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ALL COUNTY LETTER 16-01

REASON FOR THIS TRANSMITTAL

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

TO: ALL COUNTY WELFARE DIRECTORS
IHSS PROGRAM MANAGERS

SUBJECT: **REINSTATEMENT OF IMPLEMENTATION OF PROVISIONS OF SENATE BILLS 855 AND 873 (CHAPTERS 29 AND 685, STATUTES OF 2014) RELATING TO THE IHSS AND WAIVER PERSONAL CARE SERVICES PROGRAMS**

REFERENCE: *HOME CARE ASSOCIATION OF AMERICA V. DAVID WEIL* (AUGUST 21, 2015) 799 F.3d 1084; *HOME CARE ASSOCIATION OF AMERICA V. DAVID WEIL* (DECEMBER 22, 2014) 76 F. Supp. Ed 128; *HOME CARE ASSOCIATION OF AMERICA V. DAVID WEIL* (JANUARY 14, 2015) 78 F. Supp. 3d 123; [ACL 12-19 \(APRIL 11, 2012\)](#); [ACL 12-55 \(NOVEMBER 1, 2012\)](#); [ACL 14-76 \(OCTOBER 8, 2014\)](#); [ACL 14-82 \(NOVEMBER 25, 2014\)](#); [ACL 14-102 \(DECEMBER 31, 2014\)](#); [ACIN I-73-14 \(JANUARY 5, 2015\)](#); [ACL 15-10 \(JANUARY 23, 2015\)](#); [ACL 15-97 \(DECEMBER 1, 2015\)](#); SENATE BILLS [855](#) AND [873](#);

This All-County Letter (ACL) provides counties with information and instructions for implementing the provisions of Senate Bill (SB) 855 and SB 873 that established limits on the number of authorized hours providers in the In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) programs are permitted to work in a workweek. In addition, it provides information and instructions for implementing policies requiring that IHSS and WPCS providers receive compensation for travel time and wait time under certain circumstances. Finally, this ACL transmits new and revised forms and notices to be used by counties in the implementation of the provider workweek limits and travel time compensation policies.

The information provided in this ACL supersedes the information contained in ACL 14-76 (October 8, 2014) and ACL 15-10 (January 23, 2015).

BACKGROUND

On October 1, 2013, the United States Department of Labor (DOL) published the Final Rule on the Application of the Fair Labor Standards Act (FLSA) to Domestic Service (RIN 1235-AA05). The Final Rule extends the protections of the FLSA to domestic service workers by effectively removing the ability of “third party” agencies to claim an exemption for personal care workers from minimum wage and overtime pay as providers of “companionship services” or as live-in providers. In addition, the federal rules relating to pay for travel time under FLSA are made applicable to IHSS providers, including compensation for providers traveling between multiple recipients, and the federal rules relating to pay for wait time in certain circumstances under FLSA are made applicable to IHSS providers whose recipients are authorized for medical accompaniment services. The Final Rule was scheduled to go into effect on January 1, 2015.

In response to the new federal regulations, two bills, SB 855 and SB 873, were chaptered in California on June 20, 2014, and September 27, 2014, respectively. These bills relate to overtime and travel time compensation for IHSS providers. The provisions of these bills are documented in ACL 14-76 (October 8, 2014).

On December 22, 2014 and January 14, 2015, the United States District Court for the District of Columbia vacated the Final Rule insofar as it 1) precluded third-party employers from claiming applicable wage and overtime exemptions for services provided by live-in providers and employees performing companionship services and 2) revised the definition of companionship services (*Home Care Association of America v. David Weil* (2014) 76 F. Supp. 3d 128 and *Home Care Association of America v. David Weil* (2015) 78 F. Supp. 3d 123). As a result of the District Court’s decision, on January 15, 2015, California Department of Social Services (CDSS) announced a halt to the implementation of the changes related to workweek, overtime, and travel time requirements for all IHSS providers which had been initially scheduled to go into effect on January 1, 2015, pursuant to the requirements of SB 855 and SB 873.

