form changes within ten (10) calendar days of the change.

## PART A: PROVIDER INFORMATION

1. Full Name (First Name, Middle Initial, Last Name):	2. Date of Birth:	3. Gender:
	If you are under 18 years of age, you must submit a valid Work Permit with this form.	<input type="checkbox"/> M <input type="checkbox"/> F
4. Home Address (Must be physical address, <u>not</u> a Post Office box):	City:	State:   ZIP:
5. Mailing Address (if different from home address):	City:	State:   ZIP:
6. Telephone Number (with Area Code):	7. Social Security Number*:	
8. a. Driver's License # or Government Issued ID #:	b. Expiration Date:	
	c. Issuing State:	
9. a. Primary Spoken Language:	b. Primary Written Language:	

## NOTES:

- \* The collection of the Social Security Number is required pursuant to W&IC 12305.81(a), and the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a), for the purposes of verifying the individual's identity and authorization to work in the United States.

## PART B: PROVIDER DISCLOSURE

**ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX:**

- WITHIN THE PAST 10 YEARS, HAVE YOU BEEN –**
  - Convicted of or incarcerated following a conviction for a Tier 1\* crime? ..... ☐ YES   ☐ NO
  - Convicted of or incarcerated following a conviction for a Tier 2\* crime? ..... ☐ YES   ☐ NO

*\*See Page 1 of this form for a definition of Tier 1 and Tier 2 crimes.*
- IF YOU ANSWERED "YES" TO QUESTION 1.b. ABOVE,** have you obtained a certificate of rehabilitation or expungement (dismissal pursuant to PC section 1203.4) of the Tier 2 crime? ..... ☐ YES   ☐ NO  
*If YES, you must provide the county with a copy of the certificate of rehabilitation or documentation of the expungement along with this completed form.*

**GO ON TO THE NEXT PAGE**

# IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

PROVIDER'S NAME: \_\_\_\_\_

## PART C: PROVIDER DECLARATION

### I UNDERSTAND AND AGREE THAT –

- I cannot receive IHSS program funds as payment for authorized services I provide to any eligible recipient of IHSS until I have completed the entire provider enrollment process and I have been officially enrolled as a provider by the county.
- As a part of the provider enrollment process, I must provide fingerprints and undergo a criminal background check. I am responsible for paying the costs of fingerprinting and the background check.
- If it is found, either through my responses on this form, the results of the criminal background check, or some other means, that within the past 10 years, I have been convicted of or incarcerated following a conviction for a Tier 1 exclusionary crime, I will not be eligible to be an IHSS provider, and the recipient who wished to hire me will be informed that I am ineligible to be a provider because of a disqualifying criminal conviction which will not be specified.
- If it is found, either through my responses on this form, the results of the criminal background check, or some other means, that within the past 10 years, I have been convicted of or incarcerated following a conviction for a Tier 2 exclusionary crime, and I have not received a certificate of rehabilitation or had the conviction expunged –
  - I will not be eligible to be an IHSS provider, unless an IHSS recipient who wishes to hire me to provide his/her services, requests an individual waiver, or I apply for and I am granted a general exception; and
  - The IHSS recipient who wishes to hire me as his/her provider will be informed of my conviction and the types of crimes for which I was convicted, and he/she will be directed to keep the information confidential.

### IF I AM ENROLLED BY THE COUNTY AS AN IHSS PROVIDER, I UNDERSTAND AND AGREE THAT –

- If the person I provide services for receives IHSS through the Medi-Cal program, I will be considered to be a Medi-Cal provider of personal care services. Therefore, I will be required to comply with all Medi-Cal program rules relating to the provision of services.
- Payment for the authorized services I provide to an IHSS recipient will be from federal, state and/or county IHSS funds. Any false statement I provide, including false entries on the timesheet or withholding of information, may be prosecuted under federal and/or state laws.
- I will reimburse the IHSS program for any overpayments paid to me and any overpayment, individually or collectively, may be deducted from a future paycheck for services I provide to any recipient of IHSS.
- I will provide all services without discrimination based on race, religion, color, national or ethnic origin, gender, age, sexual orientation, or physical or mental disability.

**I declare, UNDER PENALTY OF PERJURY, that all of the information I have provided on this form is true and correct to the best of my knowledge, and that I agree to all of the statements listed above.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

## FOR COUNTY USE ONLY

County Representative's Signature (Optional): \_\_\_\_\_ DATE: \_\_\_\_\_



**CDSS**

**WILL LIGHTBOURNE**  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



**EDMUND G. BROWN JR.**  
GOVERNOR

January 24, 2012

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

TO: ALL COUNTY WELFARE DIRECTORS  
IHSS PROGRAM MANAGERS

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

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

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

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

REASON FOR THIS TRANSMITTAL

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

ACIN No.: I-04-12  
Page Two

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

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Attachments

c: CWDA

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

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

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

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

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

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

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

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

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

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

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

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

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

## ATTACHMENT A

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

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

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

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

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

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

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



## ATTACHMENT A

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

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

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

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

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

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

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

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

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

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

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

## ATTACHMENT A

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

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

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

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

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

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

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

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

Response: Refer to the response to Question #13.

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

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

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

Are the crime codes listed on page 8 correct?

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

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

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

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

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

18. The ACL states that in addition to the specifically listed Tier 2 crimes, the following are also disqualifying crimes:
- Any felony in which the defendant personally inflicts GBI on another person other than an accomplice or any felony in which the defendant personally uses a firearm; and
  - Any felony in which the defendant personally used a dangerous or deadly weapon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Provider Enrollment Process**

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

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

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

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

## ATTACHMENT A

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

### **Forms & Notices**

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

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

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

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

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

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

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

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

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

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

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

## ATTACHMENT A

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

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

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

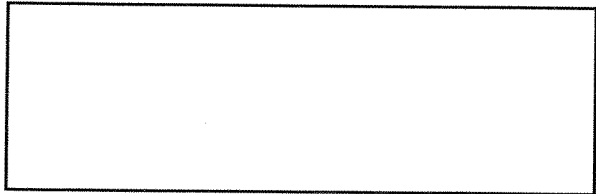
Response: You are correct that the Notice of Provider Eligibility (SOC 848) is not appropriate for a county/PA to utilize to inform an otherwise ineligible provider that a waiver submitted by a recipient has been accepted and that he or she is now enrolled to provide services for that recipient only.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

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

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

ATTACHMENT B

(ADDRESSEE)



County of: \_\_\_\_\_

Notice Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Recipient Name: \_\_\_\_\_

Recipient Case Number: \_\_\_\_\_

IHSS Office Address: \_\_\_\_\_

IHSS Office Telephone Number: \_\_\_\_\_

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

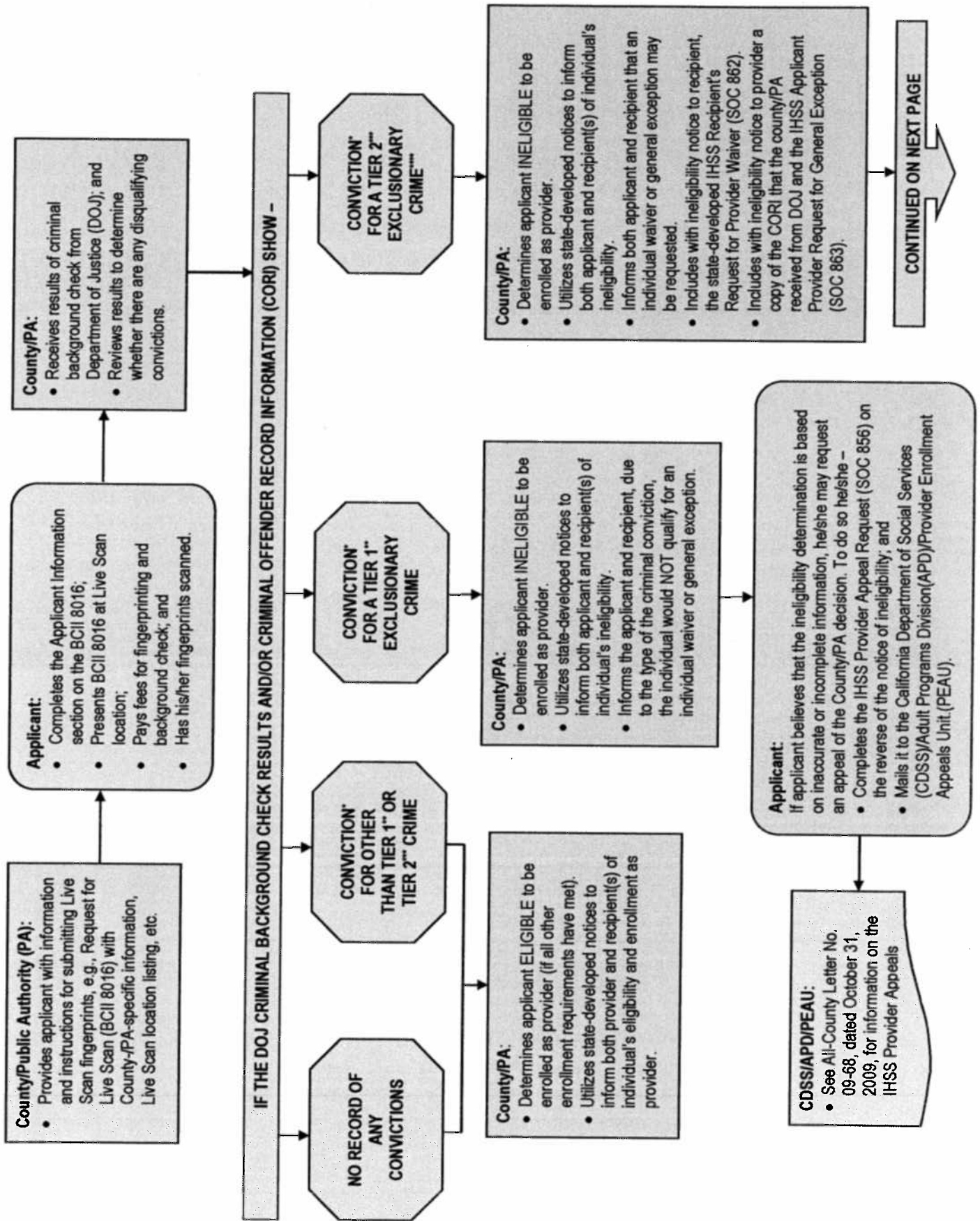
On \_\_\_\_\_, you were informed that, based on Welfare and Institutions Code, Section 12305.87, you were denied eligibility to work as an IHSS provider because you have been convicted of a felony crime.

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

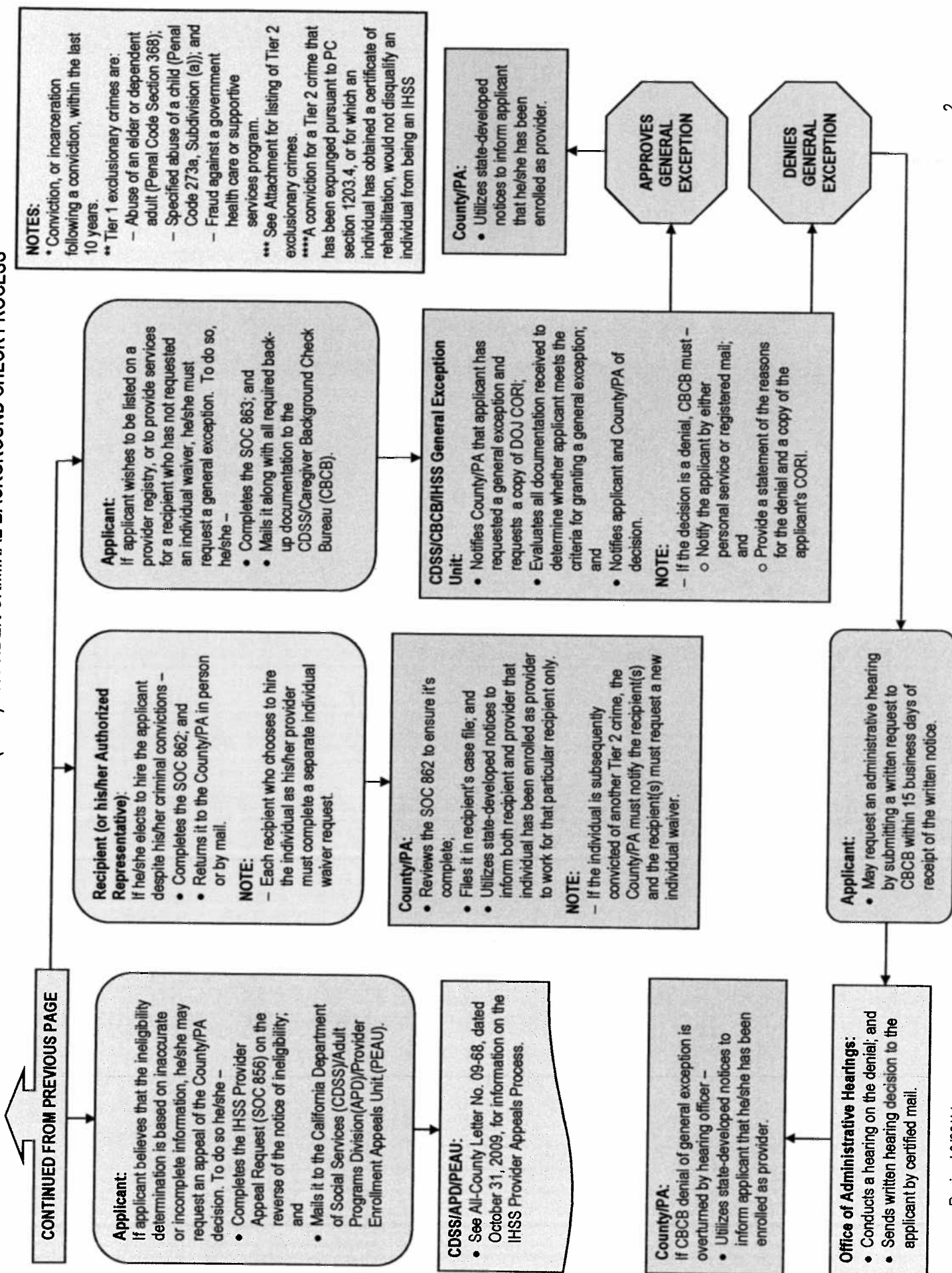
You may begin work as an IHSS provider for this recipient as of the date of this notice. This waiver allows you to work for the above-named recipient only. If you wish to work for additional recipients, you will need to obtain a waiver from each of those individuals, or you may request a general exception.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

If you have any questions about this notice, call \_\_\_\_\_.

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



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







## **Coordinated Care Initiative (CCI)**

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### **VOLUNTARY (OPTIONAL) PROVIDER TRAINING CURRICULUM\***

This curriculum is a compilation of training resources developed by the CCI Voluntary Provider Training Workgroup in accordance with Welfare & Institutions Code Section 12330. The usage of these and other training resources, by providers, is optional and can help provide consistency, accountability, and increased quality of care for In-Home Supportive Services (IHSS) consumers.

#### Acknowledgements

#### Topic 1: Introduction to In-Home Supportive Services

Overview of the IHSS Program; Properly Communicating IHSS Authorized Tasks/Hours; Properly Completing Timesheets; Provider Requirements and Responsibilities; Confidentiality and Mandated Reporting

#### Topic 2: Working with the IHSS Consumer

Professional/Ethical Caregiving; Building and Keeping Good Relationships; Consumer Rights and Responsibilities; Setting Appropriate Boundaries

#### Topic 3: Communication Skills

Building Trust; Cultural Competency; Communication Differences for Family and Non-Family Providers; Potential Barriers; Dealing with Challenging Situations; The Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality; Talking About Disabilities (Level of Control, Level of Independence); Communicating with Deaf and Hard of Hearing Consumers; Communicating with Consumers with Speech Impediments; Conflict Resolution

#### Topic 4: Care for the Caregiver

Proper Ergonomics/Body Mechanics; Correctly Lifting, Bending, and Moving to Continue Providing Care for the Consumer; Alternative Resources and Respite Care to Prevent Caregiver Burnout; Handling Loss and Grief as a Care Provider; Setting Appropriate Boundaries

#### Topic 5: Injury and Fall Prevention

Consumer Ergonomics/Body Mechanics; Safety in the Home; Transfers

#### Topic 6: Universal Precautions

Infection Control; Understanding Common Communicable Diseases; Sanitation (Soiled Clothes and Linens; Hands); Resources for Providers

#### Topic 7: Personal Care

Bowel, Bladder, and Menstrual Care; Bed Baths; Partial Sitting Baths; Tub Baths and Showers; Oral Care; Dressing; Shaving a Consumer; Repositioning

#### Topic 8: Paramedical Services

Tube Feedings; Suctioning/Tracheotomy Care; Stoma Care; Injections; Medication Management; Ostomy Care; Catheter Care; Cleaning of Equipment; Preventing Pressure Sores; Wound Care; Range of Motion

#### Topic 9: Food and Nutrition

General Nutrition Considerations (Meals, Medication, Observing Changes); Food Sanitation; Feeding/Choking Risks; Cultural Considerations; Hydration and Hydration Considerations; Use of Assistive Devices; Special Diets



#### Topic 10: Medication Management

Common Medication Side Effects; Setting Up Medi-Sets/Organization; Pain Management; Natural Medications; Medication Abuse and What To Do About It; Precautions for Providers

#### Topic 11: Use of Durable Medical Equipment (DME) in the Home

Assistive Devices Available to Consumers; Variations of Equipment; Respect for, Cleaning of, and Limitations of the Equipment; Use of Wheelchair Van Lifts and Other Adaptive Vehicles; Medical Supplies

#### Topic 12: Working with Consumers with Physical and Mental Health Disabilities

The Ten Most Common Physical Disabilities; The Ten Most Common Mental Health Disabilities; Tips for Effectively Dealing with Consumers' Disabilities

#### Topic 13: Emergency Procedures

Emergency Preparedness; In the Event of an Emergency; Emergency Contacts

#### Topic 14: Recognizing, Preventing, and Reporting Abuse and Neglect

Types of Abuse and Neglect; Getting Help

#### Topic 15: Cardio-Pulmonary Resuscitation (CPR) and First Aid - Layperson Responders

Where to Obtain Training (Optional)

*\*This Voluntary (Optional) Provider Training was developed through a stakeholder workgroup process and is intended to provide you with information and resources regarding best practices and interventions in your role as an IHSS provider. Please note, however, some material contained in this Voluntary (Optional) Provider Training Curriculum was included to help you understand the broad needs of many IHSS consumers, including needs met by sources outside the scope of the IHSS program. Certain information is intended for providers of services outside the scope of the IHSS program and/or services that require special training to be performed safely. IHSS providers must not perform services which are not authorized by the IHSS program and/or require special training.*

## FORMS COMMONLY USED IN THE IHSS PROGRAM

Form Number	Title	Status <sup>1</sup>	Form Use
<b>Assessment</b>			
SOC 293	Assessment Document	M/Integrated into CMIPS Evidence Screens	To record consumer information, Functional Index rankings, and authorization information.
SOC 293A	Needs Assessment – Face Sheet	O	To record important information regarding consumer, emergency contacts, diagnosis, physician information, medications, and household composition.
SOC 321	Request for Order and Consent – Paramedical Services	MIA/MSA	To be signed by physician indicating type of paramedical services required; amount of time to perform service and frequency of service.
SOC 332	Recipient/Employer Responsibility Checklist	M	Lists consumer responsibility as an employer. Social worker to review with consumer. Must be signed by consumer, social worker and provider. Copy provided to consumer.
SOC 426A	Recipient Designation of Provider	M	Required for recipients to designate a provider.
SOC 431	Personal Care Services Program Contract Agency Enrollment	M	Required for employees of contract agencies for programs that receive federal financial participation.
SOC 450	Voluntary Services Certification	MIA	Required when someone volunteers services when they could otherwise be paid by IHSS.
SOC 821	Assessment of Need for Protective Supervision for In-Home Supportive Services Program	MIA	To be used together with information obtained during assessment and information from other individuals /organizations in assessing the need for Protective Supervision. Must be sent to healthcare professional.
SOC 825	Protective Supervision 24-Hours-a-Day Coverage Plan	O	Used to document how 24 hour per day need for Protective Supervision is being met.
SOC 846	Provider Enrollment Agreement	M	Required for all programs that receive federal financial participation. Must be completed before timesheets processed.
SOC 864	Individualized Back-up Plan and Risk Assessment	M	To be completed for each consumer at the time of initial assessment and every year at reassessment.

<sup>1</sup> O = Optional; M = Mandatory for all cases; MIA = Mandatory if applicable; MSA = Mandatory, but county may request State Approval for Modification.

## FORMS COMMONLY USED IN THE IHSS PROGRAM

Form Number	Title	Status <sup>2</sup>	Form Use
SOC 873	Health Care Certification	M	Required for every consumer.
PUB 13	Civil Rights Pamphlet	M	Required for every case, every year.
NA (numbers vary)	Notice of Action	M	Required for every action.
<b>Eligibility</b>			
SOC 294A	IHSS Income Eligibility – Adult	MIA	Used when applicant is an adult to determine whether Medi-Cal or IHSS Share of Cost is lower.
SOC 294C	IHSS Income Eligibility – Child	MIA	Used when applicant is a minor child to determine whether Medi-Cal or IHSS Share of Cost is lower.
SOC 295	Application for Social Services	M	Required for all social service programs.
SOC 310	Statement of Facts for In-Home Supportive Services	MIA	Used only for IHSS Residual Program. (MC-210, Medi-Cal Statement of Facts, is an alternative to using SOC 310.)
<b>APS</b>			
SOC 341	Report of Suspected Dependent Adult/Elder Abuse	MIA	Required to report of suspected dependent adult/elder abuse. Must be completed by county staff when report is made by telephone.
SOC 341A	Statement Acknowledging Requirement to Report Suspected Abuse of Dependent Adults and Elders	M	All county IHSS staff must sign this form.
SOC 342	Report of Suspected Dependent Adult/Elder Financial Abuse – For Use By Financial Institutions	M	Form used by financial institutions to report suspected dependent adult/elder financial abuse. Officers or employees of institutions are mandated reporters.
SOC 343	Investigation of Suspected Dependent Adult/Elder Abuse	M	Form used to document investigation of suspected dependent adult/elder abuse.
<b>CPS</b>			
SS 8572	Suspected Child Abuse Report	MIA	Required whenever child abuse is suspected. Consumer or not. Must be completed by county staff when report is made by telephone.

<sup>1</sup> O = Optional; M = Mandatory for all cases; MIA = Mandatory if applicable; MSA = Mandatory, but county may request State Approval for Modification.

**FORM SAMPLES**

**ASSESSMENT**



# IN-HOME SUPPORTIVE SERVICES NEEDS ASSESSMENT-FACE SHEET

## A. RECIPIENT INFORMATION

NAME:			CASE NO:	TELEPHONE: (    )	DOB (MO/DATE/YR)	SEX: (CIRCLE ONE) M    F
ADDRESS (NUMBER, STREET):			IHSS COMPANION CASE(S), NAME(S) AND NUMBERS:			
CITY:	STATE:	ZIP CODE:				
RECIPIENT'S STATEMENT OF NEED:			SPECIAL DIRECTIONS:			
EMERGENCY CONTACTS/INSTRUCTIONS:			ALTERNATE RESOURCES USED: (LIST SOURCE AND SERVICE PROVIDED)			
SPECIAL CONDITIONS/MEDICAL PROBLEMS:						

## B. MEDICAL INFORMATION

DIAGNOSIS/PROGNOSIS:				DATE OF MEDICAL REQUEST:	
PHYSICIAN:	TELEPHONE: (    )	PHYSICIAN:	TELEPHONE: (    )		
PHYSICIAN:	TELEPHONE: (    )	PHYSICIAN:	TELEPHONE: (    )		
MEDICATIONS/PURPOSE					
1.	4.	7.			
2.	5.	8.			
3.	6.	9.			

## C. OTHER PERSONS IN HOUSEHOLD

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

COMMENTS:

WORKER:	TELEPHONE: (    )	DISTRICT OFFICE:	DATE:
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**REQUEST FOR ORDER AND CONSENT -  
PARAMEDICAL SERVICES**

PATIENT'S NAME

MEDI-CAL IDENTIFICATION NUMBER

TO:

Dear Doctor:

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

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

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

If you have any questions, please contact me.

SIGNED	TITLE	TELEPHONE NUMBER	DATE
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**TO BE COMPLETED BY LICENSED PROFESSIONAL**

NAME OF LICENSED PROFESSIONAL

OFFICE TELEPHONE

OFFICE ADDRESS (IF NOT LISTED ABOVE)

TYPE OF PRACTICE

TYPE OF PRACTICE

☐ Physician/Surgeon☐ Podiatrist☐ Dentist**CONTINUED ON BACK****RETURN TO: (COUNTY WELFARE DEPARTMENT)**



Does the patient have a medical condition which results in a need for IHSS paramedical services?"

