WELCOME TO THE
IHSS TRAINING ACADEMY

CORE: ENSURING QUALITY

On behalf of the California Department of Social Services (CDSS), we are pleased to offer ***Core: Ensuring Quality***. During this one-day training, participants will share best practices and take part in exercises designed to apply the principles covered and practiced during the training which will lead to greater consistency and uniformity in the assessment and authorization of IHSS services. The training curriculum will cover:

- Fair Hearings
- Program Integrity
- Paramedical Services
- Quality Assurance Activities

Objectives:

At the end of the program, the participants will be able to:

- Understand the fair hearing process, the roles of those involved, and methods for successfully presenting information which will maximize the opportunities for favorable outcomes.
- Understand the social worker's role in maintaining program integrity and identify situations that should trigger concern.
- Apply Paramedical regulations correctly, understand the social worker's role in completion of the SOC 321, and appropriately address issues that arise in authorizing Paramedical services.
- Understand the QA Initiative progress and future plans.

IHSS TRAINING ACADEMY
CORE: ENSURING QUALITY

TABLE OF CONTENTS

Welcome to the In-Home Supportive Services Training Academy

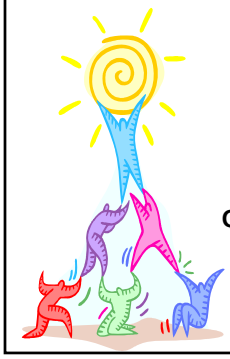
A partnership between…

- California Department of Social Services
- California Welfare Directors' Association
- California State University, Sacramento
  - College of Continuing Education
  - Institute for Social Research

Overview of Ensuring Quality

- QA Update
- Program Integrity
- Paramedical
- Fair Hearings

IHSS Quality Assurance Initiative Update



California Department of Social Services
Adult Programs Division
Quality Assurance Bureau

IHSS/PCSP QA Initiative

- Adopted as part of the Governor's 2004/2005 State Budget.
- Five major components:
  1. Ongoing Social Worker training
  2. State/county QA monitoring
  3. Development of HTGs with exception criteria
  4. Interagency collaboration to prevent/detect fraud and maximize overpayment recovery
  5. Annual error-rate studies
- Workgroups allowed for broad spectrum of input.

Discovering QA/QI Best Practices

The two QA Monitoring teams visited all 58 counties since 2005, reviewing over 8,500 case files.

Best practices sharing at regional meetings.

Sharing best practices supports building uniformity.

The QA Home Visit

Ensure the needs and services have been assessed accurately.

Reinforce uniformity.

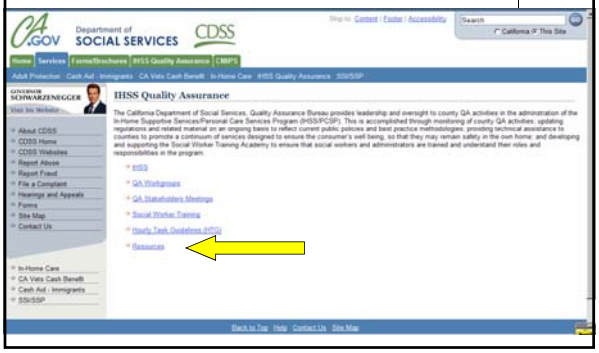
Ensure services authorized are being provided.

Opportunity to identify trends and build consistency.

Home visit checklist.

CDSS QA Monitoring Units

http://www.cdss.ca.gov/agedblinddisabled/PG1211.htm



On the Horizon

- CDSS will continue to:
  - Identify and resolve any implementation issues with QA monitoring procedures
  - Evaluate the implementation of HTGs with CSUS/ISR
  - Evaluate various utilization methods and training topics for the Social Worker Training Academy

Program Integrity

Program Integrity: Overriding Issues

If consumers are being taken advantage of, they are often afraid to report for:

- fear of placement
- fear of being without service (poor service is better than no service)
- fear of reprisal

Program Integrity: Overriding Issues

Appropriate use of IHSS funds:

- Are authorized services being provided?
- Are services provided consistent with authorized services?
- Are there services being provided that are not available through IHSS?

Five Different Types of Potential Inappropriate Uses of IHSS Funds

1. Provider claiming hours not worked.
2. Consumer willfully overstating needs.
3. Consumer forcing IP to share wages.
4. Provider coercing consumer to overstate needs or request unnecessary services to increase wages.
5. Provider performing non-IHSS services and submitting timesheets for these services.

Social Worker's Role: Program Integrity

When making home visits, be aware but don't be a "cop"

- Understand your role in fraud detection and investigation.
- Know when to involve others.
- Know the fraud referral process in your county and follow it.

Provider Claiming Hours Not Worked

- On reassessment –
  - Does it seem consumer is receiving authorized services?
  - Is provider's schedule consistent with hours authorized?
  - What services are being provided?
  - Confirm provider name.

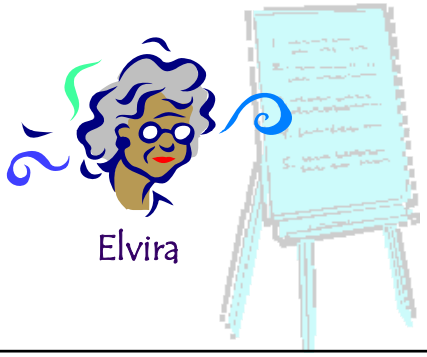
Consumer Overstating Needs

- Is functioning consistent with observations?
- Is functioning consistent with diagnosis?
- Is stated need extraordinary?

Consumer Forcing IP to Share Wages

- Provider, Public Authority or other individual/organization reports the abuse

Red Flag Activity



Paramedical Services

Paramedical Services
[MPP 30-757.19]

Characteristics of Services:

- Functional limitations prevent recipient from performing (self-care)
- Are necessary to maintain the recipient's health due to their physical or mental condition
- Tasks include:
  - administration of medication
  - puncturing the skin
  - inserting a medical device into a body orifice
  - activities requiring sterile procedures
  - activities requiring judgment based on training given by a licensed health care professional

Paramedical Services
[MPP 30-757.19]

- Services are provided when ordered by the licensed health care professional.
- Services are provided under the direction of the licensed health care professional.
- The SOC 321 should indicate the time and frequency necessary to perform the ordered services.
- Services are provided by IHSS providers at the IHSS hourly rate.

Paramedical Services
[MPP 30-757.19]

- A signed and dated SOC 321 form must be obtained from the licensed health care professional.
- The Paramedical services order must be received prior to authorization of Paramedical services.
- Other IHSS services can / should be authorized without delay, even if there is a delay in obtaining the authorization for Paramedical services.

When Considering Need for Paramedical Services

- 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?

Confirm

- Nature of services approved
  - Are they paramedical?
- Time period for which the services are authorized
  - Services should be reassessed at the time of reassessment.
- Time authorized on the form
  - Is it excessive?

Working with the Doctor

Evaluating the 'real' functional need

- They don't understand IHSS criteria or program limitations.
- May not understand services that he/she is asking for.
- May not understand the functional abilities of the consumer.
- They do not see consumer in the home.

Strategies for Communicating with the Doctor's Office

- If county has IHSS nurses, discuss concerns with him/her first.
- Be prepared.
- Talk with the doctor's back-office nurse first.
- Give the doctor facts and let them know what you need.
- Be concise and respectful of their time, but be persistent.
- Be careful of taking offense or defense when approaching the doctor.

The Young Woman and the Sailor

The Fair Hearing Process

How to Survive and Thrive

Keeping Things in Perspective

- Data of number of cases per year that go to fair hearing
  - The average number of IHSS hearings per year is **1,392**.

Data compiled from 09/1/2006 – 6/30/2007.

Survival: 4 Keys to Keep in Mind

- Dispute resolution, fair and impartial
- Search for truth
- It is not about how good a SW you are
  - Don't take it personally
- Procedures are
  - claimant friendly
  - claimant oriented

Roles and Responsibilities

- Administrative Law Judge (ALJ)
- County Representative
- Claimant / Consumer
- Authorized Representative

ALJ

- Manages the hearing.
- The ALJ is the only trier of fact, acting as both judge and jury.
- Ensures each side is given a fair opportunity to be heard.
- Renders legally complete and correct decision.

County Representative (Appeals Specialist)

- A county employee
- Responsible for preparing and/or presenting a case
- Narrows focus, identifies issues and evaluates strength of county's position
  - May negotiate Conditional Withdrawal
  - May ask for Postponement

Claimant

The person who has requested a state hearing and is or has been either:

- An applicant for or recipient of aid
- A representative of the estate of a deceased applicant or recipient
- The caretaker relative of a child
- The guardian or conservator of an applicant or recipient

Authorized Representative

- An individual or organization
- Authorized by the claimant or designated by the ALJ
- Acts for the claimant in any and all aspects of the state hearing

What is the Social Worker's Role?

Social Worker's Role

- **Before the hearing**
  - Answer recipient questions about hours authorized
  - Partner with the Appeals Specialist
    - Prepare the case
    - Review the case before the hearing
    - Conditional withdrawal

Social Worker's Role

- **At the hearing**
  - Partner with the Appeals Specialist
    - Working together
  - Critical witness
    - Presenting the case as requested

Being a Credible Witness

- Show up
- Establish your expertise
- Do your homework
- Know consumer's usual functional abilities and impairments
- Bring your complete file
- Give data, not judgments
- Avoid generalizations
- Avoid becoming defensive
- Pick your battles
- Admit if you don't know and request more time to find out

Defining the Issues

- ALJ identifies the issues and decides order of evidence
- The issues at the hearing are limited to:
  - Those issues which are reasonably related to the request for hearing, or
  - Other issues identified by either the county or claimant which they have jointly agreed, prior to or at the state hearing, to discuss.

Evidence: Burden of Proof

- The initial burden is on the county to support its action.
- It is your job to help the county meet that burden.
- This is where your testimony is crucial.

Documentation of Evidence

- Understand supporting documents
  - Annotated Assessment Criteria
  - Hourly Task Guidelines
  - Regulations
  - Medical certification

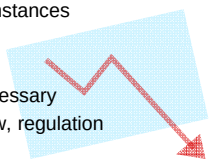
Evidence: Focus on Areas of Need

- **Observations** of the claimant.
  - Was this your first meeting with the claimant?
- **Interviews** with the claimant and other household members.
  - How much time did you spend at the claimant's home?
  - What kind of questions and in what detail did you ask?
  - Did you consider good days and bad days?
- **Review** of documentation, such as medical reports.
  - Did you ask for a medical report?
  - Did you receive one?
  - Did you rely on it for your assessment?
- **Application** of State Hourly Task Guidelines.
  - Was there an exception?
  - If so, how and why is this recipient different from the norm?

Reducing Hours

Evidence should show:

- There was an error in prior assessment
- There was a change in circumstances
- Data to support your decision
  - Be specific
  - Include medical data if necessary
- There was a change in the law, regulation or policy



Shifting Burdens

- Once the initial burden is met, burden will shift to the claimant.
- Claimant to testify about how much additional time he/she believes is needed.

Rebuttal

- Does the evidence presented change the county's position?
- Be ready to respond to all evidence presented if necessary.
- Don't be afraid to change your opinion if the evidence warrants a change.

Close of Hearing

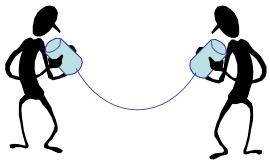
- Opportunity to make a statement.
- The task of making a closing statement belongs to the county representative.

The Decision

- Once an issue is heard, the ALJ is called upon to decide it based on evidence at the hearing.
- Decision based on the **preponderance of the evidence**.
- Neither side is presumed to be correct.

Social Worker's Role

- After the hearing
- After the hearing decision is received



Hearing Decision Exercise: Marjorie

Moving on…..

Thanks For Your Participation!