On August 21, 2015, the Appellate Court for the District of Columbia Circuit reversed the District Court’s decisions (*Home Care Association of America v. David Weil* (2015) 799 F. 3d 1084). This decision effectively reinstated the final rule described above adopted by DOL. As a result of this reversal, CDSS is reinstating implementation of the workweek, overtime, and travel time requirements for IHSS providers in the State of California.

On November 6, 2015, the State announced that the payment of overtime, travel time, and wait time compensation to providers of IHSS and WPCS would be implemented as of February 1, 2016. On November 19, 2015, the NAHC filed a Writ of Certiorari with the U.S. Supreme Court to request the Court to review the appeal.

The Supreme Court review of the appeal is entirely discretionary, and no announcement has yet been made on the Court's decision to review the case.

IMPLEMENTATION OF OVERTIME AND WAIT TIME COMPENSATION

As of February 1, 2016, IHSS/WPCS providers will be paid overtime, at a rate equal to one and one-half times the regular rate of hourly pay, when their time worked exceeds 40 hours per workweek. The term "workweek" is defined in statute as the period beginning at 12:00 a.m. on Sunday and including the next consecutive 168 hours, terminating at 11:59 p.m. the following Saturday.

Likewise, as of February 1, 2016, IHSS providers will be paid for travel time when the provider works for multiple recipients and is required to travel from one job site directly to another job site during the same workday. A provider will not be compensated for travel to and from his/her home to any IHSS recipient's location.

Additionally, as of February 1, 2016, IHSS providers may be paid for certain periods of wait time. The DOL provides two definitions for the different types of wait time: time spent engaged to wait and time spent waiting to be engaged.

- "Engaged to wait" means that the provider is not performing work duties but he/she is unable to use the time effectively for his/her own purposes. These periods of time are generally unpredictable and usually of short duration. The wait time is an integral part of the job; it belongs to and is controlled by the recipient.
- "Waiting to be engaged" means that the provider is completely relieved from performing work duties and he/she has enough time to enable him/her to use the time effectively for his/her own purposes. The provider must be informed in advance that he/she may leave the job and that he/she will not have to resume work until a specified time.

The FLSA rules require employers to pay an employee for time he/she spends "engaged to wait"; however, an employee is not required to be compensated for time he/she spends "waiting to be engaged." In order to better comprehend these terms within the ACL, the term "engaged to wait" will hereafter be referred to as "Wait Time—On Duty," and the term "waiting to be engaged" will hereafter be referred to as "Wait Time—Off Duty."

In the IHSS program wait time associated with medical accompaniment may be eligible for compensation as "Wait Time—On Duty." This will be discussed in reference to medical accompaniment services later in this ACL.

Although compensation for overtime, travel time, and wait time will be implemented on February 1, 2016, assessment of violations and penalties for violating workweek and travel time limits will not be enforced until May 1, 2016. Information regarding violations and the county review process will be discussed in a forthcoming ACL.

Calculation Of Maximum Weekly Hours And Overtime Workweek Requirements

Welfare and Institutions Code (WIC) section 12300.4 limits how many hours an IHSS provider may work in any workweek. WIC section 12301.1 further requires each IHSS recipient to have their monthly authorized hours converted into a maximum number of weekly hours that can be distributed to his/her provider(s). Effective February 1, 2016, this maximum number of weekly hours will be calculated by dividing the total number of the recipient's monthly authorized hours by four (4). This calculation was designated because it was determined to be the most efficient method to ensure that the IHSS recipient would receive all of his/her authorized monthly hours regardless of the number of days within the month itself.

This calculation is merely a guideline to inform the recipient the maximum number of hours his/her provider(s) can work in a workweek which will assist the recipient in effectively budgeting his/her service hours to ensure all of his/her monthly hours are received. However, since most months are slightly longer than four weeks, the recipient will need to allocate his/her authorized monthly hours throughout the month to ensure he/she has enough hours to cover his/her authorized services until the end of the month. This allocation does not represent a change in the current process insofar as recipients are currently required to properly allocate their monthly authorized hours throughout the month to ensure that they receive all of their authorized services, regardless of the number of days or weeks within the month. This means that for most months, the recipient will not use their entire maximum weekly hours allocation each week. The weekly hours calculation is most critical for those recipients whose maximum weekly hours exceed 40 hours in the workweek as this will determine that the recipient's workweek schedule has the potential to include overtime hours for his/her provider(s).