☐ YES ☐ NO

Is YES, list the condition(s) below:

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

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

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

Additional comments:

☐ IF CONTINUED ON ANOTHER SHEET, CHECK HERE

#### CERTIFICATION

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

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

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

SIGNATURE

DATE

#### PATIENT'S INFORMED CONSENT

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

SIGNATURE

DATE

## IN-HOME SUPPORTIVE SERVICES Recipient/Employer Responsibility Checklist

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

- 1) Provide required documentation to my Social Worker to determine continued eligibility and need for services. Information to report includes, but is not limited to, changes to my income, household composition, marital status, property ownership, phone number, and time I am away from my home.
- 2) Find, hire, train, supervise, and fire the provider I employ.
- 3) Comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

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

- 4) Verify that my provider legally resides in the United States. My provider and I will complete Form I-9. I will retain the I-9 for at least three (3) years or one (1) year after employment ends, whichever is longer. I will protect the provider's confidential information, such as his/her social security number, address, and phone number.
- 5) Ensure standards of compensation, work scheduling and working conditions for my provider.
- 6) Inform my Social Worker of any future change in my provider(s), including:

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

- 7) Inform my provider that the gross hourly rate of pay is \$\_\_\_\_\_, and that Social Security and State Disability Insurance taxes are deducted from the provider's wages.
- 8) Inform my provider that he/she may request that Federal and/or State income taxes be deducted from his/her wages. Instruct the provider to submit Form W-4 (for federal income tax withholding) and/or Form DE 4 (for state income tax withholding).
- 9) Inform my provider that he/she is covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.
- 10) Inform my provider that he/she will receive an information sheet that will state my authorized services and the authorized time given to perform those services. Inform the provider that he/she is not paid to perform work when I am away from my home (for example, when in a hospital or away on vacation).
- 11) Pay my share of cost, if any.
- 12) Verify and sign my provider's timesheet for each pay period, showing the correct day(s) and the total number of hours worked. I understand I can be prosecuted under Federal and State laws for reporting false information or concealing information. I understand that when required, it will be necessary for me to place my fingerprint on my provider's timesheet to verify the correct day(s) and hours worked. This will be necessary, so my provider can be paid.
- 13) Ensure my provider signed his/her timesheet.
- 14) Advise my provider to mail his/her signed timesheet to the appropriate address at the end of each pay period.

\_\_\_\_\_  
Recipient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## **INSTRUCTIONS FOR USE OF THE RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST**

1. This form is used for review with recipients receiving service from Individual Providers **only**.
2. Counties shall use this form to assure that recipients have been advised of and understand their basic responsibilities as employers of IHSS providers.
3. Review each item with the recipient and explain how the recipient can comply with each requirement.
4. Leave a copy of the form with the recipient.

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

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

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

## RECIPIENT DECLARATION

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

RECIPIENT'S OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE:

DATE:

PRINTED NAME:

**VOLUNTARY SERVICES CERTIFICATION**  
(PLEASE TYPE OR PRINT CLEARLY)

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

[illegible]

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

PROVIDER SIGNATURE	DATE
SOCIAL SERVICE WORKER SIGNATURE	DATE

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



**ASSESSMENT OF NEED FOR PROTECTIVE SUPERVISION  
FOR IN-HOME SUPPORTIVE SERVICES PROGRAM**☐ Release of Information Attached

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

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

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

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

(Welfare and Institutions Code §12301.21)

DATE PATIENT LAST SEEN BY YOU:	LENGTH OF TIME YOU HAVE TREATED PATIENT:
DIAGNOSIS/MENTAL CONDITION:	PROGNOSIS: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary - Timeframe:

**PLEASE CHECK THE APPROPRIATE BOXES****MEMORY**

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

Explanation: \_\_\_\_\_

**ORIENTATION**

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

Explanation: \_\_\_\_\_

**JUDGMENT**

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

Explanation: \_\_\_\_\_

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

**CERTIFICATION**

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

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

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





**PROTECTIVE SUPERVISION  
24-HOURS-A-DAY COVERAGE PLAN****PLEASE PRINT**

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

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

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

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

- The 24-hour-a-day coverage plan will be provided at all times.
- If there is any change to the 24-hour-a-day coverage plan (i.e. hospitalization, attendance in day-care programs, travel, etc.) I will immediately **notify the IHSS social worker**.
- The above name Recipient has an established need for 24-hour-a-day Protective Supervision if he/she is to remain safely in the home. The IHSS social worker has also discussed with me the appropriateness of out-of-home care as an alternative to 24-hour-a-day Protective Supervision.

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

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


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

## **INSTRUCTIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER ENROLLMENT AGREEMENT

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

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

1. During the required orientation for IHSS providers:

- I was given the requirements to be an eligible IHSS provider and a description of the IHSS program. I was informed of my responsibilities as an IHSS provider.
- I was informed of the consequences of committing fraud in the IHSS program.
- I was given the Medi-Cal toll-free telephone fraud hotline number, 1-800-822-6222 and Internet Web site, <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx> for reporting suspected fraud or abuse in the IHSS program.

2. I received a demonstration of, and understand, how to complete my timesheet. If I have been a provider (on or before October 31, 2009), I received information on the new timesheet and understand how to complete it.

- I understand the timesheet should indicate only the authorized services I performed for the recipient and the time needed to perform those authorized services. I understand that my signature on my timesheet verifies that the information I reported on it is true and correct.
- I understand that, if I am convicted of fraudulently reporting information on my timesheet, in addition to any criminal penalties, I may be required to pay civil penalties of at least \$500, and not more than \$1,000, for each violation of fraud.
- I understand that when required, it will be necessary for me to place my fingerprint on my timesheet in order to be paid.

3. I understand that I am required to complete Form I-9, a form kept on file by the recipient, which states that I have the legal right to work in the United States.

4. I understand I have the option to submit Form W-4 to request federal income tax withholding and/or Form DE 4 to request state income tax withholding from my wages. I understand that if I do not submit Form W-4 and/or DE 4, no withholding will be taken out of my wages.

5. I understand services cannot be performed when the recipient is away from his/her home (for example, when the recipient is in the hospital or away on vacation). I will contact the recipient's social worker for approval of any services that may be performed when the recipient is away from the home.

- I understand that, in the future, I will receive an information sheet that names the recipient and the services I am authorized to perform for that recipient.

6. I will cooperate with state or county staff to provide requested information related to the evaluation of a recipient's IHSS case.

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

---

Provider's Signature

---

Date



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

### SECTION 1 – RECIPIENT'S INFORMATION

RECIPIENT'S NAME:

CASE NUMBER:

### INDIVIDUALIZED BACK-UP PLAN

### SECTION 2 – SUPPORT CONTACTS

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

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

Other important numbers available to you, if needed:

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

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

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

**If you have an emergency, call: 911**

An emergency is an immediate threat to your health, welfare and/or safety.

Distribution:

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

RECIPIENT'S NAME:

CASE NUMBER:

## RISK ASSESSMENT

### SECTION 3 – GENERAL RISK ASSESSMENT

#### A. IHSS Assessment

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

#### B. Additional Risk Areas

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

**Comments**

##### B1. Living Arrangements

- ☐ Lives with others who may assist
- ☐ Lives alone, relatives/friends nearby who may assist
- ☐ Lives alone, no relatives/friends nearby

##### B2. Evacuation/Environmental Factors

- ☐ Can evacuate independently
- ☐ Can evacuate, but only with supervision/verbal direction
- ☐ Needs physical assistance to evacuate home in an emergency
- ☐ Able to access food/water independently
- ☐ Aware of emergency or crisis numbers/contacts
- ☐ Able to control lights, heat, cooling or other utilities

##### B3. Communication

- ☐ Communicates without difficulty
- ☐ Hearing impairment, communication limited
- ☐ Speech impairment, communication limited
- ☐ Can speak or hear with the use of assistive device(s)  
Assistive device(s): \_\_\_\_\_
- ☐ Able to place and receive calls independently
- ☐ Can use telephone only with assistive device(s)  
Assistive device(s): \_\_\_\_\_

### SECTION 4 – DISASTER PREPAREDNESS

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

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

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

---

RECIPIENT'S NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

---

**AGREEMENT AND SIGNATURES**

---

**SECTION 5 – AGREEMENT AND SIGNATURES**

---

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

**Recipient**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

**Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

**Other**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

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

**Recipient /Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

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

---

RECIPIENT'S NAME:

CASE NUMBER:

---

### INSTRUCTIONS

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

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

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

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

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

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

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

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

**Comments/Notes:**

Distribution:

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

## A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

County of Residence: \_\_\_\_\_

IHSS Case #: \_\_\_\_\_

IHSS Worker Name: \_\_\_\_\_

IHSS Worker Phone #: \_\_\_\_\_

IHSS Worker Fax #: \_\_\_\_\_

## B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (To be completed by the applicant/recipient)

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

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

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

### TO: LICENSED HEALTH CARE PROFESSIONAL\* –

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

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

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

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

Applicant/Recipient Name:

IHSS Case #:

**C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)****NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.**

1. Is this individual unable to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)? ☐ YES ☐ NO

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

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

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

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

4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months? ☐ YES ☐ NO

**Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.**

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

6. How long have you provided service(s) to this individual?

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

8. Indicate the date you last provided services to this individual: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.**

**D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION**

By signing this form, I certify that I am licensed in the State of California and/or certified as a Medi-Cal provider, and all information provided above is correct.

Name:

Title:

Address:

Phone #:

Fax #:

Signature:

Date:

Professional License Number:

Licensing Authority:

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.



CDSS

WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

July 27, 2011

ALL-COUNTY LETTER NO.: 11-55

TO: ALL COUNTY WELFARE DIRECTORS  
IHSS PROGRAM MANAGERS

REASON FOR THIS TRANSMITTAL

- ☒ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS

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

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

**BACKGROUND**

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

**COUNTY RESPONSIBILITIES**

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

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

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

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

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

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

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

### **ALTERNATIVE DOCUMENTATION**

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

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

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

### **GOOD CAUSE**

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

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

### **CMIPS AND CMIPS NOTICE OF ACTION (NOA) MESSAGES**

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

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

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

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

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

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

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

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



**CMIPS NOA Message 507**

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

**CMIPS II NOA Messages**

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

**Applicant Denial Message (MXX-XX):**

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

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

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

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

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

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

**Recipient Termination Message (MXX-XX):**

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

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

The county asked you to provide a medical certification by \_\_\_\_\_ (DATE) \_\_\_\_\_.

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

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

**TRANSLATIONS**

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

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

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

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

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Attachments

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MEDICAL CERTIFICATION FORM

### A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

County of Residence: \_\_\_\_\_ IHSS Case #: \_\_\_\_\_

IHSS Worker Name: \_\_\_\_\_

IHSS Worker Phone #: \_\_\_\_\_ IHSS Worker Fax #: \_\_\_\_\_

### B. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (To be completed by the applicant/recipient)

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

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

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

### TO: LICENSED HEALTH CARE PROFESSIONAL –

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

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

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MEDICAL CERTIFICATION FORM

Applicant/Recipient Name:

IHSS Case #:

**\*\*ONLY A LICENSED HEALTH CARE PROFESSIONAL SHOULD COMPLETE THE REMAINDER OF THIS FORM.\*\***

### C. MEDICAL INFORMATION (To be completed by a Licensed Health Care Professional)

1. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):
2. How long have you provided service(s) to this individual?
3. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

4. Indicate the date you last provided services to this individual: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- |  |  |
|--|--|
| 5. Is this individual <b>unable</b> to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.), or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |

*If you answered "NO" to either Question #5 OR #6, skip Questions #7 and #8 below, and complete the certification in PART D at the bottom of the form.*

*If you answered "YES" to both Question #5 AND #6, respond to Questions #7 and #8 below, and complete the certification in PART D at the bottom of the form.*

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

8. Is the condition(s) or functional limitation(s) expected to last more than 12 consecutive months?

☐ YES ☐ NO

**NOTE: THE SOCIAL WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.**

### D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and all information provided above is correct.

Name:

Title:

Address:

Phone #:

Fax #:

Signature:

Date:

Professional License Number:

Licensing Authority:

PLEASE RETURN THIS FORM TO THE SOCIAL WORKER LISTED ON PAGE 1.

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM

### NOTICE TO APPLICANT OF MEDICAL CERTIFICATION REQUIREMENT

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There has been a change in state law\* that requires each person applying for IHSS to provide a medical certification from a licensed health care professional (LHCP) before they can get IHSS.

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

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

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

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

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

The county may accept an alternate document in place of the Medical Certification Form as long as it meets all of the following requirements:

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

**If you do not provide the Medical Certification Form or alternate document to the county within 45 days, your application for IHSS will be denied. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.**

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

Due By: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Welfare and Institutions Code section 12309.1

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
NOTICE TO RECIPIENT OF MEDICAL  
CERTIFICATION REQUIREMENT**

COUNTY OF: \_\_\_\_\_

Notice Date: \_\_\_\_\_

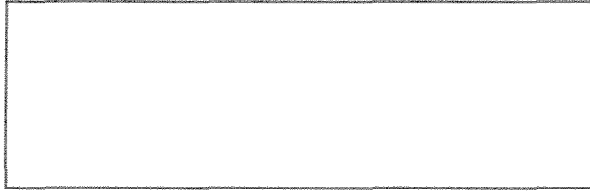
IHSS Office Address: \_\_\_\_\_

IHSS Office Telephone Number: \_\_\_\_\_

Social Worker Name: \_\_\_\_\_

Due By: \_\_\_\_\_

(ADDRESSEE)



To: In-Home Supportive Services (IHSS) Recipient

There has been a change in state law\* that requires each person getting IHSS to provide a medical certification from a licensed health care professional (LHCP) to continue to get IHSS.

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

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

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

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

Whether you give the Medical Certification Form to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within 45 days following your reassessment. If the county does not receive the Medical Certification Form by the 35th day, a notice will be sent informing you that your IHSS will stop, unless you had previously contacted the county and were given more time to submit the form.

The county may accept an alternate document in place of the Medical Certification Form as long as it meets all of the following requirements:

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

**If the county does not receive the completed Medical Certification Form or alternate document within 45 days following your reassessment, your IHSS may stop. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.**

If you are not able to get the medical certification from your LHCP within 45 days, call your social worker at the number listed above, as soon as possible.

\*Welfare and Institutions Code section 12309.1



WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

November 10, 2011

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

TO: ALL COUNTY WELARE DIRECTORS  
IHSS PROGRAM MANAGERS

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

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

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

**BACKGROUND**

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

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

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

**REASON FOR THIS TRANSMITTAL**

- ☐ State Law Change
- ☒ Federal Law or Regulation Change
- ☐ Court Order
- ☒ Clarification Requested by One or More Counties
- ☐ Initiated by CDSS



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

### **GRANTING EXCEPTIONS FOR APPLICANTS**

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

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

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

### **CMIPS INSTRUCTIONS FOR EXCEPTIONS**

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

### **NOTICES**

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

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

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

### **FORMS/CAMERA-READY COPIES AND TRANSLATIONS**

For a camera-ready copy of English and Spanish forms, contact the Forms Management Unit at: [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov). If your office has internet access, you may obtain these forms from the California Department of Social Services (CDSS) web page at: [www.dss.cahwnet.gov/cdssweb/FormsandPu\\_271.htm](http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm).

ACL No.: 11-76  
Page Four

Please note CDSS is in the process of translating the SOC 876 into the threshold languages: Spanish, Armenian and Chinese. Copies of the translated forms and publications in all other required languages can be obtained at:  
[www.dss.cahwnet.gov/cdssweb/FormsandPu\\_274.htm](http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm).

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

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

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

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

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Attachment

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
NOTICE OF PROVISIONAL APPROVAL  
HEALTH CARE CERTIFICATION EXCEPTION GRANTED**

TO:

County of: \_\_\_\_\_

Notice Date: \_\_\_\_\_

Case Number: \_\_\_\_\_

IHSS Office Address: \_\_\_\_\_

IHSS Office Telephone Number: \_\_\_\_\_

The county has provisionally approved your application for In-Home Supportive Services (IHSS). Here's what that means:

State law requires that before you can get IHSS, you have to provide the county with a health care certification completed and signed by a licensed health care professional, and you have to have an assessment of your needs completed in your own home.

The county has granted an exception so that you can get IHSS on a temporary basis **before** you meet these requirements, but you still have to provide the county with the health care certification (if you have not already provided it). You will temporarily get the services/hours shown below once you return to your own home. These services/hours are based on a preliminary assessment of your needs done while you were in a medical facility.

When you provide the county with the health care certification, the county will determine your eligibility to continue getting IHSS. If you are determined eligible, the county will do an in-home assessment to complete the determination of your services/hours.

The county asked you to provide the health care certification by \_\_\_\_\_.

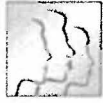
DATE

If you do not provide the county with a health care certification by this date, the IHSS you have been getting on a temporary basis will stop. If you cannot provide the certification by this date, contact your social worker before the due date to explain why and ask if the county can grant you more time.

If you have questions about the information in this notice, call your social worker.

SERVICES	AUTHORIZED # OF HOURS
<b>DOMESTIC SERVICES (per month)</b>	
<b>RELATED SERVICES (PER WEEK)</b>	
- Prepare meals	
- Meal clean-up	
- Routine laundry	
- Shopping for food	
- Other shopping/errands	
<b>NON-MEDICAL PERSONAL SERVICES (PER WEEK)</b>	
- Respiration assistance	
- Bowel and/or bladder care	
- Feeding	
- Routine bed baths	
- Dressing	
- Menstrual care	
- Assistance with walking (including getting in/out of vehicles)	
- Transferring: moving in/out of bed, on/off seats, etc.	
- Bathing, oral hygiene, grooming	
- Rubbing skin, repositioning	
- Assistance with prosthesis, help setting up medication	
<b>ACCOMPANIMENT (PER WEEK)</b>	
- To/from medical appointments	
- To/from alternative resources	
<b>PROTECTIVE SUPERVISION (PER WEEK)</b>	
<b>TEACHING/DEMONSTRATION SERVICES (PER WEEK)</b>	
<b>PARAMEDICAL SERVICES (PER WEEK)</b>	
<b>HOURS OF SERVICE AUTHORIZED FOR ONE MONTH ONLY</b>	
- Heavy cleaning	
- Yard hazard abatement	
Total weekly hours of service authorized	
Multiply by 4.33 (average # of weeks per month) to convert to monthly hours	
Add monthly authorized domestic services hours (from above)	
<b>TOTAL HOURS OF SERVICE AUTHORIZED PER MONTH</b>	





CDSS

WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

December 6, 2011

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

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

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

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

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

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

**REVISIONS TO THE SOC 873**

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

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

**REASON FOR THIS TRANSMITTAL**

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☒ Initiated by CDSS

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

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

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

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

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

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

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

- The items in Section C have been reordered and renumbered. The items that, on the prior version of the form, were the last four items in the section (Items # 5 – 8) are now listed first (Items # 1 – 4).
- At the beginning of Section C, the following note has been added: *NOTE: ITEMS # 1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.* Also, before Item #5, the following note has been added: *Please complete Items # 5 – 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.*

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

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

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



#### **REVISIONS TO THE SOC 874**

- Throughout the notice (e.g., the title, etc.), all references to the term “medical certification” have been changed to “health care certification” in order to conform with the language used in the statute.
- Information about alternative documentation requirements has been updated to reflect that, in order to be valid, the document must be signed by a LHCP *within the last 60 days*.
- Language has been added near the bottom of the notice explaining that, under certain limited circumstances, an exception may be granted which would allow an individual to temporarily receive services prior to providing the completed SOC 873 or alternative documentation to the county. The individual is still required to provide one of the documents in order to continue receiving services.

#### **REVISIONS TO THE SOC 875**

- Throughout the notice (e.g., the title, etc.), all references to the term “medical certification” have been changed to “health care certification” in order to conform with the language used in the statute.
- The following language has been deleted from the notice: “If the county does not receive the SOC 873 by the 35<sup>th</sup> day, a notice will be sent informing you that your IHSS will stop, unless you had previously contacted the county and were given more time to submit the form.”

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

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

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

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

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

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

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

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

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

[http://www.dss.cahwnet.gov/cdssweb/FormsandPu\\_274.htm](http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm).

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

Your County Forms Coordinator will distribute translated forms to each program and location. Each county must provide bilingual/interpretive services and written translations to non-English or limited-English proficient populations, as required by the Dymally-Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and/or by state regulation (MPP Division 21, Civil Rights Nondiscrimination, section 115). Questions about accessing the forms may be directed to the Forms Management Unit at [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov); questions about translations may be directed to the Language Services Unit at [LTS@dss.ca.gov](mailto:LTS@dss.ca.gov).

**CLARIFICATION REGARDING INTER-COUNTY TRANSFERS (ICTs)**

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

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

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Attachments

# IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM

## HEALTH CARE CERTIFICATION FORM

### A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name:

Date of Birth:

Address:

County of Residence:

IHSS Case #:

IHSS Worker Name:

IHSS Worker Phone #:

IHSS Worker Fax #:

### B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (To be completed by the applicant/recipient)

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

(PRINT NAME)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

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

#### TO: LICENSED HEALTH CARE PROFESSIONAL\* –

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

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

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

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

Applicant/Recipient Name:

IHSS Case #:

**C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)****NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.**

1. Is this individual unable to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)? ☐ YES ☐ NO

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

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

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

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

4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months? ☐ YES ☐ NO

**Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.**

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

6. How long have you provided service(s) to this individual?

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

8. Indicate the date you last provided services to this individual: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.**

**D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION**

By signing this form, I certify that I am licensed in the State of California and/or certified as a Medi-Cal provider, and all information provided above is correct.

Name:

Title:

Address:

Phone #:

Fax #:

Signature:

Date:

Professional License Number:

Licensing Authority:

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM

### NOTICE TO APPLICANT OF HEALTH CARE CERTIFICATION REQUIREMENT

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

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

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

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

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

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

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

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

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

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

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

DUE BY: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

(ADDRESSEE)

COUNTY OF: \_\_\_\_\_

Notice Date: \_\_\_\_\_

IHSS Office Address: \_\_\_\_\_

IHSS Office Telephone Number: \_\_\_\_\_

Social Worker Name: \_\_\_\_\_

**DUE BY:** \_\_\_\_\_

To: In-Home Supportive Services (IHSS) Recipient

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

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

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

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

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

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

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

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

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

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

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

#### DISCRIMINATION COMPLAINTS

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

You can file a discrimination complaint with:

1. FOR ALL PROGRAMS ADMINISTERED BY YOUR COUNTY WELFARE DEPARTMENT:

The County's Civil Rights Coordinator. Ask your county office for the name, address and phone number of their Civil Rights Coordinator. He/she will independently investigate your complaint.

2. Civil Rights Bureau  
California Department of Social Services  
744 P Street, MS 8-16-70  
Sacramento, CA 95814  
(916) 654-2107  
(866) 741-6241 (Toll-Free)

3. FOR THE CALFRESH PROGRAM:  
United States Department of Agriculture  
Director, Office of Civil Rights,  
Room 326-W, Whitten Bldg.  
1400 Independence Avenue, S.W.,  
Washington, D.C. 20250-9410  
(202) 720-6382 (voice and TTY)

4. FOR ALL OTHER PROGRAMS:  
Health and Human Services  
Office of Civil Rights  
90 7th Street, Suite 4-100  
San Francisco, CA 94103  
(415) 437-8310 (voice)  
(415) 437-8311 (TDD)

#### TIME LIMITS TO TAKE ACTION

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

#### LIMITS ON CERTAIN RIGHTS

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

#### QUESTIONS

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

#### PROGRAMS COVERED BY THIS PAMPHLET

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

- Multipurpose Senior Services Program (MSSP)
- Personal Care Services Program (PCSP)
- Refugee Cash Assistance
- Social Services



STATE OF CALIFORNIA

HEALTH AND HUMAN  
SERVICES AGENCY

DEPARTMENT OF  
SOCIAL SERVICES

This pamphlet is available from your Local County Welfare Office and at [www.cdss.ca.gov](http://www.cdss.ca.gov) in the following languages:

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

Also Available in large print, Braille, and Audio CD

PUB 13 (6/11)

# YOUR RIGHTS

## UNDER CALIFORNIA WELFARE PROGRAMS



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



**Tell us if you need help  
because of a disability**



**Ask for a free interpreter**



## YOUR RIGHTS

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

- You have the right to an interpreter free of charge.
- Ud. tiene derecho a un intérprete gratis
- Вы имеете право на услуги Переводчика
- 你有权利自由译员
- May karapatan kang magkaroon ng tag ugnay na walang bayad.
- Quý vị có quyền được một thông dịch viên miễn phí.
- .Koj muaj txoj caiis yuav ib tus neegtxhais lus Hmoob rau koj.
- علي مترجم دون أية تكلفة. لديك الحق في الحصول
- རྒྱུ་མཉམ་པར་འབྲེལ་བྱེད་པའི་མཁན་པོ་ལ་མཉམ་པར་འབྲེལ་བྱེད་པའི་མཁན་པོ་ལ་
- 여러분은 무료 통역 서비스를 받을 권리가 있습니다
- ناگهياري يادافش همجرت تادمخ زا دي زاد قح امش دي درگ دنم مرمب
- མཁན་པོ་ལ་མཉམ་པར་འབྲེལ་བྱེད་པའི་མཁན་པོ་ལ་
- Ви має право на безкоштовного перекладача.
- Você tem o direito a um/a interprete gratuito/al
- あなたは無料の通訳の権利を有してもいい。
- Meih maaih leiz haih duqv dauh faan waac mienh tengx meih maiv zuqc bun nyaanh.

## YOU HAVE A RIGHT TO...

1. Understand what is happening with your application and aid.

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

## IF YOU ARE HAVING PROBLEMS WITH YOUR AID OR SERVICES:

1. Keep records of all your information, documents, and contacts with the county.
2. Get a receipt when you turn anything in.
3. You can bring someone with you to a meeting with your worker.
4. Complain. There are 4 ways to do this:
  - **Informal:** You can ask to speak to a supervisor to talk about problems with a worker or to go over the rules and the proposed action on your aid or services.
  - **State Hearing:** Ask for a state hearing if there is a problem with your aid or services. **You must ask for a hearing within 90 days of the county's action.** You may be able to file after 90 days if you have a good reason, like illness or a disability.
  - **Discrimination complaint:** If you feel that the county has discriminated against you, you can make a discrimination complaint to the County's Civil Rights Coordinator or to the State Civil Rights Bureau, and to the Federal Government. You must do this within 180 days of the discrimination. For more on this, see the section beginning "Prohibited Discrimination."

If the discrimination also affects your benefits or services, **you must also ask for a state hearing** if you wish to challenge the county's decision on your benefits or services.