QA Home Visit Checklist

County: # - Name

Consumer Name: _____ HV Tool Reviewed: YES | NO Date of Visit: _____

Case Number: _____ QA Initials: _____

☐ Initial Assessment Date: Previous Interview County QA: _____

☐ Reassessment Date: Previous Interview Social Worker: _____

YES	NO	
☐	☐	**1) Consumer Notified of Date & Time for QA Home Visit**
☐	☐	**2) Identification Verified -** *Check photo ID*
☐	☐	**3) G-Line data verified** *(check if appropriately assessed - Circle if in question)*

☐ 1) Spouse / Parent ☐ 2) # in Household ☐ 3) # IHSS Recipients

☐ 4) Residence type ☐ 5) Living Arrangmnt ☐ 6) # Rooms ☐ 7) Yard

☐ 8a) Washer ☐ 8b) Dryer ☐ 8c) Stove ☐ 8d) Refrig

Discussed @ HV:

☐ ☐ **4) Health Issues / Physical Limitations -** *FI Scores Verified*

☐ ☐ **5) Any Changes in Condition or Functional Abilities**

☐ ☐ **6) Tasks Needed verses Authorized Tasks**

☐ ☐ **7) Need for Additional Services**

☐ ☐ **8) Available Alternate Resources**

☐ ☐ **9) Changes w/ Medical Appointments**

Notes:

☐ ☐ **10) Discussed Care by Provider(s):** *Check if discussed or "NA"*

☐ 1) Spouse / Parent *(circle)*
☐ 2) Relationship to provider(s)?
☐ 3) # of providers?
☐ 3) Communication issues?
☐ 4) Assistance Finding Provider?
☐ 5) How often is Provider there?

☐ 6) How long does Provider stay?
☐ 7) Can Provider complete all tasks?
☐ 8) Oversight of Provider's tasks
☐ 9) Reliability? Substitute if needed?
☐ 10) Satisfied w/ provider?
☐ 11) Does Provider get paid extra?
☐ 12) How does Provider treat you?

Notes:

☐ ☐ **11) County's Services discussed** *(check if yes)*

☐ SW Name / Contact info accessible

☐ Other Available Resource (DMEs, MOWs etc.)

Notes:

☐ ☐ **12) Understanding of:** **Services & Hours Authorized**
Rights to Request a Fair Hearing
Who Completes/Signs IP's Time Sheet

Notes:

☐ ☐ **13) Observations / Questions Regarding APS Issues**

☐ ☐ **14) If YES (above), Critical Incident Noted & Action Taken**

Notes:

DEPARTMENT OF SOCIAL SERVICES
744 P Street, MS 19-96, Sacramento, CA 95814

January 23, 2006

Reason For This Transmittal

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

ALL-COUNTY INFORMATION NOTICE NO: I-04-06

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: QUALITY ASSURANCE (QA) INITIATIVE FRAUD DETECTION AND PREVENTION ACTIVITIES

REFERENCE: CALIFORNIA DEPARTMENT OF SOCIAL SERVICES (CDSS) ALL COUNTY INFORMATION NOTICES (ACIN) I-69-04, DATED SEPTEMBER 30, 2004, AND I-24-05, DATED MAY 20, 2005

This ACIN provides information regarding QA program integrity activities for detecting and preventing fraud in accordance with QA Initiative provisions enacted by Senate Bill (SB) 1104 (Chapter 229, Statutes of 2004). Further, it identifies activities related to these provisions that were addressed by the Fraud/Data Evaluation Workgroup and supplements information provided in previous ACIN I-69-04 and I-24-05.

BACKGROUND

The QA Initiative outlined a number of enhanced activities to be performed by CDSS, the counties, and the State Department of Health Services (DHS) to improve the quality of In-Home Supportive Services/Personal Care Services Program (IHSS/PCSP) service need assessments, enhance program integrity, and detect and prevent program fraud. The Fraud/Data Evaluation Workgroup and Interagency Subcommittee were established to gain valuable input from Stakeholders to identify activities and implementation issues related to the fraud provisions of SB 1104. To facilitate this process, the Workgroup examined provisions by combining them into three primary categories: Interagency Roles and Responsibilities, Data Evaluation, and Verification of Receipt of Services.

INTERAGENCY ROLES AND RESPONSIBILITIES

As specified in ACIN I-69-04, Welfare & Institutions Code (WIC) section 12305.82 establishes the authority and process for detecting, investigating, and preventing fraud in the IHSS program. The statute extends DHS' authority to investigate fraud to the IHSS Residual program and requires counties to refer all suspected IHSS fraud to DHS

for investigation. It also provides for CDSS, DHS, and county QA staff to work together as appropriate to: (1) detect and prevent IHSS fraud based on applicable laws/regulations, which includes due process requirements; (2) take appropriate administrative action; and (3) refer suspected criminal offenses to law enforcement agencies for prosecution.

Additionally, WIC section 12305.71 addresses fraud detection and prevention as part of QA monitoring. The State and County Procedures Workgroup established policies for QA monitoring activities which included activities for preventing and detecting fraud. Preliminary instructions for how counties monitor the delivery of supportive services to detect and prevent potential fraud by providers, recipients, and others were issued in ACIN I-24-05. Explicit instructions were subsequently developed by that Workgroup and will be addressed in the IHSS QA Procedures Manual expected to be released via an All-County Letter in February 2006.

QA Monitoring and Fraud Referrals

SB 1104 QA monitoring and fraud detection and prevention provisions require a concerted effort among CDSS, DHS, and counties to coordinate activities to work together in minimizing the potential for fraud and maximizing the recovery of overpayments. Consequently, if fraud is suspected during the QA monitoring process and/or in other instances, counties that already have protocols in place to work with DHS regarding appropriate follow-up on suspected fraud may continue to do so under the direction of DHS. Counties who do not have established protocols in place to work with DHS may choose to discuss options for more extensive coordinative work by contacting them directly. Otherwise, counties should refer suspected fraud to the DHS, Investigations Branch at the field office closest to the county (Attachment A). The referrals should include as much specific information as possible such as:

- Copies of all time cards submitted for payment by provider/beneficiary, including signatures;
- Copies of all paid warrants (front and back) for the period in question;
- A completed potential overpayment form for the period in question; and
- A completed MC 609, Medi-Cal Complaint Form (See Attachment B).

DHS is required to notify CDSS, the county, and the county's public authority or non-profit consortium of any DHS conclusion of reliable evidence of fraud by a provider. In accordance with WIC section 12305.81, a person is precluded from providing or receiving payment for IHSS for ten years; following a conviction for, or incarceration following a conviction for, fraud against government health care or supportive services program. The statute also contemplates that DHS will notify the public authority or non-profit consortium of the provider's ineligibility to provide services and requires

the public authority or non-profit consortium to exclude providers from their IHSS Registry upon notice from DHS.

Overpayments

Additionally, WIC section 12305.83 provides authority for counties to recover all IHSS overpayments (including overpayments that are not fraud related). The statute specifies, in part, that when it is determined that a provider of IHSS has received an overpayment that is a debt due and owing, the county may recover the overpayment to the extent permissible under existing labor laws by offsetting against any amount currently due.

DATA EVALUATION

Another important component of SB 1104 that the Fraud/Data Evaluation Workgroup and Interagency Subcommittee focused on was data matches. The WIC section 12305.7 establishes requirements for State-level IHSS/PCSP QA and program integrity functions that include ongoing error-rate studies which also require collaborative efforts among CDSS, DHS, and counties. The findings from these studies are to be used to prioritize and direct State and county fraud detection and quality improvement. CDSS conducted a mini error-rate study involving two volunteer counties during State Fiscal Year (SFY) 2004/2005 and is currently evaluating results. CDSS is currently examining potential areas for studies for the current SFY 2005/2006.

Data evaluation/data match information was provided in ACIN I-24-05. The primary areas identified for data matches to be evaluated were:

- Medi-Cal acute hospital and skilled nursing payments;
- *Death Match Reports* from the State Controller's Office;
- The *Over 300-Hours Report* provided through the Case Management, Information and Payrolling System (CMIPS); and
- The use of the *Ad Hoc* tool developed by Electronic Data Systems to develop other criteria to identify potential fraud.

The Fraud/Data Evaluation Workgroup recommended additional areas for potential data evaluation which include conducting the following activities:

- Reviewing CMIPS out-of-state payments to ensure circumstances warrant an out-of-state payment and that the IHSS consumer has not moved out of state;
- Reviewing advance pay situations to verify that providers' time sheets are in the case; and

- Reviewing List U of the Suspended and Ineligible (S&I) List located on the side menu at DHS' website http://www.medi-cal.ca.gov/.

APPROACHES TO VERIFY RECEIPT OF SERVICES

A final area of focus for the Fraud/Data Evaluation Workgroup pertained to developing methods for verifying receipt of services for consumers. As specified in the previous ACIN I-69-04, WIC section 12305.7 provides for State-level IHSS/PCSP QA and program integrity functions that involve developing approaches to verify receipt of services for consumers with the input of Stakeholders. Additionally, CDSS is to work with the counties to determine, define, and issue instructions describing the roles and responsibilities of CDSS and the county welfare departments for evaluating and responding to identified problems and discrepancies. As part of QA monitoring, the IHSS QA Procedures Manual (developed by the State and County Procedures Workgroup) includes methods for verifying receipt of services and the roles and responsibilities of counties/CDSS. The emphasis is on ensuring a quality of care that enables the consumer to remain safely at home and to avoid institutionalization. The Fraud/Data Evaluation Workgroup (consisting of a broad scope of Stakeholders) suggested the following additional approaches to verify receipt of services:

- Develop pre-reassessment questions regarding receipt of services just prior to the reassessment in certain cases that have been determined appropriate after consideration of consumers' living circumstances and cognitive functioning;
- Conduct pilot projects to test new innovative approaches to verify receipt of services;
- Use consumer task grids to identify and check off specific tasks (This tool was shared by a consumer that found task grids very useful.); and
- Provide educational materials regarding provider/consumer responsibilities and expectations. The CDSS *Real Choice Grant—IHSS Enhancement Initiative* will be providing educational materials to consumers and providers for this purpose.

It is important to note that approaches to verify receipt of services are suggestions and are not mandated activities.

The activities identified in this ACIN pertain to the SB 1104 fraud detection and prevention provisions as addressed by the Fraud/Data Evaluation Workgroup and the Interagency Subcommittee. They are not intended to be all-inclusive and, as specified, interface with procedures established in the IHSS QA Procedures Manual.

If you have additional questions regarding this ACIN, please contact the Adult Programs Branch, Quality Assurance Bureau, at (916) 229-3494 or by email at IHSS-QA@dss.ca.gov.

Sincerely,

Original Document Signed By:

JOSEPH M. CARLIN
Acting Deputy Director
Disability and Adult Programs Division

Attachments

c: CWDA

ATTACHMENT A

DHS INVESTIGATIONS BRANCH FIELD OFFICES

Northern Section

Sacramento:	(916) 650-6630

Southern Section

Fresno:	(559) 446-2440
San Diego:	(619) 688-0143

Eastern Section

Orange:	(714) 703-2600
Rancho Cucamonga:	(909) 483-0227
West Covina:	(626) 918-6685

Western Section

Commerce:	(323) 838-7000
Gardena:	(310) 516-4677
Granada Hills:	(818) 832-3254
Bakersfield:	(661) 395-2705

CONFIDENTIAL MEDI-CAL COMPLAINT REPORT

☐ IEVS

FOR DHS STAFF ONLY
P.I. number
Case number

FOR COUNTY STAFF ONLY	
Case number	
Eligibility Worker name	Telephone number ( )

Name of person reporting complaint			Telephone number ( )
Address (number, street)		City	ZIP code
Medi-Cal beneficiary name		Date of birth	Social security number
Address (number, street)	City	ZIP code	Telephone number ( )
Provider name			Provider number
Address (number, street)	City	ZIP code	Telephone number ( )
Violation			Type code

Details of complaint

Complaint taken by	Date
Address	Telephone number ( )

FOR DHS STAFF USE ONLY

Supporting Documents

☐ MEDS _____ Date: _____

☐ CDR _____ Date: _____

☐ CLETS _____ Date: _____

☐ Other _____ Date: _____

_____ Date: _____

Action Taken

☐ P.I. Closed _____ Date: _____

☐ P.I. Referred to: _____ Date: _____

☐ Case opened _____ Date: _____

Assigned to: _____

Supervisor: _____

Program Integrity Scenario - Elvira

Elvira is an 89-year-old IHSS consumer who lives alone in a one-bedroom apartment in a large senior complex. Her diagnoses include osteoarthritis, hypertension and coronary artery disease. She has had both knees replaced. Her daughter, Marsha, who lives in Louisiana and has medical problems which prevent her from making the trip to California, has contacted you because she feels that her mother's condition is deteriorating. She states that her mother is increasingly more forgetful. As an example, she states that when she called recently, she had to explain several times who she was before Elvira understood who was calling. Marsha also states that when she called her mother at 3:00 p.m. recently, her mother stated she was still in bed because it was so cold in her apartment. Marsha states that this was very unusual for her mother because she has always been an early riser who does not believe in taking naps during the day.