The maximum number of hours an IHSS provider can claim on his/her timesheet depends on the number of recipients for whom the provider works. In no case can a provider claim more hours working for a recipient than that recipient is authorized in a month. Some scenarios follow:

- **Single provider working for a single recipient:** The maximum hours the provider may work in a workweek is the recipient's maximum weekly hours (if a recipient is authorized to receive the maximum number of hours per month allowed in the IHSS program (283 hours), his/her provider would be able to work maximum weekly hours of 70.75 hours. (283 divided by 4 = 70.75)).

Example: Jack works for Sarah. He is working for no other recipients, and she has no other providers working for her. Sarah has 156 authorized monthly hours which, when divided by four, equal 39 weekly hours. Therefore, the maximum hours Jack may work in a workweek is 39 hours, Sarah's maximum weekly hours. Sarah will budget all of her hours regardless of the number of days in the month to ensure complete coverage of her authorized hours and services throughout the month.

- **Multiple providers working for a single recipient:** The maximum weekly hours may be divided amongst the providers in any manner the recipient sees fit as long as the total hours of all providers combined in a week do not exceed the recipient's maximum weekly hours (if a recipient is authorized to receive the maximum number of hours per month allowed in the IHSS program (283 hours), the total amount of time all of his/her providers would be able to work combined is the maximum weekly hours of 70.75 hours).

Example: Recipient Nicole has two providers working for her: Steve and Kelly. Nicole has 220 authorized monthly hours which, when divided by four, equal 55 weekly hours. Nicole may divide those total weekly hours between Steve and Kelly in any way she sees fit. For example, Nicole may decide to give Steve 30 hours per week and give Kelly 25 hours per week. Nicole will budget all of her hours regardless of the number of days in the month to ensure complete coverage of her authorized hours and services throughout the month.

- **Single provider working for multiple recipients:** The maximum number of hours that the provider may claim in a workweek for all of the time he/she works for his/her recipients combined is 66 hours.

Example: David works as a provider for Peter and Denise. Peter has 100 authorized monthly hours which, when divided by four, equal 25 weekly hours. Denise has 200 authorized monthly hours which, when divided by four, equal 50 weekly hours. Since David works for two recipients, he can only work a maximum of 66 hours per workweek. Since Peter and Denise's maximum weekly hours equal 75 hours, David can only work 66 of those hours and another provider will have to be hired to work the additional 9 weekly hours. Peter and Denise will budget all of their hours regardless of the number of days in the month to ensure complete coverage of their authorized hours and services throughout the month.

There is no change in the process for how a provider completes a recipient's monthly authorized hours if a month begins or ends in the middle of a workweek. When the new month begins in the middle of the week, the provider may finish working the authorized monthly hours in the first month. When the next month begins, the recipient's hours

reset and the provider can begin providing authorized services for that month. The hours worked in the week between the two months must be worked in accordance with the recipient's maximum weekly hours and the workweek agreement discussed below.

Workweek Agreements

Welfare and Institutions Code section 12300.4(b)(4)(A) requires that a provider inform each of his/her recipients of the number of hours he/she is available to work for that recipient. CDSS has created the IHSS Program Recipient and Provider Workweek Agreement (SOC 2256) to serve as a tool to assist those recipients with multiple providers to establish a work schedule that complies with the recipient's maximum weekly hours. Additionally, the workweek agreement ensures that there will be a sufficient number of providers to serve the recipient's authorized monthly hours. The SOC 2256 is only necessary if a recipient has multiple providers and must be completed and signed by the recipient and each of his/her providers. It will document the number of hours each provider will provide authorized services for the recipient each workweek. The total number of hours in the workweek agreement must correspond to the recipient's maximum weekly hours. It should be noted that the workweek agreement is a guideline and a recipient may choose to have his/her providers work different hours within the week as long as the providers stay within the recipient's maximum weekly hours and under 66 hours if the provider works for multiple recipients.