- **Grievance:** You can file a complaint with the county if they have a grievance procedure. **This does not protect your benefits** in the way that asking for a state hearing does.

## STATE HEARINGS

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

## CONTINUING YOUR AID OR SERVICES PENDING A STATE HEARING

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

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

## HOW TO REQUEST A STATE HEARING

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

## PROHIBITED DISCRIMINATION

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

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

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

Federal Law also prohibits :

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

## EXAMPLES OF DISCRIMINATION

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

**FORM SAMPLES**

**ELIGIBILITY**



**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 <input type="checkbox"/> Male <input type="checkbox"/> Female
CITY	ZIP CODE	TELEPHONE (     )		BIRTHDATE

2. Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	ARE YOU A SPOUSE/CHILD OF A VETERAN? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER:
---	--	---

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

4. Have you received In-Home Supportive Services (IHSS) in the past? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> NAME OF PARENT <input type="checkbox"/>		
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): <input type="text"/>	B. I speak and understand English: My primary language is (see reverse side for correct code:) <input type="text"/> <input type="checkbox"/> Yes <input type="checkbox"/> No

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: <i>(ONLY IF APPLICABLE)</i>	DATE: <i>(ONLY IF APPLICABLE)</i>
REPRESENTATIVE'S RELATIONSHIP TO APPLICANT: <i>(ONLY IF APPLICABLE)</i>	REPRESENTATIVE'S TELEPHONE NUMBER: <i>(ONLY IF APPLICABLE)</i> (      )
REPRESENTATIVE'S ADDRESS: <i>(ONLY IF APPLICABLE)</i>	

**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](mailto:www.stopmedicalfraud@dhcs.ca.gov).**

**FOR AGENCY USE ONLY**

INCOME ELIGIBLE: <input type="checkbox"/> YES <input type="checkbox"/> NO	STATUS ELIGIBLE: <input type="checkbox"/> YES <input type="checkbox"/> NO	VERIFICATION:	SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTATIVE:	TELEPHONE NUMBER: (      )
RECIPIENT STATUS: <input type="checkbox"/> Refugee <input type="checkbox"/> Cuban/Haitian Entrant			SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS <i>(EXPLAIN)</i>	

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



# **FORM SAMPLES**

**APS/CPS**





**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 <input type="checkbox"/> M <input type="checkbox"/> F	ETHNICITY	LANGUAGE (✓ CHECK ONE) <input type="checkbox"/> NON-VERBAL <input type="checkbox"/> ENGLISH <input type="checkbox"/> OTHER (SPECIFY)
*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)				*CITY	*ZIP CODE	*TELEPHONE ( )
*PRESENT LOCATION (IF DIFFERENT FROM ABOVE)				*CITY	*ZIP CODE	*TELEPHONE ( )
<input type="checkbox"/> ELDERLY (65+) <input type="checkbox"/> DEVELOPMENTALLY DISABLED <input type="checkbox"/> MENTALLY ILL/DISABLED <input type="checkbox"/> PHYSICALLY DISABLED <input type="checkbox"/> UNKNOWN/OTHER						<input type="checkbox"/> LIVES ALONE <input type="checkbox"/> LIVES WITH OTHERS

**B. SUSPECTED ABUSER** ✓ Check if ☐ Self-Neglect

NAME OF SUSPECTED ABUSER	<input type="checkbox"/> CARE CUSTODIAN (type)	<input type="checkbox"/> PARENT	<input type="checkbox"/> SON/DAUGHTER	<input type="checkbox"/> OTHER						
	<input type="checkbox"/> HEALTH PRACTITIONER (type)	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> OTHER RELATION							
ADDRESS	*ZIP CODE	TELEPHONE ( )	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR

**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) <input type="checkbox"/> OWN HOME <input type="checkbox"/> COMMUNITY CARE FACILITY <input type="checkbox"/> HOSPITAL/ACUTE CARE HOSPITAL <input type="checkbox"/> HOME OF ANOTHER <input type="checkbox"/> NURSING FACILITY/SWING BED <input type="checkbox"/> OTHER (Specify)
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**E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).**

<b>1. PERPETRATED BY OTHERS (WIC 15610.07 &amp; 15610.63)</b> a. PHYSICAL <input type="checkbox"/> ASSAULT/BATTERY <input type="checkbox"/> CONSTRAINT OR DEPRIVATION <input type="checkbox"/> SEXUAL ASSAULT <input type="checkbox"/> CHEMICAL RESTRAINT <input type="checkbox"/> OVER OR UNDER MEDICATION b. <input type="checkbox"/> NEGLECT c. <input type="checkbox"/> FINANCIAL d. <input type="checkbox"/> ABANDONMENT e. <input type="checkbox"/> ISOLATION f. <input type="checkbox"/> ABDUCTION g. <input type="checkbox"/> OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)	<b>2. SELF-NEGLECT (WIC 15610.57(b)(5))</b> a. <input type="checkbox"/> PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter) b. <input type="checkbox"/> MEDICAL CARE (e.g., physical and mental health needs) c. <input type="checkbox"/> HEALTH and SAFETY HAZARDS d. <input type="checkbox"/> MALNUTRITION/DEHYDRATION e. <input type="checkbox"/> OTHER (Non-Mandated e.g., financial)
ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) <input type="checkbox"/> NO PHYSICAL INJURY <input type="checkbox"/> MINOR MEDICAL CARE <input type="checkbox"/> HOSPITALIZATION <input type="checkbox"/> CARE PROVIDER REQUIRED <input type="checkbox"/> DEATH <input type="checkbox"/> MENTAL SUFFERING <input type="checkbox"/> OTHER (SPECIFY) <input type="checkbox"/> 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: <input type="checkbox"/> DEPOSIT <input type="checkbox"/> CREDIT <input type="checkbox"/> OTHER	TRUST ACCOUNT: <input type="checkbox"/> YES <input type="checkbox"/> NO
POWER OF ATTORNEY: <input type="checkbox"/> YES <input type="checkbox"/> NO	DIRECT DEPOSIT: <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER ACCOUNTS: <input type="checkbox"/> YES <input type="checkbox"/> 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
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**I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE.** (If unknown, list contact person).

*NAME	IF CONTACT PERSON ONLY ✓ CHECK <input type="checkbox"/>	*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
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**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 #	<input type="checkbox"/> Date Mailed: <input type="checkbox"/> Date Faxed:
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**L. RECEIVING AGENCY USE ONLY** ☐ Telephone Report ☐ Written Report

1. Report Received by:	Date/Time:	
2. Assigned <input type="checkbox"/> Immediate Response <input type="checkbox"/> Ten-day Response <input type="checkbox"/> No Initial Face-To-Face Required <input type="checkbox"/> Not APS <input type="checkbox"/> Not Ombudsman	Approved by:	Assigned to (optional):
3. Cross-Reported to: <input type="checkbox"/> CDHS, Licensing & Cert.; <input type="checkbox"/> CDSS-CCL; <input type="checkbox"/> CDA Ombudsman; <input type="checkbox"/> Bureau of Medi-Cal Fraud & Elder Abuse; <input type="checkbox"/> Mental Health; <input type="checkbox"/> Law Enforcement; <input type="checkbox"/> Professional Board; <input type="checkbox"/> Developmental Services; <input type="checkbox"/> APS; <input type="checkbox"/> 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

## GENERAL INSTRUCTIONS (Continued)

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)]

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**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 <input type="checkbox"/> M <input type="checkbox"/> F	LANGUAGE (✓ CHECK ONE) <input type="checkbox"/> NON-VERBAL <input type="checkbox"/> ENGLISH <input type="checkbox"/> OTHER (SPECIFY)
ADDRESS (IF FACILITY, INCLUDE NAME)	CITY			ZIP CODE	TELEPHONE ( )
PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	CITY			ZIP CODE	TELEPHONE ( )
<input type="checkbox"/> ELDERLY (65+) <input type="checkbox"/> DEVELOPMENTALLY DISABLED <input type="checkbox"/> MENTALLY ILL/DISABLED <input type="checkbox"/> PHYSICALLY DISABLED <input type="checkbox"/> UNKNOWN/OTHER					

**B. INCIDENT INFORMATION - WHERE INCIDENT OCCURRED**

PLACE OF INCIDENT (✓ CHECK ONE)	
<input type="checkbox"/> FINANCIAL INSTITUTION <input type="checkbox"/> OWN HOME <input type="checkbox"/> CARE FACILITY <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> 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: <input type="checkbox"/> DEPOSIT <input type="checkbox"/> CREDIT <input type="checkbox"/> OTHER	TRUST ACCOUNT: <input type="checkbox"/> YES <input type="checkbox"/> NO
POWER OF ATTORNEY: <input type="checkbox"/> YES <input type="checkbox"/> NO	DIRECT DEPOSIT: <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER ACCOUNTS: <input type="checkbox"/> YES <input type="checkbox"/> NO

**E. SUSPECT INFORMATION**

NAME OF SUSPECTED ABUSER(S)	ADDRESS	DATE OF BIRTH	AGE (ESTIMATE IF UNKNOWN)
RELATIONSHIP TO VICTIM			
<input type="checkbox"/> CARE CUSTODIAN <input type="checkbox"/> PARENT <input type="checkbox"/> SON/DAUGHTER <input type="checkbox"/> HEALTH PRACTITIONER <input type="checkbox"/> SPOUSE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> 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 #	<input type="checkbox"/> Date Mailed: <input type="checkbox"/> Date Faxed:
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**H. RECEIVING AGENCY USE ONLY**    ☐ Telephone Report    ☐ Written Report

1. Report Received by:		Date/Time:
2. Assigned <input type="checkbox"/> Immediate Response <input type="checkbox"/> Ten-day Response <input type="checkbox"/> No Initial Face-To-Face Required <input type="checkbox"/> Not APS <input type="checkbox"/> Not Ombudsman		
Approved by:		Assigned to (optional):
3. Cross-Reported to: <input type="checkbox"/> CDHS, Licensing & Cert.; <input type="checkbox"/> CDSS-CCL; <input type="checkbox"/> CDA Ombudsman; <input type="checkbox"/> Bureau of Medi-Cal Fraud & Elder Abuse; <input type="checkbox"/> Mental Health; <input type="checkbox"/> Law Enforcement; <input type="checkbox"/> Professional Board; <input type="checkbox"/> Developmental Services; <input type="checkbox"/> APS; <input type="checkbox"/> Other (Specify)          Date of Cross-Report:		
4. APS/Ombudsman/Law Enforcement Case File Number:		



# **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](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](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
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**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. <u>Physical Indicators</u> : Bruises Burns Welts Fractures Dislocations Lacerations Abrasions Skin Irritations Skin disorders Bedsores Friction burns Untreated injuries Untreated medical/dental problem Stomachaches Malnutrition 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. <u>Behavioral Indicators</u> : Fear Denial Trembling Implausible/conflicting stories Regressive behavior Helplessness Non-responsiveness Resignation Agitation Depression Sleeping disturbances Excessive sleeping c. <u>Sexual Abuse Indicators</u> : Sexually transmitted disease Genital discharge/infection Genital trauma (Bruises, etc.) Difficulty walking/sitting Excessive body consciousness Fecal soiling Inappropriate sexual behavior d. <u>Financial Indicators</u> : 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
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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:**

<input type="checkbox"/> Physical	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Sexual	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Financial	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Neglect	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Abandonment	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Isolation	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Abduction	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Psychological	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded

**PERPETRATED BY SELF:**

<input type="checkbox"/> Physical Care	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Medical Care	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Health and Safety	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Malnutrition/Dehydration	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded
<input type="checkbox"/> Financial	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Unfounded

15. COMMENTS

PRINT APS SOCIAL WORKER NUMBER	SIGNATURE OF APS SOCIAL WORKER	SIGNATURE OF APS SUPERVISOR
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# **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.



Print

**SUSPECTED CHILD ABUSE REPORT**

Reset Form

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

CASE NAME: \_\_\_\_\_

PLEASE PRINT OR TYPE

CASE NUMBER: \_\_\_\_\_

<b>A. REPORTING PARTY</b>	NAME OF MANDATED REPORTER		TITLE		MANDATED REPORTER CATEGORY		
	REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS		Street	City	Zip	DID MANDATED REPORTER WITNESS THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	REPORTER'S TELEPHONE (DAYTIME) (      )		SIGNATURE		TODAY'S DATE		
<b>B. REPORT NOTIFICATION</b>	<input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> COUNTY PROBATION		AGENCY				
	<input type="checkbox"/> COUNTY WELFARE / CPS (Child Protective Services)						
	ADDRESS		Street	City	Zip	DATE/TIME OF PHONE CALL	
		OFFICIAL CONTACTED - TITLE		TELEPHONE (      )			
<b>C. VICTIM</b> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEVELOPMENTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME		
	IN FOSTER CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: <input type="checkbox"/> DAY CARE <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> FOSTER FAMILY HOME <input type="checkbox"/> FAMILY FRIEND <input type="checkbox"/> GROUP HOME OR INSTITUTION <input type="checkbox"/> RELATIVE'S HOME			TYPE OF ABUSE (CHECK ONE OR MORE) <input type="checkbox"/> PHYSICAL <input type="checkbox"/> MENTAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> NEGLECT <input type="checkbox"/> OTHER (SPECIFY)		
	RELATIONSHIP TO SUSPECT			PHOTOS TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	
<b>D. INVOLVED PARTIES</b>	<b>VICTIM'S SIBLINGS</b>						
	NAME		BIRTHDATE	SEX	ETHNICITY		
	1. _____		3. _____				
	2. _____		4. _____				
	<b>VICTIM'S PARENTS/GUARDIANS</b>						
	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 (      )	
	<b>SUSPECT</b>						
SUSPECT'S NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX    ETHNICITY		
ADDRESS			Street	City	Zip    TELEPHONE (      )		
OTHER RELEVANT INFORMATION							
<b>E. INCIDENT INFORMATION</b>	IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX <input type="checkbox"/> 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
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.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.

## 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 a 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](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) 623-0199
Lake	(707) 262-4517
Lassen	(530) 842-1687
Los Angeles (City)	(213) 482-7252
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) 573-3900
Santa Barbara	(805) 925-9554
Santa Clara	(408) 350-3200
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) 623-0199
Tuolumne	(209) 532-6272
Ventura	(805) 477-7300
Yolo	(916) 486-1876

Updated March 27, 2014



# Multipurpose Senior Services Program

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## 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.

**<http://www.aging.ca.gov/Programs/MSSP/>**

Updated May 23, 2014



## About ADHC/CBAS

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### 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.

Individuals also may pay "out-of-pocket" for services in licensed ADHC centers. Third party payers such as long-term care insurance companies, Regional Centers or the Veterans Administration also may pay for services in licensed ADHC centers.

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.

**[http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Program\\_Overview.asp](http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Program_Overview.asp)**

Updated February 24, 2014



The California Department of Developmental Services is the agency through which the State of California provides services and supports to individuals with developmental disabilities.

These disabilities include mental retardation, cerebral palsy, epilepsy, autism and related conditions. Services are provided through state-operated developmental centers and community facilities, and contracts with 21 nonprofit regional centers. The regional centers serve as a local resource to help find and access the services and supports available to individuals with developmental disabilities and their families.

## **Services Provided By Regional Centers**

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Regional centers provide diagnosis and assessment of eligibility and help plan, access, coordinate and monitor the services and supports that are needed because of a developmental disability. There is no charge for the diagnosis and eligibility assessment.

Once eligibility is determined, a case manager or service coordinator is assigned to help develop a plan for services, tell you where services are available, and help you get the services. Most services and supports are free regardless of age or income.

There is a requirement for parents to share the cost of 24-hour out-of-home placements for children under age 18. This share depends on the parents' ability to pay. For further information, see Parental Fee Program. There may also be a co-payment requirement for other selected services. For further information, see Family Cost Participation Program.

Some of the services and supports provided by the regional centers include:

- Information and referral
- Assessment and diagnosis
- Counseling
- Lifelong individualized planning and service coordination
- Purchase of necessary services included in the individual program plan
- Resource development
- Outreach
- Assistance in finding and using community and other resources
- Advocacy for the protection of legal, civil and service rights
- Early intervention services for at risk infants and their families
- Genetic counseling
- Family support
- Planning, placement, and monitoring for 24-hour out-of-home care
- Training and educational opportunities for individuals and families
- Community education about developmental disabilities

## Who Is Eligible For Services?

To be eligible for services, a person must have a disability that begins before the person's 18th birthday, be expected to continue indefinitely and present a substantial disability as defined in *Section 4512* of the *California Welfare and Institutions Code*. Eligibility is established through diagnosis and assessment performed by regional centers.

Infants and toddlers (age 0 to 36 months) who are at risk of having developmental disabilities or who have a developmental delay may also qualify for services. The criteria for determining the eligibility of infants and toddlers is specified in *Section 95014* of the *California Government Code*. In addition, individuals at risk of having a child with a developmental disability may be eligible for genetic diagnosis, counseling and other prevention services. For information about these services, see Early Start.

## Information About Programs and Services

The Department of Developmental Services is responsible for designing and coordinating a wide array of services for California residents with developmental disabilities. Regional centers help plan, access, coordinate and monitor these services and supports.

A Person-Centered Planning approach is used in making decisions regarding where a person with developmental disabilities will live and the kinds of services and supports that may be needed. In person-centered planning, everyone who uses regional center services has a planning team that includes the person utilizing the services, family members, regional center staff and anyone else who is asked to be there by the individual. The team joins together to make sure that the services that people are getting are supporting their choices in where they want to live, how and with whom they choose to spend the day, and hopes and dreams for the future.

The following is a partial list of supportive services and living arrangements available for persons with developmental disabilities:

## Day Program Services

Day programs are community-based programs for individuals served by a regional center. They are available when those services are included in that person's Individual Program Plan (IPP). Day program services may be at a fixed location or out in the community.

Types of services available through a day program include:

- Developing and maintaining self-help and self-care skills.
- Developing the ability to interact with others, making one's needs known and responding to instructions.
- Developing self-advocacy and employment skills.
- Developing community integration skills such as accessing community services.
- Behavior management to help improve behaviors.
- Developing social and recreational skills.

There are many different types of day programs that provide a diverse range of opportunities for persons with developmental disabilities. If you are interested in learning more about day program services, ask your regional center representative for assistance.

## Day Program Providers

Persons or organizations that provide day program services must be vendored by a regional center, meet any required licensing standards and meet local government requirements.

If you are interested in providing day program services, ask for information and help from the resource developer at the regional center in the area in which you wish to provide services.

## Education Services For Children with Developmental Disabilities

The public school system in California has an important role in providing services to children with developmental disabilities. In recent years, the California State Department of Developmental Services (DDS) and the California Department of Education (CDE) have become strong partners in providing early intervention services to children 0 - 3 years old and special education services to children 3 to 21 years old. Children with special needs who were served by California's Early Start Program are able to enter public school programs as preschoolers if they satisfy the eligibility criteria as a child who can benefit from special education services. Local education agencies provide special education and related services to children with disabilities in environments including the home, school, public or private preschools or child care settings. Regional centers continue to provide some services for children who are eligible under the Lanterman Developmental Disabilities Services Act that are not provided as special education and related services.

More information about educational services for children with special needs can be obtained through your local school district, local education agency or Special Education Local Plan Area.

## Work Services Home Page

The Work Services Program addresses the employment needs of persons with developmental disabilities. The Work Services Program provides work and community integration opportunities through Supported Employment Programs (SEPs) and Work Activity Programs (WAPs). These programs are available to persons who are Regional Center clients. If you or someone you know is interested in one of these programs contact your Regional Center representative for help.

Take some time to browse this website. You will find information for consumers, families, service providers, regional centers, and links & resources.

If you have any questions, please send an e-mail to [work.services@dds.ca.gov](mailto:work.services@dds.ca.gov).

## Supported Employment Services

Supported Employment (SE) services through the Department of Rehabilitation can be provided either through the vocational rehabilitation program or the HSP. SE services are aimed at finding competitive work in a *community integrated work setting* for persons with severe disabilities who need ongoing support services to learn and perform the work. SE placements can be individual placements, group placements (called enclaves), and work crews, such as landscaping crews. Support is usually provided by a job coach who meets regularly with the individual on the job to help him or her learn the necessary skills and behaviors to work independently. As the individual gains mastery of the job, the support services are gradually phased out.

The Department of Rehabilitation is the main SE service provider for adults with developmental disabilities. However, if they are unable to provide services due to fiscal reasons, the regional center may be able to help individuals served get a job by referring them to other programs that provide SE-like services, if these services are available in their area.



If you are interested in applying for SE services you should ask your regional center representative for help or you can apply directly to the local DR office in your community. The nearest DR office location and telephone number is listed in the State Government section of your telephone directory.

## Work Activity Program Services

Work Activity Program (WAP) services through the Department of Rehabilitation include paid work, work adjustment and supportive habilitation services in a *sheltered work shop setting*. WAPs provide paid work in accordance with Federal and State Fair Labor Standards. Work adjustment services may include developing good work safety practices, money management skills, and appropriate work habits. Supportive habilitation services may include social skill and community resource training as long as the services are necessary to achieve vocational objectives.

## Supported Services

Support services are provided to persons receiving services from a regional center in order to meet the goals and objectives of the Individual Program Plan (IPP) or the Individual Family Service Program (IFSP) (for children ages 0-3 years). Services may be provided through vendors approved by the regional center or through other resources.

Regional centers have a mandate not only to serve persons with developmental disabilities, but to provide services in the most cost-effective manner possible. They are required by the Lanterman Act to use all other resources or generic resources first before using regional center funds. A generic agency is one which has a legal responsibility to serve all members of the general public and receives public funds for providing those services. Other resources include natural supports, school districts, etc.

## Supported Living Services

### STANDARDIZED ASSESSMENT QUESTIONNAIRE

Fiscal Year 2012-13 Trailer Bill language ([AB 1472](#), Chapter 25, Statutes of 2012) amended section 4689 of the Welfare & Institutions Code (WIC) regarding assessments for individuals in supported living arrangements. To ensure that consumers in or entering into supported living arrangements receive the appropriate amount and type of supports to meet the person's choice and needs as determined by the IPP team, and that generic resources are utilized to the fullest extent possible, the IPP team shall complete a standardized assessment questionnaire at the time of development, review, or modification of a consumer's IPP. The questionnaire shall be used during the individual program plan meetings, in addition to the provider's assessment, to assist in determining whether the services provided or recommended are necessary and sufficient and that the most cost-effective methods of supported living services are utilized.

**Supported Living Services (SLS)** consist of a broad range of services to adults with developmental disabilities who, through the Individual Program Plan (IPP) process, choose to live in homes they themselves own or lease in the community. SLS may include:

- Assistance with selecting and moving into a home;
- Choosing personal attendants and housemates;
- Acquiring household furnishings;
- Common daily living activities and emergencies;
- Becoming a participating member in community life; and,
- Managing personal financial affairs, as well as other supports.



These services help individuals exercise meaningful choice and control in their daily lives, including where and with whom to live. SLS is designed to foster individuals' nurturing relationships, full membership in the community, and work toward their long-range personal goals. Because these may be life-long concerns, Supported Living Services are offered for as long and as often as needed, with the flexibility required to meet a persons' changing needs over time, and without regard solely to the level of disability. Typically, a supported living service agency works with the individual to establish and maintain a safe, stable, and independent life in his or her own home. But it is also possible for some individuals to supervise their services themselves, to secure the maximum possible level of personal independence.

The guiding principles of SLS are set down in Section 4689(a) of the Lanterman Act. The Department's regulations for SLS are found in Title 17, Division 2, Chapter 3, Subchapter 19 (Sections 58600 et seq) of the California Code of Regulations (CCR).

Individuals who choose to live in their own homes, and their agencies or other people who support them, often will need information about affordable housing options, sources of financial support such as Supplementary Security Income (SSI), and how to stretch a limited budget to meet living expenses. These are the ordinary challenges that are inseparable from a truly self-directed life in the community. For the many adults for whom SLS makes great sense, such challenges are often also road signs on the path to a satisfying life.

## **Affordable Housing**

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Affordable housing is a cornerstone to individuals with developmental disabilities residing in their local communities. Due to the high cost of housing in California, many individuals served by the regional centers require deep subsidies in order to make housing affordable. DDS is actively pursuing projects that will increase capacity and precipitate the construction of new affordable housing.

This site provides information about affordable housing projects in which DDS is involved. The site also links users to public and private agencies that can assist individuals with developmental disabilities in finding affordable housing.

**DDS Projects: can be found at <http://www.dds.ca.gov/AH/Home.cfm>**

- Community Placement Plan Housing
- DDS Affordable Housing (DDS-AH)
- DDS Rental Units (DDS-R)
- 2002 Housing Legislative Report (PDF)

## **Family Home Agency**

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A Family Home Agency (FHA) approves family homes which offer the opportunity for up to two adult individuals with developmental disabilities per home to reside with a family and share in the interaction and responsibilities of being part of a family. The individual with developmental disabilities receives the necessary service and supports from the family, agencies and the community to enable the individual to be a participating member of the family and the community where the family resides. The family home arrangement allows the sharing of food, shelter, experience, responsibilities and love.

The FHA is a private, nonprofit organization under contract to, and vendored by a regional center. FHAs are responsible for recruiting, training, approving and monitoring family homes, as well as providing ongoing support to family homes. Social service staff employed by the FHA make regular visits to the family home to ensure that necessary services and supports are in place, and that the match between the family and the new family member is viable, and continues to be viable.

FHA and family home services and supports are a new option which enables adults with developmental disabilities to enter into partnerships with families that promote self-determination and interdependence.