In reviewing the file, you find that the last home assessment was conducted nine months ago. You also note that Elvira's current provider has been working for her for only about three months. At the last assessment, it was noted that Elvira's apartment was clean and that she was happy with her provider. There is no indication that Elvira was experiencing mental problems. Based on the information received from Elvira's daughter, you determine that you need to do a reassessment now. At the last assessment, Elvira's needs were assessed as 75 hours per month.

When you make the phone call to schedule the visit, you need to explain several times who you are and why you are calling. When Elvira finally seems to understand, she states that everything is going just fine, so there is no need to come and see her. You tell her you are happy that everything is going okay and that you will be in the area the next day and would like to come by anyway. She agrees to see you the following afternoon.

When you arrive for the home visit, Elvira meets you at the door. She seems unclear about who you are or why you are there. You note that she is wearing a heavy sweater and a jacket, and the apartment seems very chilly. When asked, Elvira states that she is dressed this way because the gas was turned off the day before because she did not have the money to pay the bill. She states that she did not pay the gas bill because her phone bill was very high the last month. She says her phone bill was over $100, although usually it is only about $20 per month. She says that when she called the phone company, they could only tell her that there

were a large number of long distance calls. Elvira says she guesses it was because she called her daughter in Louisiana. She says she doesn't mind the cold and that she will pay the gas bill when she gets her SSI money in two weeks.

You note that Elvira's apartment does not look like it has been cleaned in some time. There is a large amount of dust on the shelves and in the corners. The kitchen floor sticks to your shoes when you walk on it. The bathtub is full of dirty linen and clothing. Elvira states that she is waiting for her provider to come back from a trip to Nevada so that the laundry can be done and she can take a bath again. She states that she is unsure about how long the provider has been gone or when she will return. She states that she is a very nice lady who has several children that often come with her when she works. Elvira states that she has always liked children and that she often gives the provider money to buy things for the children. Elvira states that she is afraid that if she decides to get another provider, she will not get any services since the last time her provider left, she had a hard time finding a new provider. She says another reason she doesn't want to change is that her provider needs the money because she is a single mother with several children. Elvira states that before she went to Nevada, her provider came two times a week, and usually spent two hours working each time she was there. Elvira states that she would like to have her provider work more hours, but she knows that the provider has other clients to take care of.

When asked about her health, Elvira states that she is doing okay and about the same as the last time you saw her. She indicates she has been having trouble getting around lately because she has been running low on her pain medications. She says that the pharmacy usually delivers her medications but that she does not remember getting the last delivery, although the pharmacy says that the delivery was made. The pharmacy clerk indicates that someone other than Elvira signed for the medications.

When you look in Elvira's refrigerator, you note that there is only a partial quart of milk, a cube of butter and a half can of tuna. Elvira says that she does not like to go to the store anymore because there are people that hang out in front of the store that scare her. She said one of her neighbors was mugged a few steps from the store. She said that her provider had been shopping for her and that she had not been out of the building since her provider had been gone.

During the last assessment, it was noted that Elvira ate her breakfast and dinner in the apartment building dining room but that the provider fixed her lunch for her. Elvira states that when the provider works, she will fix lunch for a couple of days

in advance for her which she then re-heats in the microwave on the days that the provider is not there. She tells you that she often does not go down to breakfast in the morning because it is too much effort to get going as her joints are very stiff and at night she is tired and doesn't want to bother with going down there. She states that often she will just have tea for breakfast and lunch. She also says that she sometimes does not go to the dining room for dinner, but a neighbor will sometimes bring food to her when she does not go down to the dining room.

Group Tasks

1. Identify at least five problems that need to be addressed as a result of the reassessment. For each problem, identify steps to follow and solutions, including any necessary referrals.

Sample Cover Letter to Accompany the SOC 321

<date>

< name, MD>
<address>

Dear Dr. :

Your patient, _____, has applied for or is receiving In-Home Supportive Services (IHSS), which is unskilled home care provided by someone selected by the IHSS recipient. Your patient indicates that s/he needs assistance in performing some services which are considered by the IHSS program to be paramedical in nature. The State allows payment for paramedical services through IHSS if those services are authorized by, and provided under the direction of, the patient's doctor. These services are defined in State regulations as "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." [MPP 30-757.19(c)]

Some examples of paramedical services are:

- colostomy irrigation
- catheter insertion
- injections
- sterile treatments of decubitus ulcers
- tube feeding
- diabetic glucose level testing

Attached is a form to authorize payment for the receipt of such service through the IHSS Program. If you authorize these services, your office is responsible to assure that the unlicensed provider has received training and direction on how to perform these services. I have included an envelope for the return of a completed form.

Sincerely,

IHSS Social Worker

REQUEST FOR ORDER AND CONSENT - PARAMEDICAL SERVICES

PATIENT'S NAME
MEDI-CAL IDENTIFICATION NUMBER

TO:

Dear Doctor:

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

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

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

If you have any questions, please contact me.

SIGNED	TITLE	TELEPHONE NUMBER	DATE

TO BE COMPLETED BY LICENSED PROFESSIONAL

NAME OF LICENSED PROFESSIONAL	OFFICE TELEPHONE

OFFICE ADDRESS (IF NOT LISTED ABOVE)

TYPE OF PRACTICE

TYPE OF PRACTICE

☐ Physician/Surgeon ☐ Podiatrist ☐ Dentist

CONTINUED ON BACK

RETURN TO: (COUNTY WELFARE DEPARTMENT)

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

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

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

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

Additional comments:

☐ IF CONTINUED ON ANOTHER SHEET, CHECK HERE

CERTIFICATION

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

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

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

SIGNATURE ▶ | DATE

PATIENT'S INFORMED CONSENT

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

SIGNATURE ▶ | DATE

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.19 Paramedical services, under the following conditions:

.191 The services shall have the following characteristics:

(a) are activities which persons would normally perform for themselves but for their functional limitations,

(b) are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health.

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

.192 The services shall be provided when ordered by a licensed health care professional who is lawfully authorized to do so. The licensed health care professional shall be selected by the recipient. The recipient may select a licensed health care professional who is not a Medi-Cal provider, but in that event shall be responsible for any fee payments required by the professional.

.193 The services shall be provided under the direction of the licensed health care professional.

.194 The licensed health care professional shall indicate to social services staff the time necessary to perform the ordered services.

.195 This service shall be provided by persons who ordinarily provide IHSS. The hourly rate of provider compensation shall be the same as that paid to other IHSS providers in the county for the delivery method used.

.196 The county shall have received a signed and dated order for the paramedical services from a licensed health care professional. The order shall include a statement of informed consent saying that the recipient has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the recipient, or his/her guardian or conservator. The order and consent shall be on a form developed or approved by the department.

.197 In the event that social services staff are unable to complete the above procedures necessary to authorize paramedical services during the same time period as that necessary to authorize the services described in .11 through .18, social services staff shall issue a notice of action and authorize those needed services which are described in .11 through .18 in a timely manner as provided in Section 30-759. Paramedical services shall be authorized at the earliest possible subsequent date.

30-757 PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES 30-757
(Continued)

.198 In no event shall paramedical services be authorized prior to receipt by social services staff of the order for such services by the licensed health care professional. However, the cost of paramedical services received may be reimbursed retroactively provided that they are consistent with the subsequent authorization and were received on or after the date of application for the paramedical services.

NOTE: Authority cited: Sections 10553, 10554, 12300, 12301.1 and 12301.21, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Peremptory Writ of Mandate, Disabled Rights Union v. Woods, Superior Court, Los Angeles County, Case #C 380047; Miller v. Woods/Community Services for the Disabled v. Woods, Superior Court, San Diego County, Case Numbers 468192 and 472068; and Sections 12300, 12300(c)(7), 12300(f), 12300(g), 12300.1, and 12301.2, Welfare and Institutions Code.

30-758 TIME PER TASK AND FREQUENCY GUIDELINES 30-758

Repealed by Manual letter No. SS-06-02, effective 9/1/06

NOTE: Authority cited: Sections 10553, 10554, 12300, and 12301.2, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Peremptory Writ of Mandate, Disabled Rights Union v. Woods, Superior Court, Los Angeles County, Case #C 380047; and Sections 12300, and 12301.2, Welfare and Institutions Code.

30-759 APPLICATION PROCESS 30-759

.1 Each request or application for services shall have been made in accordance with Section 30-009.22.

.11 Recipient information including ethnicity and primary language (including sign language) shall be collected and recorded in the case file.

.2 Applications shall be processed, including eligibility determination and needs assessment, and notice of action mailed no later than 30 days following the date the written application is completed. An exception may be made for this requirement when a disability determination in accordance with Section 30-771 has not been received in the 30-day period. Services shall be provided, or arrangements for their provision shall have been made, within 15 days after an approval notice of action is mailed.

.3 Pending final determination, a person may be considered blind or disabled for purposes of non-PCSP IHSS eligibility under the following conditions:

.31 For a disabled applicant, eligibility may be presumed if the applicant is not employed and has no expectation of employment within the next 45 days, and if in the county's judgment the person appears to have a mental or physical impairment that will last for at least one year or end in death.

.32 For a blind applicant, eligibility may be presumed if in the county's judgment the person appears to meet the requirements of Section 30-771.2.

Activity: The Young Woman and the Sailor

The Dilemma

A ship sank in a storm. Five survivors scrambled aboard two lifeboats. In one lifeboat were a sailor, a young woman, and a seriously ill old man. In the other boat were the young woman's fiancé and his best friend. Each lifeboat was equipped with two day's ration of water.

That evening the storm continued, and the two boats separated. The one with the sailor, the young woman, and the sick old man washed ashore on an island and was wrecked. The young woman searched all night in vain for the other boat or any sign of her fiancé.

The next day, the weather cleared, and still the young woman could not locate her fiancé. In the distance she saw another island. Hoping to find her fiancé, she begged the sailor to repair their boat and row her to the other island. The sailor agreed, on the condition that she take the sick old man's ration of water and give it to the sailor.

Distraught, she went to the old man and blurted out through tears, "I am facing a difficult decision and don't know what to do." He immediately responded, "I can't tell you what's right or wrong for you. Look into your heart and follow it." Confused by desperation, she agreed to the sailor's condition.

The next morning, the sailor fixed the boat and rowed her to the other island. Jumping out of the boat, she ran up the beach into the arms of her fiancé. Then she decided to tell him about the sailor's condition. In a rage he pushed her aside and said, "Get away from me! I don't want to see you again!" Weeping, she started to walk slowly down the beach.

Her fiancé's best friend saw her and went to her, put his arm around her, and said, "I can tell that you two have had a fight. I'll try to patch it up, but in the meantime, I'll take care of you."

DIVISION 22

22-000 STATE HEARING - GENERAL

.1 The responsibility for providing a full and impartial hearing to the claimant rests jointly with the county and the state department.

HANDBOOK BEGINS HERE

.11 The state department is responsible for the overall administration of the hearing process and the conduct of each hearing.

.12 Since the right to request a state hearing belongs to the claimant, the regulations in this chapter shall be interpreted in a manner which protects the claimant's right to a hearing.

.13 Although the specific duties and responsibilities of each agency are set forth in the following regulations, these rules shall not be used to suppress the claimant's right to a hearing. For example, although the county shall justify its action when appropriate, the county shall not discourage the claimant from proceeding with the hearing request nor relinquish its responsibility to assist the claimant in this process. The Administrative Law Judge shall conduct the hearing according to applicable procedures and the claimant shall be allowed to present evidence relevant to his/her own case.

HANDBOOK ENDS HERE

22-001 DEFINITIONS

The following definitions shall apply wherever the terms are used throughout Division 22.

a. (2) Administrative Law Judge - A person designated by the Director and thereafter assigned by the Chief Administrative Law Judge to conduct state hearings and administrative disqualification hearings. **HANDBOOK:** The Administrative Law Judge shall prepare fair, impartial and independent decisions.

a. (5) Authorized Representative - An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or Department pursuant to Sections 22-085 and 22-101 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.

(A) An authorized representative may include legal counsel, a relative, a friend, or other spokesperson.

c. (2) Claimant - The person who has requested a state hearing and is or has been either:

(A) An applicant for or recipient of aid, as defined in Section 22-001a.(3).

(B) A foster parent or foster care provider who requests a hearing on behalf of the foster child where the CWD takes action to affect the child's aid and the child resides with or has resided with the foster parent or foster care provider.

(C) A representative of the estate of a deceased applicant or recipient (see Sections 22-004.4 and .5).

