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PROGRAM SERVICE CATEGORIES AND TIME GUIDELINES
(Continued)

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- .171 Protective Supervision is available for observing the behavior of nonself-directing, confused, mentally impaired, or mentally ill persons only.
- (a) Protective Supervision may be provided through the following, or combination of the following arrangements.
- (1) In-Home Supportive Services program;
 - (2) Alternative resources such as adult or child day care centers, community resource centers, Senior Centers; respite centers;
 - (3) Voluntary resources;
 - (4) Repealed by Manual Letter No. SS-07-01
- .172 Protective Supervision shall not be authorized:
- (a) For friendly visiting or other social activities;
 - (b) When the need is caused by a medical condition and the form of the supervision required is medical.
 - (c) In anticipation of a medical emergency;
 - (d) To prevent or control anti-social or aggressive recipient behavior.
 - (e) To guard against deliberate self-destructive behavior, such as suicide, or when an individual knowingly intends to harm himself/herself.
- .173 Protective Supervision is only available under the following conditions as determined by social service staff:
- (a) At the time of the initial assessment or reassessment, a need exists for twenty-four-hours-a-day of supervision in order for the recipient to remain at home safely.
 - (1) For a person identified by county staff to potentially need Protective Supervision, the county social services staff shall request that the form SOC 821 (3/06), "Assessment of Need for Protective Supervision for In-Home Supportive Services Program," which is incorporated by reference, be completed by a physician or other appropriate medical professional to certify the need for Protective Supervision and returned to the county.

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(A) For purposes of this regulation, appropriate medical professional shall be limited to those with a medical specialty or scope of practice in the areas of memory, orientation, and/or judgment.

(2) The form SOC 821 (3/06) shall be used in conjunction with other pertinent information, such as an interview or report by the social service staff or a Public Health Nurse, to assess the person's need for Protective Supervision.

(3) The completed form SOC 821 (3/06) shall not be determinative, but considered as one indicator of the need for Protective Supervision.

(4) In the event that the form SOC 821 (3/06) is not returned to the county, or is returned incomplete, the county social services staff shall make its determination of need based upon other available information.

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(5) Other available information can include, but is not limited to, the following:

(A) A Public Health Nurse interview;

(B) A licensed health care professional reports;

(C) Police reports;

(D) Collaboration with Adult Protective Services, Linkages, and/or other social service agencies;

(E) The social service staff's own observations.

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(b) At the time of reassessment of a person receiving authorized Protective Supervision, the county social service staff shall determine the need to renew the form SOC 821 (3/06).

(1) A newly completed form SOC 821 (3/06) shall be requested if determined necessary, and the basis for the determination shall be documented in the recipient's case file by the county social service staff.

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- (c) Recipients may request protective supervision. Recipients may obtain documentation (such as the SOC 821) from their physicians or other appropriate medical professionals for submission to the county social service staff to substantiate the need for protective supervision.

- .174 Social Services staff shall explain the availability of protective supervision and discuss the need for twenty-four-hours-a-day supervision with the recipient, or the recipient's parent(s), or the recipient's guardian or conservator, the appropriateness of out-of-home care as an alternative to Protective Supervision.

- .175 (Reserved.)

- .176 County Social Services staff shall obtain a signed statement from the provider(s) of record or any other person(s) who agrees to provide any In-Home Supportive Services (IHSS) or PCSP compensable service voluntarily. The statement [Form SOC 450 (10/98)] shall indicate that the provider knows of the right to compensated services, but voluntarily chooses not to accept any payment, or reduced payment, for the provision of services.
 - (a) The voluntary services certification for IHSS shall contain the following information:
 - (1) Services to be performed;
 - (2) Recipient(s) name;
 - (3) Case number;
 - (4) Day(s) and/or hours per month service(s) will be performed;
 - (5) Provider of services;
 - (6) Provider's address and telephone number;
 - (7) Provider's signature and date signed;
 - (8) Name and signature of Social Service Worker;
 - (9) County; and
 - (10) Social Security Number (Optional, for identification purposes only [Authority: Welfare and Institutions Code Section 12302.2]).

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- .18 Teaching and demonstration services provided by IHSS providers to enable recipients to perform for themselves services which they currently receive from IHSS. Teaching and demonstration services are limited to instruction in those tasks specified in .11, .13, .14, and .16 above.
- .181 This service shall be provided by persons who ordinarily provide IHSS. The hourly rate of provider compensation shall be the same as that paid to other IHSS providers in the county for the delivery method used.
- .182 This service shall only be provided when the provider has the necessary skills to do so effectively and safely.
- .183 Services shall be authorized for no more than three months.
- .184 Services shall be authorized only when there is a reasonable expectation that there will be a reduction in the need for a specified IHSS funded service as a result of the service authorized under this category which is at least equivalent to the cost of the services provided under this category.
- (a) The reduction in cost is equivalent if the full cost of service authorized under this part is recovered within six months after the conclusion of the training period.
- .185 Within seven months after completion of teaching and demonstration in a specific case, social service staff shall report in to the Department on the results of the service. The report shall include:
- (a) The tasks taught.
- (b) The instructional method used.
- (c) The delivery method used.
- (d) The frequency and duration of the instruction.
- (e) The total need for each service to be affected both before and six months after the instruction.
- (f) The results of instruction including the number of hours of each authorized IHSS funded service to be affected by the instruction both before and six months after the end of the instruction in hours per month.
- (g) The hourly rate paid the provider.

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- .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.

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

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

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

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

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

30-759 **APPLICATION PROCESS** **30-759**

- .1 Each request or application for services shall have been made in accordance with Section 30-009.22.
 - .11 Recipient information including ethnicity and primary language (including sign language) shall be collected and recorded in the case file.
- .2 Applications shall be processed, including eligibility determination and needs assessment, and notice of action mailed no later than 30 days following the date the written application is completed. An exception may be made for this requirement when a disability determination in accordance with Section 30-771 has not been received in the 30-day period. Services shall be provided, or arrangements for their provision shall have been made, within 15 days after an approval notice of action is mailed.
- .3 Pending final determination, a person may be considered blind or disabled for purposes of non-PCSP IHSS eligibility under the following conditions:
 - .31 For a disabled applicant, eligibility may be presumed if the applicant is not employed and has no expectation of employment within the next 45 days, and if in the county's judgment the person appears to have a mental or physical impairment that will last for at least one year or end in death.
 - .32 For a blind applicant, eligibility may be presumed if in the county's judgment the person appears to meet the requirements of Section 30-771.2.

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30-759 **APPLICATION PROCESS (Continued)** **30-759**

- .4 In-Home Supportive Services payment shall be made for authorizable services, as specified in Section 30-761.28, received on or after the date of application or of the request for services as provided in Section 30-009.224, if either the recipient or the provider does not qualify for PCSP. If the ineligible recipient/provider becomes eligible for payment under PCSP, payment shall be made from PCSP as soon as administratively feasible in lieu of IHSS.
- .5 Once services have been authorized, the authorization shall continue until there is a change in eligibility or assessed level of need.
- .6 The availability or continuity of services to a recipient shall not be limited or reduced because the county fails to comply with administrative processing standards in this section and in Section 30-761.2, unless the recipient has substantially contributed to the county's failure to comply.
- .7 A written notice of action containing information on the disposition of the request for service shall be sent to the applicant in accordance with MPP Sections 10-116 and 30-763.8.
- .8 Emergency services may be authorized to aged, blind, or disabled persons prior to the completion of a needs assessment if the recipient meets the eligibility criteria specified in .3 above or in Section 30-755 and the recipient's needs warrant immediate provision of service. The county shall subsequently perform a complete needs assessment within 30 days after the date of application as specified in .4 above, and comply with the standards for application processing.
- .9 An intercounty transfer shall be initiated by the transferring county after receiving notification from the recipient or person as described in Section 30-760.1 of his/her move to a new county. This transfer shall be accomplished in accordance with the following procedures:
 - .91 The transferring county shall, within ten calendar days from the original date of notification, send (by mail or FAX) a notification of transfer form which includes a place for the names and numbers and telephones numbers of the social service workers from both the sending and receiving counties, the statement "Please sign and return a copy of this document which will verify that your county will accept responsibility for the case effective (date to be filled in)," a space for additional comments, and other documents pertaining to the transfer of responsibility and provision of IHSS to the receiving county. If faxed, mailed copy(ies) shall follow in a timely manner for auditing purposes.
 - .911 The documents required in Section 30-759.91 include, but are not limited to, an application for In-Home Supportive Services (SOC 295, 10/90); the most recent IHSS assessment, an IHSS provider eligibility update, a personal care services program provider enrollment form (SOC 428, 5/90), if applicable; a paramedical authorization form (SOC 321, 10/88), if applicable; current NOAs, and any information pertaining to overpayments and fraud investigations, if applicable.
 - .92 There shall be no interruption or overlapping of services as the result of a recipient moving from one county to another.

30-759 **APPLICATION PROCESS (Continued)** **30-759**

- .921 The transferring county is responsible for authorizing and funding services until the transfer period expires, at which time the receiving county becomes responsible.
- .922 If the recipient moves from the receiving county to a third county during the transfer period, the transferring county is responsible for canceling the transfer to the original receiving county and initiating the transfer to the new receiving county.
- .93 The receiving county shall complete and return a notification of transfer form to the transferring county within 30 days of receipt of the form.
- .931 If the notification of transfer form has not been returned within 30 calendar days by the receiving county, the transferring county shall contact the receiving county to assure that the new county has received the notification of transfer and is taking action.
- .94 As part of the transfer process, the receiving county shall complete a face-to-face assessment with the recipient during the transfer period.
- .941 There shall be no change in the recipient's level of authorized hours/benefits taken or initiated by the transferring county during the transfer period unless there is a substantive change in living arrangements or other eligibility factors as verified by the receiving county.

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- (a) Some examples of what is considered a "substantive change in living arrangements" follow:
 - 1. A change in the number of persons living in the household;
 - 2. A change in the age(s) of persons living in the household;
 - 3. A change in the layout or location of living areas;
 - 4. A change in the number of rooms in the living space;
 - 5. A change in the availability of cooking facilities;
 - 6. A change in the availability of alternate resources.
- (b) The receiving county should be notified immediately once appropriate action, including a notice of action (NOA) is taken.

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- .95 When services are discontinued by the transferring county during the transfer period, and the recipient does not appeal the discontinuance through the state hearing process, any reapplication shall be treated as a new application with the county in which the recipient currently resides (receiving county).

- .96 When an IHSS recipient appeals a discontinuance, decrease of hours, or any adverse action against him/her by the transferring county during the transferring process, the transferring county shall maintain full responsibility for the case. The transferring county is accountable for the hearing and aid paid pending (if applicable), until a hearing decision is made, after which the transfer of the case to the receiving county can be completed.

- .97 If a person has an IHSS application pending at the time he/she moves to a new county, the responsibility for completion of the application shall remain with the transferring county in accordance with the following:
 - .971 If the person is eligible at the time the county of residence changes, a transfer process can be initiated.

 - .972 If a Determination of Disability is pending, responsibility shall be retained by the transferring county until the disability determination is received. The transferring county shall forward the disability determination, along with a notification of transfer form (see Section 30-759.91), within 10 calendar days of the date the determination was received.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10950, 11102, 12301, 12305.71, and 14132.95, Welfare and Institutions Code.

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30-760	RESPONSIBILITIES	30-760
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.1 Applicant/Recipient Responsibilities

The applicant/recipient, his/her conservator, or in the case of a minor, his/her parents or guardian shall be responsible for:

- .11 Completing or participating in completion of all documents required in the determination of eligibility and need for services.
- .12 Making available to the county all documents that are in his/her possession or available to him/her which are needed to determine eligibility and need for service.
- .13 Cooperating with county fraud detection and prevention and quality assurance activities including case reviews and home visits.
- .14 Reporting all known facts which are material to his/her eligibility and level of need.
- .15 Reporting within ten calendar days of the occurrence, any change in any of these facts.
- .16 Reporting all information necessary to assure timely and accurate payment to providers of service.
- .17 Reporting within 10 calendar days when a change of residence places the recipient within the jurisdiction of another county.

.2 County Responsibilities

- .21 Informing recipients of their rights and responsibilities in relation to eligibility and need for services.
- .22 Evaluating the capacity of applicants or recipients to discharge their responsibilities as set forth in .1 above.
- .23 Assisting recipients as needed in establishing their eligibility and need for service.
- .24 Correctly determining eligibility and need.
- .25 Complying with administrative standards to ensure timely processing of recipient requests for service.

NOTE: Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 11102, 12301, and 14132.95, Welfare and Institutions Code.