For more information about Family Home Agencies, contact your local regional center or the:

*California Department of Developmental Services  
Community Services and Supports Division  
Community Development Branch  
P.O. Box 944202  
Sacramento, CA 94244-2020*

## **Foster Family Agency**

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Foster Family Agencies (FFAs) are residential options for children with developmental disabilities, that represent a collaborative effort between two service systems - developmental disabilities and social services/community care licensing. FFAs are privately operated organizations licensed by the Community Care Licensing Division of the State Department of Social Services to care for children up to age 18 in certified foster family homes. FFAs are responsible for the recruitment, training and certification of families to provide alternative homes for children. FFAs monitor and provide oversight for the homes they have certified, and have the authority to decertify homes when necessary. In addition, through the use of professional staff such as social workers, FFAs provide ongoing support to certified parent(s) and the children who live with them.

Professional foster care allows the family and/or those who know the child the best to pick and choose the best support system for the child and wrap services around the child rather than have the child fit into whatever services, i.e. group home, are available. The child is living in a "normal" way - the child lives in a family, in a neighborhood and interacts with other children living the same way. The child has as much contact with the family of origin as the family chooses. The foster home, in the most ideal situation, becomes an extension of the family system.

For more information about Foster Family Agencies, contact your local regional center or the:

*California Department of Developmental Services  
Residential Services Branch  
P.O. Box 944202  
Sacramento, CA 94244-2020*

## **Independent Living**

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Independent Living is a service provided to adults with developmental disabilities that offers functional skills training necessary to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills. Individuals typically live alone or with roommates in their own homes or apartments. These homes are not licensed.

Independent living programs, which are vendored and monitored by regional centers, provide or coordinate support services for individuals in independent living settings. They focus on functional skills training for adults who generally have acquired basic self-help skills or who, because of their physical disabilities, do not possess basic self-help skills, but who employ and supervise aides to assist them in meeting their personal needs.

For more information about Independent Living Services, contact your local regional center or the:  
California Department of Developmental Services, Residential Services Branch

## **In-Home Supportive Services**

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In-Home Supportive Services (IHSS) provides personal care and domestic services to persons who are aged, blind or disabled and who live in their own homes. IHSS is provided to those who otherwise might be placed in an out-of-home care facility but who can safely remain in their own home if IHSS services are received.

Regional centers have a mandate not only to serve persons with developmental disabilities, but to provide services in the most cost-effective manner possible. They are required by the Lanterman Act to use all other sources of funding and services before using regional center funds to provide services. Persons who receive services from a regional center and are eligible for IHSS are expected to use IHSS services available to them.

The In-Home Supportive Services (IHSS) program is administered by each county with oversight by the California Department of Social Services (CDSS). For application and eligibility information contact your local county welfare department, adult services section. Look for them in the county government section of your local telephone directory.

## **Transportation services**

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Transportation services are provided so persons with a developmental disability may participate in programs and/or other activities identified in the IPP. A variety of sources may be used to provide transportation including: public transit and other providers; specialized transportation companies; day programs and/or residential vendors; and family members, friends, and others. Transportation services may include help in boarding and exiting a vehicle as well as assistance and monitoring while being transported.

For more information about transportation services contact your regional center representative

## **Community Care Facilities**

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Community Care Facilities (CCFs) are licensed by the Community Care Licensing Division of the State Department of Social Services to provide 24-hour non-medical residential care to children and adults with developmental disabilities who are in need of personal services, supervision, and/or assistance essential for self-protection or sustaining the activities of daily living. Based upon the types of services provided and the persons served, each CCF vendored by a regional center is designated one of the following service levels:

- SERVICE LEVEL 1: Limited care and supervision for persons with self-care skills and no behavior problems.
- SERVICE LEVEL 2: Care, supervision, and incidental training for persons with some self-care skills and no major behavior problems.
- SERVICE LEVEL 3: Care, supervision, and ongoing training for persons with significant deficits in self-help skills, and/or some limitations in physical coordination and mobility, and/or disruptive or self-injurious behavior.
- SERVICE LEVEL 4: Care, supervision, and professionally supervised training for persons with deficits in self-help skills, and/or severe impairment in physical coordination and mobility, and/or severely disruptive or self-injurious behavior. Service Level 4 is subdivided into Levels 4A through 4I, in which staffing levels are increased to correspond to the escalating severity of disability levels.

For more information about Community Care Facilities, contact your local regional center or the: *California Department of Developmental Services, Residential Services Branch, P.O. Box 944202 Sacramento, CA 94244-2020*

## **Intermediate Care Facility Program Types (ICF/DD, ICF/DD-H, ICF/DD-N\*)**

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Intermediate Care Facilities (ICF) are health facilities licensed by the Licensing and Certification Division of the California Department of Public Health (CDPH) to provide 24-hour-per-day services. There are three types of ICFs, which all provide services to Californians with developmental disabilities.

- **ICF/DD** (Developmentally Disabled)  
"Intermediate care facility/developmentally disabled" is a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
- **ICF/DD-H** (Habilitative)  
"Intermediate care facility/developmentally disabled-habilitative" is a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
- **ICF/DD-N** (Nursing)  
"Intermediate care facility/developmentally disabled-nursing" is a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.
- **DD-CNC\*** (Continuous Nursing Care)  
"The Developmentally disabled-continuous nursing care" program is licensed as an ICF/DD-N. However, the license is suspended while the facility operates under a Home and Community Based Waiver program, which provides 24-hour continuous nursing care for 4-8 medically fragile regional center consumers in a residential setting. DD/CNC development is currently limited by a regional center's assessed need for this program.

\*Source: Health & Safety Code online: [www.leginfo.ca.gov](http://www.leginfo.ca.gov)

**For more information about Intermediate Care Facilities, contact your local regional center or the:**  
*California Department of Developmental Services, Health Facilities Program Section*  
1600 9th Street, Room 320 (MS 3-9), Sacramento, CA 95814 (916) 654-1965 or e-mail: [ddshfps@dds.ca.gov](mailto:ddshfps@dds.ca.gov).

**<http://www.dds.ca.gov/DDSHomePage.cfm>**

Updated from website 9/10/12

## Directory of Regional Centers

California has 21 regional centers with more than 40 offices located throughout the state that serve individuals with developmental disabilities and their families.

Regional Centers	Executive Director	Areas Serve
<b><u>Alta California Regional Center</u></b> 2241 Harvard Street, Suite 100 Sacramento, CA 95815	<b>Phil Bonnet</b> (916) 978-6400	Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba counties
<b><u>Central Valley Regional Center</u></b> 4615 North Marty Avenue Fresno, CA 93722-4186	<b>Robert Riddick</b> (559) 276-4300	Fresno, Kings, Madera, Mariposa, Merced, and Tulare counties
<b><u>Eastern Los Angeles Regional Center</u></b> 1000 South Fremont Alhambra, CA 91802-7916 <b>Mailing Address:</b> P.O. Box 7916 Alhambra, CA 91802-7916	<b>Gloria Wong</b> (626) 299-4700	Eastern Los Angeles county including the communities of Alhambra and Whittier
<b><u>Far Northern Regional Center</u></b> 1900 Churn Creek Road, #319 Redding, CA 96002 <b>Mailing Address:</b> P. O. Box 492418 Redding, CA 96049-2418	<b>Laura Larson</b> (530) 222-4791	Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, and Trinity counties
<b><u>Frank D. Lanterman Regional Center</u></b> 3303 Wilshire Boulevard, Suite 700 Los Angeles, CA 90010	<b>Diane Campbell Anand</b> (213) 383-1300	Central Los Angeles county including Burbank, Glendale, and Pasadena
<b><u>Golden Gate Regional Center</u></b> 1355 Market Street, Suite 220 San Francisco, CA 94103	<b>James Shorter</b> (415) 546-9222	Marin, San Francisco, and San Mateo counties
<b><u>Harbor Regional Center</u></b> 21231 Hawthorne Boulevard Torrance, CA 90503	<b>Patricia Del Monico</b> (310) 540-1711	Southern Los Angeles county including Bellflower, Harbor, Long Beach, and Torrance

<b><u>Inland Regional Center</u></b> 1365 S. Waterman Ave. San Bernardino, CA 92408 <b>Mailing Address:</b> P. O. Box 19037 San Bernardino, CA 92423	<b>Carol Fitzgibbons</b> (909) 890-3000	Riverside and San Bernardino counties
<b><u>Kern Regional Center</u></b> 3200 North Sillect Avenue Bakersfield, CA 93308	<b>Duane Law</b> (661) 327-8531	Inyo, Kern, and Mono counties
<b><u>North Bay Regional Center</u></b> 10 Executive Court, Suite A Napa, CA 94558	<b>Bob Hamilton</b> (707) 256-1100	Napa, Solano, and Sonoma counties
<b><u>North Los Angeles County Regional Center</u></b> 15400 Sherman Way, Suite 170 Van Nuys, CA 91406-4211	<b>George Stevens</b> (818) 778-1900	Northern Los Angeles county including San Fernando and Antelope Valleys
<b><u>Redwood Coast Regional Center</u></b> 525 Second Street, Suite 300 Eureka, CA 95501	<b>Clay Jones</b> (707) 445-0893	Del Norte, Humboldt, Mendocino, and Lake counties
<b><u>Regional Center of the East Bay</u></b> 500 Davis Street, Suite 100 San Leandro, CA 94577	<b>James M. Burton</b> (510) 618-6100	Alameda and Contra Costa counties
<b><u>Regional Center of Orange County</u></b> 1525 North Tustin Avenue Santa Ana, CA 92705	<b>Larry Landauer</b> (714) 796-5100	Orange county
<b><u>San Andreas Regional Center</u></b> 300 Orchard City Drive, Suite 170 Campbell, CA 95008	<b>Javier Zaldivar</b> (408) 374-9960	Monterey, San Benito, Santa Clara, and Santa Cruz counties
<b><u>San Diego Regional Center</u></b> 4355 Ruffin Road, Suite 200 San Diego, CA 92123-1648	<b>Carlos Flores</b> (858) 576-2996	Imperial and San Diego counties





State of California

Department of *Developmental Services*

<b><u>San Gabriel/Pomona Regional Center</u></b> 75 Rancho Camino Drive Pomona, CA 91766	<b>R. Keith Penman</b> (909) 620-7722	Eastern Los Angeles county including El Monte, Monrovia, Pomona, and Glendora
<b><u>South Central Los Angeles Regional Center</u></b> 650 West Adams Boulevard, Suite 200 Los Angeles, CA 90007-2545	<b>Dexter Henderson</b> (213) 744-7000	Southern Los Angeles county including the communities of Compton and Gardena
<b><u>Tri-Counties Regional Center</u></b> 520 East Montecito Street Santa Barbara, CA 93103-3274	<b>Omar Noorzad, Ph.D.</b> (805) 962-7881	San Luis Obispo, Santa Barbara, and Ventura counties
<b><u>Valley Mountain Regional Center</u></b> 702 North Aurora Street Stockton, CA 95202	<b>Paul Billodeau</b> (209) 473-0951	Amador, Calaveras, San Joaquin, Stanislaus, and Tuolumne counties
<b><u>Westside Regional Center</u></b> 5901 Green Valley Circle, Suite 320 Culver City, CA 90230-6953	<b>Michael Danneker</b> (310) 258-4000	Western Los Angeles county including the communities of Culver City, Inglewood, and Santa Monica

<http://www.dds.ca.gov/RC/RCList.cfm>

Updated from website 6/6/14

# Department of Developmental Services Regional Centers

(Colors correspond to areas served by each Regional Center)



Updated: July 1, 2003



**DEPARTMENT OF DEVELOPMENTAL SERVICES**

1600 NINTH STREET, Room 320, MS 3-9  
SACRAMENTO, CA 95814  
TDD 654-2054 (For the Hearing Impaired)  
(916) 654-1958



December 20, 2011

TO: REGIONAL CENTER DIRECTORS, ADMINISTRATORS AND CHIEF COUNSELORS

SUBJECT: REGIONAL CENTER CONSUMERS' RECEIPT OF DENTAL SERVICES UTILIZING DENTI-CAL INFRASTRUCTURE

As you know, the Department of Developmental Services (Department) has been working with staff from the Denti-Cal program section of the Department of Health Care Services (DHCS) regarding the use of the Denti-Cal program rules and infrastructure for the provision of dental services to regional center consumers age 21 and over. Beginning on January 13, 2012, dentists participating in the Denti-Cal program may treat regional center consumers, age 21 and over, who have Medi-Cal, consistent with the rules and payments (SMA) for the Denti-Cal program. The Department will reimburse the cost of these services with regional center funding. The development of this means of obtaining dental services represents an alternative, but does not impact regional centers' ability to purchase dental services directly from a vendored dentist.

The Department is promulgating an amendment to section 54310 of California Code of Regulations, Title 17 regarding vendorization of Denti-Cal dentists. The new provision states, in part, "...the documentation provided to the dentist by the Department of Health Care Services (DHCS) approving the dentist's enrollment in the Denti-Cal program, including the dentist in the Provider Master File and providing the dentist with a Medi-Cal provider number, constitutes vendorization for the purposes of providing services to consumers under Dentistry - Service Code 715. The dentist's status as a Denti-Cal provider is under the oversight of DHCS." Therefore, regional centers do not need to take any action to vendorize dentists providing services to this specific group of consumers through the Denti-Cal infrastructure. However, this provision does not apply when regional centers are paying for services directly.

To obtain a list of Denti-Cal dentists in your county, please visit Denti-Cal's home page at: [www.denti-cal.ca.gov](http://www.denti-cal.ca.gov), click on the "Beneficiaries" tab, then click on the "Help in locating a Medi-Cal dentist" link. The list is updated weekly by DHCS. Each month, the Department will send DHCS a file containing information about those regional center consumers who are eligible to received dental services through this system. If a dentist needs to verify eligibility, the dentist may do so by calling Denti-Cal's Provider Telephone Service Center, at (800) 423-0507. Eligible consumers may receive the same dental services previously available through DHCS' optional dental benefits; however, they are not subject to the \$1,800 annual benefit cap. The Denti-Cal website contains other helpful information for recipients, including answers to "Frequently Asked Questions" at the link above.

**"Building Partnerships, Supporting Choices"**

Regional Center Directors, Administrators and Chief Counselors  
December 20, 2011  
Page two

The Department will reimburse DHCS for services on a monthly basis on behalf of the consumer's regional center. Because all services purchased by a regional center on behalf of a consumer must be reflected in the consumer's individual program plan, use of the Denti-Cal program for these individuals is predicated on the agreement that all regional centers would accept the responsibility to purchase any service offered by Denti-Cal.

At the end of every month, DHCS will send the Department a file containing the name, UCI number, etc. of each consumer who received dental services, the type of service received, the date the service was rendered, the service provider's name and contact information, and the cost of the service. The Department will in turn send each regional center a file containing the above information for those consumers associated with that specific regional center. Although, in some cases, regional centers may not know the specifics of services provided until after the fact, it is important that regional centers receive and maintain service related information for each consumer since the services are being purchased with regional center funds. DHCS will also send the Department a monthly claim, which the Department will pay directly. The Department will then send the detailed claims data to each regional center. The regional center is responsible to run a program developed by the Department to create an invoice and attendance records, process the claim through UFS, and submit a paper claim to the Department as "info only" for Denti-Cal. The Department will issue a Technical Bulletin to regional centers explaining the invoicing and claiming processes in the near future.

If an individual is denied a service for which a dentist has requested prior authorization, the individual has a right to a Fair Hearing through the Department of Social Services. Information regarding the process for filing for a Fair Hearing is also contained on the Denti-Cal website.

If you have questions regarding this correspondence or need clarification on how to access dental services for eligible individuals, please contact me at the telephone number above.

Sincerely,

*Original Signed By*

BRIAN WINFIELD  
Acting Deputy Director  
Community Operations Division

cc: ARCA



## Home and Community-Based Services (HCBS) Waivers

HCBS Waivers allow states that participate in Medicaid, known as Medi-Cal in California, to develop creative alternatives for individuals who would otherwise require care in a nursing facility or hospital. Medi-Cal has an agreement with the Federal Government, which allows for waiver services to be offered in either a home or community setting. The services offered under the waiver must cost no more than the alternative institutional level of care. Recipients of HCBS Waivers must have full-scope Medi-Cal eligibility.

## WHAT SERVICES ARE OFFERED UNDER THESE HCBS WAIVERS?

The services available under these HCBS Waivers include case management, community transition services, private duty nursing, family training, home health aides, life-sustaining utility reimbursement, habilitation services, and respite care.

## WHO PROVIDES THE SERVICES?

There are a variety of HCBS Waiver providers, including the following:

- Licensed and certified Home Health Agencies;
- Individually licensed HCBS Waiver Providers; or
- Unlicensed caregivers.

## HOW LONG CAN ONE RECEIVE THESE SERVICES?

The beneficiary may receive these home- and community-based services as long as they are medically necessary, cost-neutral, and he/she meets the nursing facility or acute hospital level of care.

## HOW DO I BECOME A HCBS WAIVER PROVIDER?

For information on becoming one of the following HCBS waiver providers or to request an application, please contact In-Home Operations (IHO) at (916) 552-9105 or email: [IHOwaiver@dhcs.ca.gov](mailto:IHOwaiver@dhcs.ca.gov).

- HCBS Waiver Nurse Provider – RN and LVN
- Marriage and Family Therapist
- Licensed Psychologist
- Professional Corporation



- Licensed Clinical Social Worker
- Non-Profit Organizations
- Employment Agency
- Personal Care Agency
- Home and Community-Based Services Nursing Facility (Congregate Living Health Facility)
- Public Authority - In Home Supportive Services

## **HOW DOES ONE REQUEST HCBS WAIVER SERVICES?**

The beneficiary or their legal representative must contact (IHO) and request a HCBS Waiver application. Based upon the information on the Waiver application, the Nurse Evaluator II will determine if the individual meets the criteria for the HCBS waiver and schedule a home visit to discuss the waiver and waiver services that are available. Each HCBS waiver can only serve a limited number of individuals. Once that limit is reached, the names of individuals requesting waiver services will be placed on a waiting list based upon the date IHO received their completed HCBS Waiver application.

## **FOR MORE INFORMATION ABOUT IHO:**

Telephone:

- Northern California (916) 552-9105
- Southern California (213) 897-6774

Email: [IHOwaiver@dhcs.ca.gov](mailto:IHOwaiver@dhcs.ca.gov)

<http://www.dhcs.ca.gov/services/Pages/HCBSWaiver.aspx>

Updated from website 6/27/14



## **In-Home Operations**

### **QUICK REFERENCE GUIDE**

**California Department of Health Care Services**

**Long-Term Care Division**

**In-Home Operations (IHO) Branch**



#### **WEBSITE:**

**For general information about In-Home Operations  
or to view a copy of IHO's Home and Community Based Waivers**

**<http://www.dhcs.ca.gov/services/Pages/IHO.aspx>**

**E-mail: [IHOwaiver@dhcs.ca.gov](mailto:IHOwaiver@dhcs.ca.gov)**

### **IHO BRANCH CONTACT INFORMATION**

#### **NORTHERN REGION**

**P.O. Box 997437, MS 4502  
Sacramento, CA 95899-7437  
Phone (916) 552-9105  
FAX (916) 552-9150  
(916) 552-9151**

#### **SOUTHERN REGION**

**311 South Spring Street, Suite 313  
Los Angeles, CA 90013  
Phone (213) 897-6774  
FAX (213) 897-7355  
(213) 897-9314**



## IN-HOME OPERATIONS QUICK-REFERENCE GUIDE

THIS IS ONLY A REFERENCE GUIDE. PLEASE CALL ABOVE LISTED PHONE NUMBERS FOR ANY CLARIFICATION

### HCBS WAIVER SERVICES

<b>Eligibility</b>	Full-scope Medi-Cal eligible and medically eligible beneficiary. Priority enrollment for an applicant who has been authorized for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for at least six months prior to his/her 21 <sup>st</sup> birthday who meet medical eligibility criteria; and for an applicant currently in an acute hospital who is eligible for placement in an HCBS Waiver.
<b>Available Services</b>	Home and Community-Based Services (HCBS) waivers are designed to assist in supporting a participant in his/her home as an alternative to care in a licensed health care facility. HCBS waiver services include: Case management, transitional case management; community transition: private duty nursing; family training; environmental accessibility adaptations; waiver personal care; life sustaining medical equipment operation expenses, habilitation; respite care; and personal emergency response systems.
<b>Criteria for Services</b>	HCBS waiver services may be authorized when medically necessary at a cost that is not greater than what may be provided in a licensed health care facility. <b>These services must be prior authorized.</b>
<b>Place of Services</b>	The participant's home or community setting.
<b>Service Providers</b>	HCBS waiver services providers include: licensed and certified home health agencies; congregate living facilities; licensed registered nurses; licensed vocational nurses; licensed clinical social workers; marriage & family therapists; licensed psychologists; nonprofit organizations; professional corporations; personal care or employment agencies; and unlicensed caregivers.
<b>Requests for Service</b>	A HCBS Waiver application (available upon request – see contact information including: <b>website, e-mail, and phone number</b> on cover page) must be completed and returned to In-Home Operations (IHO).
<b>Required Documentation</b>	Medical records <b>(Including but not limited to)</b> : Medical information that supports the request for services; assessment and identification of skilled nursing care needs; home safety evaluation; Plan of Treatment (POT) signed by the physician, beneficiary/participant & caregivers; and a TAR requesting the services.

### IN-HOME OPERATIONS

In-Home Operations (IHO) is part of the California Department of Health Care Services (DHCS). IHO has statewide responsibility for reviewing and authorizing home and community-services through the Medi-Cal Nursing Facility/Acute Hospital (NF/AH) Waiver.

IHO has two offices in California – the Northern Regional Headquarters office, located in Sacramento, and a Southern Regional office, located in Los Angeles.

The Northern Regional office is responsible for reviewing all new statewide requests for HCBS waiver services. Upon receipt and review of the NF/AH Waiver Application, the request for the NF/AH waiver services is then forwarded to the appropriate regional office for completing the intake process and ongoing administrative case management.

## **Home and Community-Based Services (HCBS) Waivers**

Home- and Community-Based Services (HCBS) waivers are creative alternatives, allowed under federal law, for states participating in Medicaid (Medi-Cal in California), to be implemented in the home or community for certain Medi-Cal beneficiaries to avoid hospitalization or nursing facility placement. HCBS waivers are not part of the Medi-Cal State Plan benefit. Services provided under a waiver are not typically part of the benefit package available under federal Medicaid. California currently has the following seven HCBS waivers: Developmentally Disabled Waiver; Multi-Purpose Senior Services Program Waiver; Acquired Immune Deficiency Syndrome Waiver; Pediatric Palliative Care Waiver; Assisted Living Waiver; In-Home Operations (IHO) Waiver; and the Nursing Facility/Acute Hospital (NF/AH) Waiver.

The authorization and management of IHO and NF/AH waiver services are the responsibility of the IHO Branch. Under IHO, the current facility alternatives for these two HCBS waivers are: Acute Hospital; Adult or Pediatric Sub-Acute; Skilled Nursing Facility (SNF or NF level B); and, Intermediate Care Facility (ICF or NF level A).

Requests for waiver services can come from Medi-Cal providers, associated agencies, beneficiaries, families, friends, or advocates. Requests may be faxed, e-mailed, and telephoned to IHO. Upon receipt of the request for HCBS waiver services, IHO will send an HCBS Waiver application to the individual. Assessment for HCBS waiver services begins upon the receipt of the completed HCBS Waiver application by IHO.

Once a Medi-Cal home program is established for the Medi-Cal waiver participant, medically necessary waiver services are authorized by IHO that will assist the waiver participant in remaining safely at home. Additional Medi-Cal services authorized by IHO when medically appropriate for HCBS Waiver participants include equipment, supplies, therapies, and transportation. For information on these waivers please call (916) 552-9105 or visit our website at: <http://www.dhcs.ca.gov/services/Pages/IHO.aspx>

### **Nursing Facility Acute Hospital (NF/AH) Waiver**

- Services are subject to prior authorization.
- The NF/AH waiver is designed:
  - For a person who has a long-term medical condition(s) and who meet the acute hospital, subacute nursing facility, skilled nursing facility B (skilled) or A (intermediate) level of care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of institutionalization;
  - To facilitate a safe and timely transition of medically needy Medi-Cal eligible beneficiaries from a medical facility to his/her home and community; and,
  - To offer Medi-Cal eligible beneficiaries who reside in the community but are at risk of being institutionalized within the next 30 days, the option of utilizing NF/AH Waiver services to develop a home program that will assist in safely meeting his/her home medical care needs.
- Participant must be Medi-Cal eligible. This can be established in one of two ways:
  - Community deeming rules/requirements, i.e., the regular financial rules for Medi-Cal eligibility; or,
  - Institutional deeming rules/requirements, i.e., the individual is assessed to be Medi-Cal eligible “as if” he/she were in a long-term care facility.

- Authorized services must be cost-neutral to the Medi-Cal program. This means that the total cost of providing waiver services and all other medically necessary Medi-Cal services to the participant must cost the same or less than the services would cost if incurred by the Medi-Cal program for providing care to the waiver participant in a comparable level facility.
- NF/AH waiver services include: Case management, transitional case management, community transition services, private duty nursing (including shared nursing services); family training; minor environmental accessibility adaptations; personal care services; medical equipment operating expenses; habilitation; respite care; and personal emergency response systems (including installation and testing).
- Services are provided in the participant's home that has been assessed to be a safe environment by an IHO Nurse Evaluator or an IHO designee.
- Services are authorized through appropriate licensed and certified home health agencies; congregate living facilities; licensed registered nurses; licensed vocational nurses; licensed clinical social workers; marriage & family therapists; licensed psychologists; nonprofit organizations; professional corporations; personal care or employment agencies; and unlicensed caregivers.
- Implementation of NF/AH waiver services also involves the active participation of the family and/or primary caregiver in the home care program. Participants must have an identified support network system available to them in the event the HCBS provider of direct care services is not able to provide the total number of hours approved and authorized by IHO. A family member and/or a primary caregiver should be proficient in the tasks necessary to care for the participant at home to ensure care is not interrupted. This proficiency requirement may be satisfied by training, as necessary to safely carry out the plan of treatment and/or by providing direct care to the participant on an ongoing basis. The involvement of the family and/or the primary caregiver helps to ensure a safe home program for the participant.
- Services are prescribed by the participant's community-based primary care physician in accordance with regulations outlined in the CCR, Title 22, Division 3.