(D) The caretaker relative of a child with regard to the child's application for or receipt of aid.

(E) The guardian or conservator of an applicant or recipient.

(F) The sponsor of an alien, see MPP Sections 43-119, 44-353, and 63-804.1.

(G) A Transitional Child Care provider who receives direct payments for child care services on behalf of a Transitional Child Care family.

c. (7) County or CWD Representative - An employee who is assigned the major responsibility for preparing and/or presenting a hearing case on behalf of the CWD. (See Section 22-073.13.)

22-004 REQUEST FOR A STATE HEARING

.1 A request for a state hearing may be either written or oral.

.2 A written request concerning county administered state aid programs shall be filed with the CWD, and for all other state aid programs, the request shall be filed with the California State Department of Social Services in Sacramento.

.21 A written request for hearing may be made in any form.

.211 Claimants are encouraged to use the reverse side of the Notice of Action (NA) or DFA 377 form series or other CDSS-approved forms.

.212 The county agency shall assist the claimant in filing a request for a state hearing. The request for a state hearing should identify the aid program involved, as well as, the reason for dissatisfaction with the particular action or inaction involved in the case. If an interpreter will be necessary, the claimant should so indicate on the hearing request.

.22 When a written request for a state hearing is received by the CWD, a copy shall be forwarded to the State Hearings Division in Sacramento no later than three working days after its receipt.

22-009 TIME LIMIT ON REQUEST FOR A STATE HEARING

.1 The request for a state hearing shall be filed within 90 days after the date of the action or inaction with which the claimant is dissatisfied.

.11 If the claimant received adequate notice of the action (see Section 22-001a.(1)), the date of the action shall be the date on which the notice was mailed to the claimant.

.12 Where a request for a state hearing concerns the current amount of aid the request shall be filed within 90 days, but the period of review shall extend back to the first of the month in which the first day of the 90 day period occurred.

22-049 THE HEARING - GENERAL RULES AND PROCEDURES

.1 Attendance at the hearing is ordinarily limited to the claimant, authorized representative (as defined in Section 22-001a.(5)), county representative, legal counsel, authorized interpreter, and witnesses relevant to the issue. Other persons may attend the hearing if the claimant agrees to or requests their presence and the Administrative Law Judge determines that their presence will not be adverse to the hearing.

.11 Appearance by the claimant (in person or by the authorized representative) shall be required at the hearing, unless the hearing is a rehearing or further hearing.

.12 The Administrative Law Judge shall be permitted to exclude a witness during the testimony of other witnesses.

.13 Both the county and the claimant shall have the right to have a representative present throughout the hearing. Both the county representative and the claimant's authorized representative shall have the right to designate another person to be present and advise the representative throughout the hearing. This individual may be a witness who testifies on behalf of the county or claimant and in this circumstance, Section 22-049.12 would not apply. If this individual is a witness, he/she may not be present as an advisor until after he/she has testified.

.14 The Administrative Law Judge shall have the authority to exclude persons who are disruptive of the hearing.

.2 The hearing shall be conducted in an impartial manner.

.3 All testimony shall be submitted under oath, affirmation, or penalty of perjury.

.4 The proceedings at the hearing shall be reported by tape recorder or otherwise perpetuated by mechanical, electronic, or other means capable of reproduction or transcription.

.5 The issues at the hearing shall be limited to those issues which are reasonably related to the request for hearing or other issues identified by either the county or claimant which they have jointly agreed, prior to or at the state hearing, to discuss.

.51 If the rights of any party will be prejudiced by the consideration of a reasonably related issue raised at the hearing, the hearing shall be continued or the record held open subject to the provisions of Section 22-053.3 so that such party may prepare his/her case.

.52 If the claimant contends that he/she is not adequately prepared to discuss the issues because he/she did not receive adequate notice required by Section 22-071.1, this issue shall be resolved by the Administrative Law Judge at the hearing.

.521 If the Administrative Law Judge determines that adequate notice was provided, the claimant shall agree to discuss the substantive issue or issues or the case will be dismissed.

.522 If the Administrative Law Judge determines that adequate notice was not provided, the case shall be postponed unless the claimant waives the adequate notice requirement for purposes of proceeding with the hearing, and agrees to discuss the substantive issue or issues at the hearing.

.523 If the notice was not adequate and involved a discontinuance, suspension, cancellation, termination or reduction of aid, other than those referred to in Sections 22-072.1 through .13 aid shall be reinstated retroactively and the provisions of Section 22-072.5 shall apply.

.53 In cases in which a jurisdictional issue is raised, either by one of the parties or by the Administrative Law Judge, the parties must be prepared to submit evidence on the substantive issues except as provided in Sections 22-049.532 and 22-054.4.

.531 No determination of the timeliness of the hearing request or of any other jurisdictional issue will ordinarily be made at the hearing. The request will be dismissed by a written decision if the Administrative Law Judge determines that jurisdiction does not exist, e.g. request untimely or no subject matter jurisdiction.

.532 If, prior to or at the hearing, both parties agree to discuss only the jurisdictional issue, or the Administrative Law Judge on his/her own motion determines that only the jurisdictional issue will be discussed, the parties need not submit evidence on the substantive issues and the Administrative Law Judge shall take evidence only on the jurisdictional issue. Within ten days from the date of the hearing, the Administrative Law Judge shall:

(a) Inform the parties in writing that the hearing will not proceed on the substantive issues and a decision will be prepared solely on the jurisdictional issue, or

(b) Inform the parties that an additional hearing will be held on the substantive issues, and provide the parties a minimum of ten days in which to prepare on the substantive issues unless the time is waived by both parties. In this case, the Administrative Law Judge's proposed decision will address both the jurisdictional and substantive issues.

.6 An interpreter shall be provided by the state if, prior to the hearing, a party requests an interpreter or if at the hearing, the Administrative Law Judge determines that an interpreter is necessary.

.61 When the state hearing is to be held with the assistance of an interpreter, the Administrative Law Judge shall determine if the interpreter has been certified by the Department.

.611 If the interpreter has been certified, the qualifications and competency of the interpreter need not be further examined.

.612 If the interpreter has not been certified, the Administrative Law Judge shall:

(a) Examine the qualifications and competency of the interpreter.

(b) Disqualify any interpreter determined by the Administrative Law Judge not to be competent for interpretation purposes.

(c) Assure objective interpretation by, at his/her discretion, disqualifying interpreters who are:

(1) Claimant's relatives, friends, or an authorized representative.

(2) County staff who participated in making the decision complained of.

(3) The county appeals representative.

(4) Any other individual determined by the Administrative Law Judge to be detrimental to the hearing process or having a bias or the appearance of being biased.

.62 When the state hearing is held with the assistance of an interpreter the Administrative Law Judge shall assure objective interpretation.

.63 A separate oath or affirmation to translate accurately shall be administered to all interpreters.

.7 The rights of the claimant and the county shall include the right to:

.71 Examine parties and witnesses.

.72 Conduct such cross-examination as may be required for a full disclosure of the facts.

.73 Introduce exhibits.

.74 Bring witnesses.

.75 Examine all documents prior to and during the hearing.

.76 Question opposing witnesses and parties on any matter relevant to the issues even though that matter was not covered in the direct examination.

.77 Make oral or written argument.

.78 Rebut the evidence.

.8 The following shall apply to communications concerning the hearing:

.81 All documents submitted by either the claimant or the county shall be made available to both parties.

.811 Copies of all such documents shall be provided to the claimant free of charge.

HANDBOOK BEGINS HERE

(a) See Section 22-073.25 regarding position statement requirements.

HANDBOOK ENDS HERE

.82 Merits of a pending state hearing shall not be discussed between the Administrative Law Judge and a party outside the presence of the other party.

.9 Whenever it is necessary that another county be joined as a party to the action in order to dispose of all issues, the Administrative Law Judge shall so order and shall, subject to Section 22-053.3, postpone the hearing, hold the record of the hearing open, or continue the hearing as necessary.

.91 A postponement for this reason shall be deemed a postponement for good cause.

22-050 EVIDENCE

.1 The taking of evidence in a hearing shall be conducted by the Administrative Law Judge in a manner best suited to ascertain the facts and to control the conduct of the hearing.

.11 Prior to taking evidence, the Administrative Law Judge shall identify the issues and shall state the order in which evidence shall be received.

.2 Except as provided below, evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.

.21 The rules of evidence as applicable in judicial proceedings shall not be applicable in state hearings.

.22 The Administrative Law Judge shall be permitted to exclude evidence which is irrelevant, cumulative or unduly repetitious.

.23 The Administrative Law Judge shall exclude evidence which is privileged under the Evidence Code if the privilege is claimed in accordance with law.

.3 Although evidence may be admissible under Section 22-050.2, the Administrative Law Judge shall consider the nature of the evidence in assessing its probative value.

.4 "Official Notice" describes the manner in which an Administrative Law Judge or the Director will recognize the existence and truth of certain facts which have a bearing on the issue in the case, without requiring the actual production of evidence to prove such facts. Official notice may be taken of either a proposition of law or a proposition of fact.

.41 The Administrative Law Judge or Director shall take official notice of those matters which must be judicially noticed by a court under Section 451 of the Evidence Code.

HANDBOOK BEGINS HERE

.411 Generally, Section 451 of the Evidence Code provides that judicial notice must be taken of laws, statutes, regulations, official records, and facts and propositions which are of such universal knowledge that they are not reasonably subject to dispute.

HANDBOOK ENDS HERE

.42 The Administrative Law Judge may take official notice of those matters set forth in Section 452 of the Evidence Code.

HANDBOOK BEGINS HERE

.421 Generally, Section 452 of the Evidence Code provides that official notice may be taken of facts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy.

HANDBOOK ENDS HERE

.43 The Administrative Law Judge may take official notice of any generally accepted technical fact relating to the administration of public social service.

.44 With respect to matters under Subsection .43 above and subdivision (f) of Section 451 and Section 452 of the Evidence Code which are of substantial consequence to the determination of the action, each party shall be given reasonable opportunity, subject to Section 22-053.3, before the decision is submitted, to present information relevant to:

.441 The propriety of taking official notice, and

.442 The tenor of the matter to be noticed.

22-053 POSTPONEMENTS AND CONTINUANCES FOR ADDITIONAL EVIDENCE

.1 Postponements shall be granted under limited circumstances.

.11 A hearing involving the Food Stamp Program shall be postponed upon the initial request of the claimant prior to the hearing for up to 30 days.

.111 Any aid pending, if appropriate, shall continue at least until the next scheduled hearing. See Section 63-804.64 in the Food Stamp Program.

.112 In all other programs, a hearing may be postponed upon the request of the claimant only if such request meets the good cause criteria set forth in Section 22-053.16.

(a) The Department shall have the authority to request verification from the claimant to support the reason why he/she cannot attend the hearing on the scheduled date.

.12 Upon the request of the county, a hearing shall be permitted to be postponed:

.121 By the Administrative Law Judge at the hearing.

.122 Any postponement granted under Section 22-053.12 shall be deemed postponed with good cause.

.13 The Chief Administrative Law Judge shall have the authority to postpone a hearing prior to the hearing.

.131 Any postponement granted under Section 22-053.13 shall be deemed postponed with good cause.

.14 The Administrative Law Judge shall have the authority to postpone a hearing, at the hearing, and continue any applicable aid pending if:

.141 The claimant establishes good cause as specified in Section 22-053.16.

.142 The county has failed to furnish adequate notice within the meaning of Sections 22-001.1a.(1) and 22-049.52, and the claimant requests the postponement.

.15 The Administrative Law Judge shall have the authority to postpone a hearing, for any other reason at his/her discretion.

.151 The Administrative Law Judge shall order that aid pending be continued only if the postponement is necessary to insure a full and fair hearing and the postponement did not result from any act or omission on the part of the claimant.

.16 Good cause shall be established if the claimant or authorized representative establishes that the case should be postponed due to:

.161 Death in the family.

.162 Personal illness or injury.

.163 Sudden and unexpected emergencies which prevent the claimant or the authorized representative from appearing.

.164 A conflicting court appearance which cannot be postponed.

.165 The county, when required, does not make a position statement available to the claimant not less than two working days prior to the date of the scheduled hearing, or the county has modified the position statement (as defined in Section 22-073.252) after providing the statement to the claimant, and the claimant has waived decision deadlines contained in Section 22-060.

.2 Continuances for additional evidence shall be granted under limited conditions.