30-761 NEEDS ASSESSMENT STANDARDS**30-761**

- .1 Services shall be authorized only in cases which meet the following condition:
- .11 The recipient is eligible as specified in Sections 30-755 or 30-780, except that services may be authorized on an interim basis as provided in Section 30-759.3.
 - .12 A needs assessment establishes a need for the services identified in Section 30-757 consistent with the purposes of the IHSS program, as specified in Section 30-700.1, except as provided in Section 30-759.8.
 - .13 Social services staff of the designated county department has had a face-to-face contact with the recipient in the recipient's home at least once within the past 12 months, except as provided in Sections 30-761.215 through .217, and has determined that the recipient would not be able to remain safely in his/her own home without IHSS. If the face-to-face contact is due but the recipient is absent from the state but still eligible to receive IHSS pursuant to the requirements stated in Section 30-770.4, Residency, the face- to-face requirement is suspended until such time as the recipient returns to the state.
 - .14 Performance of the service by the recipient would constitute such a threat to his/her health/safety that he/she would be unable to remain in his/her own home.
- .2 Needs Assessments
- .21 Needs assessments are performed:
 - .211 Prior to the authorization of IHSS services when an applicant is determined to be eligible, except in emergencies as provided in Section 30-759.8.
 - .212 Prior to the end of the twelfth calendar month from the last face-to-face assessment except as provided in Sections 30-761.215 through .217.
 - (a) If a reassessment is completed before the twelfth calendar month, the month for the next reassessment shall be adjusted to the 12-month requirement except as provided in Section 30-761.215 through .217.

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- .213 Example: If a recipient's initial face-to-face assessment for IHSS was completed on December 12th, the county may complete the next reassessment anytime prior to December 31st of the following year.
- .214 Example: If a reassessment is completed on September 15th, prior to the actual twelfth calendar month because of a change in the recipient's condition, the next reassessment shall occur anytime prior to September 30th of the following year.

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- .215 Except for IHSS Plus Waiver cases, prior to the end of the eighteenth calendar month from the last reassessment if the county opted to extend the assessment in accordance with these regulations. A county may opt to extend the time for a reassessment for up to six months beyond the regular 12-month period on a case-by-case basis if the county can document that all the following conditions exist, except as provided in Section 30-761.216:
- (a) The recipient had at least one reassessment since the initial program intake assessment; and
 - (b) The recipient's living arrangement has not changed since the last annual assessment; and
 - (1) The recipient lives with others (i.e., spouse, parent, live-in provider, housemate, children, a relative or non-relative); or
 - (2) Has regular meaningful contact with persons interested in the recipient's well being other than his/her provider; and
 - (c) The recipient is able to satisfactorily direct his/her care; or:
 - (1) If the recipient is a minor, his/her parent or legal guardian is able to satisfactorily direct the recipient's care; or
 - (2) If the recipient is incompetent, his/her conservator is able to satisfactorily direct the recipient's care; and
 - (d) There has not been any known change in the recipient's supportive services needs in the previous 24 months; and

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NEEDS ASSESSMENT STANDARDS (Continued)

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- (e) There have not been any reports to, or involvements of, an adult protective services agency or other agencies responsible for addressing the health and safety of individuals documented in the case record since the last assessment; and
 - (f) The recipient has not had a change in provider(s) in the previous six months; and
 - (g) The recipient has not reported a change in his/her supportive services needs that requires a reassessment; and
 - (h) The recipient has not been hospitalized in the previous three months.
- .216 If some, but not all, conditions specified in Section 30-761.215(a) through (h) are met, the county may consider other factors in determining if the extended assessment period is appropriate. The factors include, but are not limited to:
- (a) Involvement in the recipient's care from a social worker case manager or similar representative of a human services agency, such as Multi Services Seniors Program (MSSP), Linkages, a regional center, or county mental health program; or
 - (b) Prior to the end of the twelfth calendar month following the last assessment, the county receives a medical report from a physician or other licensed health care professional that states the recipient's medical condition is not likely to change.
 - (1) For purposes of this regulation, a licensed health care professional means a medical professional licensed in California by the appropriate California Regulatory Agency, acting within the scope of his or her license or certificate as defined in the California Business and Professions Code, and who has knowledge of the recipient's medical history.
- .217 If the county opts to extend the reassessment period as provided in Section 30-761.215 through .216, the county shall document the basis of the decision in the case file.
- .218 When the county has information indicating that the recipient's need for supportive services is expected to decrease in less than 12 months, the county may reassess the recipient's needs in less than 12 months since the last assessment.
- .219 The county shall reassess the recipient's need for services:
- (a) Any time the recipient notifies the county of a need to adjust the service hours authorized due to a change in circumstances; or

30-761 **NEEDS ASSESSMENT STANDARDS (Continued)** **30-761**

- (b) When there is other pertinent information which indicates a change in circumstances affecting the recipient's need for supportive services.

- .22 Repealed by Manual Letter No. 82-67 (10/1/82).

- .23 The designated county department shall not delegate the responsibility to do needs assessments to any other agency or organization.

- .24 The needs assessment shall identify the types and hours of services needed and the services which will be paid for by the IHSS program.

- .25 No services shall be determined to be needed which the recipient is able to perform in a safe manner without an unreasonable amount of physical or emotional stress.

30-761**NEEDS ASSESSMENT STANDARDS (Continued)****30-761**

- .26 Social service staff shall determine the need for services based on all of the following:
- .261 The recipient's physical/mental condition, or living/social situation.
 - (a) These conditions and situations shall be determined following a face-to-face contact with the recipient, if necessary.
 - .262 The recipient's statement of need.
 - .263 The available medical information.
 - .264 Other information social service staff consider necessary and appropriate to assess the recipient's needs.
- .27 A needs assessment and authorization form shall be completed for each case and filed in the case record. The county shall use the needs assessment form developed or approved by the Department. The needs assessment form shall itemize the need for services and shall include the following:
- .271 Recipient information including age, sex, living situation, the nature, and extent of the recipient's functional limitations, and whether the recipient is severely impaired.
 - .272 The types of services to be provided through the IHSS program, the service delivery method and the number of hours per service per week.
 - .273 Types of IHSS provided without cost or through other resources, including sources and amounts of those services.
 - .274 Unmet need for IHSS.
 - .275 Beginning date of service authorization.

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- .28 Services authorized shall be justified by and consistent with the most recent needs assessment, but shall be limited by the provisions of Section 30-765.
- .3 IHSS staff shall be staff of a designated county department.
- .31 Classification of IHSS assessment workers shall be at the discretion of the county.
- .32 IHSS assessment workers shall be trained in the uniformity assessment system.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code. Reference: Sections 12301.1 and 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

30-763	SERVICE AUTHORIZATION	30-763
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- .1 Services staff shall determine the need for only those tasks in which the recipient has functional impairments. In the functions specified in Section 30-756.2, a functional impairment shall be a rank of at least 2.
 - .11 The applicant/recipient shall be required to cooperate to the best of his/her ability in the securing of medical verification which evaluates the following:
 - .111 His/her present condition.
 - .112 His/her ability to remain safely in his/her own home without IHSS services.
 - .113 His/her need for either medical or nonmedical out-of-home care placement if IHSS were not provided.
 - .114 The level of out-of-home care necessary if IHSS were not provided.

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- .12 Applicant/recipient failure to cooperate as required in Section 30-763.11 shall result in denial or termination of IHSS.
- .2 Using the needs assessment form, services staff shall calculate the number of hours per week needed for each of the services determined to be needed by the procedure described in Section 30-763.1.
- .3 Shared Living Arrangements: The following steps apply to assessing need for clients who live with another person(s). With certain exceptions specified in Section 30-763.4, the need for IHSS shall be determined in the following manner.
 - .31 Domestic Services and Heavy Cleaning
 - .311 The living area in the house shall be divided into areas used solely by the recipient, areas used in common with others, and areas not used by the recipient.
 - .312 No need shall be assessed for areas not used by the recipient.
 - .313 The need for services in common living areas shall be prorated to all the housemates, the recipient's need being his/her prorated share.
 - .314 For areas used solely by the recipient, the assessment shall be based on the recipient's individual need.
 - .32 Related Services need shall be assessed as follows:
 - .321 When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the recipient's need is his/her prorated share.

30-763**SERVICE AUTHORIZATION (Continued)****30-763**

- .322 When the service is not being provided by a housemate, and is being provided separately to the recipient, the assessment shall be based on the recipient's individual need.
- .33 The need for protective supervision shall be assessed based on the recipient's individual need provided that:
- .331 When two (or more) IHSS recipients are living together and both require protective supervision, the need shall be treated as a common need and prorated accordingly. In the event that proration results in one recipient's assessed need exceeding the payment and hourly maximums provided in Section 30-765, the apportionment of need shall be adjusted between the recipients so that all, or as much as possible of the total common need for protective supervision may be met within the payment and hourly maximums.
- .332 For service authorization purposes, no need for protective supervision exists during periods when a provider is in the home to provide other services.
- .34 The need for teaching and demonstration services shall be assessed based on the recipient's individual need, except when recipients live together and have a common need, the need shall be met in common when feasible.
- .35 Other IHSS Services:
- .351 The recipient's need for transportation services, paramedical services and personal care services shall be assessed based on the recipient's individual need.
- .352 The need for yard hazard abatement shall not be assessed in shared living arrangements, except when all housemates fall into one or more of the following categories:
- (a) Other IHSS recipients unable to provide such services.
 - (b) Other persons physically or mentally unable to provide such services.
 - (c) Children under the age of fourteen years.

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30-763 SERVICE AUTHORIZATION (Continued)**30-763****.4 Exceptions when assessing needs in shared living arrangements:****.41 Able and Available Spouse**

.411 When an IHSS recipient has a spouse who does not receive IHSS, the spouse shall be presumed able to perform certain specified tasks unless he/she provides medical verification of his/her inability to do so.

.412 An able spouse of an IHSS recipient shall be presumed available to perform certain specified tasks except during those times he/she is out of the home for employment, health or for other unavoidable reasons and the service must be provided during his/her absence.

.413 When the recipient has an able and available spouse there shall be no payment to the spouse or any other provider for the following services as described in 30-757:

- (a) Domestic
- (b) Related Services
- (c) Yard Hazard Abatement
- (d) Teaching and Demonstration
- (e) Heavy Cleaning

.414 When an able spouse is not available because of employment, health, or other unavoidable reasons, a provider may be paid for the following services only if they must be provided during the spouse's absence:

- (a) Meal Preparation
- (b) Transportation
- (c) Protective Supervision

.415 An able and available spouse or other provider may be paid for providing:

- (a) Personal care services
- (b) Paramedical service

30-763**SERVICE AUTHORIZATION (Continued)****30-763**

- .416 In addition to those services listed in Section 30-763.445, a spouse may be paid to provide the following services when he/she leaves full-time employment or wishes to seek employment but is prevented from doing so because no other suitable provider is available:
- (a) Transportation
 - (b) Protective Supervision
- .42 Landlord/Tenant Arrangements
- .421 When the recipient is the tenant, the need for domestic and heavy cleaning services shall be based on the living area used solely by the recipient. No need for yard hazard abatement shall be assessed. The needs assessment shall take into account any services the landlord is obligated to perform under the rental agreement.
- .422 When the recipient is the landlord, the need for domestic and heavy cleaning services shall be assessed for all living areas not used solely by the tenant. The needs assessments shall take into account any services the tenant is obligated to perform under the rental agreement.
- .43 If the recipient has moved into a relative's home primarily for the purpose of receiving services, the need for domestic and heavy cleaning services shall be assessed only for living areas used solely by the recipient. Yard hazard abatement services shall not be provided.

30-763 **SERVICE AUTHORIZATION (Continued)** **30-763**

- .44 When the recipient is under eighteen years of age and is living with the recipient's parent(s), IHSS may be purchased from a provider other than the parent(s) when no parent is able to provide the services for any of the following reasons:
- .441 when the parent(s) is absent because of employment or education or training for vocational purposes.
 - .442 if the parent(s) is physically or mentally unable to perform the needed services.
 - .443 when the parent is absent because of on-going medical, dental or other health-related treatment.
 - .444 up to eight hours per week may be authorized for periods when the parent(s) must be absent from the home in order to perform shopping and errands essential to the family, or for essential purposes related to the care of the recipient's siblings who are minors.
- .45 When the recipient is under eighteen years of age and is living with the recipient's parent(s), IHSS may be purchased from a parent under the following conditions:
- .451 All of the following conditions shall be met:
 - (a) The parent has left full-time employment or is prevented from obtaining full-time employment because of the need to provide IHSS to the child;
 - (b) There is no other suitable provider available;
 - (c) If the child does not receive the listed services the child may inappropriately require out-of-home placement or may receive inadequate care.
 - .452 For the purposes of Section 30-763.451(b), a suitable provider is any person, other than the recipient's parent(s), who is willing, available, and qualified to provide the needed IHSS.

30-763 SERVICE AUTHORIZATION (Continued) 30-763

.453 When both parents are in the home, a parent may receive a payment as an IHSS provider only under the following conditions:

- (a) The conditions specified in Sections 30-763.451(a) through (c) shall be met.
- (b) The nonprovider parent shall be unable to provide the services because he/she is absent because of employment or in order to secure education as specified in Section 30-763.441, or is physically or mentally unable to provide the services, as specified in Section 30-763.442.
- (c) If the nonprovider parent is unable to provide services because he/she is absent for employment or educational purposes, payment shall be made to the provider parent only for services which are normally provided during the periods of the nonprovider parent's absence as indicated above.