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### **ONLINE RESOURCES FOR MEDI-CAL SERVICES**

Long-Term Care Division HCBS Waivers and Programs:

<http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx>

California Code of Regulations, Title 22, Division 3: [www.ccr.oal.ca.gov](http://www.ccr.oal.ca.gov)

Medi-Cal Provider Bulletins: [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)

State Statutes – Health and Safety Code; Welfare and Institutions Code: [www.oal.ca.gov](http://www.oal.ca.gov)



# ASSISTANCE DOG SPECIAL ALLOWANCE (ADSA) PROGRAM

## FACT SHEET

### What?

The Assistance Dog Special Allowance (ADSA) Program provides a monthly payment to eligible persons who use a guide, signal, or service dog to help them with needs related to their physical disabilities. The allowance is to help pay the costs of food, grooming, and health care for the dogs.

### Who?

To be eligible for the ADSA program, an individual must meet **all four** of the following criteria:



**I**

Lives in California



**II**

Is blind, deaf, hard of hearing, or physically disabled



**III**

Uses the services of a trained guide, signal, or service dog



**IV**

Receives benefits from one or more of these programs:

- SSI – Supplemental Security Income
- SSP – State Supplementary Payment
- IHSS – In-Home Supportive Services
- SSDI – Social Security Disability Insurance (SSDI recipients must also meet federal poverty guidelines)
- CAPI – Cash Assistance Program for Immigrants

### How?

To obtain an application or more information about the ADSA program, contact:

**California Department of Social Services**

**Office of Services to the Blind**

**744 P Street, M.S. 8-16-94**

**Sacramento, CA 95814**

**ADSAUser@dss.ca.gov**

**Phone: (916) 657-2628 or TTY (916) 651-6248**

**[www.cdss.ca.gov/cdssweb/Assistance\\_184.htm](http://www.cdss.ca.gov/cdssweb/Assistance_184.htm)**



PUB 294 (7/11)

**The Laws and Regulations Governing this Program Are:**  
**Welfare and Institutions Code Sections 12553 and 12554**  
**CDSS Manual of Policies and Procedures Section 46-430**  
**[www.cdss.ca.gov/getinfo/pdf/eas14.pdf](http://www.cdss.ca.gov/getinfo/pdf/eas14.pdf)**

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



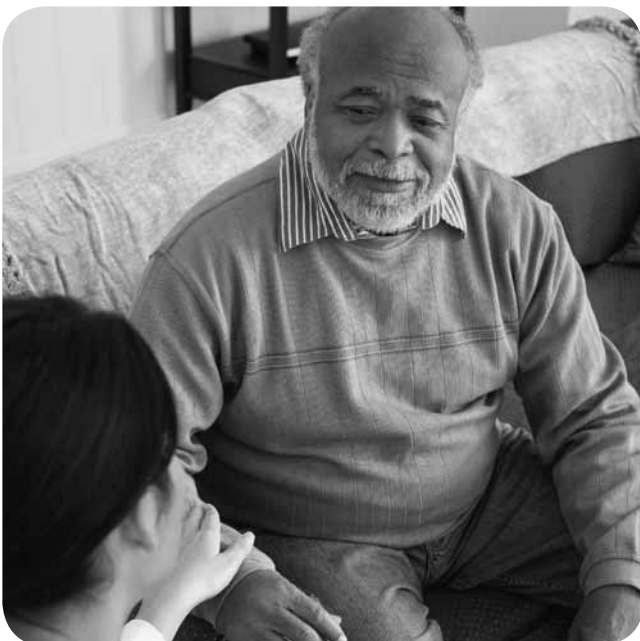
## Overview of the IHSS Program

### **The IHSS program provides services to eligible people over the age of 65, the blind and/or disabled.**

The goal of the IHSS program is to allow you to live safely in your own home and avoid the need for out of home care.

Services almost always need to be provided in your own home. This could be a house, apartment, hotel, or the home of a relative.

If you receive Supplemental Security Income (SSI) or meet all Medi-Cal income eligibility requirements, you may be able to receive IHSS services. IHSS is a Medi-Cal program and is funded by federal, state, and county dollars.



### **Services**

These are the types of services IHSS can provide:

- Personal care services like dressing, bathing, feeding, toileting
- Paramedical services like helping with injections, wound care, colostomy and catheter care under the direction of a licensed medical professional
- House cleaning
- Cooking
- Shopping
- Laundry
- Accompaniment to and from medical appointments

**Some of the things IHSS cannot pay for include:**

- Moving furniture
- Paying bills
- Reading mail to you
- Caring for pets, including service animals
- Gardening
- Repair services
- Sitting with you to visit or watch TV
- Taking you on social outings
- Waiting for you in the doctor's office

# Application Process

## 1. How to Apply

Contact the In-Home Supportive Services program in your county. A county representative will ask you questions to gather information about the nature of your disability, things that you need help with, your income, and assets. This may take up to 20 minutes.

## 2. Home Visit

A social worker will come to your home to determine the types of authorized services that you need and the number of hours for each service. Some of the things the county will consider are your medical condition, living arrangement, and any resources that may already be available.

## 3. Health Care Certification Form

You will receive a form for your doctor to complete, certifying your need for IHSS. This form must be completed before services can be authorized.

## 4. Authorization

The county will send you a Notice of Action (NOA) telling you if you have been approved for IHSS. The NOA will specify what services have been approved, how much time is authorized for each service, and how many total monthly hours have been approved.

# Hiring Provider(s)

Once eligibility is established, you can hire one or more people to provide your care. A friend or relative may serve as your care provider, or a referral may be obtained through the IHSS Public Authority Caregiver Registry. Your care provider must complete all the necessary provider enrollment steps prior to starting work. You or your provider can contact your social worker or Public Authority for more information about provider enrollment requirements.



# IHSS Consumer and Provider Job Agreement

**This job agreement will help explain job duties and work schedule. You can use this form to guide your discussion with your new provider.**

**Complete and sign this job agreement. Use it as a record of agreed upon responsibilities.**



**1. This job agreement is between:**

\_\_\_\_\_  
Consumer/Employer  
Print Name

&

\_\_\_\_\_  
Provider/Employee  
Print Name

**2. The consumer and provider agree to the following general rules.**

**The consumer agrees to:**

- Assign and direct the work of the provider.
- Let the provider know ahead of time, whenever possible, when hours or duties change.
- Not ask the provider to do work for anyone other than him/her or do things that have not been authorized by IHSS.
- Sign the provider's timesheet on time if it correctly shows the hours that were worked.

**The provider agrees to:**

- Perform the agreed upon tasks and duties.
- Call the consumer as soon as possible if they are late, sick, or unable to work.
- Come to work on time (see hours of work on the back of this page).
- Keep personal calls at a minimum and not make long distance telephone calls using the consumer's telephone.
- Not ask to borrow money or ask for a cash advance.
- Give the consumer a two-week notice, whenever possible, before taking a vacation or leaving the job.

**3. The provider will be paid at the rate set by the county for IHSS providers.**

**4. The hours of work for this job are shown below.**

Changes in the scheduled days and hours are to be agreed upon by both parties, with advance notice. Some providers may need to work split shifts each day in order to meet the consumer’s needs.

	MON	TUES	WED	THURS	FRI	SAT	SUN
Hours							
Hours							

**5. IHSS does not pay provider gas or transportation expenses.**

The consumer and provider, by signing this document, agree to the terms outlined above. If the agreement changes, both parties will initial and date the changes.

\_\_\_\_\_  
Consumer/Employer Signature

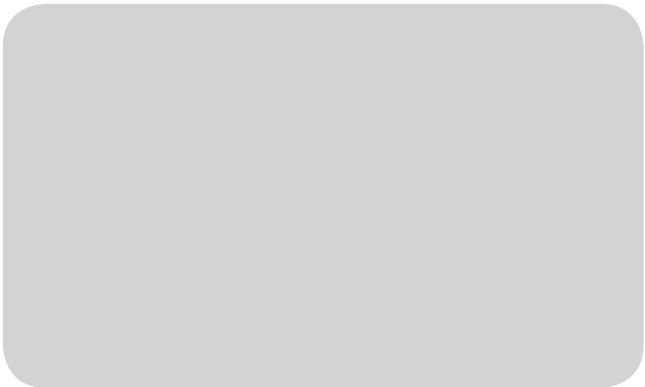
\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Provider/Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number



## Getting Started With Your New Provider



### Starting off on the right foot

During your first meeting with a new provider, it is important to tell them what you expect. It is best to talk about any difficult issues and agree on things before he/she starts work.

Some of the things you may want to talk to your provider about are listed below.

- **Authorized tasks review**

Explain what tasks the provider will be doing for you and how much time he/she can spend on each task. The county will send you a list of authorized tasks and the amount of time authorized when they approve or change your hours. Be sure to tell your provider how you would like to have the tasks done.

- **Health issues**

Tell your provider about any allergies, special diet needs, and other issues that require special care.

- **Infectious diseases**

It is best for you and your provider to tell each other if either of you have any infectious diseases, including HIV, Hepatitis, Tuberculosis (TB), and others.

- **Supplies**

Show the provider where supplies are kept and how to correctly use any special equipment.

- **Medications**

Explain what help you need, if any, and go over your daily medication schedule.



- **Emergency information**

Share all of the information your provider needs to know if an emergency happens. Include who to call in case of an emergency and how to get out of the house. Post emergency information in an easy to see place at all times.

- **Work schedule**

Be clear on what days your provider will be coming and how many hours he/she will work each day. Agree on a way to keep track of hours so you can make sure the timesheet is filled out correctly. Consider using a calendar or note pad as a way to keep track of tasks and hours worked each day.

- **Contact information**

Give each other all the telephone numbers where you can be reached and the best times for you to contact each other.



- **Transportation for medical appointments and errands**

IHSS does not pay for the cost of gas, car insurance, or public transportation. Make sure you are clear on who will pay these costs, and that your provider has car insurance and a valid driver's license.





## IHSS Authorized Tasks

Mark the tasks you need your provider to do and show how often the task needs to be done. Talk about anything special you want him/her to know as you go through the list. Write notes to help your provider remember your requests.

**REMEMBER:** IHSS will only pay for services that have been authorized by your social worker. When authorizing hours for someone to help you, your social worker considered the things you were able to do safely without help. It is important for you to remain as independent as possible, so you should not ask your provider to do things you can do for yourself safely.

Use the chart below to show whether the tasks need to be done daily (D), weekly (W), monthly (M), or on another schedule (O) such as two times per week.

D=Daily	W=Weekly	M=Monthly	O=Other
---------	----------	-----------	---------

Authorized Task	How often	Notes
<b>Housework</b>		
<input type="checkbox"/> Mop kitchen and bathroom floors		
<input type="checkbox"/> Clean bathroom		
<input type="checkbox"/> Make bed		
<input type="checkbox"/> Change bed linen		
<input type="checkbox"/> Clean sinks		
<input type="checkbox"/> Clean stovetop		
<input type="checkbox"/> Clean oven		
<input type="checkbox"/> Clean refrigerator		
<input type="checkbox"/> Vacuum/sweep		
<input type="checkbox"/> Wipe counter		
<input type="checkbox"/> Dust		
<input type="checkbox"/> Empty trash		

Authorized Task	How often	Notes
<b>Meals</b>		
<input type="checkbox"/> Prepare meals		
<input type="checkbox"/> Meal cleanup		
<b>Laundry</b>		
<input type="checkbox"/> Wash, dry, fold, and put away laundry		
<b>Shopping</b>		
<input type="checkbox"/> Grocery shopping		
<input type="checkbox"/> Other shopping and errands		
<b>Personal Care Services</b>		
<input type="checkbox"/> Dressing		
<input type="checkbox"/> Grooming and oral hygiene		
<input type="checkbox"/> Bathing		
<input type="checkbox"/> Bed bath		
<input type="checkbox"/> Bowel and bladder care		
<input type="checkbox"/> Menstrual care		
<input type="checkbox"/> Help with walking		
<input type="checkbox"/> Move in and out of bed		
<input type="checkbox"/> Help on/off seat or in/out of vehicle		
<input type="checkbox"/> Repositioning		
<input type="checkbox"/> Rub skin		
<input type="checkbox"/> Assistance with prosthesis/meds		
<b>Paramedical Services</b>		
<input type="checkbox"/> Blood sugar checks		
<input type="checkbox"/> Injections		
<input type="checkbox"/> Other paramedical services		
<b>Accompaniment Services</b>		
<input type="checkbox"/> To medical appointments		
<input type="checkbox"/> To alternative resources		



## Suggestions on How to Handle Money



If your provider is authorized to shop and run errands, you will need to give him/her the money to pay for the items you need. It is important that you take steps to protect both of you when you give your provider money.

1. If you need to have your provider get money out of your purse or wallet, always watch him/her. If the wallet or purse is in another room, ask him/her to bring it to you so you can get the cash out.
2. When the provider returns, count the change, look at the receipt to make sure that only those items requested were purchased, and ask your provider to initial the log.
3. Keep receipts in a large envelope or folding file so you can easily answer any questions that come up.
4. Do not share any of your bank information with your provider.

Be very organized about the use of money to help avoid misunderstandings.

## Keeping a Log

You should write down the amount of money you gave to your provider, the amount spent, and the amount of change returned. You can use a notebook for this or copy the log provided on the back of this page. Below is a sample of how to complete the log.

Date	Money given to provider			Amount Spent (from receipts)	Change returned to consumer		
	Amount \$	Consumer Initials	Provider Initials		Amount \$	Consumer Initials	Provider Initials
10/15/12	\$20.00	FM	SS	\$16.85	\$3.15	FM	SS
10/22/12	\$5.00	FM	SS	\$4.25	\$0.75	FM	SS

# IHSS Expenditure Log

Consumer Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_



Date	Money given to provider			Amount Spent (from receipts)	Change returned to consumer		
	Amount \$	Consumer Initials	Provider Initials		Amount \$	Consumer Initials	Provider Initials

## Communicating With Your Provider



### How you communicate with your provider can affect the quality of care you receive.

Having good communication is the first step to a positive working relationship.

In order to communicate well, always state your needs clearly. Listen to how your provider responds and ask questions about anything you do not understand.

#### Take time to learn about your provider.

- Ask your provider what name he/she would like to be called and use that name.
- Ask about any habits your provider may have that could affect you such as smoking, and talk about habits you have that your provider should be aware of.

#### Make sure what you are saying is being understood by your provider.

- Don't talk too fast or too slow.
- If you are talking to your provider and he/she looks confused, ask them if they understand what you are saying. By asking your provider, you will know for sure if he/she understood you or if you need to provide more details.

#### Helpful hints for good communication.

- Keep the lines of communication open to avoid misunderstandings.
- It may help to use humor and patience when dealing with difficult situations. The tone of your voice can also improve the outcome.
- Take responsibility for your own feelings and respect your provider's concerns by using "I" statements.



For example:

*"I see/hear/feel (state the issue).*

*It makes me feel (state your feelings).*

*I need (state a possible solution)."*



This might sound like:

***"I understand this task is hard to learn, but it makes me feel uncomfortable when you grumble under your breath. I would like you to ask me for more direction and let me know what you are feeling so we can work out the problem."***

***"This is the third time this week you have been 20 minutes late. I'm feeling frustrated because my schedule is off when you are late. I need you here on time."***

## **Keep the lines of communication open and focused on your care.**

- Be friendly, but keep your relationship as professional as possible. Remember he/she is there to provide IHSS services for you.
- Your provider may not want to share details about his/her personal life. Respect their privacy.
- Cultural differences may sometimes affect how you get along and may create misunderstandings. Talk about these things immediately and work on a solution that will satisfy both of you.



## Deciding When to Fire a Provider

**As an employer, you have the right to fire your provider for any reason, but you should think about this decision carefully before you take action.**



### **Can the problems be solved?**

It can be hard to tell someone that you no longer need their services. Try to work on any minor problems with your provider before you decide to fire him/her.

### **Talk to your provider about your concerns.**

Try to tell your provider as soon as you see a problem. It is best not to let problems build up, but if they do, make a list of the things you are unhappy about and decide what must change in order for you to keep your provider. Have an open talk with your provider and reach agreements about any improvements you need to see in his/her job performance. Tell him/her when the improvements will need to be made.

Remember that communication is a two-way street. Allow your provider to ask questions and be open to any thoughts and concerns he/she may have.

If you are not comfortable about having this talk alone, ask a friend or family member to be there to support you.

### **If your provider is not willing to improve.**

If your provider does not improve his/her performance, it may be time to end his/her employment. If it is possible, it is best to give your provider two weeks' notice. This will give him/her time to look for a new job and you time to get a new provider.



## **Terminate an unsafe provider right away!**

If your provider is treating you in an abusive or threatening manner, you should call 911 and fire him/her immediately. Your personal safety is most important. If you need help doing this, call your IHSS county office, friends, or family members to help you.

Some reasons for firing your provider might be:

- Not meeting your care needs
- Stealing your money or personal property
- Coming in late often or not coming to work at all
- Using your personal property without permission



### ***If You Need A New Provider Quickly***

If you have to fire your provider without notice, you have several options to find a new person quickly:

- Contact your Public Authority for a list of available providers.
- Ask a family member or friend for short-term help (remember all providers must be fingerprinted and pass a criminal background check to be paid by IHSS).

***Always contact your IHSS county office  
if you change providers.***



## Recognizing Abusive Behaviors

**Sometimes a provider, family member (including a child), or friend steps over the line and becomes abusive.**

In California, abusing a child, a person over 65, or anyone between the ages of 18 and 64 who has physical or mental limitations, is a crime punishable by law.

Abuse can occur in many ways including physical or sexual abuse, financial abuse, neglect, and psychological abuse or intimidation. Here are some examples of abuse:

- Being slapped, hit, choked, pinched, kicked, shoved, raped, or molested.
- Being constantly yelled at, threatened with bodily harm, or threatened to be left alone.
- Being left alone by a care provider when you cannot get necessary food, water, clothing, shelter, or health care.



- Being kept from getting mail, telephone calls, or visitors; or prevented from leaving your home without good reason.
- Having money, property, or items of value being taken by force or without your approval.
- Being neglected by someone who should be providing care, food, or water.

### ***Report Abuse!***

**If you are being abused, even by a family member, you should get help right away by contacting:**

- **911**
- **Adult Protective Services (APS)**

(     )



## Supervising Your Provider

**As an employer, you will need to supervise your provider. This may feel uncomfortable if you have never done this before. However, the following information may help.**

**1. Let your provider know what tasks must be completed each time he/she works.**

If it seems like there is not enough time to do all the authorized services, you and your provider should talk about how to make the best use of the IHSS time authorized. If your condition changes and you need more or less hours, contact your county IHSS office.



**2. Communicate your needs.**

Your provider needs to know how you like things done so he/she can complete tasks in a way that works for you.

- **Be clear.** Explain in as much detail as possible how you would like your provider to complete each authorized task. Keep in mind the amount of time your provider has to do the task. You may be more comfortable starting with things like housework or laundry before talking about any personal care needs.
- **Be patient.** You may need to remind your provider how you would like him/her to do things more than once.
- **Be specific.** If you would like your authorized tasks done in a specific way, let your provider know.

**3. Be reasonable in what you expect.**

- A new provider may need to work for you a few times before learning your expectations and needs.

#### **4. Let your provider know how things are going.**

- **Say something positive** when he/she does things the way you like them done.
- **Say something to correct** your provider when tasks are not completed the way you want them. Politely let him/her know how you specifically want things done.

Some helpful tips include:

- Use a friendly tone of voice.
- Don't blame or humiliate your provider.
- Treat your provider with respect.

#### **5. It is important NOT to ask your provider to do unauthorized tasks or services not covered.**

When the social worker assesses your needs, he/she will decide which IHSS services to authorize for you. You should not ask your provider to do services not authorized or not covered by IHSS. If you need help with tasks not covered by the IHSS program such as taking care of pets, assistance with mail or finances, or accompaniment to social activities, you should ask family members, friends, church volunteers, or others to help you.

#### **6. Make good use of time.**

As your provider's employer and supervisor, it is your job to make sure he/she is completing the IHSS services within the authorized time. Your provider should not be doing anything except providing IHSS services to you while they are being paid as an IHSS care provider.

Your provider should NOT be:

- Making personal telephone calls
- Watching TV
- Spending too much time visiting with you
- Bringing children or others to work
- Doing his/her personal business or activities



## Paramedical Services

### What is a Paramedical Service?

**In IHSS, paramedical services are services that require authorization and training by a medical professional before they can be provided.**

**Some examples of paramedical services are:**

- Administering medication or giving injections
- Blood/urine testing
- Wound care
- Catheter care and ostomy irrigation
- Any treatments requiring sterile procedures
- Enemas, digital stimulation, or the insertion of suppositories
- Tube feeding
- Suctioning

**Let your new provider know what will be expected.**

During the job interview, you should discuss all of the IHSS services, including paramedical, for which you have been approved IHSS hours. Some providers may not be comfortable providing some types of personal care and/or paramedical services and may not want the responsibility that comes with this type of care.

**Your provider must be trained to perform paramedical services.**

IHSS regulations require that a licensed healthcare professional, such as a doctor, order and direct the paramedical services. Your doctor will need to complete a paramedical form, and you will also need to sign this form. The completed form must be received by the county before your provider can be paid to provide these services.

- You need to make arrangements for your new provider to be trained by your doctor on how to provide any paramedical services you need and the risks involved. If you are not sure about how the services should be done, you should also ask your doctor about this.



- You and your provider should also know what to do if there is an emergency while your provider is performing paramedical services.
- It is very important that your provider NOT perform any paramedical service for you until he/she has received proper training by a licensed healthcare professional.



### ***Things to keep in mind:***



Always be sure that your provider washes his/her hands and wears gloves before performing any paramedical task. This will help to protect the health of both you and your provider.



Paramedical services needs may change more frequently than other services. If your needs change, you should contact your social worker so he/she can request a new paramedical order from your doctor.



Your provider may also need to receive additional training on any new paramedical services your doctor may order.

## Finding, Interviewing and Hiring a Provider

### Finding a Provider

Hiring a provider is an important task, and you should take the time to find the right person.

As the employer, you can hire anyone who meets IHSS provider enrollment requirements and can meet your needs. This may be a family member, friend, or someone referred from the Public Authority Registry. Other ways to find a provider may be through your church, posting a flyer, placing an ad in your local newspaper, or simply by word of mouth.

Remember to be careful about what personal information you give out about yourself in this process. Never put your home address on a flyer. If you cannot find a provider, contact your county IHSS office or Public Authority for assistance.

### Interviewing Providers

Before you interview a provider, you should take the time to review the services that have been authorized for you and how much time has been authorized for each service. If you feel that one provider cannot provide all of the services you need or work all of the authorized hours, you may wish to hire more than one provider. If you have specific needs, such as a special diet or finding someone who is capable of lifting, be sure to mention this during the interview.

You may find the following steps helpful:

1. Screen applicants through a telephone interview.
2. Meet in person with the strongest candidates.
3. Check references.



### Telephone Screening Interview

During this phone call, you should get a good idea of the person's availability, experience, and ability to perform the needed tasks. This is also a good time to let them know that IHSS providers must attend a provider orientation, be fingerprinted, and pass a background check. If you are satisfied with the person, the next step would be to set up a time to meet with him/her to discuss your needs and authorized services and find out more about him/her.

## Face-to-Face Interview

This interview can take place in your home or in a public place nearby. Consider asking a friend or family member to join you so that they can help with the interview and help decide who to hire. If possible, it is a good idea to interview more than one person. Make notes during the interview that you can refer to later when checking references or choosing who to hire. Here is some additional information to talk about during the interview:

- Ask to see identification. This may be a valid California driver's license or identification card with a photo.
- Explain your expectations for work behavior including the use of your belongings, arrival and departure times, and other information that will be important for the person you hire to know.
- Go over the services and hours authorized for you.
- Ask if they have been an IHSS provider before, and if they have gone through the provider enrollment process, including being fingerprinted.
- Give them a chance to ask you questions about the job and the services that you need.

## Checking Provider References

Checking references will provide you with valuable information about the person you are thinking about hiring. When calling references, ask questions that will give you an idea of the kind of work they did, how long they were employed, their reliability, and their strengths and weaknesses. Keep notes about what the references tell you as this may help you decide who to hire.

## Making the Decision

Look at your notes and compare the strengths, qualifications, and references of each person you interviewed and decide which one best meets your needs. Once you have made your decision, let the person know and then contact your county IHSS office so that your provider can begin the enrollment process if they have not already done this.





## Setting and Maintaining Boundaries

### **Part of your job as the employer is to set expectations for your provider.**

#### **Restrictions on tasks and hours.**

- Do not ask your provider to do things or work hours that have not been authorized. IHSS will not pay for unauthorized tasks or extra hours.

#### **Professional behavior when the workplace is a home.**

- Your provider should not bring children or others to your home. Your home is a workplace, and his/her job is to provide IHSS services for you.
- Your provider should not be spending his/her time visiting with you instead of working. Your provider may need to be politely reminded to stay on task.
- He/she should bring his/her own lunch or dinner if working at meal time.
- He/she should not use your property or belongings for his/her own needs.

#### **Protecting your privacy.**

- Your provider should not share your name, address, telephone number, health, family situation, or behaviors with any unauthorized people.



- It is important for your provider to know about your health conditions and family contacts in case of an emergency. However, keep other personal information private.
- Your provider should not have access to your checkbook, bank accounts, credit cards, financial information, or to money that is kept in your home.
- You should secure any valuables in a safe place and not tell your provider where they are kept.