.21 If the Administrative Law Judge conducting the hearing determines that evidence not available at the hearing is necessary for the proper determination of the case, the Administrative Law Judge shall have the authority to continue the hearing to a later date or close the hearing and hold the record open for a stated period not to exceed 30 days in order to permit the submission of additional documentary evidence.

22-059 COMMUNICATIONS AFTER HEARING

.1 Communications to the Department concerning a case subsequent to the hearing shall be excluded from the record and shall be disregarded prior to the adoption and release of the decision of the Director except that:

.11 Oral and written communications after the hearing concerning the status of the decision, or the date of delivery of additional evidence to be submitted under the provisions of Section 22-053.21, or protesting an Administrative Law Judge's determination under Section 22-072.63 with respect to aid pending a hearing or a disqualification request under the provisions of Section 22-055, are not improper; and

.12 An Administrative Law Judge shall have authority on his/her own motion or at the request of either party to reopen the record for receipt of additional information, if all parties are notified of the reason for the reopening and the submission of such evidence conforms to the requirements of Sections 22-053.21 and .3.

22-060 DISPOSITION OF STATE HEARINGS

.1 All state hearings shall be decided or dismissed within 90 days from the date of the request for state hearing except in those cases where the claimant waives such requirement or the claimant withdraws or abandons the request for hearing.

22-061 SUBMISSION OF PROPOSED DECISION/ADOPTION

.1 After the hearing has been closed, the Administrative Law Judge shall submit a proposed decision for review by the Chief Administrative Law Judge and submission to the Director, or shall adopt a final decision pursuant to the authority delegated to the Administrative Law Judge by the Director.

22-069 COUNTY WELFARE RESPONSIBILITY

.1 Each county shall furnish to the State Hearings Division the name of an individual who, in coordination with the Chief Administrative Law Judge, is responsible for discharging the requirements of Sections 22-069 through 22-078.

HANDBOOK BEGINS HERE

.11 Sections 22-069 through 22-078 describe the responsibilities of the county in the state hearing process.

HANDBOOK ENDS HERE

.12 The county responsibility shall include:

.121 Investigation of the case and assistance to the claimant prior to the hearing; and

.122 Presentation of the county's position during the hearing; and

.123 Compliance with state hearing decisions.

22-073 COUNTY WELFARE AGENCY RESPONSIBILITY PRIOR TO THE STATE HEARING

.1 Upon receipt of a request for hearing or notice from the Department that a recipient has filed a request for a state hearing, the county shall provide aid pending the state hearing in accordance with Section 22-072, when entitlement exists.

.13 Each case for which a state hearing request has been filed shall be assigned to a county representative who shall assume the major responsibility for preparing the case in accordance with the requirements of this Division and/or presenting it at the hearing. The county representative shall not have had immediate prior involvement with the case.

.2 Prior to the hearing, the county representative shall:

.21 Determine the issues raised by the hearing request.

.211 If the request for hearing does not clearly set forth the claimant's basis for appeal, the county representative shall immediately contact the claimant for clarification.

.22 After determining the issues, the county representative shall review the applicable statutes, regulations and policies in light of the evidence which exists in the case record.

.221 In conducting this initial review, the representative shall contact the eligibility worker and other county personnel as appropriate.

.222 When assistance of the Department is required to clarify any questions, such assistance shall be sought without delay.

.23 After conducting the initial review, the county representative shall make a determination concerning the appropriateness of the county action and the need for and advisability of a hearing. Disagreements and misunderstandings shall be resolved quickly, at the lowest possible administrative level, thereby avoiding unnecessary hearings.

.231 If the county representative concludes that the county action was incorrect, the county representative shall contact the claimant and attempt to resolve the case without a hearing.

(a) The county representative shall have the authority to make such a decision. The conditional withdrawal procedure described in Section 22-054.21 is usually appropriate in such instances.

.232 If the county representative concludes that the county action was correct, the county representative shall contact the claimant and:

(a) Inquire if the claimant plans to attend the hearing;

(b) Determine if there are any further contentions which the claimant will attempt to raise at the hearing; and

(c) Provide any and all information which can be of assistance to the claimant in preparing for the hearing. This shall include revealing to the claimant any and all regulations and evidence including that which might be favorable to the claimant's case. The county

representative may explain to the claimant the right to withdraw the request for hearing but shall not be permitted to request such a withdrawal. The claimant shall also be informed of the availability of any free legal representation. If the claimant is not fluent in English and if bilingual services apply as specified in Section 21-115, an explanation of the hearing procedures shall be made in the claimant's language.

.24 The county representative shall determine if an interpreter will be necessary at the hearing or if a home hearing will be necessary.

.241 The county representative shall notify the State Hearings Division if the claimant has requested an interpreter or home hearing.

.242 The county representative shall report without delay to the State Hearings Division any changes in the claimant's address or any other circumstances which might affect the necessity for or conduct of the hearing.

(a) This responsibility to report changes in the claimant's circumstances continues after the hearing until a decision is rendered.

.25 Prior to each hearing, the county representative shall prepare a typewritten position statement.

.251 The position statement shall summarize the facts of the case and set forth the regulatory justification for the county's action.

(a) If the issue concerns the amount of aid, grant adjustment, or a demand for repayment, the county representative shall include in the position statement a complete final budget computation, month by month, for the period in issue.

(b) The county shall include as attachments to the position statement copies of documentary evidence and a list of witnesses which the county intends to use during the hearing.

(1) The documents shall be itemized on the last page of the position statement and attached as exhibits.

.252 If the county has received a 10-day prior notice of the date and time of the scheduled hearing, a copy of the position statement shall be made available to the claimant at the CWD, not less than two working days prior to the date of the scheduled hearing.

HANDBOOK BEGINS HERE

Example:

The hearing is scheduled for Friday. Absent any intervening holidays, the position statement shall be available by the opening of business the preceding Wednesday.

HANDBOOK ENDS HERE

.253 If the county, when required, does not make the position statement available not less than two working days prior to the date of the scheduled hearing, or if the county modifies the position statement after providing the statement to the claimant, the hearing shall be postponed upon the request of the claimant conditioned upon the waiver of decision deadlines contained in Section 22-060. A modification is defined as a change which substantively revises the position statement.

.26 While preparing for the hearing, the county representative shall determine if the presence of the eligibility worker or other county witnesses would be helpful for the resolution of the issue.

.3 At the hearing, the county representative shall assume full responsibility for presentation of the county's case. Such presentation shall include:

.31 Summarizing the written position statement.

.32 Examining county witnesses.

.33 Cross-examining the claimant and the claimant's witnesses.

.34 Responding to any questions from the claimant or Administrative Law Judge concerning the case; and

.35 Having the county case record available at the hearing. The county representative shall have authority at the hearing to make binding agreements and stipulations on behalf of the CWD.

.36 Having the burden of going forward in the hearing to support its determination.

22-085 AUTHORIZED REPRESENTATIVE

.1 The claimant may authorize a person to represent him/her during all aspects of the hearing process by signing and dating a written statement to that effect or by stating at the hearing that the person is so authorized. If the claimant is not present at the hearing, the written statement authorizing a representative to act on behalf of the claimant for hearing purposes shall be signed and dated by the claimant on or after the date of the action or inaction with which the claimant is dissatisfied.

.11 The authorization may be limited in scope or duration by the claimant, and may be revoked by the claimant at any time. The authorization shall be presumed to be a valid authorization. Such presumption is rebuttable.

.12 If the claimant is not present at the hearing and the written authorization does not meet the requirements set forth in Section 22-085.1, the Administrative Law Judge may proceed with the hearing if the circumstances indicate that the claimant wishes to proceed with the hearing process. In such cases, an amended authorization shall be submitted after the hearing as described in Sections 22-085.22 and .221.

HANDBOOK BEGINS HERE

.13 The above requirements are for hearing purposes only. For pre-hearing requirements and the release of information to authorized representatives, see Section 19-005.

HANDBOOK ENDS HERE

.2 If the claimant has not authorized the representative in writing and is not present at the hearing, the person may be recognized as the authorized representative if he/she is an attorney or if, at the hearing, the person swears or affirms under penalty of perjury that the claimant has so authorized him/her to act as the claimant's authorized representative, and the Administrative Law Judge further determines the person is so authorized.

.21 The Administrative Law Judge may make the determination by contacting a collateral source (e.g., the claimant).

.22 In all such cases a written authorization shall be submitted within five days from the hearing unless this time period is extended by the Administrative Law Judge.

.221 If no written authorization is submitted, the case shall be considered abandoned and shall be dismissed by written decision after the hearing. See Section 22-054.

.23 If, at the hearing, the person cannot swear or affirm under penalty of perjury that the claimant has authorized him/her to act as the claimant's authorized representative because the claimant is incompetent, in a comatose condition, suffering from amnesia or a similar condition, the hearing may proceed at the Administrative Law Judge's discretion if the person is a relative, or a person who has knowledge of the claimant's circumstances and who completed and signed the Statement of Facts on the claimant's behalf.

.3 Whenever the claimant is represented by an authorized representative, the authorized representative shall be furnished a copy of all notices and decisions concerning the state hearing which are provided to the claimant.

.4 After a person or organization has been authorized to represent the claimant, the county, after notification of the authorization, shall send copies of any subsequent correspondence that it has with the claimant regarding the state hearing, to the claimant and the authorized representative simultaneously.

EVIDENTIARY PRINCIPLES

Direct evidence is evidence that directly proves a fact, without an inference or presumption, and which in itself, if true, conclusively establishes the fact. (Evidence Code (Ev. C.) §410) Except where additional evidence is required by statute, the direct evidence of one witness who is entitled to full credit is sufficient for proof of any fact. (Ev. C. §411)

The Evidence Code (Evid. Code) deals with general rules as to the determination of credibility of witnesses. The rule provides as follows: "Except as otherwise provided by statute, the court or jury may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following:

"(a) His demeanor while testifying and the manner in which he testifies.

"(b) The character of his testimony.

"(c) The extent of his capacity to perceive, to recollect, or to communicate any matter about which he testifies.

"(d) The extent of his opportunity to perceive any matter about which he testifies.

"(e) His character for honesty or veracity or their opposites.

"(f) The existence or nonexistence of a bias, interest, or other motive.

"(g) A statement previously made by him that is consistent with his testimony at the hearing.

"(h) A statement made by him that is inconsistent with any part of his testimony at the hearing.

"(i) The existence or nonexistence of any fact testified to by him.

"(j) His attitude toward the action in which he testifies or toward the giving of testimony.

"(k) His admission of untruthfulness."

(Evid. Code §780)

"Hearsay evidence" is evidence of a statement that was made other than by a witness while testifying at the hearing and that is offered to prove the truth of the matter stated. (Evidence Code §1200(a))

Evidence of a writing made as a record of an act, condition, or event is not made inadmissible by the hearsay rule when offered to prove the act, condition, or event if:

(a) The writing was made in the regular course of a business;

(b) The writing was made at or near the time of the act, condition, or event;

(c) The custodian or other qualified witness testifies to its identity and the mode of its preparation; and

(d) The sources of information and method and time of preparation were such as to indicate its trustworthiness.

(Evidence Code §1271)

If weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger and more satisfactory evidence, the evidence offered should be viewed with distrust. (Evidence Code §412)

In administrative tribunals, the party asserting the affirmative of the issue generally has the burden of proof. (*Cornell* v. *Reilly* (1954) 127 Cal.App.2d 178, 273 P.2d 572; and California Administrative Agency Practice, California Continuing Education of the Bar (1970) p.183)

The burden of producing evidence is the obligation of a party to produce evidence sufficient to avoid a ruling against him on the issue. (Evidence Code (Evid. Code) §110) The burden of producing evidence as to a particular fact is initially on the party with the burden of proof as to that fact. (Evid. Code §550)

The burden of proof is the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court. Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence. (Evidence Code §115)

The county has the burden of going forward in the state hearing to support its determination. (§22-073.36)

In the June 1995 UCLA Law Review, Professor Michael Asimow discusses review of California administrative agency actions which allow discretion to the agency.