.454 The IHSS provided shall be limited to:

- (a) Related services, as specified in Section 30-757.13.
- (b) Personal care services, as specified in Section 30- 757.14.
- (c) Assistance with travel, as specified in Section 30-757.15.
- (d) Paramedical services, as specified in Section 30-757.19.
- (e) Protective supervision, as specified in Section 30-757.17, limited to that needed because of the functional limitations of the recipient. This service shall not include routine child care or supervision.

.46 When the recipient is a parent living with his/her child(ren) who is under fourteen years of age and who is not eligible or does not need IHSS.

30-763 **SERVICE AUTHORIZATION (Continued)** **30-763**

- .461 The recipient's need for domestic and heavy cleaning services in common living areas, and for related services shall be assessed as if the child(ren) did not live in the home.
- .462 The child(ren)'s needs shall not be considered when assessing the need for services, including domestic or heavy cleaning in areas used solely by the child(ren).
- .47 Live-in Providers:
 - .471 Domestic and heavy cleaning services shall not be provided in areas used solely by the provider. The need for related services may be prorated between the provider and the recipient, if the provider and the recipient agree. All other services shall be assessed based on the recipient's individual need, except as provided in Sections 30-763.33 and .34.
- .5 Having estimated the need according to Sections 30-763.1 and .2, and after making the adjustments identified in Sections 30-763.3 and .4 as appropriate, the remaining list of services and hours per service is the total need for IHSS services.
- .6 Identification of Available Alternative Resources
 - .61 Social services staff shall explore alternative in-home services supportive services which may be available from other agencies or programs to meet the needs of the recipient as assessed in accordance with Section 30-761.26.
 - .611 Social services staff shall arrange for the delivery of such alternative resources as necessary in lieu of IHSS program-funded services when they are available and result in no cost to the IHSS program or the recipient except as provided in Section 30-763.613.

30-763 **SERVICE AUTHORIZATION (Continued)** **30-763**

- .612 The IHSS program shall not deliver services which have been made available to the recipient through such alternative resources, except as provided in Section 30-763.613.
- .613 In no event shall an alternative resource be used at the financial expense of the recipient, except:
 - (a) At the recipient's option; or
 - (b) When the recipient has a share of cost obligation which shall be reduced by the amount necessary for the purchase of the alternative resource.
- .62 Social services staff shall explore with the recipient the willingness of relatives, housemates, friends or other appropriate persons to provide voluntarily some or all of the services required by the recipient.
 - .621 Social services staff shall obtain from the recipient a signed statement authorizing discussion of the case with any persons specified in Section 30-763.62.
 - .622 Social services staff shall not compel any such volunteer to provide services.
- .63 Social services staff shall document on the needs assessment form the total need for a specific service, which shall then be reduced by any service available from an alternative resource. The remaining need for IHSS is the adjusted need.
- .64 Social Services staff shall obtain a signed statement from the provider(s) of record or any other person(s) who agrees to provide any IHSS/PCSP compensable service voluntarily. The statement [Form SOC 450 (10/98)] shall indicate that the provider(s) knows of the right to compensated services, but voluntarily chooses not to accept any payment, or reduced payment, for the provision of services. (See MPP Section 30-757.176 for information regarding the voluntary services certification form).
- .7 The Determination of Services Which Shall be Purchased by IHSS
 - .71 Services shall be authorized to meet all of the adjusted need for IHSS up to the appropriate service maximum identified in Section 30- 765.
 - .72 These services shall not be authorized concurrently with the SSI/SSP nonmedical out-of-home care living arrangement.
- .8 Notice of Action

30-763 **SERVICE AUTHORIZATION (Continued)** **30-763**

- .81 Whenever an IHSS needs assessment is completed the recipient shall be sent a notice of action in accordance with the requirements of MPP 10-116 and 30-759.7. In addition to the information required in 10- 116, the notice shall include:
- .811 a description of each task for which need is assessed.
- .812 the number of hours authorized for the completion of the task.
- .813 identification of hours for tasks increased or decreased and the difference from previous hours authorized.
- .9 Miller vs. Woods and Community Service Center for the Disabled vs. Woods.

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.91 Background

On October 21, 1983 the Court of Appeal, Fourth Appellate District, issued a decision in the consolidated case of Miller vs. Woods and Community Service Center for the Disabled vs. Woods. The court declared invalid MPP 30-463.233c (now 30-763.233c) which provided that no need for protective supervision may be assessed when a housemate is in the home.

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.92 Case Review Procedures

- .921 The county shall identify no later than June 30, 1984 all open IHSS cases with recipients living with a housemate where a need for protective supervision as defined in 30-757.17 may exist.
- .922 The county shall determine through recipient contact whether a need for protective supervision exists unless the case record provides conclusive evidence which indicates that no need exists.

.93 Authorization and Notification

- .931 The county shall complete a new Needs Assessment form to authorize protective supervision. The authorization shall be effective as of May 1, 1984.

30-763 SERVICE AUTHORIZATION (Continued) 30-763

.932 The county shall send a Notice of Action to all affected recipients which shall state: "Hours for protective supervision are authorized based on the Miller vs. Woods and Community Service Center for the Disabled vs. Woods court action."

.94 Recordkeeping

.941 The county shall maintain a listing of those recipients who were previously not authorized to receive protective supervision because of the presence of a housemate.

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.942 DSS will provide each county with a computer generated listing which identifies any recipient whose address matches the address of an Individual Provider. The listing should be used as an aid and cross-check in the case review process; the listing is not a substitute for the case review.

.943 For those recipients with an Individual Provider, the listing in Section 30-763.941 will be generated through use of a special reason code indicating increased hours due to the Miller vs. Woods court decision.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12300, 12309, and 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code; and Miller v. Woods/Community Services for the Disabled v. Woods, Superior Court, San Diego County, Case Numbers 468192 and 472068.

30-764 **INDIVIDUAL PROVIDER COMPENSATION** **30-764**

.1 Computation of Payment

- .11 Social service staff shall determine the amount of the IHSS payment required to purchase services to meet the IHSS adjusted need as specified in 763.41 above.
- .12 The IHSS payment shall be determined by multiplying the monthly adjusted need for IHSS hours by the base payment rate used by the county, except as provided in .14 below.
- .13 The hours and amount of compensation available for personal attendant providers shall be determined by county social services staff. The payment shall be the minimum necessary to obtain adequate service to meet the authorized service needs of the recipient.

.2 Rate of Compensation

- .21 The base rate of compensation used by the county shall not be less than the legal minimum wage in effect at the time the work is performed, except when personal attendants are employed.
- .22 In advance pay cases, the base rate paid by the recipient to the provider shall not be less than the base rate used by the county for the authorized IHSS payment.
- .23 The recipient shall develop a work schedule which is consistent with the authorized service hours at the county's base rate. If the recipient finds that a work schedule cannot be established without requiring payment in excess of the county's base rate, the recipient shall bring such information to the county's attention. The county will determine if payment in excess of the base rate is necessary. Any additional costs resulting from the recipient's actions in work scheduling or increasing the rate paid per work unit shall be borne by the recipient unless prior county approval has been obtained.
- .24 No adjustments in the IHSS payment shall be made for meals and lodging provided to the provider by the recipient except as specified in Section 30-763. However, any income received by the recipient through this means is countable income for eligibility purposes as specified in Section 30-775 and shall be reported as such by the recipient.

30-764 INDIVIDUAL PROVIDER COMPENSATION 30-764

.3 Employer Responsibilities

- .31 As employers recipients have certain responsibilities for standards of compensation, work scheduling and working conditions as they apply to IHSS individual providers. The county will assure that all recipients understand their basic responsibilities as employers.

- .32 Non live-in employees shall be compensated at the base rate for the first forty hours worked during a work week. Each hour, or fraction thereof, worked in excess of forty hours during a work week shall be compensated at one and one-half times the base rate.

30-765 **COST LIMITATIONS** **30-765**

- .1 The following limitations shall apply to all payments made for in-home supportive services:
- .11 The maximum services authorized per month except as provided in Section 30-765.3, under IHSS to any recipient determined to be severely impaired, as defined in Section 30-753(s)(1) shall be that specified in Welfare and Institutions Code Section 12303.4(b) or as otherwise provided by law.

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- .111 The IHSS service hours for a severely impaired recipient receiving services through the individual provider mode of delivery shall not exceed 283 hours per month effective July 8, 1988. (Welfare and Institutions Code Section 12303.4(b)(1)).
- .112 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.
- .113 Welfare and Institutions Code Section 12300(g)(2) states:
- "Any recipient receiving services under both Section 14132.95 and this article shall receive no more than 283 hours of service per month, combined, and any recipient of services under this article shall receive no more than the applicable maximum specified in Section 12303.4." (See Section 30-765.11.)

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- .12 The maximum services authorized per month except as provided in Section 30-765.3, under non-PCSP to any recipient determined not to be severely impaired shall be that specified in Welfare and Institutions Code Section 12303.4(a) or as otherwise provided by law.

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- .121 The IHSS service hours for a recipient who is not determined to be severely impaired and receives services through the individual provider mode of service delivery shall not exceed 195 hours per month effective July 8, 1988 (Welfare and Institutions Code Section 12303.4(a)(1)).
- .122 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.

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30-765 COST LIMITATIONS (Continued)**30-765**

- .13 The statutory maximum service hours per month shall be inclusive of any payment by IHSS for a restaurant meal allowance established in accordance with the Welfare and Institutions Code Section 12303.7.
 - .131 The statutory maximum for individuals receiving services through the individual provider mode of service delivery and eligible for the restaurant meal allowance shall be determined by multiplying the statutory maximum hours of service by the county wage rate, subtracting the restaurant meal allowance (see Section 30-757.134(a)(1)(A)) from this product and dividing the remainder by the county hourly wage rate.
 - .132 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.
- .14 The county shall not make monthly payments of IHSS monies to recipients in excess of the computed maximums in Sections 30-765.11, .12 and .13. The sum of the IHSS monthly payment and the recipient's share of cost, if any, shall not exceed the appropriate maximum.
- .2 The statewide wage rate for individual providers shall be determined by the Department. Effective July 8, 1988, the statewide wage rate is \$4.25.

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- .21 DHS regulation Section 51535.2 reads:

Reimbursement Rates for Personal Care Services Program.

- (a) For the individual provider mode for providing personal care services, the reimbursement rate shall be a maximum of \$5.50 per hour of service: provided, however, that the reimbursement rate in each county shall not exceed the rate in each county for the individual provider mode of service in the IHSS program pursuant to Article 7 (commencing with Section 12300) of Part 3 of Division 9 of the Welfare and Institutions Code, as it existed on September 28, 1992.

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- (b) For the contract mode for providing personal care services pursuant to Welfare and Institutions Code Sections 12302 and 12302.1, the reimbursement rates shall be those specified in the contract between the county and the agency contractor not to exceed the following maximum rates for services provided through State fiscal year 1993-1994 as follows:

(1)	Butte	\$ 9.65
(2)	Nevada	\$10.34
(3)	Riverside	\$12.29
(4)	San Diego	\$10.49
(5)	San Francisco	\$12.28
(6)	San Joaquin	\$ 9.50
(7)	San Mateo	\$12.65
(8)	Santa Barbara	\$11.76
(9)	Santa Clara	\$11.11
(10)	Santa Cruz	\$13.61
(11)	Stanislaus	\$10.51
(12)	Tehama	\$11.30
(13)	Ventura	\$11.04

- (c) Nothing in this section is intended to be a limitation on the rights of providers and beneficiaries or on the duties of the Department of Social Services, pursuant to Welfare and Institutions Code Section 12302.2 subdivision (a). Contributions, premiums and taxes paid pursuant to Welfare and Institutions Code Section 12302.2, subdivision (a) shall be in addition to the hourly rates specified in subdivision (a) of this section.

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30-765 COST LIMITATIONS (Continued)**30-765**

- .3 IHSS recipients receiving services through the individual provider mode of delivery shall not receive less service hours per month than he/she received during June 1988, without a reassessment of need. The reassessment shall not result in an automatic reduction in authorized hours, unless the recipient no longer needs the hours.
- .4 These regulations shall remain in effect until July 1, 1990, unless a later enacted regulation extends or repeals that date.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12300, 12303.4, and 14132.95, Welfare and Institutions Code.