## ***Things to Avoid***

- Do not let your provider sign your name at any time.
- Do not sign a timesheet that is incorrect.
- Do not sign a blank timesheet.
- Do not share your bank information with your provider and do not add their name to your savings, checking, or credit card accounts.
- Do not share your Social Security number.
- Ask for a receipt if you give money to your provider to purchase something for you.
- Do not leave valuables or important documents in a visible location.
- Keep an eye on things such as telephone usage, medications, etc.
- Do not let him/her borrow money, vehicles, or personal belongings.
- Do not get involved in your provider's personal life.

## Timesheets

**As the employer, you are responsible for keeping track of the number of hours a provider works each day and checking to make sure that the correct number of hours are entered on timesheets.**

If you have multiple providers, you must also make sure that each provider does not work more than the number of hours they have been assigned.

### Keeping track of service hours.

- Timesheets are sent to each provider two times each month and are attached to the check and/or pay stub that the provider receives.
- If you have more than one provider, you will need to decide how many hours each provider should work each month. If you need help with this, contact your county IHSS office.
- The authorized hours should be spread throughout the month to ensure that your care needs are met. In most cases, the hours worked the first half of the month should be about half of your total hours.

***Providers are only eligible to be paid for the authorized hours they worked.***

- It is YOUR responsibility to let each provider know how many hours are assigned to him/her. Make sure you and your provider(s) agree on the number of hours of work for each week.
- Use a calendar or other tool to keep track of the amount of time worked by your provider(s). Fill in the number of hours worked every time he/she works and ask him/her to write their initials next to the number.
- Before signing the timesheet, compare the hours the provider has put in with your records to make sure he/she included only hours actually worked.

## **Here are some additional tips to help you and your provider avoid timesheet problems:**

1. Use black or blue ink only to write the hours worked. Numbers must be readable. Timesheets completed in pencil will not be accepted.
2. A zero (0) should be entered for any days that the provider does not work.
3. Make sure you and your provider agree on how many hours he/she worked before you sign the timesheet. If you have disagreements with your provider about the number of hours worked and cannot reach agreement, call your county IHSS office for help.
4. Check to make sure the hours on the timesheet for the pay period are not more than the hours that are authorized. Your provider will not be paid for any additional hours.
5. Do not send any other documents with the timesheet.
6. Do not use correction fluid or tape to fix an entry. To correct a mistake, cross out what's wrong and enter the correct information. Both you and your provider should initial any change.
7. Do not cross out or change the names or pay periods in the boxes at the top of the timesheet. Timesheets are only good for the person and pay period listed.
8. Sign and date the timesheet in ink at the end of the pay period, **and not before**. Both you and the provider must sign the timesheet **after** the hours have been worked.
9. Timesheets are due as soon as possible after the 15th and the last day of each month. The correct mailing address is provided by your county.
10. If the provider moves, he/she must notify the local IHSS office or Public Authority to request an address change form. This should be done within 10 days of moving.

## **Common Timesheet Mistakes**

- Information is left out.
- The timesheet is not signed by both the provider and the consumer.
- A pencil is used to fill out or sign the timesheet.
- The numbers cannot be read.
- A mistake is covered with correction fluid or tape.
- The number of hours worked in the pay period is not entered correctly.
- Some of the information on the timesheet is torn off when the pay stub (the upper part of the form) was detached.
- The timesheet is mailed before the last day worked in the pay period.
- More hours are claimed than were authorized for payment.

**Making any of these mistakes will cause a delay in processing because the timesheet will be returned for correction.**

## Share-of-Cost

### What is a Share-of-Cost?

Most people receive IHSS as a part of their Medi-Cal benefits. Depending on the amount of income received, some people must agree to pay a certain amount each month toward their Medi-Cal expenses, before Medi-Cal will pay.

The money that must be paid before Medi-Cal will pay is called a Share-of-Cost (SOC). The SOC allows a person with income above the allowed amount to receive IHSS if he/she agrees to pay the SOC.

Your SOC may be paid to your IHSS provider, a pharmacy, doctor's office, or when purchasing other medical services or goods.

### How Does Share-of-Cost Work?

You will pay your share to the provider when you receive an "Explanation of Share-of-Cost" letter that identifies the amount of the SOC to be paid that pay period. The SOC amount will also appear on your provider's timesheet under "Share-of-Cost Liability."



The amount you need to pay your provider may change each pay period, depending on whether you have paid your SOC for other medical expenses before the timesheet is processed each pay period.

If you have more than one IHSS provider, you will not be able to choose which provider your SOC is paid to. Any SOC that you have not paid will be subtracted from the first IHSS provider's timesheet that is processed by the county. If you or your provider have questions about the SOC, contact your county IHSS or Public Authority office.

## Here are some examples of how Share-of-Cost works:

### Example 1:

Mrs. Smith has a SOC of \$200 for the month of June.	<b>\$200</b>
She sees her doctor on the 5 <sup>th</sup> and pays \$50 at the doctor's office.	<b>-\$50</b>
She fills a prescription on the 6 <sup>th</sup> and pays \$60 at the pharmacy.	<b>-\$60</b>
The total amount Mrs. Smith has paid toward her SOC is \$110 (\$50 + \$60).	<b>\$110</b>
When Mrs. Smith's provider submits his timesheet on the 16 <sup>th</sup> , Mrs. Smith has a remaining SOC balance of \$90 (\$200 – \$110).	<b>\$90</b>
The State will deduct \$90 from her provider's paycheck.	
Mrs. Smith will need to pay her IHSS provider/employee \$90.	<b>\$90</b>

### Example 2:

Mr. Lee has a SOC of \$100 for the month of June.	<b>\$100</b>
He sees his doctor on the 5 <sup>th</sup> and pays \$75 at the doctor's office.	<b>-\$75</b>
He fills a prescription on the 6 <sup>th</sup> and pays \$25 at the pharmacy.	<b>-\$25</b>
The total amount of Mr. Lee's expenses is \$100 (\$75 + \$25).	<b>\$100</b>
Mr. Lee has met his SOC for the month.	<b>\$0</b>
Mr. Lee's provider submits her timesheet on the 16 <sup>th</sup> .	
The State will pay for all of the authorized hours worked in June, and Mr. Lee will not have to pay any money to his IHSS provider.	<b>\$0</b>

## Teaching and Demonstration

**Teaching and Demonstration services may be authorized to allow your provider to teach you how to perform some of the IHSS services that you currently receive.**

### Eligible Services

Your provider may be paid to show you how to perform the following services:

- Housework such as sweeping, vacuuming, washing and waxing your floors, washing your kitchen counters and sinks, and cleaning the bathroom.
- Preparing and cleaning up after meals.
- Washing and drying your laundry.
- Personal care services such as feeding, bathing, and dressing.
- Yard work for removal of high grass or weeds when they could cause a fire.

### Important Information

If you would like to find out if you are eligible to have your provider teach you how to do some of the services you now receive, here are some things you need to know:

- Your provider must have the skills to be able to teach you how to perform the services.
- Teaching and Demonstration services can only be authorized for three months.



- The goal of Teaching and Demonstration is to allow you to become more independent. This means that because you will need less help after your provider has finished teaching you how to do the services for which Teaching and Demonstration is approved, your IHSS hours may be reduced.

Contact your county IHSS office for more information on this service. Your social worker will determine whether this service can be approved for you.

# THE WRONG AND THE BETTER WAY TO DOCUMENT

When thinking about, “How do I document this case,” always paint a solid picture of need so that others who review the case will be able to understand the need for services and hours authorized. This solid picture should always identify the consumer’s functional impairments and the risk they pose to the consumer, and should spell out how In-Home Supportive Services will reduce the risk. In addition, remove all judgmental comments; instead, simply report observed behaviors and environmental conditions.

Here are a few examples that reflect two different ways to document FI ranking and/or hours authorized. The “better way” examples are often abbreviated versions of appropriate documentation. Documentation should always include information about the FI ranking and the hours authorized:

**Wrong way:** “The consumer needs Meal Preparation services.”

**Better way:** “Consumer has congestive heart failure, which causes her to become short-of-breath, with minor exertion. As a result, she is only able to prepare a light breakfast (she states she has more energy in the morning), and needs meal preparation services for lunch and dinner.”

*[NOTES: Here the second example presents a description of functioning, but is missing information regarding types of meals and time required to prepare the meals and number of days a week needed.]*

**Wrong way:** “Consumer’s house is filthy.”

**Better way:** “During the home visit, I observed animal feces on the floor in several places. Consumer’s couch appeared stained, and had the odor of urine emanating from it. I noticed a pile of unwashed dishes in the kitchen sink, and a layer of black mold in the bathroom sink.”

*[NOTES: Here the “better way” presents facts and detailed observations; the statement, as originally written, could be an expression of the worker’s judgment based on her own standards of cleanliness and does not provide information regarding how the social worker came to this conclusion.]*

**Wrong way:** “Consumer needs one hour per week for Ambulation.”

**Better way:** “During the home visit, I observed consumer attempting to ambulate. His gait appeared unsteady – he nearly fell twice during the visit – and he stated that he is afraid to walk unassisted. Consumer stated that he spends approximately 8-9 minutes per day, getting to and from the bedroom, bathroom and kitchen. This is equivalent to 1 hour per week for Ambulation.”

*[NOTES: MPP 30-757.14(k) defines Ambulation as, “consisting of assisting the recipient with walking or moving the consumer from place to place inside the home...” Based on the information, this consumer would also need assistance to and from the car for medical appointments. It should be evaluated and addressed here.]*



**Wrong way:** “Consumer no longer needs Bathing services.”

**Better way:** “Telephone call from consumer. She stated that her broken wrist is completely healed, and that her orthopedic surgeon removed her arm-cast today. She further stated that she is now bathing for herself, unassisted. Bathing services removed as of this date.”

*[NOTES: In this case, the consumer stated no further need for Bathing services, but the removal of a cast does not, per se, mean that the consumer can return to the former functioning level immediately. The worker would need additional information about the consumer’s functioning now before eliminating Bathing. It is possible that the orthopedic surgeon will prescribe a regimen of physical therapy to regain functioning in the consumer’s hand. If the fracture was in the consumer’s dominant hand, then it is probable that the consumer will still need assistance with Bathing and Dressing until full functioning is regained.]*

**Wrong way:** “Consumer needs total care. Maximum hours authorized.”

**Better way:** “Consumer has Multiple Sclerosis, and she spends the entire day in bed. She requires assistance with all ADLs and IADLs because she lacks the physical strength and endurance to perform any Domestic and Related Services or Personal care.”

*[NOTES: Here the “better way” presents a description of functioning, and its connection to the specific types of services needed to address the impairment. Good documentation would also address hours of service needed. The social worker should not assume that all consumers who need care in most or all areas of IHSS would need maximum hours. Appropriate questions should be asked to determine specific tasks, amount of time, and frequency needed.]*

**Wrong way:** “Consumer needs Protective Supervision.”

**Better way:** “According to the physician’s evaluation on a SOC 821, the consumer has a diagnosis of dementia from Alzheimer’s disease and a history of wandering in the street, unable to recognize danger.”

*[NOTES: Here the physician’s evaluation suggests elements of the consumer’s behavior and cognitive limitations that could assist the SW in concluding that Protective Supervision is warranted. However, a full evaluation should be done by the SW, using the Protective Supervision criteria found in MPP 30-757.17 et seq. Additional information should be gathered about current behavior that consumer exhibits that places him/her at risk for injury, hazard or accident. Additionally, information should be solicited from others involved in the care of the consumer such as involved family members, the Regional Center, Mental Health, Day Care Centers, schools, etc.]*

**Wrong way:** “Consumer was uncooperative.”

**Better way:** “Three months ago, I suggested to consumer that the local Senior Center would be a resource for him, for both socialization and daily lunches. To date, he continues to state a feeling of isolation; however he has not contacted the Senior Center yet.”

*[NOTES: The “better way” describes the consumer’s statements and actions and the social worker’s efforts to resolve some of the issues identified during the home visit; the “wrong way” suggests uncooperativeness. Consumers have the right to refuse services, and not to follow the SW’s suggestions. While, from the SW’s perspective, going to the Senior Center could reduce social isolation, the social worker should determine if there are other issues that can be resolved such as of transportation.]*

## HEY, HEY, HEY, READ ALL ABOUT IT!

### IHSS Social Workers are Documenting! Documenting! Documenting!

Documentation is important in each and every one of our IHSS cases; it allows the reader to have a visual picture of what took place while the social worker was in the home, and what has transpired since the home visit. This is important when, and if, the case is transferred to another worker or another county. It lays a foundation, which a consumer's history is built on. Case narrative is the reader's visual picture of what has been going on with the consumer, his/her family dynamics, living environment, provider history and any changes in the consumer's health conditions.

Documentation / Narrative will be a valuable resource to you when you need to fall back on certain dates and times that a particular incident took place. It can be anything from a consumer being hospitalized, to a consumer alleging abuse by a caretaker. (Remember however, narrative alone is not enough if there is an allegation of abuse, you must also cross-report any abuse to APS/Law Enforcement on a SOC 341).

When documenting your case it is simple, just pretend that you work for the local news paper, no it is not the Daily Planet, it is the "IHSS" or the "Independent Helping Services Sentinel". Sentinel means "Look out, or Guard" which is the job of each social worker to look out for the best interest of their consumer, and guard them against possible fraud, or neglect. As a reporter for the Sentinel, it is your job to be accurate, grab the reader's attention and tell a story that will allow your reader to be there with you.

Remember you are a star reporter, the Clark Kent of Social Services, you may not have a cape, and phone booths are really hard to find these days, but you have something more powerful, and that is you are a social worker. You are providing services to the elderly and dependent adult allowing them to remain in their own home as long as possible. So what you need to do to insure safety, and insure that your consumer is receiving the appropriate services, is simple, just follow the rules of journalism: Who, What, When, Where, How, and Why. So grab your mighty pen, which can write faster than a speeding bullet, okay maybe not faster, but pretty quickly, and practice the following:

Who is calling you?	The client, doctor, family member, Lois Lane, or a friend?
What are they calling you about?	Need a new provider, changes in their medical conditions, no longer in the home, hospitalized, can't find a phone booth or just needing information about other community resources that may be available to them.
When did the incident occur?	Was it today, yesterday, last week, last year or will it be sometime in the future.
Where was the client when it occurred?	In her own home, in the hospital or riding a locomotive.
How has this affected the client?	Emotionally, physically, financially? Did the provider quit, or has consumer hired a new provider.
Why did this happen?	Was it because of the consumer, the provider, a family member? Was it because of bills were not being paid, or because of theft?

\*Remember the importance of documentation: “If it isn’t documented it did not happen.”

State Hearings:

When going to a State Hearing, it is important that you have completed an assessment tool, covering each area of service, and documented the home visit. The State Hearing Judge will rely on documented information from your case, and testimony from you, the consumer, and other witnesses. If you did not document certain events, and the consumer denies that you addressed these issues, it will be a case of “he said, she said” and the Judge usually will err on the side of the consumer. So for better results on those rare occasions when you have a case that is appealed by a consumer, you need to make sure that your documentation is accurate, filed appropriately in your case, and that it allows the reader reviewing your case to build a visual picture of what transpired during your home visit, and how you came up with your assessments, and the hours you granted or denied.

If you follow the simple rules of journalism, who knows-one day when a new social worker comes down the road and picks up one of your cases they may say “Wow who was that Super Social Worker?!!!!!!”

### **County Quality Assurance:**

- Any QA desk reviews and home visits completed with findings and finalization of the remediation process.
- Any referrals made, including the date and the name of the entity.

### **Spouse Provider Eligibility:**

- Eligibility of spouse provider and reference to the existing regulations and Welfare and Institutions Codes (W&IC).
- The status of the recipient's spouse (e.g., Able and Available, Unable and Available, etc.), and include any pertinent details regarding the spouse's ability and availability.

### **Parent Provider Eligibility:**

- Eligibility of parent provider(s) and reference to existing regulations and W&IC.
- Discuss and document the employment and/or educational schedule of parent(s).
- If the parent is not employed full-time, ask and document the reason.

### **Minor Recipient Eligibility:**

- The application of Age Appropriate Guidelines.
- All services received at school or from other sources.

- For Protective Supervision eligibility, document all four requirements necessary in determining eligibility for minors:
  - Minor is nonself-directing due to the mental impairment/mental illness;
  - Minor is likely to engage in potentially dangerous activities;
  - Minor also needs more supervision than a minor of comparable age who is not mentally impaired/mentally ill pursuant to Garrett v. Anderson;
  - 24 hours-a-day supervision is needed in order for the minor to remain at home safely.

### **Provider Information:**

- Verify the providers actively working for the recipient; include the names and verification that a valid IHSS Recipient Designation of Provider form (SOC 426A) is on file.
- The relationship(s) of provider(s) to the recipient.

### **Critical Incidents/Referrals:**

- All critical incidents, including type, date, referrals made, and resolution, if known.
- Any fraud referrals made to the appropriate parties.

### **Forms:**

- All forms that were utilized.
- Confirm that the pamphlet titled, Your Rights Under California Welfare Programs (PUB 13), and Voter Registration were provided to the recipient.

- All reasons why forms are missing, not signed, refused, and/or incorrectly completed and the necessary steps taken to rectify the issue.

### **State Administrative Hearings:**

- Any details and outcomes of past State hearings for use in determining continued eligibility for services.

### **Additional Information:**

- Any additional comments needed to support the recipient's case (e.g. inter-county transfer details, change in services/hours due to the recipient's health, etc.).



### **Case Disposition:**

- The case approval or denial including date of action, justification for the approval/denial, and the total number of monthly authorized hours.

If you have any questions, please contact **CDSS Adult Programs Division** at (916) 651-3494 or [IHSS-Training@dss.ca.gov](mailto:IHSS-Training@dss.ca.gov).



April  
2015

CDSS APD Policy & Quality Assurance Branch

# **CDSS In-Home Supportive Services**



## **IHSS Quality Assurance**

## **Case Narrative Guide**

This guide identifies key elements necessary to document the assessment and authorization of In-Home Supportive Services (IHSS). The inclusion of all the information specified below in a recipient's case file will help create comprehensive case documentation and consistency necessary for quality assessments.

Using this guide to document recipients' needs will assist social workers in preparing for state hearings and responding to inquiries from management or other organizations that are responsible for coordinating the authorization of services, such as Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), or Managed Health Care Plans. In addition, providing thorough documentation assists other social workers who may later assume responsibility for an existing case or when Inter-County Transfers occur.

### **General Information:**

- Date of the home visit.
- Start and end time of the home visit.
- List those present at the home visit.
- Assessment Type: Initial, Reassessment, Inter-County Transfer (ICT), Change Assessment (proration or increase/decrease in authorized hours), or Quality Assurance (QA) Findings & Recommendations.
- Living Situation: type of home [e.g., apartment, Single Room Occupancy (SRO), single story house, etc.].
- Living Arrangement: If the recipient resides in a shared living arrangement, indicate the number of rooms used solely by the recipient and/or shared with other residents in the household. If others live in the home, verify and document the living arrangement and the relationship(s) to the recipient, i.e. spouse, roommate, relative, etc. Also, if a shared living arrangement exists, note whether any of the following apply: live-in provider, recipient moved into a relative's home primarily for the purposes of receiving services, landlord/tenant, etc.
- Recipient's authorized representative (AR) (if applicable, e.g., power-of-attorney, conservator, guardian, etc.), provider, family members, etc.

- Companion case(s): names and case numbers.
- Names of persons other than the recipient/AR participating in the assessment; include information about relationship to recipient or agency affiliation.



### **Recipient Information:**

- Age and gender of the recipient.
- Recipient's primary language and translator information, if applicable.



**Social Worker Observations:**

- Appearance of the recipient (include physical well-being, signs of abuse and/or neglect).
- Functional abilities and limitations demonstrated and/or reported by the recipient.
- Physical limitations such as blind, deaf, or nonverbal.
- Mental abilities/limitations.
- Appearance of the home: identification of risks or safety issues, strong odors, visible Durable Medical Equipment (DME), oxygen equipment/use, etc.
- Safety concerns within the home: indicate safety issues and/or barriers.
- Any other general observations which may contribute to the assessment of the recipient's need for IHSS, or need for referrals to other organizations.

**Functional Abilities/Limitations:**

- Recipient's statements of abilities to safely perform Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs) and any functional limitations that prevent the recipient from performing ADLs and IADLs.
- Availability and use of Durable Medical Equipment (DME).

**Recipient Health Information:**

- All healthcare providers and details about frequency and duration of visits.
- Any authorized medical accompaniment and wait times, and if the optional IHSS Program Accompaniment to Medical Appointment form (SOC 2274) was utilized.
- Any emergency room visits and/or hospitalizations since last reassessment or since the intake assessment.
- Medical conditions including diagnoses, current symptoms, reported ailments, and treatments.
- Include any information provided on the IHSS Health Care Certification form (SOC 873) or other documents signed by healthcare professionals (primary conditions relating to functional limitations).
- Any discrepancies identified between the recipient or the AR's statements and documentation from healthcare professionals.
- Changes in condition since the last assessment.
- List of medications.
- Any in-home nursing/medical care information.
- Recipient's statement of why he/she feels unable to remain safely in his/her own home without IHSS.
- Whether or not the recipient would need skilled-nursing facility care if he/she were unable to remain at home.
- Disaster Preparedness Code.

**IHSS Service Information:**

- Description of necessary services per Functional Index (FI) rankings and assessed hours.
- All calculations of time per tasks.



**Paramedical:**

- Approval of Paramedical Services: details about the recipient's reported needs and the reported needs on the Request for Order and Consent – Paramedical Services form (SOC 321) and details about any contact(s) made with the recipient's healthcare professional to clarify the recipient's needs and the appropriate amount of authorized Paramedical Service hours.
- Denial of Paramedical Services: details about the denial of Paramedical Services including any supporting documents.



**Protective Supervision Documentation:**

- Reported incidents in which the recipient placed himself/herself in any harm and/or danger and any precautions taken to prevent future risks (ask if there have been any incidents during the previous year regarding quality of care).
- All supporting evidence of need for Protective Supervision and details on how the 24-hour need is met.
- The re-evaluation for Protective Supervision and the Protective Supervision 24-Hours-a-Day Coverage Plan form (SOC 825) or care plan were completed during each reassessment.
- Social worker's attempt to obtain the Assessment of Need for Protective Supervision for IHSS Program form (SOC 821).
- Information from collaborative sources that support the authorization of Protective Supervision, such as an Individual Education Plan (IEP), Alta Regional Center reports, mental health reports, etc.
- All evidence that supports the denial of Protective Supervision services, include regulations as appropriate.
- Update Disaster Preparedness Code during reassessment.

- If the recipient's FI rank is 5 in Ambulation/Transfer, provide documentation to justify how the client is eligible for Protective Supervision.
- IHSS Individualized Back-up Plan and Risk Management form (SOC 864) should be completed for IPO and CFCO recipients.

**Unmet Need(s):**

- Any efforts to seek/offer resources, which may address any unmet needs.
- If resources are already in place, document the details of the resources.
- Any safety issues and referrals made to the appropriate agency.
- Discussion with recipient regarding whether he/she can remain safely in his/her own home given there are unmet need hours and the associated risks of not having these needs met.



**Alternative Resources:**

- Social worker explored the availability of alternative resources.
- All services from formal alternative resources, including the source of the services, the services provided, frequency, and duration. Include services such as CBAS, MSSP, services received at school, Regional Center services, any in-home nursing services, etc.
- All informal resources, such as family, friends, and neighbors. Document services provided, including the frequency and duration. If the individual is eligible to be paid by IHSS for providing services, document the request for and the receipt of the Voluntary Services Certification form (SOC 450).
- If the recipient receives Medi-Cal In-Home Operations (IHO) services, document the hours received and services provided.

**Independent Choices:**

- Details regarding the recipient's choice of where he/she lives.
- Recipient having the choice and control of his/her daily schedules.
- Recipient having the choice to participate in community activities (e.g. going to the library, attending church, shopping, etc.).
- Recipient having the choice to seek employment, if desired.



CDSS

WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

April 17, 2015

ALL-COUNTY INFORMATION NO.: I-20-15

TO: ALL COUNTY WELFARE DIRECTORS  
IHSS PROGRAM MANAGERS

SUBJECT: NEW IN-HOME SUPPORTIVE SERVICES (IHSS) *QUALITY ASSURANCE CASE NARRATIVE GUIDE*

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☒ Initiated by CDSS

The purpose of this All-County Information Notice (ACIN) is to provide counties with information regarding the availability of the recently developed *IHSS Quality Assurance (QA) Case Narrative Guide*.

This guide is intended to assist and support county social workers in identifying key elements of the IHSS assessment and authorization process, by providing a standardized best practices guide for comprehensive IHSS case documentation.

## BACKGROUND

The development of the *QA Case Narrative Guide* stemmed from the Coordinated Care Initiative (CCI), and the California Department of Social Services' (CDSS) commitment to provide ongoing IHSS technical assistance to all counties. This is the first of several guides that are currently in development to assist county staff in the administration of the IHSS program.

## QUALITY ASSURANCE CASE NARRATIVE GUIDE

The foundation of the contents included in this narrative guide is built on the elements contained in the IHSS Needs Assessment form (SOC 293). Additionally, the guide has incorporated components from comprehensive case narrative samples from several counties which were collected as best practices during State QA monitoring reviews. The final step of the process was to provide our county partners with an opportunity to provide comments on the draft narrative guide, which resulted in additional changes before finalization.

The key elements identified in this guide include, but are not limited to, detailed case documentation of the following:

- Social Worker Observations
- Recipient Functional Abilities/Limitations
- Protective Supervision
- Alternative Resources
- Parent Provider Eligibility
- Critical Incidents/Referrals
- Paramedical Services
- Unmet Need

## **RECIPIENT INDEPENDENT CHOICES**

California's Community First Choice Option (CFCO) program allows recipients more choice and control of the IHSS services that they receive. Under CFCO, a recipient has the choice of having a parent or spouse as their provider, a choice previously only allowed under the IHSS Plus Option program. CFCO also allows for additional services, including Teaching and Demonstration, that was only allowed under the IHSS-Residual Program.