"In exercising discretion, an agency generally must consider and balance various factors established by statute, constitution or common law. A reviewing court decides independently whether the agency considered all of the legally relevant factors and whether it considered factors that it should not have considered." [Footnotes omitted] "Within the legal limits constraining an agency's discretion, the agency has power to choose between alternatives. A court must not substitute its judgment for the agency's, since the legislature delegated discretionary power to the agency, not to the court. Nevertheless, a court should reverse if an agency's choice was an abuse of discretion. [Footnotes omitted] Review for abuse of discretion consists of two distinct inquiries: the adequacy of the factual underpinning of the discretionary decision and the rationality of the choice." [Footnotes omitted] (Asimow, Michael, 42 UCLA Law Review 1157, 1228, 1229, June 1995)

The 9th Circuit Court of Appeals has required that the ALJ in a social security case develop the record, even when the claimant is represented. There is a heightened duty when the claimant is mentally ill. As the Court said:

> "The ALJ in a social security case has an independent 'duty to fully and fairly develop the record and to assure that the claimant's interests are considered.' *Smolen*, 80 F.3d at 1288 (quoting *Brown* v. *Heckler*, 713 F.2d 441, 443 (9th Cir. 1983)). This duty extends to the represented as well as to the unrepresented claimant. Id. When the claimant is unrepresented, however, the AU must be especially diligent in exploring for all the relevant facts. *Cox* v. *Califano*, 587 F.2d 988, 991 (9th Cir. 1978). In this case, Tonapetyan was represented, but by a lay person rather than an attorney. The ALJ's duty to develop the record fully is also heightened where the claimant may be mentally ill and thus unable to protect her own interests. *Higbee* v. *Sullivan*, 975 F.2d 558, 562 (9th Cir.1992). Ambiguous evidence, or the ALJ's own finding that the record is inadequate to allow for proper evaluation of the evidence, triggers the ALJ's duty to 'conduct an appropriate inquiry.' *Smolen*, 80 F.3d at 1288; *Armstrong* v. *Commissioner of Soc. Sec. Admin.*, 160 F.3d 587, 590 (9th Cir.1998). The ALJ may discharge this duty in several ways, including: subpoenaing the claimants physicians, submitting questions to the claimants physicians,

continuing the hearing, or keeping the record open after the hearing to allow supplementation of the record. *Tidwell* v. *Apfel*, 161 F.3d 599, 602 (9th Cir. 1998); *Smolen*, 80 F.3d at 1288." (*Tonapetyan* v. *Halter* (2001) 242 F. 3d 1144, 1150)

Although a treating physician's opinion is generally afforded the greatest weight in disability cases, it is not binding on an ALJ with respect to the existence of an impairment or the ultimate determination of disability. Magallenes v. Bowen, 881 F.2d 747, 751 (9th Cir. 1989). When there is a conflict between the opinions of a treating physician and an examining physician, as here, the ALJ may disregard the opinion of the treating physician only if he sets forth "specific and legitimate reasons supported by substantial evidence in the record for doing so." Lester v. Chater, 81 F. 3d 821, 830 (9th Cir. 1996); see also Cotton v. Bowen, 799 F. 2d 1403, 1408 (9th Cir. 1986). Although the contrary opinion of a non-examining medical expert does not alone constitute a specific, legitimate reason for rejecting a treating or examining physician's opinion, it may constitute substantial evidence when it is consistent with other independent evidence in the record. Magallanes, 881 F.2d at 752. (*Tonapetyan* v. *Halter* (2001) 242 F. 3d 1144, 1148,49)

A witness does not have to be a doctor to give expert testimony on certain medical issues. (See, e.g., Longuy v. La Cociete Francaise de Bienfaisance Mutelle (1921) 52 CA 370 [dealing with nurses]; Delia S. v. Torres (1982) 134 CA 3d 471 [dealing with licensed clinical social workers])

Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of a claimant's impairment(s), including symptoms, diagnosis and prognosis, what the claimant can still do despite impairment(s), and physical or mental restrictions. Medical opinions may be received from treating sources, nontreating sources who have examined the claimant (e.g., consulting physicians or psychologists), and nonexamining sources (e.g., physicians and psychologists who work for insurance companies, disability determination services) other than those who work for the disability determination services (DDS) or SSA. (For treatment of DDS or SSA physicians, consult POMS DI 24515.007.) In addition to considering medical opinions, evidence from other sources (e.g., chiropractors) may be used to help understand how the claimant's impairment affects his or her ability to work. (Program Operations Manual System (POMS) DI 24515.002A.)

When the case record contains an opinion from a claimant's treating source, it may be given controlling weight or more weight than an opinion from a nontreating source. Give controlling weight to a treating source's medical opinion regarding the nature and severity of the claimant's impairment(s) if the opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques and it is not inconsistent with the other substantial medical or nonmedical evidence in the case record. (POMS DI 24515.003A.2.) Generally, give more weight to:

(1) Medical opinions from sources who have examined the claimant than from sources which have not examined the claimant.

(2) Treating source opinions than nontreating source opinions. (POMS DI 24515.005)

(3) An opinion from a medical source who provides relevant supporting evidence (e.g., medical signs, laboratory findings) and a better explanation for the opinion.

(4) An opinion consistent with other evidence of record.

(5) The opinion of a specialist about medical issues related to the source's specialty.

(Program Operations Manual System (POMS) DI 24515.003A.4.)

OTHER

Provisions of law relating to a public assistance program shall be fairly and equitably construed to affect the stated objects and purposes of the program. (Welfare and Institutions Code §11000)

"Regulation" means every rule, regulation, order, or standard of general application or the amendment, supplement or revision of any such rule, regulation, order or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure, except one which is related only to the internal management of the state agency. "Regulation" does not mean or include any form prescribed by a state agency or any instructions relating to the use of the form, but this provision is not a limitation upon any requirement that a regulation be adopted pursuant to this part when one is needed to implement the law under which the form is issued. (Government Code §11342 b.) (Handbook §17-001.1)

"Handbook" material is informational only; it explains and illustrates regulatory sections by example. It is advisory and interpretive in the sense of illustrating appropriate application of a regulation; it may recommend specific processes or methods of implementation of a regulation. However, in order to provide a single source document for departmental clients (county welfare departments, licensees, etc.), appropriate statutes, regulations of other agencies, and court orders will be incorporated verbatim when the result would be helpful to understanding and full compliance with pertinent mandates in any specific program. In addition, it will include published operational standards by which DSS staff evaluate performance within DSS programs, forms, forms' instructions, and other informational materials. (Handbook §17-001.2)

Manual letters are informational. They are used to transmit new or revised DSS Regulations or "handbook" sections. They describe the material transmitted and explain the reasons for adoption; give the effective date, filing instructions plus any relevant information. (Handbook §17-001.3)

All-County Letters are informational and serve to provide explanatory materials for regulations, material of general interest, or interim procedural information (e.g., new reporting dates). They may be used to clarify statewide questions, but do not change previously-Issued regulatory material. They may also be used to trigger required responses by all counties when the basic authority for such is in regulation. (Handbook §17-001.4)

Information notices or unnumbered letters are used to transmit statewide information of short-term interest, booklets, or other materials (including single advance copies of newly adopted regulations). They serve to explain the purpose in sending the attachment; they may include a brief description or summary. (Handbook §17-001.5)

Fair Hearing Roles
Division 22

Administrative Law Judge (ALJ)

Division 22 – "A person designated by the Director and thereafter assigned by the Chief Administrative Law Judge to conduct state hearings and administrative disqualification hearings. Handbook: The Administrative Law Judge shall prepare fair, impartial and independent decisions." [MPP Section 22-001 a. (2)]

- Determines order and manner of proof.
- Decides issues of fact and law, asks questions, makes credibility determinations. The ALJ is the only trier of fact, acting as both judge and jury. (Example: Are meals prepared separately for the claimant and his IHSS housemate? This is an issue of fact. If the meals are prepared separately, can the needs assessment for meal preparation be prorated if there is not a health and safety reason for separate meals? This is an issue of law.)
- Ensures each side is given a fair opportunity to be heard. Must act with courtesy and respect but it's not judge's job to make any of the participants happy with the decision.
- After the hearing, reviews exhibits, considers testimony, renders legally complete and correct decision, exercises judicial independence. When in conflict with program or blazing new or controversial areas, writes proposed decisions. Most of the ALJ's case time is spent in this activity.

Division 22 – "The taking of evidence in a hearing shall be conducted by the Administrative Law Judge in a manner best suited to ascertain the facts and to control the conduct of the hearing." [MPP Section 22-050.1]

- ALJ gives great discretion in determining the manner of proof and the order of proof and to control the hearing.
- Duty to develop the record at the administrative hearing – ALJs are going to be proactive. They are going to participate by asking questions. The judges have a duty to ask questions to follow through with issues that they determine are important to the case.
- Will get variations in style from one judge to another. For example, some may have the SW take the lead during the hearing, while others will want the information filtered through the Appeals Specialist and want the Appeals Specialist to operate more or less as an attorney.
- How does SW navigate? Know your case backwards and forwards, know your role, be flexible and be adaptable.

County Representative / Appeals Specialist

Division 22 – "An employee who is assigned the major responsibility for preparing and/or presenting a hearing case on behalf of the CWD." [MPP Section 22-001 (c)(7)]

"Each case for which a state hearing request has been filed shall be assigned to a county representative who shall assume the major responsibility for preparing the case in accordance

with the requirements of this Division and/or presenting it at the hearing." [MPP Section 22-073.13]

"At the hearing, the county representative shall assume full responsibility for presentation of the county's case. Such presentation shall include:

- Summarizing the written position statement.
- Examining county witnesses.
- Cross-examining the claimant and the claimant's witnesses.
- Responding to any questions from the claimant or Administrative Law Judge concerning the case; and
- Having the county case record available at the hearing.
- The county representative shall have authority at the hearing to make binding agreements and stipulations on behalf of the CWD.
- Having the burden of going forward in the hearing to support its determination." [MPP Section 22-073.3]

- Appeals Specialist is responsible for these things, though the information gathering is a shared responsibility.
- The case should not be 'turned over' to the SW at hearing.

Claimant

Division 22 – "The person who has requested a state hearing and is or has been either:
(A) An applicant for or recipient of aid, as defined in Section 22-001a.(3).
(B) A foster parent or foster care provider who requests a hearing on behalf of the foster child where the CWD takes action to affect the child's aid and the child resides with or has resided with the foster parent or foster care provider.
(C) A representative of the estate of a deceased applicant or recipient (see Sections 22-004.4 and .5).
(D) The caretaker relative of a child with regard to the child's application for or receipt of aid.
(E) The guardian or conservator of an applicant or recipient.
(F) The sponsor of an alien, see MPP Sections 43-119, 44-353, and 63-804.1. [MPP Section 22-001c.(2)]

- NOTE: For IHSS (B) and (F) are not likely.
- A provider cannot be a claimant – can be a witness or the Authorized Representative.
- ALJs understand that the provider has interest in outcome because the hours are linked to provider income.

Authorized Representative

Division 22 – "An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or Department pursuant to Sections 22-085 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing." [MPP Section 22-001a.(5)]

- How do you know there is an AR? Appeals Specialist should know.
- An Authorized Representative may be a professional such as an attorney or paralegal, or may be a non-professional such as a relative, friend or provider.
- ALJs are aware that a provider's testimony might be influenced by her desire not to have her wages cut, but also realize that the provider is more aware of daily care needs of a consumer than a SW who visits only at assessment time. ALJs evaluate provider's testimony considering both those aspects.
- The AR can show up at the hearing – he/she just needs to fill out a form before proceedings begin.

Social Worker

There is no Division 22 language addressing the social worker's role directly – so what is their role?

- The SW is a very important part of the hearing.
- The SW is a critical witness!
- But, the SW might be asked questions to prove that status. Questions might include how long you've been on the job, whether you've had medical training, etc. Be prepared to answer without defensiveness. And remember to mention the Training Academy training you've attended as well as any other pertinent training you've had by your county or other sources.
- It is your specific knowledge of the case and your specific ability to speak to your assessment that creates the dimensions in the case.
- Preparation is key to success – and preparation for hearing starts at the initial assessment.
- When you go into an assessment, you should bring the possibility that there could be questions about the case in the future. Document and assess thoroughly.
- When judges write decisions, they do so recognizing that the losing party may appeal. You may want to do the same, i.e., when you do an assessment, think whether the claimant has said something that they might say in a hearing should they appeal. Think how you would respond.

☐ **WITHDRAWAL** ☐ **CONDITIONAL WITHDRAWALS**

OF
REQUEST FOR HEARING

Case Name: _____ County Case No: _____

State Hearing No: _____ Filing Date: _____

County: _____ Hearing Date: _____

Hearing Time: _____

I, _____, the undersigned do hereby:

☐ Withdraw my request for a state hearing before the State Department of Social Services. I understand that by withdrawing my request, I lose my right to a hearing on that request. I also understand that by withdrawing my request for hearing, aid which has been paid because of the request will stop without further notice. I may, however, file a new hearing request raising the identical issue provided that the new request is timely per Manual of Policies and Procedures Section 22-009.