Additionally, CDSS has created the IHSS Program Provider Workweek and Travel Agreement (SOC 2255) to assist IHSS providers who work for multiple recipients on the same day with establishing a work schedule in order to stay within the maximum workweek limit of 66 hours. Providers who work for multiple recipients on the same day and travel between locations to provide IHSS to those recipients should be advised that the SOC 2255 must be completed in order for him/her to be compensated for his/her travel time. The SOC 2255 includes the travel time section in Part B, which requires the provider to indicate the names of the recipients he/she is providing services to, as well as the addresses and the estimated travel time. Without this information, payment for travel time cannot be processed. If the SOC 2255 form is not completed and submitted to the county IHSS office for processing, the provider will not be paid for any travel time he/she may be compensated for until after the form is submitted.

Once the SOC 2255 or SOC 2256 is completed and submitted to the county, it is not necessary to update the form whenever the work schedule needs to be temporarily adjusted due to a change in circumstances. The SOC 2255 only needs to be updated and resubmitted when a change in providers and/or circumstances cause a permanent change in any provider's work schedule. The county should work with the recipient to obtain the SOC 2256 whenever a permanent change in any of the information contained on the form is needed and may be able to coordinate the receipt of the corrected SOC 2256 at reassessment.

Notification Of Maximum Weekly Hours (Soc 2271 And Soc 2271a)

In order to assist a recipient to schedule his/her provider(s)'s weekly hours, he/she will receive the IHSS Program Recipient Notice of Maximum Weekly Hours (SOC 2271A) which will inform the recipient of his/her maximum weekly hours. Each provider of an IHSS recipient will be informed of his/her recipient's maximum weekly hours and the services he/she may provide via the IHSS Program Provider Notice of Recipient Authorized Hours and Services (SOC 2271). Both of these documents will be issued beginning February 1, 2016, and will be used by both the recipient and provider to aid in establishing the weekly work schedule of the provider(s). Recipients and providers will receive these notifications whenever there is a change in the recipient's authorized monthly hours, coinciding with the release of the Notice of Action informing the recipient of the change in hours and/or whenever a new service is added or a service is eliminated.

Adjusting Recipient's Maximum Weekly Hours

On occasion, it may be necessary for a recipient to authorize his/her provider to work more than the recipient's maximum weekly hours as identified on the SOC 2271A. The recipient may make such an authorization without requesting approval from the county as long as the hours worked:

- **Do not result in the provider working more than 40 hours in a workweek when the recipient is authorized 40 hours or less in a workweek; or**

Example: Provider Steve works 30 weekly hours providing services for his recipient Nicole. One week Nicole gets sick and requires Steve to remain for an extra two hours to assist her. Because the increase in hours will only increase his weekly hours (for that week) to 32 hours and does not result in hours over 40, Nicole does not need to request approval from the county to adjust Steve's schedule.

- **Do not result in the provider receiving more overtime hours than he/she normally works in a calendar month;**

Example: Provider Jack works 45 weekly hours providing services for his recipient Sarah (a total of 20 hours overtime in the month). One week Sarah requests Jack to work an additional two hours to assist her. She tells him that she will adjust his work schedule in the next week so that he works two less hours that week to make up the time and to keep him from working over her monthly authorized hours. Jack normally has 10 overtime hours in the two week period. By increasing Jack's hours in the first week to 47 and reducing his hours down in the following week to 43 and having Jack work his regular schedule for

the remainder of the month, Sarah maintains Jack's overtime hours to 10 hours for the two week period. Therefore, Sarah does not need to request approval from the county to adjust Jack's schedule.

However, if Sarah requests Jack to work an additional fifteen hours in the first week for a total of 60 hours and adjusts his work schedule in the following weeks so that he works 43 hours in the 2nd week and then 37 hours and 40 hours in the remaining weeks, then Jack would work 3 hours more overtime than he normally works in a calendar month. Therefore, Sarah would need to call the county for approval because Jack would be working 23 hours of overtime when he normally works 20 overtime hours in the calendar month.