42 California Federal Register (CFR) Section 441.530 specifies the qualities of Home and Community-Based settings that are required for the CFCO program. These requirements shall be reviewed and documented during the assessment process, and include, but are not limited to:

- Details regarding the recipient's choice of where he/she lives;
- Recipients having choice and control of their daily schedules;
- Recipients having the choice to participate in community activities; and
- Recipients having the choice to seek employment, if desired.

## **DISTRIBUTION OF THE GUIDE**

CDSS, in collaboration with the California State University, Sacramento, will distribute an initial narrative guide to each designated county trainer later this month. A copy of this guide will also be provided to county QA staff during CDSS monitoring visits.

Additionally, this guide will be added to the IHSS Training Academy curriculum and will also be available on the CDSS website at the following link:

<http://www.cdss.ca.gov/agedblinddisabled/PG1214.htm>.

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Page Three

If you have any questions regarding this new guide, please contact the Adult Programs Policy and Quality Assurance Branch, Quality Assurance and Improvement Bureau, Research and Training Development Unit at [IHSS-Training@dss.ca.gov](mailto:IHSS-Training@dss.ca.gov) or at (916) 651-3494.

Sincerely,

***Original Document Signed By:***

HAFIDA HABEK, Chief  
Adult Programs Policy & Quality Assurance Branch  
Adult Programs Division



## CHALLENGING CASE SCENARIO

### SARAH

You are a new worker on a caseload. One of your consumers, Sarah, is due for a reassessment. You read the case record and learn that Sarah is a 71-year-old woman who lives alone in a three-bedroom house. Sarah's diagnoses include rheumatoid arthritis, hypertension, and heart disease. She is deaf in her left ear and has had both knees replaced and the joints in her right hand replaced. She currently has minimal use of her right hand and almost no use of her left hand. She walks slowly with a cane. She has a three-wheel electric scooter that she uses when she goes outside of her house. She uses the scooter to go to a nearby grocery store and restaurant. She says she prefers to use the cane inside of her house because she wants to maintain her ability to ambulate within the house and is afraid she will lose this if she relies on the scooter for inside mobility. She currently receives assistance with Domestic and all Related Services as well as some assistance with Bathing, Oral Hygiene and Grooming, with Care and Assistance with Prosthesis (setting up her Medi-set), Transfer and Accompaniment to Medical Appointments which includes physical therapy. Sarah has a niece who lives on the East Coast who she seldom has contact with, but no other family. She has been known to have many pets and is very attached to them. She spends her time watching TV and trying to be active in community activities. She has access to a computer and is able to use it with her right hand.

Sarah has been receiving IHSS for approximately five years, and the case record indicates that she has had several social workers during that time for various reasons. The case record also contains numerous notes regarding frequent phone calls, most of which are complaints about the providers and the quality of their services. You note that in the last year she has gone through five different providers. There is also indication that Sarah frequently calls and requests assistance with utility bills and paying for medications which she says are not covered by Medi-Cal. She states she knows of other people that get the same medications paid for by Medi-Cal but her pharmacist refuses to "jump through the hoops".

The case record indicates that the last call made to the county was last month. During this phone call, Sarah states that she learned at the last Public Authority Advisory Committee meeting that there is now an IHSS Quality Assurance section in the county. She states that she is happy to know that the county is now assuring the quality of the services that she receives and that she would like for them to come out and talk to her about the quality of the services she has been getting. When asked for specific information, she states the following current complaints:

- She prints recipes from the Food Channel and asks the housekeeper to use them and the provider refuses. She does not like the food that the provider prepares and would prefer to eat her meals at the nearby restaurant.
- She asks the provider to change her sheets each day when she comes (three days per week) and the provider says she does not have enough time. She wants the provider to have more hours so she can change the sheets three times per week. She says she sleeps better when her sheets smell fresh.
- She expects the provider to care for her pets.
- The provider refuses to drive Sarah to lunch when she goes out with her friends once every week.
- She needs a "lift chair" because she often has trouble getting up from a seated position and fell once.

Sarah indicates that unless these things are corrected, she will be firing her current provider. The case record indicates that there was a recent call from the Public Authority indicating that Sarah has asked that they send her a new list of providers to interview, but that they currently do not have any names to send to her.

The notes documenting the last telephone call indicate that Sarah had a great deal of difficulty hearing on the telephone and that the social worker had to repeat information several times. The social worker also indicated in the notes that Sarah is just an unhappy person, that there are no providers who could provide services to her satisfaction, and that Sarah will not listen to her when she explains that her requests are beyond the scope of IHSS.

### **Group Tasks – Part 1 – Preparing for the Home Visit**

- What things will I need to know before going on the home visit?
- What questions will I ask to get clear and concise information?
- What approach could I take to maximize my success?
- What environmental issues should I consider?

### **Group Tasks – Part 2 – Addressing Issues**

When you arrived for the home visit, Sarah begins by pulling out a list of problems that she wants to discuss. All of the issues previously identified by Sarah in her most recent phone call were on the list.

- Assume that during the home visit you attempted to resolve all of the issues that were identified and any additional issues that you believed that needed to be addressed. As a group, identify the information you gave to Sarah in response to each of the issues you have been assigned.
- How do you think Sarah responded to the information you gave her?
- Are there any IHSS services that Sarah is not receiving that she may qualify for?
- What referrals would you make to try to resolve some of Sarah's complaints and maximize her ability to remain safely at home?
- Identify any additional information you will need to obtain before completing the assessment and any additional forms that you will need.

### **Group Tasks – Part 3 – Authorization of Hours**

- Complete the Documentation Worksheet to show how the hours were assessed for the tasks indicated. Include appropriate documentation.
- Determine if an HTG exception exists and, if so, document the reason for the exception on the Documentation Worksheet.
- Complete the data entry grid for the tasks indicated.

## AUTHORIZING HOURS – SARAH

### Bathing and Grooming

Sarah requires assistance getting in and out of the tub, washing her body, shampooing her hair and brushing her hair. Sarah says that she has always bathed on a daily basis and that it is a problem for her that her provider comes only 3 days per week. She says that she has very dry skin and that her doctor has told her that she should bathe every day using a special moisturizing soap. You determined during the home visit that Sarah's FI rank for Bathing and Grooming is a "4". Sarah indicates that it takes her about 20 minutes to bathe, which includes shampooing her hair. It takes 10 minutes to blow dry and brush her hair after bathing. Her neighbor comes over on the days when the provider is not there and helps her bathe and do her hair.

### Documentation Worksheet

Bathing, Oral Hygiene, and Grooming							
FI Rank (Enter)	4						
	Low	High					
Rank 2	0.50	1.92					
Rank 3	1.27	3.15					
Rank 4	2.35	4.08					
Rank 5	3.00	5.10					

	Low	High
Rank 2	00:30	01:55
Rank 3	01:16	03:09
Rank 4	02:21	04:05
Rank 5	03:00	05:06

**Note: Compare Total Need with above range.**

Task	Need Per Occurrence	# of Times Per Day	# of Days Per Week	Total Need
Assistance with bathing (getting in/out of tub, washing body and hair)				
Blow dry/brush hair after bathing				
Oral hygiene				
Grooming				

Reason for assistance:

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

### Data Entry Grid

Total Assessed Need	Adjustments	Individual Assessed Need	Alternative Resources/Refused/Voluntary	Net Adjusted Need

## Meal Preparation

Sarah indicates during the home visit that she has toast and tea for breakfast each day which she can prepare herself. She indicates that she likes to eat her main meal in the middle of the day because she does not sleep well when she eats a large meal in the evening. She states she usually has a cup of soup or something light in the evening which she fixes herself.

Sarah states her provider comes 3 days per week, and that she usually tries to prepare her main meal while she is there as well as meals for her to reheat on the days she is not there. Sarah's FI rank for Meal Preparation and Cleanup is a "3" based on the fact that while she has someone prepare all seven main meals, she reheats four of her weekly meals that her provider prepares in advance. Sarah says it usually takes the provider about 1 hour each time she is there to prepare her main meal and the meals for the days that she is not there. The types of meals she prepares typically include some type of meat/poultry, starch and fresh vegetable.

In response to Sarah's complaints about the types of meals and quality of meals her current provider cooks, the social worker discussed the following options: Restaurant Meals Allowance and Meals on Wheels. Sarah said that she would not accept Meals on Wheels because she had tried it before and the food was so bad she had ended up feeding it to her pets. She thinks that Restaurant Meals Allowance would be better for her because she could go to the nearby restaurant each day and order whatever she wanted.

### Documentation Worksheet

Meal Preparation			Needs help with <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner				
FI Rank (Enter)	3						
	Low	High	Meal	Example of Typical Meal	Need Per Meal	# of Days Per Week	Total Need
Rank 2	3.02	7.00	Breakfast				
Rank 3	3.50	7.00	Lunch				
Rank 4	5.25	7.00	Dinner				
Rank 5	7.00	7.00	Snacks				
			Reason for assistance:				
			Shared living exceptions (required when services not prorated):				
			Additional information to document exceptions to guidelines and identification of Alt. Resources such as MOW:				
<i>Note: Compare Total Need with above range.</i>							

### Data Entry Grid

Total Assessed Need	Adjustments	Individual Assessed Need	Alternative Resources/Refused/Voluntary	Net Adjusted Need

## **Ambulation**

Sarah is able to ambulate inside of her apartment without assistance. She also is able to ambulate to and from the car when she goes to medical appointments because she uses an electric scooter when she goes outside of the house. She does require assistance getting the electric scooter in and out of the vehicle at home and at the destination. She goes to her primary care doctor once per month and to physical therapy two times per week. Her FI ranking in Ambulation is a "3". While Sarah is able to get in and out of the provider's car without assistance, it takes 5 minutes to retrieve her scooter and load it into the car for her to use when she arrives at the doctor's office. It takes another 5 minutes for the provider to remove the scooter from her car, to get it ready for Sarah to use it to ambulate from the parking lot to the doctor's office. The same times are necessary to load the scooter back into the provider's car when leaving the doctor's office, and finally to remove it from the car when arriving back at Sarah's home. She also requires assistance to her car when she attends an advisory committee meeting once per month. Sarah states that she takes public transportation (Medi-van) when she goes to physical therapy, but prefers to have her provider take her to the doctor and to the advisory committee meetings. Sarah indicates that Medi-Cal pays for the transportation to the physical therapist. She states that additional time is needed when she goes to the doctor because her provider must wait for her there and it takes about two hours.

## Documentation Worksheet

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

	Low	High
Rank 2	00:35	01:45
Rank 3	01:00	02:06
Rank 4	01:45	03:30
Rank 5	01:45	03:30

**Note: Compare Total Need with above range.**

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

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

Assistance From House To Car And Car To House For Medical Appt. & Alt. Resource				
	Time Assessed	# of Times	Total Need Per Month	Total Need Per Week (Monthly Need ÷ 4.33)
Assisting transfer in and out of car and with putting scooter in and out of car for trip to M.D.				
Assistance putting scooter in and out of Medi-van for trips to PT				

Reason for assistance:

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

## Data Entry Grid

Total Assessed Need	Adjustments	Individual Assessed Need	Alternative Resources/Refused/Voluntary	Net Adjusted Need

**IN-HOMESUPPORTIVE 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 T

YOUR  
IHSS  
OFFICE

Your County

Sarah Rockford  
123 Main Street  
Mytown, CA 99999

Case Number

60-10-123345-00

Date Mailed

02-08-2008

Your Authorization for In-Home Supportive Services has been changed effective 03-01-2008

NOW				WAS			
Your Countable Income:	\$			Your Countable Income:	\$		
Minus SSI/SSP Benefit Level:	\$			Minus SSI/SSP Benefit Level:	\$		
Your Share of Cost:	\$			Your Share of Cost:	\$		
Minus Assessed IHSS Cost:	\$			Minus Assessed IHSS Cost:	\$		
Income in Excess of Assessed Cost:	\$			Income in Excess of Assessed Cost:	\$		
<b>SERVICES</b>	HOURS NOW	PREVIOUS HOURS	(+) INCREASE OR (-) DECREASE	<b>SERVICES</b>	HOURS NOW	PREVIOUS HOURS	(+) INCREASE OR (-) DECREASE
DOMESTIC SERVICES per month:	6.00	6.00		ACCOMPANIMENT SERVICES per week:			
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.				Medical Appointment:	0.23	0.23	0.00
HEAVY CLEANING (one month only):				To Alternative Resources:			
RELATED SERVICES per week:				YARD HAZARD ABATEMENT:			
* Prepare Meals:	3.00	2.00	+1.00	Remove Grass, or Weeds, Rubbish (one month only):			
** Meal Cleanup:	1.50	2.00	- .50	Remove Ice, Snow, per week:			
Routine Laundry:	1.00	1.00		PROTECTIVE SUPERVISION per week:			
Shopping for Food:	1.00	1.00		TEACHING/DEMONSTRATION per week: (no more than three months duration)			
Other Shopping Errands:	.50	.50		* PARAMEDICAL SERVICE per week:			
NON-MEDICAL PERSONAL SERVICES per week:				TOTAL WEEKLY HOURS X 4.33:			
* Respiration Assistance:				ADD DOMESTIC SERVICE HOURS:			
* Bowel, Bladder Care:				ADD HEAVY CLEANING:			
* Feeding:				ADD REMOVE GRASS, ETC.:			
* Routine Bed Baths:				TOTAL MONTHLY HOURS (rounded to the nearest tenth)	48.8	50.6	-1.8
* Dressing:					NOW		WAS
* Menstrual Care:				Restaurant Meal Allowance:	\$		\$
* Ambulation:	.08	0.00	+ 0.08				
* Move In/Out of Bed:	.50	.50					
* Bathe, Oral Hygiene/Grooming:	2.00	3.00	-1.00				
* Rub Skin, Repositioning, Help On/Off Seats, In/Out of Vehicle:	.08	.08					
* Care/Assistance with Prosthesis:							

☐ "Since you meet the criteria for 20 hours or more in starred (\*) ser you can get an advance payment to pay your own provider. If you to get advance payment, contact your service worker. The double sta (\*\*) service is included in the 20 hours only when assistance with fee 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 (Co Federal Regulations), State Regulations (California Administrative Code and State Department of Social Services Manual of Policies and Proceed

Your authorization for In-Home Supportive Services has been changed effective 03/01/2008

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: 01 Service Worker: Mary Worker SW#: All Telephone: 555-555-5555

**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.**

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS AND OTHER PROGRAMS THAT INTERACT WITH IHSS

<b>AAA</b>	See Area Agency on Aging
<b>AAP</b>	See Adoption Assistance Program
<b>Activities of Daily Living (ADL)</b>	Basic personal activities that include bathing, dressing, transferring, toileting, mobility and eating.
<b>ACIN</b>	See All County Information Notice
<b>ACL</b>	See All County Letter
<b>ADCRC</b>	See Alzheimer's Day Care Resource Centers
<b>ADHC</b>	See Adult Day Health Care
<b>ADL</b>	See Activities of Daily Living
<b>Administrative Law Judge (ALJ)</b>	The judge employed by CDSS to adjudicate Fair Hearings
<b>Adoption Assistance Program</b>	Program administered through DSS and counties that provides financial assistance for up to two years for adoptive parents to meet the special needs of children who were formerly placed in California's foster care system.
<b>Adult Day Health Care (ADHC) / CBAS</b>	Day care program administered through the Department of Aging that provides health, therapeutic and social services which serve the specialized needs of frail elderly persons and adults with functional impairments at risk of institutionalization. ADHCs often transport participants to the site. Services provided at the ADHC are Alternative Resources for IHSS.
<b>Aged</b>	As provided in federal Social Security Act, persons age 65 and older.
<b>All County Information Notice (ACIN)</b>	A letter distributed to all counties and available on the CDSS website that informs counties of information of interest to them. They are issued by all CDSS Programs and are designated a number for reference.
<b>All County Letter (ACL)</b>	A letter distributed to all counties and available on the CDSS website that interprets policy. They are issued by all CDSS Programs and are designated a number for reference.
<b>ALJ</b>	See Administrative Law Judge
<b>Alzheimer's Day Care Resource Centers (ADCRC)</b>	Day care program administered through the Department of Aging that provides services to persons with Alzheimer's disease and other related dementias who are often unable to be served by other program. The centers provide respite as well as training and support for families and professional caregivers.
<b>Adult Protective Services (APS)</b>	Program charged with investigation of complaints of elder and dependent adult abuse and providing ameliorating services. Administered through county social services agencies with oversight from California Department of Social Services.
<b>APS</b>	See Adult Protective Services



## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Area Agency on Aging (AAA)</b>	Agencies established in each state under the provisions of the federal Older Americans Act to meet the needs of persons age 60 and older in local communities. There are discretionary funds for the local Area Agency on Aging to use to meet the unique needs of the community it serves, but all Area Agencies have a Meals on Wheels Program, at least one MSSP, and a Linkages Program.
<b>Assisted Living</b>	A facility that provides, at extra expense to residents, needed personal care and other assistance as needed with ADLs and IADLs, but does not provide round the clock skilled nursing facilities. Facilities generally provide less intensive care than nursing facilities and emphasize resident privacy and choice. Because care is an “add on” at extra cost, Assisted Living residents are potentially eligible for IHSS.
<b>Backup</b>	Provision for alternative arrangements for the delivery of services that are critical to consumer well being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them.
<b>Benefits Identification Card (BIC)</b>	A card issued to a Medi-Cal recipient which contains eligibility information.
<b>BIC</b>	See Benefits Identification Card (Also known as Medi-Cal card)
<b>Brown Bag Program</b>	A program administered by the Department of Aging under which volunteers collect and distribute surplus food to low-income seniors.
<b>CC</b>	See County Contract
<b>CAD</b>	California Association for the Deaf
<b>California Department of Aging (CDA)</b>	The State department responsible for oversight of Programs within the local AAA.
<b>California Department of Developmental Services</b>	Agency that provides services and supports to individuals with developmental disabilities which include mental retardation, cerebral palsy, epilepsy, autism and related conditions. Services provided through state-operated developmental centers and community facilities and contracts with 21 regional centers.
<b>California Department of Health Services (DHCS)</b>	See California Department of Health Care Services. Name changed 7-1-07.
<b>California Department of Health Care Services (CDSS)</b>	The single state agency responsible for all Medi-Cal expenditures including PCSP and IPW.
<b>California Department of Mental Health (CDMH)</b>	State agency that provides community and hospital-based services to adults who have a serious mental illness and children with a severe emotional disorder. The following types of services are administered by the state and directly provided or arranged by local (county) mental health departments: rehabilitation and support; evaluation and assessment vocational rehabilitation; individual service planning; residential treatment; medication education and management, case management and wrap around services.
<b>California Department of Social Services (CDSS)</b>	The State department responsible for oversight of Programs within the county departments of social services.

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Caregiver</b>	A person who cares for or helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers are relatives, friends or others who volunteer their help. Paid caregivers provide services in exchange for payment for services rendered.
<b>Case Management Information and Payrolling System (CMIPS)</b>	The computer system that handles the payroll for IPs and helps workers manage their caseloads. It also gathers demographic information about consumers and providers for management purposes.
<b>Case Management Information and Payrolling System II (CMIPSII)</b>	Updated version of the CMIPS system that integrates documentation and systems. Roll out implementation starting in 2012.
<b>CBO</b>	See Community Based Organization
<b>CCL</b>	See Community Care Licensing
<b>CCR</b>	California Code of Regulations
<b>CDDS</b>	See California Department of Developmental Services
<b>CDMH</b>	See California Department of Mental Health
<b>CDSS</b>	See California Department of Social Services
<b>CDA</b>	See California Department of Aging
<b>CDHS</b>	See California Department of Health Services
<b>Center for Medicaid and State Operations (CMSO)</b>	The component within CMS responsible for federal administration of Medicaid (Medi-Cal) and the State Children's Health Insurance (SCHIP) programs.
<b>Centers for Medicare and Medicaid Services (CMS)</b>	Agency in federal Dept. of Health and Human Services responsible for federal administration of Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP). Formerly known as the Health Care Financing Administration (HCFA).
<b>CFNP</b>	Certified Family Nurse Practitioner
<b>CFR</b>	Code of Federal Regulations. The CFR contains regulations officially adopted by federal agencies. Federal regulations that govern Medicaid (Medi-Cal) are contained in 42 CFR §430 et seq.
<b>CIN</b>	See Client Index Number (pronounced "sin.")
<b>Cl or Clt</b>	See Client (Also referred to as recipient or consumer)
<b>Client</b>	The person receiving IHSS. Also referred to as recipient or consumer.
<b>Client Identification Number (CIN)</b>	A number assigned to each individual who receives any type of public assistance benefit or public social service in the State. The same number is used by every program an individual uses.
<b>CMIPS</b>	See Case Management Information and Payrolling System (pronounced as "see-mips")
<b>CMS</b>	See Centers for Medicare and Medicaid Services.
<b>CMSO</b>	See Center for Medicaid and State Operations

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>COLA</b>	See Cost of Living Adjustment
<b>Community Based Organization (CBO)</b>	A social service agency, usually non-profit, that provides social services to the community. They tend to specialize in target population and function.
<b>Community Care Licensing (CCL)</b>	The organization within CDSS that is responsible for licensing and monitoring Child Day Care facilities and Residential Facilities for Adults.
<b>Community First Choice Options (CFCO)</b>	The Community First Choice Option is a new Medicaid state plan option that will be available in October 2011. It will allow states to provide a broad range of personal attendant services and supports to eligible individuals based on functional needs. As an incentive, participating states will receive additional federal funding through an enhanced federal Medicaid match of 6%. Since it is a state plan option, states must provide these services to all eligible individuals, offering a real choice to individuals and helping those who are in institutions or on waiting lists for services.
<b>Community Transition</b>	Activities that are undertaken to assist an institutionalized person to return to the community or facilitate a person served in a congregate living arrangement in the community to their own home.
<b>Consumer</b>	The person receiving IHSS (Also referred to as client or recipient)
<b>Co-Payment</b>	A fixed dollar amount that a Medicaid (Medi-Cal) beneficiary is expected to pay at the time of receiving a specified covered service from a provider. May only be imposed on certain groups of beneficiaries, only with respect to certain services, and only in nominal amounts as specified in federal regulation. There is no PCSP or IPW co-payment. (Not to be confused with Share of Cost.)
<b>Contract County (CC)</b>	A county that has a contract with an agency to provide IHSS services through the agency's employees.
<b>Contract County Mode</b>	One of the three modes of delivering service to IHSS consumers. Other modes include Homemaker Mode and Independent (Individual) Provider modes.
<b>Coordinated Care Initiative (CCI)</b>	The coordinated care initiative aims to improve service delivery for all Medi-Cal beneficiaries, but particularly those who need coordination the most – the 1.1 million people eligible for both Medicare and Medi-Cal coverage (“dual eligible beneficiaries”) and the 160,000 Medi-Cal-only beneficiaries who rely on long-term services and supports (LTSS).
<b>Cost of Living Adjustment (COLA)</b>	An annual increase in a governmental benefit based on the Consumer Price Index
<b>County Welfare Director's Association (CWDA)</b>	A group of county administrative staff that meets with CDSS to discuss policies and funding, to advocate on behalf of the counties' interests and to lobby for legislation on the State and Federal levels.
<b>CWDA</b>	See County Welfare Directors' Association
<b>CDHCS</b>	See California Department of Health Care Services
<b>CDSS</b>	See California Department of Social Services

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>DMH</b>	Department of Mental Health
<b>D Status</b>	See Denied Status
<b>Denied Status</b>	A term indicating that a person has been denied eligibility for IHSS. Indicated by a “D” in the F1 field of the SOC 293.
<b>Dependent Adult</b>	Any person residing in California, between the ages of 18 and 64, who has physical or mental limitations that restrict his/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. Also includes any person between ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility.
<b>Dtr</b>	Daughter
<b>Disability</b>	For SSI/SSP and Medi-Cal (and therefore for IHSS), as defined in §1614(a)(3) of the Social Security Act, disability means the inability of a person age 18 or older to engage in substantial gainful activity (work) by reason of any medically determinable physical or mental condition that can be expected to result in death or to last for a continuous period of not less than 12 months. For children (age 17 and younger), the child must have a physical or mental condition that results in marked and severe functional limitations. The condition also must be expected to result in death or to last for a continuous period of not less than 12 months. (In California, the Department of Social Services Disability Evaluation Division determines disability).
<b>Disabled</b>	As provided in § 1905(a)(vii) of the Social Security Act, the term “disabled” means persons under the age of 65 who have been determined to have a disability for social security purposes. See also Disability.
<b>DME</b>	See Durable Medical Equipment
<b>Dual Eligible (Full Benefit)</b>	An individual eligible for both Medicare and Medicaid (Medi-Cal) coverage, including the payment of the person’s Medicare premium, deductibles, and coinsurance. (Also known as Medi-Medi)
<b>Durable Medical Equipment (DME)</b>	Assistive devices to assist people with impairments and braces and artificial limbs.
<b>E Status</b>	See Eligible Status
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>	Medicaid’s comprehensive child health program for individuals under the age of 21. Authorized under §1905(r) of the Social Security Act. Includes periodic screening of children including vision, dental and hearing services. Also requires that any medically necessary health care services listed in §1905(a) of the Act be provided to a EPSDT beneficiary even if the service has not been specifically included in State Plan. Federal EPSDT regulations are located in 42 CFR §441.50 et seq.
<b>EBB</b>	See Electronic Bulletin Board
<b>EDS</b>	See Electronic Data Systems
<b>Elder</b>	Any person residing in California who is 65 years of age or older (WIC 15610.27)

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Electronic Bulletin Board (EBB)</b>	A message sent from CDSS to the CMIPS terminal announcing information about changes in CMIPS or time-sensitive information.
<b>Electronic Data Systems (EDS)</b>	Fiscal agency for processing IHSS provider timesheets and acting as payrolling agent which includes withholding appropriate federal and state taxes and issuing W-2s.
<b>Eligible Status</b>	A term indicating that a person has been determined eligible for IHSS services. Indicated by an “E” in Field F1 on the SOC 293.
<b>Eligibility Determination</b>	Processes employed to determine whether an individual meets the requirements specified in the State plan to receive Medicaid benefits. Requirements include determining whether a person is a member of an eligibility group specified in the State plan and meets income and resource standards and citizenship/immigration status. Eligibility determinations must be performed by the Medicaid agency or another agency specified in 42 CFR §431.10(c) with which the Medicaid agency has an agreement as provided in 42 CFR §431.10.(d).
<b>Eligibility Worker (EW)</b>	A term used by some counties to designate the county staff who determine Medi-Cal eligibility and Share-of-Cost (SOC) for Income Eligible (IE) consumers.
<b>Emergency Backup</b>	See backup.
<b>EPDST</b>	See Early and Periodic Screening, Diagnosis and Treatment
<b>EW</b>	See Eligibility Worker
<b>Fair Hearing</b>	The administrative procedure that affords individuals the statutory right and opportunity to appeal adverse decisions regarding eligibility and benefits to an independent arbiter. A fair hearing may be requested when denied eligibility, when eligibility is terminated, or when denied a covered benefit or service. It may be requested when there is a decrease in hours in any task and if the county declines to increase hours requested by the consumer.
<b>Federal Income Tax (FIT)</b>	Taxes withheld from IP pay checks based on information completed by the IP on the W-4 form
<b>Federal Financial Participation (FFP)</b>	Technical term for federal matching funds paid to states for allowable expenditures for services or administrative costs.
<b>Federal Insurance Contribution Act (FICA)</b>	Federal law that authorizes taxes on the wages of employed persons to provide for contributions to the federal Old Age, Survivors and Disability Insurance (OASDI – Social Security) and Medicare Health Insurance (Part A) programs. Covered workers and their employers pay FICA taxes in equal amounts. FICA is withheld from all providers’ pay except if the provider is the parent of the consumer, regardless of the age of the consumer or the spouse of the consumer or the child of the consumer if that child is under the age of 21. The 2007 FICA withholding rate is 7.65%.
<b>Federal Poverty Level (FPL)</b>	The federal government’s working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain groups of beneficiaries. The FPL is adjusted annually for inflation and is published by the Department of Health and Human Services in the form of Poverty Level Guidelines by household size.