☐ Conditionally withdraw my request for a state hearing before the State Department of Social Services. I understand that by conditionally withdrawing my request for hearing, aid which has been paid because of the hearing request will stop without further notice. I understand that the county will issue a redetermination notice within 30 days and that I must request a hearing within **90 DAYS** of the county's notice if I am not satisfied with the county's reconsideration of my case. Upon such renewal, I shall have the same rights I would have had if I had not signed this conditional withdrawal.

NOTE: A conditional withdrawal must provide that the actions of both parties will be completed within 30 days.

The reasons for or conditions of this withdrawal are: _____

_____

_____

_____

_____

_____

Signed

_____
(County Representative) (Date)

_____
(County Address)

_____
(City) (Zip Code)

_____
(Telephone Number)

Signed

_____
(Claimant) (Date)

_____
(Address)

_____
(City) (Zip Code)

_____
(Telephone Number)

NOTE: A Conditional Withdrawal must also be signed by a County Representative or it is invalid.

Decreasing IHSS Hours – County Responsibility at Fair Hearings

If the county wishes to decrease IHSS hours and the consumer or his/her authorized representative requests a fair hearing, the burden is on the county to establish why it is authorizing fewer hours. If the county fails to meet its burden, it may not reduce the IHSS hours. It is the position of the State Hearings Division that the county can meet this burden in one of the following ways:

- By establishing that there has been a change in law or misapplication of law requiring that a specific IHSS need(s) that was previously authorized no longer be authorized.

  For example: If the county had authorized protective supervision for a recipient with no mental impairment, the county could correct that error at the next assessment.

- By establishing that there has been a change or misapplication in State policy requiring that a specific IHSS need no longer be authorized.

  For example: If the county had authorized waiting time in the area of medical transportation contrary to State policy, the county could correct that misapplication of policy at the next assessment.

- By establishing that there has been a change in the claimant's medical condition requiring the reduction of IHSS hours from the prior assessment of IHSS.

  For example: If four hours weekly had been authorized for ambulation at the prior assessment shortly after the claimant had had a stroke, the county could reduce her need for ambulation at the next annual assessment if her condition had improved and she had less need than previously assessed.

- By establishing that the claimant or provider told the county social worker at the assessment that fewer hours of IHSS are needed than previously assessed in a particular need area or areas. In such case, the judge will make a finding as to the current need based on testimony at the hearing including testimony about the assessment, county records such as the written record of the assessment, and medical records.

- If the first county social worker was incompetent and biased in favor of the claimant and as a result made a completely unreasonable assessment of hours. The burden would be on the county to prove the incompetence and unreasonableness of the first social worker.

(Excerpt from the notes from the SHD CDSS Training Bureau, March 27, 2000, Item No. 00-03-01A)

Rules of Evidence
Some Things to Consider

Rules of Evidence

- The rules of evidence as applicable in judicial proceedings are not applicable in state hearings.
- Evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.
- The ALJ is permitted to exclude evidence which is irrelevant, cumulative or unduly repetitious.
- The ALJ can exclude evidence which is privileged under the Evidence Code if the privilege is claimed in accordance with the law.
- Although evidence may be admissible, the ALJ considers the nature of the evidence in assessing its probative value. [MPP 22-050.2 & .3]
- Note:
  - This is part of claimant friendly process. Set up to be friendly for non-legal (lay) people.
  - It is also friendly to counties in that neither side is expected to be lawyers.
  - Hearsay evidence is admissible.
  - While formal rules of evidence as practiced in court are relaxed, judges still need to control the hearing and may not admit irrelevant or repetitious evidence.
  - ALJs must balance and weigh the probative value (tendency or reason to prove the fact or issue under dispute) of the evidence.

Weight versus Admissibility

Hearsay –

- Definition: "Hearsay evidence" is evidence of a statement that was made other than by a witness while testifying at the hearing and that is offered to prove the truth of the matter stated. [Evidence Code §1200(a)]
- In a state hearing, hearsay may / would be admitted but would be given different weight.
- Note:
  - Be aware of the source of your testimony.
  - Generally, the more direct the evidence, the more reliable.
  - Be aware of the extent to which you are relying on the observations and statements made during the home visit and the extent to which you are relying on supporting documentation.

Credibility –

- ALJ has to assess credibility in all instances and needs to question both sides to make sure he/she understands how each side arrived at their respective time computations.
- ALJ will resort to demonstrations to test the capacity of the claimant to give that sort of testimony.
- Credibility does not necessarily mean one person is telling the truth and the other is lying. It may be that one person misunderstood the other such as in a needs assessment at a home visit.

Opinion –

- There will be differences in opinion.
- ALJ must consider all of the evidence.
- You don't have to be a doctor to offer an opinion, but be aware, according to some case law in the disability field, ALJs are to give the greatest weight to the opinions of treating physicians.
- SW has burden to show specifically where and how the treating physician decision isn't correct and shouldn't be followed by the ALJ. It is a big hill to climb…but can be done.
- Look at medical opinion, dissect and respond to it. Be specific!
- Not going to make the case just by stating that the MDs don't understand the program.
- With the exception of Paramedical services and in a different sense Protective Supervision, the opinions of a treating physician will go to need, not time per task.

Fair Hearings Scenario – Marjorie

Part 1 – Making the Case

Marjorie is a 67-year-old woman who lives with her daughter, Betty, in a large three-bedroom house. Marjorie has been receiving IHSS for five years. She lived independently until two years ago when she moved in with her daughter because Betty was concerned about the decline in Marjorie's mental status. (Note: For this exercise, assume that Marjorie moved in with her daughter to receive IHSS.)

Marjorie's diagnoses include arthritis, hypertension and dementia. During Marjorie's last assessment, she was assessed for 283 hours of service which included 35.58 hours per week of Protective Supervision. A need for Protective Supervision was approved based on information from her doctor and daughter. This information indicated that Marjorie had, on several occasions, left the house and on two occasions had to be brought home by the police.

You have recently been assigned to Marjorie's case and performed a reassessment because Betty called and said that Marjorie had just returned from the hospital because she had a major stroke which left her pretty much confined to bed. During the reassessment, you discuss the need for Protective Supervision with Betty. You indicate to her that you believe Marjorie will no longer be eligible for Protective Supervision. You explain that the reason Marjorie previously qualified for this service was that she placed herself at risk for injury, hazard or accident because of her wandering and other behaviors. Betty appears to understand, but states that since her mother needs more help because she is confined to bed, she doesn't think the hours should change. After reviewing all of the services with Betty, you return to the office and prepare the necessary paperwork to complete the assessment. You also discuss the case with your supervisor and the RN who reviews all Protective Supervision cases. The RN contacts Marjorie's long-time physician who indicates verbally that because of the impacts of her stroke, Marjorie is no longer able to place herself at risk for injury, hazard, or accident. Although Betty feels like her mother needs more care and that the hours should not change, the actual total hours assessed were decreased to 116.87 hours per month and you've determined that Marjorie no longer qualifies for Protective Supervision. The assessed need for some other services was also changed because of the change in Marjorie's functioning and due to recent policy/program changes.

After receiving the NOA, Betty calls. She is in tears and states that she wants to have her mother reassessed. She states that nothing has changed since you were there, but she feels that you missed something during the assessment because Marjorie now requires more care than she did before. You tell her that unless something has changed, you will not be able to do a reassessment. She states that she cannot survive without the income and wants to know what she can do. You direct her to the information on the back of the NOA regarding her right to a hearing and provide her with the toll-free number.

You have received information indicating that Betty has requested a fair hearing. You have been asked by the county Appeals Worker to prepare information which substantiates the reasons for the decrease in hours. The Appeals Worker states that she has contacted Betty and she wishes to appeal all of the hours that were decreased.

Group Tasks

Group 1:

1. Review the prior assessment and reassessment (Documentation Worksheet) for:
    - Domestic,
    - Meal Preparation,
    - Meal Cleanup, and
    - Routine Laundry.
2. Review service authorization specifics, and if your group does not agree with the assessment of any of the service categories, be prepared to state why and identify actions you would take prior to the hearing.
3. Be prepared to present your findings as if you are a witness in the fair hearing.

Group 2:

1. Review the prior assessment and reassessment (Documentation Worksheet) for:
    - Shopping for Food,
    - Other Shopping and Errands,
    - Ambulation, and
    - Moving In/Out of Bed (Transfer).
2. Review service authorization specifics, and if your group does not agree with the assessment of any of the service categories, be prepared to state why and identify actions you would take prior to the hearing.
3. Be prepared to present your findings as if you are a witness in the fair hearing.

Group 3:

1. Review the prior assessment and reassessment (Documentation Worksheet) the following services:
    - Bathing and Grooming,
    - Routine Bed Baths,
    - Dressing, and
    - Bowel and Bladder Care.
2. Review service authorization specifics, and if your group does not agree with the assessment of any of the service categories, be prepared to state why and identify actions you would take prior to the hearing.
3. Be prepared to present your findings as if you are a witness in the fair hearing.

Group 4:

1. Review the prior assessment and reassessment (Documentation Worksheet) the following services:
    - Feeding,
    - Repositioning/Rubbing Skin,
    - Care and Assistance with Prosthetic Devices,
    - Accompaniment to Medical Appointments, and
    - Protective Supervision.
2. Review service authorization specifics, and if your group does not agree with the assessment of any of the service categories, be prepared to state why and identify actions you would take prior to the hearing.
3. Be prepared to present your findings as if you are a witness in the fair hearing.

Assessment Worksheet
County of Fictitious

Consumer: Marjorie
Date of Assessment: July 25, 2006

Service Category	Times Per Day	Times Per Week	Time per Occurrence	Auth Hours	Comments
Domestic				3.00	Guideline prorated by 2
Meal Prep				3.50	They eat together. 7.00 hours ÷ 2
Meal Cleanup				1.75	Clean up at same time 3.50 ÷ 2
Routine Laundry				.50	State guideline ÷ 2
Food Shopping				.50	State guideline ÷ 2
Other Shopping				.50	No proration per policy.
Respiration					
Bowel/Bladder	6	42	5 min.	3.50	Help on and off toilet
Feeding	3	21	10 min.	3.50	Needs help with all meals
Bed Baths					
Dressing	2	14	10 min.	2.33	Needs help putting on and taking off clothes
Menstrual Care					
Ambulation	10	70	5 min.	5.83	Stand by assistance needed
In/Out Bed	4	28	2 min.	.93	Gets in and out of bed 2 x day
Bathing/Oral Hygiene/Grooming	1	7	30 min	3.50	Cannot bathe or do other grooming
Rubbing Skin/ Repositioning					
Care/Assistance w/Prosthesis	3	21	5 min	1.75	Takes 5 medications
Accomp. To Med. Appts.				1.00	Goes to dr. 1 x month
Accomp. To Alt. Resources					
Paramedical					
Protective Sup.				35.58	PCSP SI – Eligible for 283 hours total IHSS.