30-766**COUNTY PLANS****30-766**

- .1 Each county welfare department shall develop and submit a county plan to CDSS no later than 30 days following receipt of its allocation, which specifies the means by which IHSS will be provided in order to meet the objectives and conditions of the program within its allocation.
 - .11 The plan shall be submitted to CDSS and shall be based upon relevant information, as specified in Welfare and Institutions Code Sections 12301 and 14132.95, including, but not limited to the information specified below:
 - .111 Projected caseload, hours paid, and costs per month/quarter by mode;
 - .112 Modes of IHSS and PCSP service delivery the county intends to use;
 - .113 Estimated program costs for both the IHSS and PCSP programs;
 - .114 Methods the county will utilize to control non-PCSP program costs to comply with required fiscal limitations; and
 - .115 Program design intended to meet PCSP requirements.
 - .12 County plans and amendments shall be effective upon submission.
 - .13 CDSS shall review each county plan for compliance with Welfare and Institutions Code Sections 12300, et seq. and 14132.95, regulations of CDSS and DHS, and when appropriate, issue departmental approval.
 - .131 CDSS, when appropriate, shall adjust funding levels contained in the plan, as a condition of approval.
 - .132 A county plan which includes IHSS administrative costs shall not be issued departmental approval.
 - .133 If, after review, CDSS determines that a county plan is not in compliance, the Department shall require the county to amend its plan.
 - .134 CDSS shall develop a county plan for counties which have not submitted plans within the required time frame, based on CDSS' estimate for those counties. Such plans shall be effective upon written notification to the county.

30-766 COUNTY PLANS (Continued)**30-766**

- .14 In the event that funds are available for reallocation, special consideration shall be given to those counties which submit their county plans by the due date.
 - .141 CDSS shall be permitted to reallocate funds from counties which are late based on CDSS's estimate for those counties.
- .15 Each county shall monitor its expenditures monthly. Upon discovery by either CDSS or the county that anticipated expenditures will exceed the amount of the county's base allocation, the county shall immediately submit to CDSS for approval an amended plan.
 - .151 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.
 - .152 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.
- .16 Counties shall not reduce authorized services or hours of service to recipients in order to remain within their allocation.
- .17 All state-mandated program costs, after the required county contribution, shall be eligible for reimbursement from state social service funds. If appropriated funds are insufficient to reimburse counties for all state-mandated costs, the state shall fully reimburse the counties for all state-mandated program costs, less the required county contribution.
- .18 The portion of county expenditures which, after the county contribution, exceeds the allocation, shall not be eligible for reimbursement from state social service funds if such deficit is caused by:
 - .181 Noncompliance with the requirements of the state-approved county plan or State allocation plan; or
 - .182 Non-state-mandated costs; or
 - .183 IHSS administrative costs.

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- (a) Some examples of situations where reimbursement would not be made are:
- (1) A county chooses to give a wage/benefit increase to IHSS providers which is higher than that provided in the Budget Act; or
 - (2) A county chooses to expand its use of a more expensive service delivery mode beyond the level of caseload and hours growth for each mode that is built into the Budget Act; or
 - (3) A county chooses to enter into a third party contract at an hourly rate higher than the maximum established for that county; or
 - (4) A county chooses to shift to a more expensive mode without providing for noncomitant offsetting savings in other areas, and causing a cost overrun.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; Chapter 939, Statutes of 1992. Reference: Sections 10102, 12301, 12302, 12306, 12308, 13002, and 14132.95, Welfare and Institutions Code; and Chapter 93, Statutes of 1989 (Budget Act of 1989).

- .1 The county shall arrange for the provision of IHSS through one or more of the methods specified below in accordance with an approved county plan:

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Counties may choose modes of delivery that best meet the needs of their recipient population in their county demographic situation (WIC 12302). However, state reimbursement can be available only within the constraints imposed by the annual budget act (WIC 12300) and state allocation plan (WIC 10102), all of which must be reflected in state-approved individual county plans. Counties which exceed the constraints run the risk of not receiving full reimbursement if the cost overrun was due to non-state mandated costs, i.e., costs within county control, or more expensive modes used beyond amounts approved in an individual county plan.

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30-767 SERVICE DELIVERY METHODS (Continued)**30-767**

- .11 County Employment.
 - .111 The county shall be permitted to hire service providers in accordance with established county civil service requirements or merit system requirements. The county shall be permitted to consider such providers as temporary employees if approved by the appropriate civil service system.
 - .112 The county shall insure that each service provider is capable of and is providing the services authorized.
- .12 Purchase of Service from an Agency.
 - .121 The county may contract with an agency to provide service in accordance with the requirements of Division 10 and 23. The contract shall include a provision requiring the contractor to maintain a listing of contract recipients, their authorized hours, service hours provided and the amount paid for those services to the contract agency.
 - .122 The county shall insure that the contractor guarantees the continuity and reliability of service to recipients, supervision of service providers, that each service provider is capable of and is providing the service authorized and complies with the requirements of Division 21 (Civil Rights).
 - .123 The county shall insure that preference is given to the selection of providers who are recipients of public assistance or other low-income persons who would qualify for public assistance in the absence of such employment, except in regard to persons recruited by the recipient.
- .13 Purchase of Service From An Individual.
 - .131 The county shall make payment under this delivery method through the payrolling system as described in Section 30-769.
 - .132 The county shall make a reasonable effort to assist the recipient to obtain a service provider when the recipient is unable to obtain one individually.

30-767 SERVICE DELIVERY METHODS (Continued)**30-767**

- .133 The county shall have the right to change from one to another of the three delivery methods outlined above or from payment in advance to payment in arrears when any of the following apply:
- (a) It has been determined that a recipient is using his/her payment for other than the purchase of authorized services.
 - (b) The recipient has failed to submit time sheets, as specified in Section 30-769.737 within 90 days from the date of payment.
 - (c) The recipient has not provided timely payment to his/her providers.
- .2 Counties may elect to contract with a nonprofit consortium or may create a public authority to provide for the delivery of IHSS.
- .21 The board of supervisors shall establish a public authority by ordinance.
- .211 The public authority shall be separate from the county. Employees of the public authority shall not be considered to be employees of the county for any purpose.
- .212 The ordinance shall designate the governing body of the public authority and specify the qualifications of the individual members, the procedures for nomination, selection, appointment, tenure and removal of members, and such other matters as the board of supervisors deems necessary for the operation of the public authority.
- (a) The board of supervisors may designate itself as the governing body of the public authority.
 - (1) If the board of supervisors is the governing body, the ordinance shall require the appointment of an advisory committee of no more than 11 members.
 - (2) No fewer than 50 percent of the advisory committee shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).
 - (b) If the board of supervisors does not designate itself the governing body of the public authority, it shall specify by ordinance the membership of the governing body of the public authority.

30-767 SERVICE DELIVERY METHODS (Continued)**30-767**

- (1) No fewer than 50 percent of the members of the governing body shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).
- .213 Before appointing members to the governing body or advisory committee, the board of supervisors shall solicit recommendations from the general public and interested persons and organizations through a fair and open process which includes reasonable written notice and a reasonable time to respond.
 - (a) The provisions at Section 30-767.213 shall be met by satisfying the requirements governing legislative bodies outlined in Government Code and other state and federal law, including, but not limited to, the Ralph M. Brown Act (Government Code Section 54950 et seq.) and the Americans with Disabilities Act.
- .214 Prior to initiating delivery of IHSS through a public authority, the county shall enter an agreement with the public authority specifying the purposes, scope or nature of the agreement, the roles and responsibilities of each party including provisions which ensure compliance with all applicable state and federal labor laws, and compliance with all statutory and regulatory provisions applicable to the delivery of IHSS. This agreement shall also specify the fiscal provisions under which the public authority shall be reimbursed for its performance under the agreement. The county, in exercising its option to establish a public authority, shall not be subject to competitive bidding requirements.
- .215 Prior to initiating the delivery of IHSS through a public authority, the county shall submit to the California Department of Social Services a copy of the agreement as specified in Section 30-767.214 along with the following information concerning the public authority:
 - (a) Organization chart of the public authority.
 - (b) Funding provision for public authority costs, including how the proposed rate was developed.
 - (1) The rate development process and the public authority hourly rate must be approved by Department of Health Services prior to initiating the delivery of services.
 - (c) Public authority staffing classifications and duties.
 - (d) A description of how the functional requirements of Welfare and Institutions Code Section 12301.6(e) will be met.

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- (e) The requirements of Welfare and Institutions Code Section 12301.6(e) are listed in Section 30-767.23.

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- .216 If the public authority contracts with another entity to provide the delivery of IHSS, the agreement shall satisfy the requirements of Manual of Policies and Procedures Chapter 23-600 relating to contracting.
- .217 All costs claimed for the delivery of services under an agreement as specified in Section 30-767.214 shall be claimed in compliance with criteria for rate setting found at Section F, attachment 4.19-B of the California Medicaid State Plan.
- (a) A county shall use county-only funds to fund both the county share and the state share of any increase in the cost of the program, including employment taxes, due to any increase in provider wages or benefits negotiated or agreed to by a public authority or nonprofit consortium unless otherwise provided for in the annual budget act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect until the Department has obtained the approval of the State Department of Health Services.
- .22 A county may contract with a consortium for delivery of services.
- .221 A consortium entering a contract under Section 30-767.22 shall have a governing body composed as described in Section 30-767.212(b)(1), or shall have established an advisory committee composed as described in Sections 30-767.212(a)(1) and (2).
- .222 Such contracts shall be subject to the provisions of Manual of Policies and Procedures Chapter 23-600.
- .223 A consortium entering a contract under Section 30-767.22 shall be deemed to be the employer of IHSS personnel referred to recipients as described in Section 30-767.23 for the purposes of collective bargaining over wages, hours and other terms and conditions of employment.
- .23 Any public authority or consortium shall provide the following minimum services:

30-767 SERVICE DELIVERY METHODS (Continued) 30-767

- .231 Provide registry services to recipients receiving services pursuant to Section 30-767.23.
 - (a) Assistance in finding providers through the establishment of a registry.
 - (b) Investigation of the qualifications and background of potential providers listed on the registry.
 - (c) Establishment of a referral system under which potential providers are made known to recipients.
- .232 Provide access to training for providers and recipients.

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- (a) Access to training for providers and recipients does not mean that the county or the Public Authority is under any obligation:
 - (1) to provide the training directly, to pay for training provided in the community, to pay for the provider's time to attend or to accompany the recipient to training, to pay for transportation to the training, or to pay for any materials required by the training; or
 - (2) to screen or be responsible for the content of any training it tells providers and/or recipients is available in the community; or
 - (3) to ensure that any provider or recipient attended/completed any training.

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- .233 Perform any other function related to the delivery of IHSS.
- .234 Ensure that the requirements of the Personal Care Services Program pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are met.
- .24 Any public authority may adopt reasonable rules and regulations for the administration of employer-employee relations.

30-767 SERVICE DELIVERY METHODS (Continued)**30-767**

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- .241 The Employer-Employee Relations Policy for Public Authorities Delivering In-Home Supportive Services is available from the California Department of Social Services as a model for public authorities. Public authorities may adopt, reject, or modify the policy in part or in its entirety.

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- .25 Public authorities and consortia must submit cost reports and such other data as required for the Case Management, Information and Payrolling System (CMIPS).
- .26 Any county that elects to provide for in-home supportive services pursuant to this section shall be responsible for any increased costs to the CMIPS attributable to such election. The Department shall collaborate with any county that elects to provide in-home supportive services pursuant to this section prior to implementing the amount of financial obligation for which the county shall be responsible.
- .3 No recipient of any services specified in Section 30-757.14 or .19 shall be compelled to accept services from any specific individual, except for individuals recruited by the recipient's guardian, conservator, or, in the case of recipients who are minors, by their parents.
- .31 For those recipients who are receiving services through the delivery methods described in .11 and .12 above, hiring preference shall be given to qualified persons recruited by the recipient to deliver services. For the purpose of this section a qualified person is one who meets the minimum requirements established by the contract agency or the County Civil Service or Merit Systems.

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.4 Personal Care Services Program Providers

DHS regulation Section 51181 reads:

Personal Care Services Provider.

A personal care services provider is that individual, county employee, or county contracted agency authorized by the Department of Health Services to provide personal care services to eligible beneficiaries. An individual provider shall not be a family member, which for purposes of this section means the parent of a minor child or a spouse.

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.5 Personal Care Services Program Provider Enrollment

DHS regulation Section 51204 reads:

Personal Care Services Provider.

All providers of personal care program services must be approved by Department of Health Services and shall sign the "Personal Care Program Provider/Enrollment Agreement" form [SOC 426 1/93] designated by the Department agreeing to comply with all applicable laws and regulations governing Medi-Cal and the providing of personal care service. Beneficiaries shall be given a choice of service providers.

- (a) Individual providers will be selected by the beneficiary, by the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian. The beneficiary or the beneficiary's personal representative, or in the case of a minor, the legal parent or guardian shall certify on the provider enrollment document that the provider, in the opinion of the beneficiary, is qualified to provide personal care so long as the person signing is not the provider.
- (b) Contract agency personal care providers shall be selected in accordance with Welfare and Institutions Code Section 12302.1. The contract agency shall certify to the designated county department that the workers it employs are qualified to provide the personal care services authorized.

.6 Provider Audit Appeals

DHS regulation Section 51015.2 reads:

Providers of Personal Care Services Grievance and Complaints.

Notwithstanding Section 51015, when a provider of personal care services has a grievance or complaint concerning the processing or payment of money for services rendered, the following procedures must be met:

- (a) The provider shall initiate an appeal, by submitting a grievance or complaint in writing, within 90 days of the action precipitating the grievance or complaint, to the designated county department identifying the claims involved and specifically describing the disputed action or inaction regarding such claims.