- **And do not result in a provider working for multiple recipients working more than the maximum weekly limit of 66 hours.**

Example: David works a total of 65 hours providing services for his recipients Peter and Denise. In one week, Denise needs David to work an additional hour and tells him she will adjust his weekly hours the following week so that he works 1 hour less for her. Since David works for 2 recipients, the maximum number of hours he can work per week is 66 hours. Denise's request will not exceed the 66 hour limit; therefore, Denise does not need to request approval from the county to adjust David's schedule. However, David will have to work one less hour in another week to ensure that he does not work more overtime than he normally does in a calendar month.

In a situation in which a recipient has more than one provider and one of the providers becomes ill or is otherwise unable to work in a given week, the recipient can assign some or all of his/her weekly hours to the other provider, even if this would cause that provider to work overtime. This recipient may do so without requesting approval from the county as long as the hours worked by the single provider do not cause him/her to work more than the recipient's maximum weekly hours or, if the provider works for more than one recipient, causes him/her to work in excess of 66 hours in the workweek.

Example: Recipient Nicole has two providers working for her: Nicole has 220 authorized monthly hours which, when divided by four, equal 55 weekly hours. Normally, Steve works 30 hours per week for Nicole and Kelly works 25 hours a week for Nicole. However, one week, Kelly gets sick and cannot work. Nicole assigns Kelly's 25 hours to Steve, raising his weekly work hours to 55. Because Steve's temporary 55-hour workweek does not exceed Nicole's maximum weekly hours of 55 hours, Nicole does not need to request permission from the county to temporarily increase Steve's weekly work hours in this way. However, if Steve works for another recipient, he will only be able to accept the additional hours from Nicole if he works 11 hours or less for

his other recipient. If he works more than 11 hours for his other recipient, Steve will have to decline the additional hours (causing Nicole to have to hire another temporary provider to work Kelly's hours until she is able to return to work) or he will have to reduce the number of hours he works for his other recipient to keep his weekly work hours at 66 hours or less.

As required under statute, and consistent with current recipient practice, a recipient is assessed for his/her needs and then authorized a monthly service amount based on this need. As such, a recipient can never authorize any provider to work more than his/her total authorized monthly services hours. Therefore, when a recipient authorizes a provider to work extra hours during a week, he/she must have that provider work fewer hours in the other week(s) of the same calendar month to ensure that the provider does not work more than his/her authorized monthly service hours.

Overtime Approval/Exception Process

Effective February 1, 2016, if a recipient needs his/her provider to work more than the recipient's maximum weekly hours and the work performed will not meet one of the criteria in the previous section, the recipient will be required to contact the county to obtain a one-time exception to allow the provider to work the additional overtime hours.

An exception thus is defined as a request by an IHSS recipient to a county to allow the recipient to adjust his/her maximum weekly hours to allow his/her provider to work additional hours during a particular workweek, which may cause the provider to work and be compensated for additional overtime hours within a calendar month.

Counties shall utilize the following criteria to determine whether to approve an exception request:

- a) The additional hours must be necessary to meet an unanticipated need;
- b) The additional hours must be related to an immediate need that cannot be postponed until the arrival of a back-up provider as designated on the IHSS Program Individual Emergency Back-Up Plan (SOC 827) form; and
- c) The additional hours must be related to a need that would have a direct impact on the IHSS recipient and would be needed to ensure his/her health and/or safety.

If the exception request meets all of the above criteria, the county shall approve the request; otherwise, the county shall deny it. WIC section 12301.1(b)(1)(C) states that the county, "...shall not unreasonably withhold approval..." of an exception request.

Examples of an acceptable exception request include, but are not limited to:

- An unforeseen situation (such as an illness) occurs which requires the provider to furnish more of an authorized service to the recipient than would otherwise be required during a typical workweek (for example, extra laundry services to clean soiled linen or clothing; extra bowel and bladder care; etc.);
- Malfunctioning of a piece of medical equipment (such as a mechanical wheelchair, breathing apparatus, etc.) requires the provider to drive to a medical office to get the equipment repaired or replaced, increasing his/her authorized hours for shopping/other errands.