HTG DOCUMENTATION WORKSHEET

Category	Documentation of Hours **Important: This Worksheet Should Be Used in Conjunction with Time Per Task Tools** **For all Tasks Include Time for Clean Techniques/Universal Precautions When Required**
Domestic (Housework) **FI Rank (Enter): 5** **Guideline: 6.00 hours per month per household**	Task / Total Need / Adjustments / Authorized Routine housework per MPP: **1.08** / **1.08** Additional time: **1.00** / **1.00** Reason for assistance: **TOTAL 2.08 HRS** **Confined to bed. Cannot do any housework.** Additional information to document Need and Adjustments (include shared living factors and other factors such as size of dwelling, Alt. Resources, etc.): **Moved in with daughter to receive IHSS. Uses 1 room exclusively. Allow 1.08 hours per room. In addition, allow 1.00 hour per month for frequent bed changes due to incontinence.** Reason for more or less time than guideline (extra bedding changes, etc.):
Laundry **In home ☐ Out-of-home ☐** **FI Rank (Enter): 5** **Guideline In-Home: 1.00 hour per week** **Guideline Out-of-Home: 1.50 hours per week** ***Note: Laundry facilities on premises of apartment complex, mobile home park, etc. considered in-home (DSS Policy)***	Task / Total Need / Adjustments / Authorized Routine laundry: **1.50** / **1.50** Additional time: Reason for assistance: **TOTAL 1.50 HRS** **Confined to bed. Cannot do any laundry.** Additional information to document Need and Adjustments (include laundry done separately, etc.): **Laundry done separately and extra laundry due to incontinence.** Reason for more or less time than guideline (extra laundry due to incontinence, etc.):
Shopping and Errands **FI Rank (Enter): 5** **Guideline Food Shopping: 1.00 hour per week** **Guideline Other Shopping/Errands: 0.50 hours per week**	Task / Total Need / Adjustments / Authorized Food shopping: **1.00** / **.50** / **.50** Other shopping/errands: **.50** / **.25** / **.25** Reason for assistance: **TOTAL FOOD SHOPPING .50 HRS** **TOTAL OTHER SHOPPING .25 HRS** **Unable to do any shopping.** 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: **Other shopping not prorated during prior assessment – error.**

Meal Preparation

FI Rank (Enter)		5
	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

Needs help with ☐ Breakfast ☐ Lunch ☐ Dinner

Meal	Example of Typical Meal	Need Per Meal	Times Per Week	Total Need
Breakfast	**Tea/Toast/Poached Egg**	**5 min**	**7**	**.58**
Lunch	**Soup/Sandwich**	**10 min**	**7**	**1.17 ÷ 2**
Dinner	**Meat/Veg/Potato**	**30 min**	**7**	**3.50 ÷ 2**
Snacks	**None per dau.**			

Reason for assistance:

Needs total assistance. **TOTAL 2.92 HRS**

Shared living exceptions (required when services not prorated):
Breakfast not prorated. **Per dau. she does not eat breakfast. Brkfst prepared only for mom. Other meals are shared.**

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

Current assessment based on actual time for meals as stated by dau.

Meal Cleanup

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

Note: 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.

	Frequency (Daily, 3 x week, etc.)	Assessed Time Per Occurrence	Total Need
Breakfast			
Lunch	**Daily**	**10 min**	**1.17 ÷ 2**
Dinner	**Daily**	**15 min**	**1.75 ÷ 2**

Reason for assistance: **TOTAL 1.46 HRS**
Confined to bed.

Shared living exceptions:

Additional information to document exceptions to guidelines and identification of Alt. Resources:
Breakfast and lunch dishes are done at same time. Takes 10 min. per dau.

Ambulation

FI Rank (Enter)		5
	Low	High
Rank 2	0.58	1.75
Rank 3	1.00	2.50
Rank 4	1.75	3.50
Rank 5	1.75	3.50

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Walking inside home				
Retrieving assistive devices				
Assistance from house to car & in/out of car for medical appt. and to Alt. Resource				

Reason for assistance:
No time allowed as consumer confined to bed.
Additional information to document exceptions to guidelines and identification of Alt. Resources:

Bathing, Oral Hygiene, and Grooming

FI Rank (Enter)		5
	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

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance with getting in/out of tub/shower				
Oral hygiene	10 min	2	7	2.33
Grooming	5 min	1	7	.58
Shampoo hair	30 min		1	.50

Reason for assistance: **TOTAL 3.41 - .50 = 2.91 HRS**

Cannot remember to groom self or how to brush teeth. Time includes getting and putting supplies away.

Additional information to document exceptions to guidelines and identification of Alt. Resources:
VNA helps her dau. shampoo hair 1 x per week in bed. Reduce auth. hrs by .50 as this is an Alternative Resource.
Does not get in tub or shower. Daughter gives bed baths.

Routine Bed Baths

FI Rank (Enter)		5
	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

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Bed baths	20 min	1	7	2.33

Reason for assistance: **TOTAL 2.33 HRS**

Cannot get into bathroom for shower or bath. Time based on dau. statement that it takes total of 20 minutes for bed bath including getting and putting away supplies.

Additional information to document exceptions to guidelines and identification of Alt. Resources:
Auth. hours reduced due to VNA coming to provide bed bath 3 times per week. 2.33 – 1.00 = 1.33 Auth.

Dressing

FI Rank (Enter)		5
	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

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance with clothing, shoes, socks/stockings	5	2	7	1.17
Assistance with putting on/taking off corsets, elastic stockings, braces, etc.				
Bringing tools to consumer				

Reason for assistance: **TOTAL 1.17 HRS**

Is not able to assist with dressing. Decrease from last year because she only wears nightgowns.

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

Bowel and Bladder Care

FI Rank (Enter)	5
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

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance with getting on/off toilet/commode				
Wiping/cleaning consumer	**2 min** **5 min**	**5** **2**	**35** **14**	**1.17** **1.67**
Assist with using, emptying, cleaning bedpans/commodes, urinals, etc.				
Application of diapers	**2 min**	**7**	**49**	**1.63**
Changing barrier pads	**2 min**	**2**	**14**	**.47**

Reason for assistance:
Incontinent of B/B. Cannot get into bathroom. **TOTAL 4.94 HRS**

Additional information to document exceptions to guidelines and identification of Alt. Resources:
Dau. states that takes about 1 hour per day to assist with bowel and bladder care. Could not provide details, therefore I used my best guess.

Menstrual Care

Note: Functional Index Rank does not apply

	Low	High
	0.28	0.80

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

Reason for assistance: **N/A**

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

Note: 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)	5
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

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance from standing, sitting, or prone position to another, or transfer from one piece of equipment or furniture to another				

Reason for assistance:
Does not need to be transferred. Confined to bed.

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

Feeding

FI Rank (Enter)		3
	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

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Feeding or related assistance with consumption of food and fluid intake	**5 min**	**3**	**21**	**1.75**

Reason for assistance: **TOTAL 1.75 HRS**

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

I observed her drinking from a water bottle during the assessment, so I think she needs minimal help with eating. Above time should be sufficient.

Repositioning / Rubbing Skin

Note: Functional Index Rank does not apply

	Low	High
	0.75	2.80

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Rubbing skin to promote circulation	**5 min**	**2**	**14**	**1.17**
Turning in bed and other repositioning	**5 min**	**5**	**35**	**2.92**
Range of motion exercises				

Reason for assistance: **TOTAL 4.09 HRS**

Dau. rubs skin in the a.m. and at night time. Per daughter is turned 5 times per day.

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

Note: Functional Index Rank does not apply

	Low	High
	0.47	1.12

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance with taking off/putting on and maintaining/ cleaning prosthetic devices and vision and hearing aids				
Assistance with the self-administration of medications	**5 min**	**3**	**21**	**1.75**

Reason for assistance: **TOTAL 1.75 HRS**

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

Accompaniment to Medical Appts.

Appt Type (Specify doctor, dentist, etc.)	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*
Doctor	**1 x mo**	**1.00**	**2.00**	**.46**

Reason for assistance: **TOTAL .46 HRS**
Requires total assistance. Dau. must accompany. Must wait at doctor's but time not allowed per policy.

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

Accompaniment to Alt. Resources

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

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

Reason for assistance:

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

Heavy Cleaning

Tasks to be performed:	Hours Assessed

Reason for assistance:

Remove Ice, Snow

Note: Limited to removal of snow, or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

Tasks to be performed:	Hours Assessed

Reason for assistance:

Note: Remember that this service is seasonal and should not be authorized on a yearly basis.

Yard Hazard Abatement

Note: Limited to light work in the yard for removal of high grass or weeds and rubbish when constituting a fire hazard.

Tasks to be performed:	Hours Assessed

Reason for assistance:

Note: Remember that this service should not be routinely authorized on an ongoing basis.

Addendum to Fair Hearings Scenario – Marjorie

Strengthening Your Case / Establishing Credibility

The following are some of the ways the social worker can establish credibility during the hearing:

1. The social worker should be prepared to describe her experience in the IHSS program, if asked about this by the ALJ. S/he should include the number of years s/he has been performing assessments, and any specific training that they have had that is job related or helps them in their job.

2. Provide general information about their caseload that is related to the case being appealed. In this scenario, this would include assessing Protective Supervision, cases involving the elderly, and cases involving people who have had strokes and are confined to bed.

3. If you performed any research which supports your needs assessment, present any written evidence for inclusion in the record. (Examples: Copies of Internet articles or informational material that has been provided to Training Academy participants regarding diseases, mental illness, etc.)

4. Information should be provided about the actual assessment. Also include information regarding others that you discussed the assessment with including any county nursing staff, doctors, or their staff. If possible, have statements signed by the individuals involved that can be admitted to the hearing record.

5. The social worker should be prepared to show that they did a thorough investigation and considered all of the tasks that are included within each category of service. This would include amount of time spent performing the assessment.

6. If there were telephone discussions or a reassessment was done prior to the hearing, this information should also be presented along with a description of what was discussed and the outcome of these conversations or re-evaluations**.** Copies of documents from the case file including narrative notes which document conversations or reassessments and any follow-up letters should be presented for inclusion into the record. If agreements were made to change the assessment on any of the services prior to the hearing, also include this information.

Possible Issues that May Arise at the Hearing – Questions and Answers

1. The consumer appears with a representative from an advocacy group to represent her. You did not know prior to the hearing that she had an Authorized Representative (A/R).

   Response: The consumer is not required to notify the county that they will have a representative at the hearing. There is no response required.

2. The county begins by presenting the reasons for the reduction in services. When it is time for the consumer and A/R to make statements, the ALJ indicates to them that he has a 90-year-old mother with similar medical problems and he understands how family members end up giving 24-hour care.

   Response: This information, in itself, would not be an indication that the ALJ should be recused. If this type of situation does occur, SWs should be diligent in presenting all of the facts in the case. If the SW does not provide full and clear facts, a greater possibility for bias and assumptions exists.

   If the county feels that the hearing decision does not reflect the actual facts and documentation that were presented in the case, the county should ask for a re-hearing and indicate that they feel that the ALJ may have been biased based on his/her own experience with a relative with similar needs.

3. The A/R begins by stating that she has the entire record from the most recent hospital stay that she would like to have admitted to the record. She states the hospital record shows much care is required and supports the argument that hours should not be reduced.

   Response: The county may request that the hearing record be left open so that they can have an opportunity to review the information to see if it would change the assessment. In all cases where new information is presented, the ALJ will give the county an opportunity to review the material at the hearing. Because there is a large amount of material that is being asked to be included in the record, the ALJ may ask the A/R to narrow down what is being submitted to what is pertinent in this case. For example, the hospital discharge summary and any discharge planner's notes and doctor's discharge orders should give a clear indication of the condition of the consumer at the time of discharge. In this case, because there is a significant amount of material being submitted, it is reasonable to ask that the record be left open.

4. The A/R states that in addition to the services that were reduced or eliminated, it is clear that there are other services where there are not enough hours assessed, and there are services needed where no time was given. For example, she states that the consumer now has a decubitus which requires dressing changes two times per day.

   Response: The ALJs will try to address all issues that existed at the time of the assessment in the current hearing with the goal of avoiding an additional hearing in the future, which is beneficial to all involved. If new services are requested, the ALJ will probably ask if the need for those services existed at the time of the assessment. If they did, they will be included in the hearing even if the need for the service was not identified in the assessment. In the case of the decubitus, if the decubitus existed at the time of the assessment, the ALJ would probably indicate that the matter will be included in the hearing decision and would leave the record open to allow the county to obtain a SOC 321 and assess the need. *(Hopefully, in cases where a consumer is confined to bed, the SW will address the issue of skin condition/existence of decubiti during the assessment process.)*

5. The A/R states that some services were reduced due to the availability of an alternative resource, Visiting Nurses Association (VNA). She states that VNA has recently indicated they are no longer able to provide those services.

   Response: This is new information for the county. Although, the county cannot be expected to act on information that has not been made available, it would be reasonable for the county to agree to increase the hours based on the VNA services no longer being available. (The county already knows how much additional time should be assessed because this time was deducted from the individual need identified on the SOC 293 when determining the hours to be authorized for purchase.)

6. The A/R presents a letter from the consumer's new doctor and a Protective Supervision form (SOC 821) stating that she needs Protective Supervision. The county has not reviewed the letter or the form. The letter states that because Marjorie is confined to bed, she is not able to get out of the house in case of an emergency. There is no indication of any behavior which places her at risk for injury, hazard, or accident.

Response: The county should respond that the information received from the new doctor is new and that the new doctor may not be familiar with IHSS Protective Supervision and what the criteria is, and that there is no indication in the doctor's statement that indicates that the consumer places herself at risk. The county should indicate that they based their assessment on the information received from Marjorie's long-time doctor. The county should also reference court cases which apply in Protective Supervision which are applicable (*Calderon v. Anderson).*