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- (b) The designated county department shall acknowledge the written grievance or complaint within 15 days of its receipt.
- (c) The designated county department shall review the merits of the grievance or complaint and send a written decision of its conclusion and reasons to the provider within 30 days of the acknowledgment of the receipt of the grievance or complaint.
- (d) After following this procedure, a provider who is not satisfied with the decision by the designated county department may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later than one year after receiving notice of the decision.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12301.6, 12302, 12302.1, and 14132.95, Welfare and Institutions Code and Section 54950 et seq., Government Code.

30-768	OVERPAYMENTS/UNDERPAYMENTS	30-768
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.1 Definition of Overpayment for Non-PCSP Payments

- .11 Overpayment means that cash payment was made for the purchase of IHSS or services were delivered in an amount to which the recipient was not entitled.
 - .111 Services payments paid pending a state hearing decision as required by MPP 22-022.5 are not overpayments and cannot be recovered.

30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued)**30-768****.2 Amount of Overpayment for Non-PCSP Payments**

When the county has determined that an overpayment has occurred, the county shall calculate the amount of overpayment as follows:

.21 Overpayment due to the recipient's failure to use total direct advance payment for the purchase of authorized hours.**.211 Authorization based on an hourly rate**

- a. Determine the number of service hours for which the recipient received a direct advance payment in excess of those service hours actually paid for.
- b. Multiply this amount by the hourly wage rate used in computing the recipient's authorized payment.

.212 Authorization for a personal attendant

When services are delivered by a personal attendant, the amount of the overpayment is the difference between the amount that should have been paid and the amount which was actually paid.

.213 When the recipient receives a direct advance payment to purchase services in a given month, but fails to submit a reconciling time sheet within 45 days from the date of payment, there is a rebuttable presumption that the unreconciled amount is an overpayment.**.22 Overpayment due to excess service authorization****.221 Authorization based on an hourly rate**

- a. Determine the number of service hours for which payment was made in excess of the correct service authorization.
- b. Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.222 Authorization for a personal attendant

When services are delivered by a personal attendant, the amount of overpayment is the difference between the amount paid and the amount which would have been paid if the service authorization was correct.

30-768 **OVERPAYMENTS/UNDERPAYMENTS (Continued)** **30-768**

.23 Overpayment due to incorrect share of cost

Where the correct share of cost was more than the recipient paid, the resulting overpayment is determined by subtracting the amount paid from the correct amount.

.24 Overpayment due to nonpayment of share of cost

Where the service hours were provided to the recipient, but he/she did not pay his/her obligated share of cost, the county should initiate overpayment recovery for the entire amount of the IHSS payment for the month in which the recipient was ineligible.

.25 Overpayment due to nonexpenditure of restaurant meal allowance

Where the recipient received an allowance for the purchase of restaurant meals, and used none of the allowance for that purpose, or if the recipient was ineligible for a restaurant meal allowance he/she received, the entire amount is an overpayment.

.3 Recovery of Overpayments for Non-PCSP Payments

.31 Limitations on amount of Recovery

.311 The repayment liability of the recipient shall be limited to the amount of liquid resources and income excluded or disregarded by the SSI/SSP Program. Liquid resources are cash or financial instruments that can be converted to cash, except funds set aside for burial.

.312 When an overpayment results from the recipient's failure to spend the entire amount of an advance direct payment for the purchase of authorized services, the difference in value between the hours purchased and the hours authorized shall be considered an available resource in determining repayment liability.

.32 Methods of Recovery

.321 The county may recover overpayments using any one or a combination of the methods listed below.

(a) Balancing

(1) Balancing means recovery of all or a portion of an overpayment by applying a repayable underpayment against it.

30-768 **OVERPAYMENTS/UNDERPAYMENTS (Continued)** **30-768**

(2) An underpayment shall not be balanced against an overpayment if the underpayment is discovered and payable prior to the time an overpayment is discovered and adjustable.

(b) Payment Adjustment

(1) Payment adjustment means that the county reduces payment for future authorized services to offset an overpayment.

(2) If the service payment is reduced to adjust for previous overpayments, the recipient shall be responsible for paying the current month's adjustment amount to the service provider in addition to any share of cost.

(c) Voluntary Cash Recovery

(1) Voluntary cash recovery means repayment voluntarily made to the county by a recipient who has incurred an overpayment.

(2) The recipient shall be given the option of voluntary cash repayment of all or a part of the amount to be adjusted in lieu of payment adjustment.

(d) Civil Judgment

The county shall have the authority to demand repayment and file suit for restitution for any unadjusted portion of an overpayment.

.33 Notice of Action

If the county determines that an overpayment has occurred as defined in .11 above and proposes to recover the overpayment, the county shall notify the recipient of the following:

.341 The period of time during which the overpayment occurred.

.342 The reason for the overpayment.

.343 The amount of overpayment and a description of how the amount was calculated.

.344 The method by which the county proposes to recover the overpayment.

.4 Definition of Underpayment for Non-PCSP Payments

.41 Underpayment means the recipient was entitled to more service than was authorized or that the share of cost paid by the recipient was greater than the correct amount.

30-768 **OVERPAYMENTS/UNDERPAYMENTS (Continued)** **30-768**

- .411 An underpayment has occurred when the county has failed to determine the correct share of cost or authorize the correct amount of service when all essential information was available to the county.
- .412 An underpayment has not occurred when there is a disagreement in the county's exercise of discretion or opinion, where discretion or opinion is allowed in the determination of the need for service.

.42 Amount of Underpayment

When the county has determined that an underpayment has occurred, the county shall calculate the underpayment as follows:

- .421 Incorrect Service Authorization
 - (a) Subtract the number of hours actually authorized from the number of hours to which the recipient was entitled.
 - (b) Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.422 Share of Cost

When the correct share of cost was less than the recipient paid, the resulting underpayment is determined by subtracting the correct amount from the amount paid.

.423 Restaurant Meals

When the amount paid was less than the amount to which there was entitlement, subtract the amount paid from the correct amount.

.43 Method of Payment

- .431 Underpayments shall be adjusted by an increase in the service authorization when the unauthorized service for which there was entitlement was yard hazard abatement or heavy cleaning, and the service was not previously provided through another source at no cost to the recipient.
- .432 All other underpayments shall be corrected by a retroactive payment issued to the recipient in an amount equal to that of the calculated underpayment.

30-768 **OVERPAYMENTS/UNDERPAYMENTS (Continued)** **30-768**

.44 Notice of Action

If the county determines that an underpayment has occurred as defined in .4 above, the county shall notify the recipient of the following:

- .441 The time period during which the underpayment occurred.
- .442 The reason for the underpayment.
- .443 The amount of the underpayment, and a description of how the amount was calculated.
- .444 The method by which the county proposes to adjust the underpayment.

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.5 DHS regulation Section 50781 reads:

Potential Overpayments

- (a) A potential overpayment occurs when any of the following conditions exist, as limited by (c).
 - (1) A beneficiary has property in excess of the property limits for an entire calendar month.
 - (2) A beneficiary or the person acting on the beneficiary's behalf willfully fails to report facts and those facts, when considered in conjunction with the other information available on the beneficiary's circumstances, would result in ineligibility or an increased share of cost.
 - (3) A beneficiary has other health coverage of a type designated by the Department [of Health Services] as not subject to post-service reimbursement, and the beneficiary or the person acting on the beneficiary's behalf willfully fails to report such coverage.

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- (b) A beneficiary of the person acting on the beneficiary's behalf willfully fails to report facts if he/she has completed and signed a Medi-Cal Responsibilities Checklist, form MC 217, and a Statement of Facts and has, within his/her competence, done any of the following:
 - (1) Provided incorrect oral or written information.
 - (2) Failed to provide information which would affect the eligibility or share of cost determination.
 - (3) Failed to report changes in circumstances which would affect eligibility or share of cost within 10 days of the change.
- (c) If a change occurred in a person's circumstances and that change could not have been reflected in the person's eligibility determination for the month in which the change occurred or the month following because of the 10 day notice requirements specified in Section 50179, no potential overpayment exists in that month or in the following month if appropriate.

.6 DHS regulation Section 50786 reads:

Action on Overpayment -- Department of Health Services or County Unit Contracted to Collect Overpayments

- (a) Upon receipt of a potential overpayment referral, the Department's Recovery Section or the county unit contracted to collect overpayments shall:
 - (1) Determine the amount of Medi-Cal benefits received by the beneficiary for the period in which there was a potential overpayment.
 - (2) Compute the actual overpayment in accordance with the following:
 - (A) When the potential overpayment was due to excess property, the actual overpayment shall be the lesser of the:

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1. Actual cost of services paid by the Department during that period of consecutive months in which there was excess property throughout each month.
 2. Amount of property in excess of the property limit during that period of consecutive months in which there was excess property throughout each month. This excess amount shall be determined as follows:
 - a. Compute the excess property at the lowest point in the month for each month.
 - b. The highest amount determined in a. shall be the amount of the excess property for the entire period of consecutive months.
- (B) When the potential overpayment was due to increased share of cost, the actual overpayment shall be the lesser of the:
1. Actual cost of services received in the share of cost period which were paid by the Department.
 2. Amount of the increased share of cost for the share of cost period(s).
- (C) When the overpayment was due to excess property and increased share of cost, the actual overpayment shall be a combination of (A) and (B).
- (D) When the potential overpayment was due to other factors which result in ineligibility the overpayment shall be the actual cost of services paid by the Department.

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(E) Potential overpayments, due to beneficiary possession of other health coverage that is not subject to post-service reimbursement, shall be processed by the Department to determine and recover actual overpayments in all cases. The actual overpayment in such cases shall be the actual cost of services paid by the Department which would have been covered by a private health insurance or other health coverage, had the coverage been known to the Department. The actual overpayment shall not include any costs which can be recovered directly by the Department from the health insurance carrier or other source.

(3) Refer those cases where there appears there may be fraud to the Investigations Branch of the Department.

(4) Take appropriate action to collect overpayments in accordance with Section 50787.

.7 DHS regulation Section 50787 reads:

Demand for repayment

(a) The Department or the county unit contracted to collect overpayments shall demand repayment or actual overpayments in accordance with procedures established by the Department.

(b) The Department or the county unit contracted to collect overpayments may take other collection actions as permitted under state law.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 12304.5 and 14132.95, Welfare and Institutions Code.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS**30-769**

- .1 This section governs the procedures that shall be followed by counties making payments under the delivery method specified in Section 30-767.13. Counties shall not enter into any agreements or contracts to make payment to individual providers.
- .2 County Responsibility
 - .21 The CRT counties shall directly input required data and initiate transactions into the system via terminals located in the county.
 - .22 The Paper counties shall input required data and initiate transactions on prescribed forms and submit those forms to the payrolling contractor.
 - .221 Exception: Special preauthorized transactions may be initiated by phone to the payrolling contractor. The prescribed document shall subsequently be sent from the payrolling contractor to the county confirming the transaction.
 - .23 For purposes of the payrolling system, the initial authorization period begins in the calendar month in which the first day of authorization occurs and continues until changed.

30-769 **PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)** **30-769**

.24 General Process

.241 The counties shall:

- (a) Enter prescribed data on all recipients and providers, as defined in Section 30-767.13, into the payrolling system.
- (b) Change data as necessary to ensure correct payment to the correct individual.
- (c) Authorize the disbursement of all funds paid by the payrolling contractor by:
 - (1) Reviewing all time sheets prior to entry of time sheet data into the system to ensure consistency between hours reported and hours authorized.
 - (2) Reviewing any significant discrepancies between hours reported and hours authorized to determine the reason and take corrective action as indicated.
 - (3) Initiating special transactions as described in .25 below.
- (d) Retain completed time sheets as required by Section 23-353 in such a manner that they are easily accessible for review.
- (e) Respond to and resolve payment inquiries from recipients and providers. The payrolling contractor will provide all necessary information.

.25 Special Transaction

.251 Special transactions are used to handle situations which fall outside the normal payroll process. Counties shall be held responsible for closely monitoring and controlling the use of the following transactions.

.252 The county shall initiate emergency/supplemental checks for:

- (a) Payments resulting from retroactive state hearing decisions.
- (b) Payments resulting from prior underpayments.
- (c) Payments in excess of the base rate as provided in Section 30-764.

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30-769 **PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)** **30-769**

- (d) Payments for severely impaired recipients in advance pay status who become eligible for payment between a pay cycle.
 - (e) Payments where the county finds that an emergency situation exists.
 - (f) Payments to counties for reimbursements of emergency checks as described in .26 below.
 - (g) Payments for other unusual situations not provided for by the regular payrolling process and where the county deems appropriate.
 - (h) Payments for time sheets submitted three or more months beyond the current payroll cycle.
- .253 A request for a replacement check shall be made expeditiously by the county but no sooner than five (5) days from the date the original check should have been received.
- .254 A void transaction shall be used:
- (a) When a payroll check is returned to the payrolling contractor or county.
 - (b) When a payroll check is mutilated.
 - (c) When a payroll check is not in the possession of the county or the payrolling contractor.
- .255 Adjustment transactions shall be used to make adjustments to tax records when any of the following occur:
- (a) An overpayment.
 - (b) An underpayment.
 - (c) An incorrect deduction.
- .26 County issued payments shall only be issued in cases of extreme emergency when the county finds that the emergency check procedure provided in .252 is not adequate.