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Federal Register (FR)</b>	The official federal daily publication that contains proposed rules, final regulations and notices of federal agencies and organizations as well as Executive Orders and other Presidential documents. Cited by volume number and page number(s).
<b>Federal Unemployment Tax (FUTA)</b>	Tax paid by the State on behalf of Providers that pays for federal supplemental Unemployment Insurance Benefits (UIB)
<b>Fee for Service</b>	A method of paying providers for services rendered to individuals. Under fee-for-service system, the provider is paid for each discrete service rendered to an individual.
<b>FFP</b>	See Federal Financial Participation
<b>FI</b>	See Functional Index or Fiscal Intermediary
<b>FICA</b>	See Federal Insurance Contribution Act
<b>Fiscal Agent or Fiscal Intermediary</b>	The entity that processed or pays Medicaid vendor billings under contract with the Medicaid agency. In California, the fiscal agent for IHSS is Electronic Data Systems (EDS).
<b>FIT</b>	See Federal Income Tax
<b>FPL</b>	See Federal Poverty Level
<b>FR</b>	See Federal Register
<b>Functional Index (FI)</b>	A numeric rank between 1 and 5 assigned by the worker that reflects the consumer's level of dependence on human assistance in various functions.
<b>FUTA</b>	See Federal Unemployment Tax
<b>Genetically Handicapped Persons Program (GHPP)</b>	A program administered by the Department of Health Care Services that provides case management services to persons genetic diseases. GHPP Eligible Medical Conditions Include: <u>Diseases of the Blood; Cystic Fibrosis; Diseases of the Brain and Nerves; Diseases of the Protein Metabolism; Diseases of Carbohydrates Metabolism; Disease of Copper Metabolism; Von Hippel-Lindau Disease (VHL).</u>
<b>GHPP</b>	See Genetically Handicapped Persons Program
<b>Grid</b>	The right side of the SOC 293 (the portion of the form where individual service authorizations are recorded).
<b>HCBS</b>	Home and Community-Based Services
<b>Health Insurance Counseling and Advocacy Program (HICAP)</b>	A program administered by the California Department of Aging that provides both community education sessions open to the public and individualized one-to-one counseling on Medicare, managed care, and other private health insurance issues.
<b>Health Insurance Portability and Accountability Act of 1996 (HIPPA)</b>	Federal law that requires (among other provisions) that each state's Medicaid management information system (MMIS) have the capacity to exchange data with the Medicare Program. Also mandates certain standards and practices with regard to the privacy of consumer health information. Your county can advise you about how HIPPA affects the IHSS Program.
<b>HHA</b>	See Home Health Agency

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>HICAP</b>	See Health Insurance Counseling and Advocacy Program
<b>HIPPA</b>	See Health Insurance Portability and Accountability Act of 1996
<b>HM</b>	See Homemaker
<b>Home Health Aide</b>	A person who, under the supervision of a home health agency, assists elderly, ill or a person with a disability with household chores, bathing personal care, and other daily living needs. Medi-Cal and Medicare pay for Home Health Aid services under certain circumstances. If a Home Health Aid is providing services to a consumer, that service is considered an Alternative Resource.
<b>Home Health Agency (HHA)</b>	A company licensed by CDHS to provide Home Health Services
<b>Home Health Services</b>	Provision of part-time or intermittent nursing care and home health aide services. California has opted to include physical therapy, occupational therapy, speech pathology and audiology services. Services must be ordered by a physician as part of a plan of care that the physician reviews at least every 60 days.
<b>Homemaker (HM)</b>	A county-employed IHSS care provider. Very few counties use the HM mode.
<b>Homemaker Mode</b>	One of the three methods of delivering service to IHSS consumers. Under this mode, county employees provide IHSS services. Other modes include Contract County and Independent (Individual) Provider modes.
<b>HTG</b>	See Hourly Task Guideline
<b>Hourly Task Guideline (HTG)</b>	A range of time associated with an FI score for a particular function that reflects common times authorized for the associated service category. They are a tool for workers to use when authorizing services; workers are expected to make exceptions to the HTGs when appropriate to meet the needs of the consumer.
<b>HV</b>	Home Visit
<b>I Status</b>	See Interim Eligible
<b>IA</b>	See Interagency Agreement
<b>IADL</b>	See Instrumental Activities of Daily Living
<b>ICF</b>	See Intermediate Care Facility
<b>ICF/DD</b>	See Intermediate Care Facility for the Developmentally Disabled. People who live in an ICF/DD are not eligible for IHSS.
<b>ICT</b>	See Inter-county transfer
<b>IEP</b>	Individualized Education Plan (for those students with specialized educational needs)
<b>Independent Provider/ Individual Provider (IP)</b>	Terms used interchangeably to refer to the person hired by the consumer to provide authorized IHSS services.



## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>IE</b>	See Income Eligible for IHSS purposes. When used in the Medi-Cal eligibility determination process IE indicates ineligible.
<b>IHMC</b>	In Home Medical Care
<b>IHO</b>	See In Home Operations
<b>IHSS</b>	See In-Home Supportive Services
<b>IHSS State Fund</b>	An IHSS state fund in the California State Treasury
<b>Independent Provider/Individual Provider Mode</b>	One of the three methods of delivering service to IHSS consumers. Other modes include Contract County and Homemaker modes. 99% of the State's IHSS caseload is served by IPs.
<b>IHSS Plus Option (IPO)</b>	A portion of IHSS that serves consumers whose providers are their spouses or, if the consumer is a minor, his/her parent, and those who receive IHSS Restaurant Meal Allowance in lieu of IHSS Meal Prep or opt for Advance Pay
<b>IMD</b>	See Institutions for Mental Disease
<b>I&amp;R</b>	See Information and Referral
<b>Ineligible</b>	A person determined not eligible to receive services.
<b>Information and Assistance Program</b>	A California Department of Aging program under which trained staff provide information as well as assistance and follow-u to link seniors and adults with functional impairments and their families with programs and services in their community.
<b>Information and Referral (I&amp;R)</b>	A function performed by county staff of providing information and making referrals to appropriate agencies that can provide the needed assistance.
<b>In Home Operations</b>	The organization within Department of Health Care Services that oversees the development and implementation of home and community based programs under Medi-Cal.
<b>In-Home Supportive Services (IHSS)</b>	The umbrella term applying to PCSP, IPW and Residual IHSS
<b>In-Home Supportive Services Employer-Employee Relations Act (IHSS-EERA)</b>	Creates a single Statewide Authority to conduct statewide negotiations with IHSS providers.
<b>Institutions for Mental Disease (IMD)</b>	A public or private facility that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (disorders). Includes not just public or private hospitals for individuals with mental illness but also nursing homes or other long-term care facilities that primarily serve such individuals. People who live in an IMD are not eligible for IHSS>
<b>Instrumental Activities of Daily Living (IADL)</b>	Activities related to independent living, including preparing meals, managing money (not covered by IHSS), shopping for groceries or personal items, laundry, performing light or heavy housework, and communication (also not covered by IHSS).



## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Interagency Agreement (IA)</b>	A formal document that sets forth the responsibilities that are assumed by two or more governmental agencies in their pursuit of common goals and objectives. (Example: CDSS administers the IHSS program through an Interagency Agreement with California Department of Health Services.)
<b>Inter-County Transfer (ITC)</b>	The process of transferring IHSS from one county to another when the consumer moves. It assures that the consumer will not lose services or have his/her services reduced solely because s/he moved.
<b>Interim Status</b>	Provisional IHSS approval in Aid Code 28 or 68 pending disability or blindness determination. Indicated by an "I" in the F1 field of the SOC 293.
<b>Intermediate Care Facility (ICF)</b>	A public or private facility that provides long term care for people who are aged or disabled or recovering from an illness, accident or surgery. People who reside in an ICF need minimal or no nursing services. People who live in an ICF are not eligible for IHSS.
<b>Intermediate Care Facility for the Developmentally Disabled (ICF/DD)</b>	A public or private facility that provides health and habilitation services to individuals with mental retardation or related conditions. ICF/DD facilities have four or more beds and must provide active treatment to their residents. People who live in an ICF/DD are not eligible for IHSS.
<b>IP</b>	See Independent Provider/Individual Provider
<b>IPO</b>	See IHSS Plus Option
<b>L Status</b>	See Leave Status
<b>LCD</b>	The organization within the California Department of Health Care Services that is responsible for the following activities: licensing 30 different types of health care facilities and providers; investigating over 11,000 complaints each year regarding concerns expressed about care provided by these health facilities and providers; Certifying that over 160,000 nurse assistants, home health aides and hemodialysis technicians can provide specific services; approving training programs for these health care worker categories; licensing over 3,000 Nursing Home Administrators and approving over 100 Continuing Education Providers; and providing consumer Education and provider education to improve the quality of health care.
<b>Leave Status</b>	IHSS has been temporarily suspended because of an event such as hospitalization or traveling out of the country. Indicated by an "L" in the F1 field of the SOC 293.
<b>Legal Representative</b>	A person who has legal standing to make decisions on behalf of another person (e.g. a guardian or conservator who has been appointed by the court or an individual who has power of attorney granted by the person.)
<b>Legally Responsible Individual</b>	A person who has a legal obligation under the provisions of state law to care for another person. Legally responsible individuals include the parents (natural or adoptive) of minor children, legally-assigned caretaker relatives of minor children, and spouses.
<b>Level of Care</b>	The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the Medicaid State plan.

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Live in Provider</b>	A person not related to the consumer who moves in with the consumer to provide IHSS.
<b>Long Term Care Ombudsman Program</b>	Program administered through California Department of Aging authorized by federal Older Americans Act and State Older Californians Act that investigates and tries to resolve complains made by, or on behalf of, individual residents of long term care facilities.
<b>MBU</b>	Medi-Cal Budget Unit
<b>MC</b>	Managed Care
<b>Meals on Wheels (MOW)</b>	AAA-funded home delivered meals to seniors and, in some cases, other homebound individuals. If an IHSS consumer gets MOW, that is an alternative resource for Meal Prep
<b>Medical out-of-home care facility</b>	Includes acute care hospitals, skilled nursing facilities and intermediate care facilities. Residents are not eligible for IHSS.
<b>Medi-Cal Card</b>	See Beneficiary Identification Card (BIC)
<b>Medi-Cal Eligibility Data System</b>	The statewide system maintained by the California Department of Health Services which contains Medi-Cal eligibility recipient information.
<b>Medi-Medi</b>	See Dual Eligible
<b>MEDS</b>	See Medi-Cal Eligibility Data System
<b>Mixed Mode</b>	Term indicated consumer is served by more than one type of provider.
<b>MN</b>	Medically Needy
<b>Mode</b>	The type of provider that serves the consumer. There are 3 types: Individual/Independent Provider, Contract Agency or Homemaker. It is possible for a consumer to be served by more than one mode at the same time. This is called "Mixed Mode."
<b>MOE ( Maintenance of Effort)</b>	A requirement contained in certain legislation or regulations that program must maintain/contribute a specified level of financial effort in a specified area in order to receive Federal assistance funds, which ensures that those Federal funds are used to supplement, but not supplant, expenditures.
<b>MOW</b>	See Meals on Wheels
<b>MPP</b>	See Manual of Policies and Procedures
<b>MSSP</b>	See Multipurpose Senior Services Program
<b>Multipurpose Senior Services Program (MSSP)</b>	Case management and some funds to purchase items and services of support for seniors who would be institutionalized at the SNF level. The total cost of care (including IHSS) must be less than the cost of SNF care
<b>NMOHC</b>	See Nonmedical out-of-home care facilities.
<b>NOA</b>	See Notice of Action (sounds like "Noah")

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Nonmedical out-of-home care facilities</b>	Community care facilities and homes of relatives which are exempt from licensure where recipients are certified to receive board and care payment level from SSP. Residents are not eligible for IHSS.
<b>Non-Severely Impaired (NSI)</b>	A consumer who does not need 20 hours a week or more in designated services
<b>Notice of Action (NOA)</b>	A CMIPS-generated letter to the consumer explaining all decisions made on a case, citing the authority for the decision and informing the consumer of his/her appeal rights
<b>NSI</b>	See Non-Severely Impaired
<b>OHC</b>	Other Health Coverage (such as private health insurance)
<b>Ombudsman Program</b>	See Long-Term Care Ombudsman Program
<b>Out of-Home Care Facility</b>	A housing unit other than the recipients own home. Includes medical out-of-home care facilities and Nonmedical out-of-home care facilities. Residents of out-of-home care facilities are not eligible for IHSS. (See Own Home; Medical out-of-home care facilities and Nonmedical out-of-home care facilities.
<b>Own Home</b>	Place where individual chooses to reside. Does not include an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or a board and care facility. Persons receiving SSI/SSP payment for nonmedical out-of-home living arrangement are not considered to be living in their own home.
<b>PA</b>	See Public Authority
<b>PACE</b>	See Program of All-inclusive Care
<b>PC</b>	Phone call
<b>PD</b>	See Presumptive Disability
<b>Personal Care Services Program (PCSP)</b>	A Medicaid-funded IHSS Program for almost all IHSS recipients
<b>Personal Needs Allowance (PNA)</b>	The amount of money that a Medicaid consumer that resides in a nursing facility or ICF/DD is allowed to keep for personal expenses like haircuts and laundry.
<b>Persons Living With Aids (PLWAs)</b>	Individuals who have Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection.
<b>PCSP</b>	See Personal Care Services Program
<b>PI</b>	See Policy Interpretation
<b>PLWAs</b>	See Persons Living With Aids
<b>PNA</b>	See Personal Needs Allowance
<b>Policy Interpretation (PI)</b>	A written response from CDSS to a county answering how to apply a policy to a particular case.

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Presumptive Disability</b>	Allows consumers with certain specified conditions to be presumed disabled while a disability determination is made.
<b>Prior Authorization</b>	As used in Medi-Cal refers to a mechanism employed to control the use of covered items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital care). Prior authorization is obtained by Medi-Cal providers through the submission of a Treatment Authorization Request (TAR) to a designated Department of Health Services location.
<b>Program for All-Inclusive Care for Elderly (PACE)</b>	A Federally funded waiver program that is based on the On Lok model of long term care for seniors on Medi-Cal. PACE provides all social and medical care for eligible individuals. People enrolled in PACE are not eligible for IHSS.
<b>Provider</b>	The person who provides the IHSS-authorized care.
<b>Public Authority (PA)</b>	An organization responsible to administer a provider registry for IHSS, provide access to training for IPs and consumers and to be the IPs' employer of record for meet and confer purposes
<b>Public Employment Relations Board (PERB)</b>	Is a quasi-judicial administrative agency charged with administering the collective bargaining statutes covering employees of California's public schools, colleges, and universities, employees of the State of California, employees of California local public agencies (cities, counties and special districts), trial court employees and supervisory employees of the Los Angeles County Metropolitan Transportation Authority.
<b>QA</b>	See Quality Assurance
<b>QI</b>	See Quality Improvement
<b>Quality Assurance (QA)</b>	Process of looking at how well services are provided. The process may include formally reviewing the services furnished to a person or group of persons, identifying and correcting problems, and then checking to see if the problem was corrected.
<b>Quality Improvement (QI)</b>	A term used to identify how counties utilize information obtained through QA and other activities to improve quality in the administration of the IHSS program.
<b>RCFA</b>	See Residential Care Facility for the Aged
<b>Record Status</b>	A term indicated that an application for IHSS has been taken. Indicated by a "R" in the F1 field of the SOC 293.
<b>Related Services</b>	An IHSS term that refers to the following services: Meal Preparation and Cleanup, Laundry, Food Shopping and Other Shopping/Errands.
<b>Rehabilitation</b>	Services that have the purpose of improving/restoring a person's physical or mental functioning.
<b>Residential Care Facility for the Aged (RCFA)</b>	Board and Care for people age of 65 and over. People who live in a RCFA are not eligible for IHSS
<b>Residual</b>	IHSS for eligible consumers who are not eligible for PCSP or IPW.

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Resources</b>	Items of economic interest (sometimes referred to as assets) that are not income. Includes financial instruments, certain personal property and real estate (other than individual's home).
<b>Room and Board</b>	"Room" means shelter type expenses such as rent and utilities; board refers to three meals a day or any other full nutritional regimen.
<b>SCIF</b>	See State Compensation Insurance Fund
<b>SDI</b>	See State Disability Insurance
<b>Self Administration</b>	The administration of medications or other procedures by a person without assistance.
<b>Senior Companion Program</b>	Program administered through California Department of Aging under which low-income senior volunteers provide peer support to frail older persons in their local communities.
<b>Severely Impaired (SI)</b>	Consumers who need 20 hours a week or more in specified services
<b>Share-of-Cost (SOC)</b>	The portion of cost the consumer is responsible to pay for services, based on his/her income See Also Spenddown
<b>Single Room Occupancy (SRO)</b>	A room in a residential hotel.
<b>Single State Agency</b>	The state agency designated by the federal government to administer the State Medicaid Plan. In California, the Single State Agency is the California Department of Health Services. The Single State Agency is not required to directly administer the program, but must maintain ultimate authority and responsibility for the administration of the State Medicaid Plan.
<b>Skilled Nursing Facility (SNF)</b>	An institution that provides skilled nursing and ancillary care to its residents. It is a medical facility. Its residents do not qualify for IHSS.
<b>SNF</b>	See Skilled Nursing Facility (pronounced "sniff")
<b>SOC</b>	See Share of Cost if used as an acronym in a sentence. If SOC precedes a number, it indicates the number of a form used by the Social Services System. IHSS-specific forms begin with the SOC designation.
<b>Social Security Administration (SSA)</b>	The federal agency that administers Social Security Title II benefits (green check for eligible people based on earnings), and Title XVI (gold check SSI/SSP for low income aged, blind and aged individuals)
<b>Social Security Number (SSN)</b>	An identification number assigned by the Social Security Administration (SSA)
<b>SPA</b>	See State Plan Amendment
<b>Spenddown</b>	The process whereby an individual who would otherwise be ineligible for Medicaid benefits due to excess income "spends down" the excess income by incurring medical expenses that are deducted from income in order to qualify for Medicaid (see also Share of Cost)
<b>SSA</b>	See Social Security Administration
<b>SSI</b>	See Supplemental Security Income
<b>SSN</b>	See Social Security Number

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>SSP</b>	See State Supplemental Program
<b>SRO</b>	See Single Room Occupancy
<b>State Compensation Insurance Fund (SCIF)</b>	The State organization that manages Worker's Compensation coverage for all IHSS Providers
<b>State Disability Insurance</b>	A 0.6% tax withheld from providers' wages to pay a stipend if the provider is unable to work because of a disability
<b>State Income Tax (SIT)</b>	Taxes withheld from an IP's pay check based on information IP provides on a W-4 form
<b>State Medicaid Plan</b>	Document developed by State that specifies eligibility groups the state will serve, the benefits the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program. The State plan must be submitted to and approved by CMS. See also State Plan Amendment (SPA).
<b>State Plan Amendment (SPA)</b>	Document prepared by states and submitted to CMS for review and approval requesting authority to amend their State Medicaid Plan. Amendments may address changes in eligibility criteria, covered benefits or provider reimbursement methodology. States must also amend their State Plan to conform to changes in federal Medicaid law.
<b>State Supplemental Program (SSP)</b>	The amount by which a state elects to supplement the basic SSI cash assistance to individuals and couples.
<b>State Unemployment Insurance (SUI)</b>	Tax paid to a state workforce agency (Employment Development Department) that is used solely for the payment of benefits to eligible unemployed workers. Tax is paid by the State on behalf of IPs who earn at least \$1,000 per quarter.
<b>Statewideness</b>	Requirement that a state must operate its Medicaid programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived with CMS approval through the Waiver process.
<b>Status Eligible</b>	People financially eligible for IHSS because they receive SSI/SSP
<b>SUI</b>	See State Unemployment Insurance
<b>T Status</b>	See Terminated Status
<b>TAD</b>	See Turn Around Document
<b>TAR</b>	See Treatment Authorization Request
<b>Target Group</b>	Group of Medicaid beneficiaries who have similar needs, conditions or characteristics to whom a state elects to furnish waiver services. Common target groups include older persons, individuals with physical disabilities, persons who have experienced a brain injury, and persons with developmental disabilities. States specify target group(s) that it services in the waiver.

## GLOSSARY OF TERMS AND ABBREVIATIONS USED IN IHSS

<b>Targeted Case Management</b>	Optional State Plan Medicaid services that are furnished to assist Medicaid beneficiaries to gain access to needed medical, social, educational, and other services. May be furnished to target groups specified by the state on a statewide or less than statewide basis.
<b>TC</b>	Telephone call
<b>TCM</b>	See Targeted Case Management
<b>Terminated Status</b>	Eligibility for IHSS has been terminated.
<b>Third Party Liability (TPL)</b>	Term used to refer to another source of payment for Medicaid covered services provided to a beneficiary. Examples include Medicare, private health insurance coverage, automobile and other liability insurance and medical child support.
<b>Title II</b>	Title II of the Social Security Act the federal statute that authorizes Social Security benefits based on FICA payments made
<b>Title XVI</b>	Title XVI of the Social Security Act (20CFR416 et seq.), SSI/SSP.
<b>Title XIX</b>	Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) the federal statute that authorizes the Medicaid program.
<b>Title 23</b>	In-Home Supportive Services Employer-Employee Relations Act
<b>Treatment Authorization Request (TAR)</b>	An electronic or written request submitted by a Medi-Cal provider on behalf of a Medi-Cal beneficiary to a designated Medi-Cal Field Office which requests authorization to provide items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital or home health agency).
<b>TPL</b>	See Third Party Liability
<b>Turn Around Document (TAD)</b>	When data from a CMIPS data input form has been keyed into CMIPS, the System generates a form populated with all current CMIPS data called a Turn Around Document (TAD). The TAD indicates the new/changed data fields with an asterisk (*). The TAD is used as the form to enter new/changed data for data entry.
<b>WC</b>	See Workers' Compensation
<b>Welfare and Institutions Code (WIC)</b>	Where IHSS State statutes are recorded
<b>WIC</b>	See Welfare and Institutions Code
<b>Workers' Compensation (WC)</b>	State-mandated system under which employers assume the cost of medical treatment and wage losses for employees who suffer job-related illnesses or injuries, regardless of who is at fault. For IHSS providers, The State Compensation Insurance Fund (SCIF) manages coverage.

## THE CURE: REFUELING YOUR TANK

What percentage of the time do you get an adequate amount of each of these?

	0	10	20	30	40	50	60	70	80	90	100%
1. Proper rest											
2. Good nutrition											
3. Daily exercise											
4. Time alone											
5. Time to read and learn											
6. Spiritual growth											
7. Intimacy and love											
8. Fun, joy, and play											
9. Quality time with family and friends											
10. New interests or hobbies											
11. Regular vacations											
12. Sense of purpose											

Choose one area that is low and creatively brainstorm some ways to increase the time devoted to this area by 10% over the next month. The purpose in setting a modest goal is to be sure it is attainable. Set yourself up to win. Let both your intuition and your logic tell you which is most important to improve. Frequently, a small improvement in one critical area can make a big difference.

*Adapted from "You don't have to go home from work Exhausted!"*

*By Ann McGee-Cooper, 1992*