Examples of an exception request that does not meet all of the above referenced criteria include, but are not limited to:

- The provider wants to work additional hours during a given week in order to take time off for personal business or vacation the following week;
- The recipient requests the provider to work additional hours to complete an authorized service during a particular workweek rather than in another workweek for a reason which does not concern a medical necessity and will have no impact on the health and/or safety of the recipient (for example, the recipient wants all of the vacuuming and dusting done in one week rather than spread over two weeks with no medical necessity for doing so).

An IHSS recipient seeking an exception must make the request either prior to the event which caused the need for the exception request or as soon as safely possible afterwards in order to avoid endangering the health and safety of the recipient. Counties should advise recipients to make the request prior to the submission of the timesheet for the pay period in which the adjusted workweek occurred to ensure the provider is paid appropriately and timely.

In the event an IHSS recipient who has an authorized representative is unable to contact the county IHSS office, the recipient's authorized representative may contact the county to initiate the exception request. However, if the recipient's authorized representative is the provider for whom the exception is being requested, he/she is not permitted to contact the county on behalf of the recipient to make the exception request unless he/she is the parent, guardian, or person having legal custody of a minor recipient or the conservator, spouse, or registered domestic partner of an adult recipient. Documentation of the relationship between the recipient and the provider can be established by referring to the information entered in the Provider's Relationship to Recipient field (item #8) on the IHSS Program Recipient Designation of Provider form (SOC 426A). This is consistent with the statutory requirements related to providers

acting as authorized representatives for their recipients being unable to sign individual waivers to allow the providers to work for the recipients despite disqualifying felony convictions (as stated in ACL 12-19, dated April 11, 2012).

An IHSS recipient seeking an exception may contact the county to make the request via telephone or written correspondence. If the request is made via telephone, the county IHSS staff may approve or deny the exception request immediately while speaking with the recipient. Regardless of the method employed, the county IHSS staff must document the exception request in the Case Management, Information, and Payrolling System II (CMIPS II). An automatic approval/denial response letter will be generated that will be sent to both the recipient and the provider(s) within ten calendar days of the receipt of the exception request.

If the county approves the exception request, the recipient will be sent the IHSS Program Notice to Recipient Approval of Exception to Exceed Weekly Hours (SOC 2266) and the provider(s) will receive the IHSS Program Notice to Provider Approval of Exception to Exceed Weekly Hours (SOC 2266A). Each of these notices will remind the recipient and provider(s) that the provider(s) will need to adjust their hours before the end of the calendar month to avoid exceeding the recipient's monthly authorized hours.

If the county denies the exception request, the recipient will be sent the IHSS Program Notice to Recipient Denial of Exception to Exceed Weekly Hours (SOC 2267), and the provider(s) will be sent the IHSS Program Notice to Provider Denial of Exception to Exceed Weekly Hours (SOC 2267A). The SOC 2267 will provide details for the recipient explaining why the exception request was denied. The notices also inform both the recipient and the provider(s) that if the hours have already been worked and documented on the provider's timesheet that the hours will be paid but a violation will be assessed against the provider. Like the SOC 2266/2266A, these notices also remind the provider(s) and recipient that the hours claimed by one or more providers (if the denied exception hours were worked) will need to be adjusted later in the same calendar month to avoid exceeding the recipient's monthly authorized hours.

If the recipient or his/her authorized representative did not seek approval and the provider worked extra hours and documented the hours on his/her timesheet, when the timesheet is submitted for processing and payment to the Timesheet Processing Facility (TPF), the payment will be processed. However, CMIPS II will be triggered to send a notification to the county IHSS office informing that office of the additional hours worked by the provider. Within five business days after receiving the notification from the TPF, the county IHSS office has the option to review the circumstances and to determine whether or not county approval of the adjustment was necessary and, if county approval was needed, to contact the recipient to discuss the reason the additional hours were worked to determine whether or not it meets the criteria for an exception.