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) 30-769

- .261 The county shall issue checks for an amount not to exceed ninety (90%) percent of the amount the recipient/provider should receive.
- .262 The county shall be reimbursed for payments made under .261 above by the payrolling contractor using the emergency/supplemental check transaction.
- .263 The county shall not receive reimbursement until an emergency/ supplemental transaction has been initiated to pay the recipient/ provider the remaining balance.
- .264 The county shall receive a time sheet before the transaction in .261 or .263 above shall occur. Exception: The county may issue a check prior to receipt of a time sheet for a severely impaired recipient who opted for advance pay.
- .27 The counties shall be responsible for verifying eligibility of recipients for IHSS between January 1, 1978 and December 31, 1979 as needed for retroactive tax payments.
- .28 The county shall ensure that all providers are informed of the requirements they must meet in order to be paid.
- .3 The County Has The Sole Responsibility For Determining And Investigating Fraud And Forgery for Non-PCSP
 - .31 The county shall, with no effect on current county procedures:
 - .311 Identify suspected fraud cases;
 - .312 Determine if actual fraud exists;
 - .313 Take appropriate action as necessary.
 - .32 The county will be notified by the payrolling contractor if an original check has already been cashed when a replacement check is requested. The county shall then follow the applicable procedure in the user's manual.
- .4 PCSP Fraud or Forgery

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.41 DHS regulation Section 50782 reads:

Fraud occurs if an overpayment occurs and the beneficiary or the person acting on the beneficiary's behalf willfully failed to report facts as specified in Section 50781(b) with the intention of deceiving the Department, the county department or the Social Security Administration for the purpose of obtaining Medi-Cal benefits to which the beneficiary was not entitled.

.42 If PCSP fraud or forgery occurs, DHS will follow the procedures cited in DHS regulation Section 50793.

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.5 Return Check Procedures

.51 Counties which receive a returned check from a provider or recipient shall follow the applicable procedures in the user's manual.

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30-769 **PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)** **30-769**

.6 Refunds/Recoupment

.61 Counties which receive refunds or recoupments shall:

.611 Deposit the money received in a county account; and

.612 Send a monthly check to the payrolling contractor for the amount of refund/recoupment received during the previous month in accordance with applicable procedures in the User's Manual.

.7 Recipient Responsibility

.71 It is the responsibility of the recipient to report to social services staff accurately and completely all information necessary to complete the SOC 311.

.72 The recipient, within his/her physical, emotional, educational or other limitations, shall:

.721 Designate the authorized hours per provider within the total of the recipient's authorized hours.

.722 Designate each provider(s) portion of the share of cost.

.723 Sign and date the prescribed time sheet to:

(a) Verify payment of the share of cost to the appropriate provider(s).

(b) Verify that services authorized were rendered by the appropriate provider.

.724 Inform social services staff of any changes affecting the payrolling process.

.73 Payments for authorized services rendered shall be sent to the recipient's appropriate provider. The recipient shall not receive payment for services except as provided in .731 through .734 below.

.731 Severely impaired recipients as defined under Section 30-753, shall have the option of choosing to directly receive their payment at the beginning of each authorized month. Such payment shall be the net amount exclusive of the appropriate withholdings.

30-769 **PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)** **30-769**

- .732 In direct payment cases, where a recipient is incapable of handling his/her financial and legal affairs and has a legal guardian or conservator, direct payment shall be made to the recipient's legal guardian or conservator at such person's request.
- .733 Payment may be made to a recipient's guardian, conservator, substitute payee, or person designated by the recipient.
- .734 When payment is made as a result of a state hearing decision.
- .735 If the recipient is severely impaired he/she shall be notified in writing of the right to hire and pay his/her own provider, and to receive his/her monthly cash payment in advance.
- .736 When direct payment is made to a recipient, guardian, conservator, or substitute payee, the provider shall be hired, supervised, and paid by such payee. In such cases, the recipient or the person authorized to act in the recipient's behalf shall insure that the services provider is capable of and is providing the services authorized.
- .737 It shall be the responsibility of the severely impaired recipient, legal guardian or conservator who receives payment in advance to submit their provider's time sheets at the end of each authorized service month to the appropriate county social services office.

.8 Provider Benefits

- .81 The department has elected to provide the worker's compensation coverage required by Welfare and Institutions Code Section 12302.2 through a single statewide insurance policy. Additional insurance coverage will not be reimbursed as an IHSS program cost.
- .82 The department has elected to handle the payment of the unemployment insurance tax, unemployment disability insurance tax, and social security tax required by Welfare and Institutions Code Section 12302.2 through the payrolling system.
- .83 The department has elected to require the payrolling contractor to deduct the employee's share of the following taxes from the payment to the provider or the recipient:

30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) 30-769

- .831 Social security.
 - .832 State disability insurance.
 - .84 The department has elected to deduct and transmit the state and federal income tax withholdings due on the provider's earnings for those providers who voluntarily request this service.
- .9 Excessive Compensation
- (See Section 30-769.91 (Handbook) for examples of excessive compensation)

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- .91 Excess compensation to an individual provider but is not necessarily limited to the following circumstances:
 - .911 The provider was paid for more hours than authorized or more hours than worked.
 - .912 The provider was paid at a higher hourly rate than appropriate.
 - .913 The share of cost withheld from provider's payment was less than the recipient affirms was paid to the provider.

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- .92 All excess provider compensation is recoverable. The county shall demand repayment from the provider. The county shall be permitted to seek recovery of excess compensation by civil suit.
 - .93 Provider Fraud or Forgery
- If the county suspects that excess provider payment occurred because of fraudulent devices of the provider, forgery, or collusion between the provider and the recipient, the county shall investigate the suspected fraud, forgery, or collusion. If the facts warrant prosecution and the county does not have an investigative unit, the county shall refer the matter directly to the county district attorney's office for investigation and possible prosecution.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code.

30-770 ELIGIBILITY STANDARDS**30-770**

- .1 Persons applying for IHSS under Sections 30-755.112, .113 and .114 shall meet the SSI/SSP eligibility standards except as modified by Section 30-755.1.
- .2 Detailed eligibility standards shall be those located in 20 CFR Part 416, except as modified by IHSS regulations beginning with Section 30-750.
- .3 Definitions.
 - .31 For the purposes of eligibility for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18, or under the age of 22 and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him/her for gainful employment.
 - .311 For the purposes of deeming for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18.
 - .312 Regularly attending school means being enrolled in eight semester or quarterly hours weekly in a college or university, or 12 hours weekly in a secondary school. In a course of vocational or technical training, 15 clock hours weekly are required; without shop practice, at least 12 hours weekly are required.
 - .313 Eligible spouse means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual who has not been living apart from such other aged, blind, or disabled individual for more than six months.
- .4 Residency
 - .41 Residency in State Required

To be eligible for IHSS, an individual shall be a U.S. citizen, or an eligible alien pursuant to Welfare and Institutions Code Section 11104. The individual shall also be a California resident, physically residing in the state except for temporary absence as noted below in Sections 30-770.42 through .45, with the intention to continue residing here.

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Welfare and Institutions Code Section 11104 states:

"Aliens shall be eligible for aid only to the extent permitted by federal law.

"An alien shall only be eligible for aid if the alien has been lawfully admitted for permanent residence, or is otherwise permanently residing in the United States under color of law. No aid shall be paid unless evidence as to eligible alien status is presented."

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.42 Physical Absence from the State

Physical absence from the state indicates a possible change of state residence. The county shall make inquiry of a recipient who has been continuously absent from the state for 30 days or longer in order to ascertain the recipient's intent to maintain California residency. If the inquiry establishes that the recipient is no longer a California resident, authorization for IHSS shall be discontinued.

.421 The county inquiry to the recipient will require the recipient to submit a written statement that:

- (a) Declares his/her anticipated date of return to the state, or his/her intent not to return to the state;
- (b) Declares his/her reason for continued absence from the state; and
- (c) Provides needed information on his/her location and status of household arrangements.

.422 The county will include in the inquiry to the recipient a statement that his/her failure to respond to the inquiry by a specified date will result in his/her ineligibility and the discontinuation of IHSS.

30-770 ELIGIBILITY STANDARDS (Continued)**30-770****.43 Evidence of Residence Intention**

.431 The written statement of the recipient is acceptable to establish his/her intention and action on establishing residence unless the statement is inconsistent with the conduct of the person or with other information known to the county.

.432 If the recipient does not respond by the specified date to the inquiry of residence, it shall be presumed that he/she does not intend to maintain California residency, and authorization for IHSS shall be discontinued when the absence exceeds 60 days in accordance with regulations (Sections 30-759.7 and 10-116).

.433 If the recipient responds to the inquiry and advises the county that he/she does not intend to return to California, authorization for IHSS shall be discontinued in accordance with regulations.

.44 Absence from State for More than 60 Days

.441 If the recipient responds to the inquiry and advises the county that he/she intends to maintain his/her California residence, but he/she remains or has remained out of state for 60 days or longer, his/her continued absence is prima facie evidence of the recipient's intent to have changed his/her place of residence to a place outside of California, unless he/she is prevented by illness or other good cause from returning to the state at the end of 60 days. Such absence in itself is sufficient evidence to support a determination that the recipient has established residence outside of California. Therefore, his/her intent to return must be supported by one or a combination of the following:

- (a) Family members with whom the recipient lived, currently live in California;
- (b) The recipient has continued maintenance of his/her California housing arrangements (owned, leased, or rented);
- (c) The recipient has employment or business interest in California;
- (d) Any other act or combination of acts by the recipient which establishes his/her intent to reside in California.

30-770 ELIGIBILITY STANDARDS (Continued)**30-770**

- .442 Even if the recipient's intent to reside in California is supported by .441 above, the following evidence shall be utilized to determine the recipient's intent to reside in California:
- (a) The recipient has purchased or leased a place of residence out of state since leaving California;
 - (b) The recipient has been employed out-of-state since leaving California;
 - (c) The recipient has obtained an out-of-state motor vehicle driver's license after leaving California;
 - (d) The recipient has taken any other action which indicates his/her intent to establish residence outside of California.

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- .443 Welfare and Institutions Code Section 1110 states that if a recipient is prevented by illness or other good cause from returning to California at the end of 60 days, and has not by act or intent established residence elsewhere, he shall not be deemed to have lost his residence in this state. The following is added by Welfare and Institutions Code Section 11100.1(a):

For purposes of the In-Home Supportive Services Program ... "good cause," as defined in Section 11100, shall include, but is not limited to, the following:

- (1) Outpatient medical treatment necessary to maintain the recipient's health where the medical treatment is not available in California.
- (2) Short-term schooling or training necessary for the recipient to obtain self-sufficiency where training which would achieve that objective is not available or accessible in California.
- (3) Court-issued subpoena or summons.

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30-770 ELIGIBILITY STANDARDS (Continued)**30-770**

- (a) For outpatient medical treatment out of state, good cause for continuing to receive benefits while absent from the state for more than 60 days shall also include the situation where the medical treatment is not accessible in California.
- (b) Accessible in these regulations means attainable for the recipient in California, given the dysfunctioning and needs of the recipient.
- (c) Other good cause reasons for continuing to receive IHSS benefits while absent from the state for over 60 days shall be consistent with the good cause reasons contained in Welfare and Institutions Code Section 11100.1.
 - (1) The situation shall be of an urgent or emergency nature:
 - (2) The service required shall be necessary to maintain the physical or psychological health of the recipient:
 - (3) The services required or like services shall be either not available or not accessible in California.

.444 A recipient absent from California for more than 60 days and who is not prevented from returning to this state because of illness or other good cause shall have his/her authorization for IHSS discontinued in accordance with regulations.

.45 Absence from the State Exceeding Six Months

.451 Authorization for IHSS shall be suspended for any recipient who leaves the state and who remains absent from the state for a period which exceeds six months, notwithstanding the fact that the recipient has continued to receive IHSS benefits beyond 60 days because he/she was prevented from returning to the state due to illness or other good cause, as specified in Sections 30-770.43 and .44. Suspension of benefits will be in accordance with notice of Action regulations contained in Sections 30-759.7 and 10-116.

