STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY ARNOLD SCHWARZENEGGER, *Governor*

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

April 4, 2006

ALL-COUNTY INFORMATION NOTICE NO. I-21-06

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

Reason For This Transmittal

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

SUBJECT: PROTECTIVE SUPERVISION FORM (SOC 821)

REFERENCE: SENATE BILL (SB) 1104 (CHAPTER 229, STATUTES of 2004)
WELFARE AND INSTITUTIONS CODE SECTION (WIC) 12301.21

The purpose of this All-County Information Notice (ACIN) is to inform counties of the new Protective Supervision Form SOC 821, (copy attached) which can be accessed at our Forms Website address: http://www.dss.cahwnet.gov/pdf/SOC821.PDF. As part of the Quality Assurance Initiative, SB 1104 enacted WIC Section 12301.21 which requires the development of a standard form to obtain the appropriate certification for a person's need for Protective Supervision in a consistent manner statewide. The Protective Supervision form was developed by California Department of Social Services (CDSS), in conjunction with the California Welfare Directors Association (CWDA) and various other stakeholders.

The form is to be utilized at the time of the initial assessment when the county worker identifies the potential need for Protective Supervision. The county shall request that the recipient's physician or other appropriate medical professional complete the Protective Supervision form and return it to the county. The completed Protective Supervision form will be used in conjunction with other pertinent information to determine the recipient's need for Protective Supervision. In the event the Protective Supervision form fails to be returned, the county shall make its determination of need based on the available evidence.

At the time of a recipient's reassessment for receiving authorized Protective Supervision, the county worker shall determine if the Protective Supervision form is to be renewed. If the county worker determines that a renewed form is or is not necessary, the county worker shall document the basis for their determination in the recipient's case file.

Any questions regarding this form should be directed to Adult Programs Operations Bureau, Operations and Technical Assistance Unit at (916) 229-4000.

Sincerely,

Original Document Signed By:

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

Attachment

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

■ Release of Information Attached

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

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

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

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

(Welfare and Institutions Code §12301.21)

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

PLEASE CHECK THE APPROPRIATE BOXES

MEMORY

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

Explanation:____

ORIENTATION

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

Explanation:____

JUDGMENT

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

Explanation:____

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

CERTIFICATION

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

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

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