30-770 ELIGIBILITY STANDARDS (Continued)**30-770**

- .452 In-Home Supportive Services shall not be resumed until the recipient, upon returning to the state, requests a reassessment of need from the county, and the reassessment has been completed in accordance with regulations (Section 30-763).
- .46 Outside the United States While Absent from the State
- .461 In-Home Supportive Services shall be discontinued for any recipient who is outside the United States for all of any month, or for 30 days in a row, as such an individual is no longer eligible to receive SSI/SSP. Discontinuation of benefits will be in accordance with notice of action regulations.
- (a) Upon the individual's return to the United States, and upon his/her reestablishment as an SSI/SSP recipient, an SSI/SSP eligible recipient, or an individual who would be eligible for SSI/SSP except for excess income, he/she may again apply for IHSS benefits. The county shall redetermine IHSS eligibility and perform a needs assessment based on current circumstances.
- (b) "United States" includes the 50 states, the District of Columbia, and the Northern Mariana Islands.
- .47 Continuation of IHSS While Absent from the State
- .471 When the county has determined that the recipient is entitled to the continuation of IHSS benefits while absent from the state (the recipient is absent from the state for 60 or more days and is prevented from returning due to illness or other good cause, as determined in Sections 30-770.42, .43, and .44), the following apply:
- (a) The recipient shall continue to receive the same number of hours of IHSS that were authorized prior to his/her temporary absence. This level of authorization will continue until a reassessment is required.
- (b) The recipient's out-of-state individual provider (IP) shall be reimbursed at the county's lowest current IP base rate.
- (c) The recipient must continue to mail time sheets to the county as required by regulations.

30-770 ELIGIBILITY STANDARDS (Continued)**30-770****.5 State Program Noncitizen Status**

.51 A noncitizen victims of human trafficking, domestic violence, or other serious crimes as defined under the Trafficking and Crime Victims Assistance Program (TCVAP), MPP Chapter 70-100, shall be eligible for IHSS if all other eligibility criteria are met.

.511 A victim of human trafficking must meet the same eligibility criteria as those used for the TCVAP found in MPP Sections 70-102 and 70-103.1. For examples of documentation requirements, please see Sections 70-103.2 through .4.

.512 A victim of domestic violence or other serious crimes must meet the same eligibility criteria as those used for the TCVAP found in MPP Section 70-104.1. For examples of the definition of a noncitizen victim of serious crime, please see Handbook Section 70-104.11. For examples of documentation requirements, please see Section 70-104.12.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Senate Bill 1569 (Chapter 672, Statutes of 2006). Reference: Sections 13283 and 18945, Welfare and Institutions Code.

30-771 LINKAGE 30-771

- .1 Aged - An aged individual shall be considered to be one who is 65 years of age or older.

- .2 Blindness - An individual shall be considered to be blind for purposes of IHSS if:
 - .21 He/she has central visual acuity of 20/200 or less in the better eye with use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less.

 - .22 He/she is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.

- .3 Disability - An individual shall be considered to be disabled for the purposes of IHSS if one of the following applies:
 - .31 He/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of not less than 12 months.

 - .32 In the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity.

 - .33 He/she is permanently and totally disabled as defined under a state plan approved under Title XIV as in effect for October 1972 and received aid under such plan on the basis of disability for at least one month prior to July 1973 and for December 1973, provided that he/she is continuously disabled as so defined.

- .4 Additional criteria regarding aged, blindness and disabled eligibility shall be applied as outlined in 20 CFR 416, Subpart 1.

30-773 RESOURCES**30-773**

- .1 All resources, both liquid and non-liquid, shall be evaluated based upon their equity value with the exception of automobiles, which shall be evaluated as specified in .6(c) below.
- .2 Each aged, blind, or disabled individual whose eligibility for aid commenced on or after January 1, 1974 may have countable resources not in excess of \$1,500 in value and be eligible.
- .3 An individual who is living with either an eligible or ineligible spouse may have countable resources not in excess of \$2,250 in value and remain eligible.
 - .31 The \$2,250 limitation includes the resources of such spouse.
- .4 The resources of a recipient child who is living with his/her parent, parents, or parent and spouse of parent, shall be deemed to include that portion of the countable resources of his/her parent(s) and spouse of parent which exceeds \$1,500 in value in the case of one parent, or \$2,250 in value in the case of two parents or parents or parent and spouse.
 - .41 For the purposes of this section, a recipient child is an unmarried person under the age of 18.
- .5 Individuals receiving AB, ATD, or OAS in December 1973, including individuals who applied for aid in December 1973 and met all the conditions of eligibility for payment in that month, shall continue to be subject to the property limitations in effect in December 1973 unless the recipient would be advantaged by the regulations regarding resource limitations currently in effect.
- .6 In determining the countable resources of an individual, and spouse if any, the following items shall be excluded:
 - (a) The home.
 - (b) Household goods and personal effects to the extent that the combined equity value does not exceed \$2,000. Where the equity value exceeds \$2,000, the excess shall be counted toward the resources limitation.

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30-773 **RESOURCES (Continued)** **30-773**

- (h) Any other resources deemed excludable by the Secretary of Health and Human Services under the provisions of Title XVI of the Social Security Act.
- (i) Restricted allotted land owned by an enrolled member of an Indian tribe.
- (j) Per capita payments distributed pursuant to any judgment of the Indian Claims Commission or the Court of Claims in favor of any Indian tribe as specified in Public Law 93-134.
- (k) Shares of stock and money payments made to Alaskan Natives under the Alaskan Native Claims Settlement Act provided that the payments or stock remain separately identifiable and are not commingled with nonexempt resources. Any property obtained from stock investments under the Act shall not be exempt.
- (l) Tax rebates, credits or similar temporary tax relief measures which state or federal laws specifically exclude from consideration as a personal property resource. The specific rebates and credits listed in Section 30-775.42(a) shall also be exempt as property provided that the monies retained are not commingled and are separately identifiable as a proportionate share of the recipient's property.
- (m) Otherwise countable resources shall be exempt up to the amount of benefits paid on behalf of the applicant/recipient for long-term care services under a State certified long-term care insurance policy or certificate, certified by the State to provide such exemption.
 - (1) Any income generated by such exempt property is countable as income in the month received. See Section 30-775.

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- (A) An example of income generated by such exempt property would be rental income generated by an exempt resource.

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- (2) The burden shall be rebuttably presumed to have been met if the applicant/recipient presents a "SERVICE SUMMARY" signed by a representative of the insurance company verifying that the applicant/recipient is a holder of an insurance policy or certificate certified by the State to provide the exemption, and specifying the total amount of qualifying benefits paid out under the policy to date.
- (3) The amount of the qualifying benefits stated to have been paid in the "SERVICE SUMMARY" referred to in Section 30-773.6(m)(2) shall be the amount of the exemption to which the applicant/recipient is entitled.
- (4) If the statement by the insurance company is found to be erroneous, the county shall promptly notify the California Department of Health Services.
- (5) If the statement by the insurance company is such that the county cannot determine whether the applicant/recipient is covered by a qualifying policy or the amount of the benefits paid out on behalf of the beneficiary, the county shall deny the exemption. When an exemption is denied, the county shall refer the recipient to the California Department of Health Services for assistance and shall notify the California Department of Health Services of the reasons for this determination.

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30-773 **RESOURCES (Continued)** **30-773**

- .73 During the period that the excess property is held and is under disposition, in accordance with the individual's agreement to dispose of the property, any IHSS payments made shall be considered to be overpayments.
 - .731 The net proceeds from the disposition of the excess property shall be considered to be available for liquidation of overpayments occurring during the disposition period in accordance with Section 30-768.3.
- .74 The disposition of the excess property shall be accomplished within a six-month period in the case of real property and within three months in the case of personal property.
 - .741 The time period shall begin on the date the agreement is signed by the individual.
 - (a) In the case of a disabled individual, the time period shall begin on the date of the disability determination.
 - .742 The time limits may be extended another three months where it is found that the individual had "good cause" for failing to dispose of the property within the original time period.
 - (a) "Good cause" shall exist if, despite reasonable and diligent effort on his/her part, he/she was prevented by circumstances beyond his/her control from disposing of the property.

NOTE: Authority cited: Section 22009(b), Welfare and Institutions Code. Reference: Section 22004, Welfare and Institutions Code.

30-775 **INCOME** **30-775**

- .1 Income means the money or other gain periodically received by an individual for labor or service, or from property, investment, operations, etc. Income may be in the form of cash, including checks and money orders; in-kind items; real property; or personal services.
 - .11 When the item of receipt is not in the form of cash, the cash equivalent shall be determined.
 - .12 An individual's or individual and eligible spouse's income shall include all of his/her or their income in cash or in-kind, both earned and unearned.

30-775 **INCOME (Continued)** **30-775**

- .13 An individual's income shall also include those amounts of income of his/her eligible spouse, or, if the individual is a child as defined in Section 30-770.3, of his/her parent and parent's spouse residing in the same household.
 - .14 If income after applying the allowable disregards or exclusions exceeds the appropriate SSI/SSP benefit level, the excess shall be applied to the cost of IHSS.
- .2 Earned Income
- .21 Earned income means:
 - .211 Gross wages.
 - .212 Net earnings from self-employment.
 - (a) Net earnings shall be determined by deducting from gross earnings from self-employment all ordinary and necessary business expenses. Principal payments on encumbrances and personal income taxes shall not be considered expenses. Schedules attached to Form 1040 of the IRS for various types of self-employment may be used to verify allowable expenses.
 - .213 Those amounts of countable earned income deemed to be available to the individual from the income of his/her ineligible spouse, or parent(s) in the case of a recipient child.
 - (a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.
 - (b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.
- .3 Unearned Income.
- .31 Unearned income means all other available income.
 - .32 In evaluating the amount of unearned income which is available to the individual, consideration shall be given to any necessary costs involved in obtaining or securing the income.

30-775 INCOME 30-775

- .33 Unearned income includes, but is not limited to, the following:
 - .331 Support and maintenance furnished in cash or in-kind.
 - (a) A person who meets the criteria in Section 46-325.51 shall have the household of another SSI/SSP benefit level used to compute share of cost in lieu of counting the support and maintenance as unearned income.
 - (1) A person subject to the above procedure may still be eligible for IHSS if living in his/her own home as defined in Section 30-753.
 - .332 Any payments received as an annuity, pension, retirement, disability, OASDI, unemployment, veteran's or workmen's compensation benefit.
 - .333 Prizes and awards.
 - .334 Gifts, support and alimony payments, and inheritances.
 - .335 Rents, dividends, interests, and royalties.
 - .336 The proceeds of any life insurance policy to the extent that they exceed the amount expended by the beneficiary for purposes of the insured individual's last illness and burial expenses or \$1,500, whichever is less.
 - .337 Those amounts of countable unearned income deemed to be available to the individual from the income of his/her ineligible spouse or parent(s) in the case of a recipient child.
 - (a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.
 - (b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.

30-775 **INCOME (Continued)** **30-775**

- (d) Home produce.
 - (1) The value of agricultural products which are not raised in connection with a trade or business and are utilized for consumption by the household.
 - (A) If the produce is sold, the net earnings shall be countable as earned income.
- (e) Foster care payments.
 - (1) Payments for the foster care of a child who is not an eligible individual but who resides in the same home as such individual and was placed there by a public or nonprofit agency.
- (f) Support payment from an absent parent.
 - (1) One-third of any payment received from an absent parent for an eligible individual who is a child as defined in Section 30-770.3.
 - (A) The remainder shall be countable as unearned income.
- (g) Readers and educational scholarships for the blind.
 - (1) Funds, not available to meet basic needs, awarded for readers and educational scholarships by a high school, institution of higher learning, or a vocational or technical training institution to a recipient due to his/her blindness while he/she is regularly attending any public school or any institution of higher learning in this state.
- (h) Vendor payments.
 - (1) Payments made from any source to a vendor in order to meet the needs of the recipient for medical or social services, as determined by the county welfare department. When the vendor is the recipient's spouse, the provisions of .213 above shall apply.

30-775 **INCOME (Continued)** **30-775**

- (m) Domestic Volunteer payments.
 - (1) Payments made under the Domestic Volunteer Services Act of 1973 to welfare recipients who are VISTA volunteers.
- (n) Supplemental food assistance.
 - (1) The value of supplemental food assistance received under the Child Nutrition Act (WIC) and the National School Lunch Act, as specified in Public Laws 92-433 and 93-150.
- (o) Energy assistance allowances.
 - (1) Payments or allowances made under any federal, state or local laws for the purpose of energy assistance, e.g., Low Income Energy Assistance Program (EAP), Energy Crisis Assistance Program (ECAP), and Crisis Intervention Programs (CIP) payments.
 - (A) Such payments or allowances shall be clearly identified as energy assistance by the legislative body authorizing the program or providing the funds.

.43 The following disregards shall be applied in the order listed below:

- .431 Infrequent or irregular income.
 - (a) Unearned income.
 - (1) Unearned income which does not exceed \$60 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.
 - (b) Earned income.
 - (1) Earned income which does not exceed \$30 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.
- .432 Student exemption.
 - (a) Up to \$1,200 per calendar quarter of the earned income of the recipient who is a child and a student, but in no instance more than \$1,620 per calendar year.

30-775 **INCOME (Continued)** **30-775**

- .433 The first \$20 per month.
 - (a) The first \$20 of earned or unearned income per month not disregarded above. If the eligible individual or individual and eligible spouse has:
 - (1) Only earned income, the disregard shall be applied to that income.
 - (2) Only unearned income, the disregard shall be applied to that income.
 - (3) Both types of income, the disregard shall first be applied toward the unearned income, and any amount of the disregard remaining shall be applied to the earned income.

- .434 Earned income.
 - (a) The first \$65 per month of earned income not disregarded above plus one-half of the remainder.

- .435 Work expenses of the blind.
 - (a) Earned income not disregarded above of a blind individual in the amount of ordinary and necessary expenses related to work activity, and only to the extent that they are paid or to be paid. Broad categories of expenses shall include but not be limited to the following:
 - (1) Transportation to and from work.
 - (2) Job performance.
 - (3) Qualification for promotion.

- .436 Income necessary to achieve self-support.
 - (a) Earned or unearned income not disregarded above and received by an individual who is blind or disabled as defined in Sections 30-771.2 and .3 to the extent that such income is needed to implement a plan of self-support.

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Welfare and Institutions Code Section 12306.5 states that any public or private agency, including a contractor as defined in Welfare and Institutions Code Section 12302.1, who maintains a list or registry of prospective In-Home Supportive Services providers shall require proof of identification from a prospective provider prior to placing the prospective provider on a list or registry or supplying a name from the list or registry to an applicant for, or recipient of, In-Home Supportive Services.

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- .11 Proof of identification shall not be required for prospective providers to remain on a list or registry that existed before April 1, 1988. However, proof of identification shall be required prior to providing those prospective providers' names to an applicant or recipient of In-Home Supportive Services, or prior to providing the names of any prospective providers where proof of identification has not been established.

- .12 Proof of identification shall include, but is not limited to, one of the following:
 - .121 A positive photograph identification from a government source, such as:
 - (a) a valid California driver's license;
 - (b) a valid identification card issued by a government agency; or
 - (c) a valid military identification card.

 - .122 A valid student identification card issued by an accredited college or university.

HANDBOOK BEGINS HERE**.1 Scope of Services**

DHS regulation Section 51183 reads:

Personal Care Services.

Personal care services include (a) personal care services and (b) ancillary services prescribed in accordance with a plan of treatment.

(a) Personal care services include:

- (1) Assisting with ambulation, including walking or moving around (i.e. wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.
- (2) Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub, or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.
- (3) Dressing includes putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
- (4) Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

HANDBOOK CONTINUES

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY
(Continued)

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- (5) Repositioning, transfer, skin care, and range of motion exercises.
- (A) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, or sofa, and the like, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.
- (B) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.
- (6) Feeding, hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, manipulating food on plate. Cleaning face and hands as necessary following meal.
- (7) Assistance with self-administration of medications. Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.
- (8) Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.
- (9) Paramedical services are defined in Welfare and Institutions Code Section 12300.1 as follows:
- (A) Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

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30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY
(Continued)

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- (B) Paramedical services are activities which persons could perform for themselves but for their functional limitations.
 - (C) Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health.
- (b) Ancillary services are subject to time per task guidelines when established in Sections 30-757 of the Department of Social Services' Manual of Policies and Procedures and are limited to the following:
- (1) Domestic services are limited to the following:
 - (A) Sweeping, vacuuming, washing and waxing of floor surfaces.
 - (B) Washing kitchen counters and sinks.
 - (C) Cleaning the bathroom
 - (D) Storing food and supplies.
 - (E) Taking out the garbage.
 - (F) Dusting and picking up.
 - (G) Cleaning oven and stove.
 - (H) Cleaning and defrosting refrigerator.
 - (I) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.
 - (J) Changing bed linen.
 - (K) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

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**30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY
(Continued)****30-780**

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- (2) Laundry services include washing and drying laundry, and is limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending, or ironing, folding, and storing clothing on shelves, in closets or in drawers.
- (3) Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs; compiling a list, bending, reaching, and lifting, managing cart or basket, identifying items needed, putting items away, phoning in and picking up prescriptions, and buying clothing.
- (4) Meal preparation and cleanup including planning menus; e.g., washing, peeling and slicing vegetables; opening packages, cans and bags, mixing ingredients; lifting pots and pans; reheating food, cooking and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.
- (5) Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance is necessary to accomplish the travel limited to:
 - (A) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after staff of the designated county department has determined that no other Medi-Cal service will provide transportation in the specific case.
 - (B) Accompaniment to the site where alternative resources provide in-home supportive services to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

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- (6) Heavy Cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.
 - (7) Yard hazard abatement which is light work in the yard which may be authorized for:
 - (A) removal of high grass or weeds and rubbish when this constitutes a fire hazard.
 - (B) removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.
 - (c) Ancillary services may not be provided separately from personal care services listed in subsection (a) above.
- .2 Personal Care Services Program Tasks

DHS regulation Section 51350 reads:

Personal Care Services.

- (a) Personal care services as specified in Section 51183 are provided when authorized by the staff of a designated county department based on the state approved Uniformity Assessment tool. To the extent not inconsistent with statutes and regulations governing the Medi-Cal program, the needs assessment process shall be governed by the Department of Social Services' Manual of Policies and Procedures Sections 30-760, 30-761, and 30-763.
- (b) Personal care services may be provided only to a categorically needy beneficiary as defined in Welfare and Institutions Code, Section 14050.1, who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. The services shall be provided in the beneficiary's home or other locations as may be authorized by the Director subject to federal approval. Personal care services authorized shall not exceed 283 hours in a calendar month.

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30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY
(Continued)**30-780**

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- (c) Personal care services will be prescribed by a physician. The beneficiary's medical necessity for personal care shall be certified by a licensed physician. Physician certification shall be done annually.
- (d) Registered nurse supervision consists of review of the service plan and provision of supportive intervention. The nurse shall review each case record at least every twelve months. The nurse shall make home visits to evaluate the beneficiary's condition and the effectiveness of personal care services based on review of the case record or whenever determined as necessary by staff of a designated county department. If appropriate, the nurse shall arrange for medical follow-up. All nurse supervision activities shall be documented and signed in the case record of the beneficiary.
- (e) Paramedical services when included in the personal care plan of treatment must be ordered by a licensed health professional lawfully authorized by the State. The order shall include a statement of informed consent saying that the beneficiary has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the beneficiary, the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian.
- (f) Grooming shall exclude cutting with scissors or clipping toenails.
- (g) Menstrual care is limited to external application of sanitary napkin and cleaning. Catheter insertion, ostomy irrigation and bowel program are not bowel or bladder care but paramedical.
- (h) Repositioning, transfer skin care, and range of motion exercises have the following limitations:
 - (1) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

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**30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY
(Continued)****30-780**

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

.3 Personal Care Services Program Required Documentation

DHS regulation Section 51476.2 reads:

Personal Care Services Records.

Each county shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of personal care services provided to a Medi-Cal beneficiary. Records shall be made at or near the time the service is rendered or the assessment or other activity is performed. Such records shall include, but not be limited to the following:

- (a) Time sheets
- (b) Assessment forms and notes
- (c) All service records, care plans, and orders/prescriptions ordering personal care.

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30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780
(Continued)

- .4 Eligibility for PCSP shall be limited to those IHSS recipients who do not receive IHSS advance payment as specified in Section 30-769.731.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan amendment, Approved pursuant to Sections 12301.2 and 14132.95(b), Welfare and Institutions Code.

30-785 IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS WAIVER PROGRAM 30-785**(a) Program and Special Definitions**

- (1) The IHSS Plus Waiver program will follow the IHSS, Program Definitions and Special Definitions, specified in MPP Section 30-700 and 30-701, unless otherwise specified.

(b) Eligibility

- (1) A person is eligible for the IHSS Plus Waiver who is a California resident, living in his/her own home and is aged, blind or disabled according to Medi-Cal based definitions, and;
- (2) Has been found eligible for full-scope federally funded Medi-Cal based upon either;
- (A) receipt of cash assistance through SSI/SSP, CalWORKs cash aid or Foster Care, or
- (B) an eligibility determination completed by a Medi-Cal Eligibility Worker for full-scope federally funded Medi-Cal, in accordance with Medi-Cal regulations located at Title 22, California Code of Regulations (CCR), Division 3, Subdivision 1, Chapters 1 and 2, and;
- (3) Has an assessed need, based upon a needs assessment as described in MPP Section 30-761, and;
- (4) Receives at least one of the following;
- (A) Restaurant Meal Allowance as specified in MPP Section 30-757.134;
- (B) Advance Pay as specified in MPP Section 30-769.73;
- (C) Service(s) provided by his/her spouse as allowed in MPP Section 30-763.41; or
- (D) Service(s) as a minor child provided by his/her parent as allowed in MPP Section 30-763.45, and;

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(5) Any applicable share of cost has been met.

(A) In determining the applicable share of cost the following shall apply;

1. Medi-Cal rules regarding share of cost will be followed for purposes of determining Medi-Cal eligibility in accordance with Title 22, CCR, Division 3, Chapter 2, Articles 10, 11 and 12.
2. To the extent a recipient comes within the terms of the supplemental payment program described in Welfare and Institutions Code Section 12305.1, a share-of-cost compensation as described in that section shall be performed. The applicable share of cost for such recipients shall include the supplementary payment authorized in that section.

(c) Process for Determination of Eligibility for IHSS Plus Waiver Services

- (1) The process for determining eligibility for the IHSS Plus Waiver program shall be in accordance with MPP Section 30-755.2.

(d) Need

- (1) Designated county staff shall determine the recipient's level of ability, dependence, physical assistance and need in accordance with MPP Section 30-756.

(e) Program Content

- (1) IHSS Plus Waiver program content shall be the same as the program content expressed in MPP Section 30-757.
 - (A) A person who is eligible for a service provided pursuant to the IHSS Plus Waiver shall not be eligible for any service through the IHSS program.
 - (B) A person who is eligible for all of their services pursuant to the PCSP shall not be eligible for any service through the IHSS Plus Waiver or IHSS programs.

(f) Time Per Task and Frequency Guidelines

- (1) When assessing the need for services the assessed time shall be in accordance with MPP Section 30-758.

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(Continued)**(g) Application Process**

- (1) The IHSS Plus Waiver application process shall follow the MPP Section 30-759, except for 30-759.3.
- (2) Presumptive disability is determined in accordance with Medi-Cal regulations located at Title 22, CCR, Division 3, Section 50167(a)(1)(C).
- (3) Additionally, for those not already determined eligible for full-scope federally funded Medi-Cal, a determination for Medi-Cal eligibility must be completed before final eligibility for the IHSS Plus Waiver can be established.
- (4) Intercounty transfers of the IHSS Plus Waiver service case must be coordinated with the intercounty transfer of the Medi-Cal eligibility case.

(h) Responsibilities

- (1) IHSS Plus Waiver applicant/recipient and county responsibilities shall be the same as the responsibilities specified in MPP Section 30-760(b).

(i) Needs Assessment Standards

- (1) Services shall be authorized only in cases which meet the conditions established in MPP Section 30-761.1 and eligibility as specified in MPP Section 30-785(b).
- (2) Needs Assessments are performed in accordance with MPP Section 30-761.2, except;
 - (A) A reassessment must be completed prior to the end of the twelfth calendar month from the last assessment.
- (3) IHSS staff shall be staff of a designated county department as specified in MPP Section 30-761.3.

(j) Service Authorization

- (1) Authorization for services shall be determined in accordance with MPP Section 30-763.

(k) Individual Provider's Compensation

- (1) The computation of payment, rate of compensation and employer responsibilities for the IHSS Plus Waiver program shall follow the guidelines specified in MPP Section 30-764.

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(Continued)**(l) Cost Limitations**

- (1) The cost limitations that apply to all payments made for IHSS Plus Waiver Services shall follow the guidelines specified in MPP Section 30-765.

(m) County Plans

- (1) Each county welfare department shall develop and submit a county plan to CDSS no later than 30 days following receipt of its allocation, which specifies the means by which the IHSS Plus Waiver program will be provided in order to meet the objectives and conditions within its allocation as specified in MPP Section 30-766.

(n) Service Delivery Methods

- (1) The county shall arrange for the provision of IHSS Plus Waiver through one or more of the Service Delivery Methods as specified in MPP Sections 30-767.11, .12 and .13.

(o) Overpayment/Underpayments

- (1) For purposes of determining overpayments, action on overpayments and demand for repayment for an IHSS Plus Waiver recipient. DHS regulation Sections 50781, 50786 and 50787 (MPP Handbook Sections 30-768.5, .6 and .7) shall apply.

(p) Payrolling for Individual Providers

- (1) Counties shall follow the payrolling-for-individual-providers procedures, specified in MPP Section 30-769, for individual providers who provide services to IHSS Plus Waiver recipients.

(q) Provider Identification

- (1) Proof of provider identification shall follow the guidelines specified in IHSS, Provider Identification, MPP Section 30-776.

NOTE: Authority cited: Sections 10553, 10554, 12300, 14132.95, and 14132.951, Welfare and Institutions Code; and 42 USC, Section 1315(a) of the Social Security Act. Reference: Sections 12300, 12305.1, 14132.95, and 14132.951, Welfare and Institutions Code, and Special Terms and Conditions (STC) for the California IHSS Plus Waiver, granted under Section 1115 Demonstration Project.

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