If the additional hours were worked and claimed on the Part A timesheet (covering the first fifteen days of the month), the county has the option of waiting until the submission of the Part B timesheet (covering the time period from the 16th day of the month until the final day of the month) to determine if the excess hours claimed in the Part A timesheet were properly adjusted during the second half of the month.

If the county chooses to review the circumstances that led to the additional hours being worked and determines that the circumstances warrant approval of the exception, the county can manually grant the exception request in the CMIPS II system and cancel the processing of the violation.

If the county chooses not to review or is unable to determine the circumstances that led to the additional hours being worked, after five days from when the notification was sent by the TPF, a violation will be automatically sent to the provider and an informational notice regarding the violation will be sent to the recipient. At that time, the provider may contact the county IHSS office within ten calendar days of the date on the violation notification to request an official county review of the circumstances and the subsequent violation. If the county determines that the circumstances warrant an exception, the violation against the provider will be rescinded.

If the recipient or his/her authorized representative did seek approval for the extra hours and the approval was denied but the provider worked the hours and documented them on his/her timesheet, when the timesheet is submitted for processing for payment to the TPF, the payment will be processed and a violation notice will be automatically sent to the provider and an informational notice regarding the violation will be sent to the recipient.

Policies and procedures regarding violations, including the county dispute and state administrative review process will be addressed in a forthcoming ACL.

Approval For Recurring Needs

Pursuant to WIC section 12301.1(b)(1)(A), a county IHSS office may adjust the weekly hours of a recipient for any particular week for known recurring or periodic needs of the recipient. Effective February 1, 2016, in situations in which the county becomes aware during a recipient's assessment, or any time thereafter, of a recipient's recurring need that requires an adjustment of his/her weekly hours, the county can adjust the recipient's weekly hours and issue an IHSS Notice to Recipient Approval for Provider to Work Alternate Schedule Due to Recurring Event notice (SOC 2268) which will detail the adjustment to his/her weekly hours. A similar notice, the IHSS Program Notice to Provider Approval to Work Alternate Schedule Due to Recurring Event (SOC 2269) will be sent to the provider(s) informing him/her of the adjustment in the recipient's weekly

hours. Counties are advised to annotate the recipient case file to indicate the reason for the recurring need that requires the adjustment of the weekly hours. Additionally, the county should set forth a date as to when an evaluation may be necessary to determine if the recipient's needs have changed and the exception is no longer warranted.

Travel Time

Beginning February 1, 2016, if a provider works for more than one recipient at different locations on the same day, he/she will be eligible to be paid for time spent traveling between the two recipients, up to seven hours per workweek.

Travel time payment covers the time it takes the provider to travel directly from the location where he/she provides services for one recipient to another location where he/she provides services for a different recipient on the same day. Travel time does not include the time it takes the provider to travel from his/her own home to the location where he/she provides services for a recipient or back home after the work is completed. However, if the provider provides services to a recipient in the provider's own home and then travels to another location to provide services to another recipient, the provider can claim travel time for the time it takes to travel from his/her home to the second location where he/she provides services. However, the provider will not be compensated for the time it takes to travel from the second recipient's home back to his own home after the services have been provided.

Example: David lives with his brother Peter and provides both Peter and their sister Denise with services as their provider. Denise lives in her own home 45 minutes from David and Peter's home. Since David provides services to both Peter and Denise each day, he may claim 5 hours, 15 minutes (45 minutes per day), of travel time each week for traveling from his own home (where he provides services to Peter) to Denise's home (where he provides services to her).

The provider will get paid for actual travel time regardless of the method of travel used (driving a car, taking public transit, walking, riding a bicycle). The cost of the travel (gas, bus fare, etc.) is not compensable.

The provider is responsible for keeping track of his/her travel time each week so that he/she can report it on the travel claim form. The time spent traveling between recipient locations does not count toward the provider's maximum weekly hours of 66 hours or the recipient's maximum weekly hours and is not deducted from any recipient's monthly authorized hours.

To calculate the wage rate when traveling from a recipient in one county to a recipient in another county, the provider must indicate on the travel claim form which recipient

he/she is traveling to since the wage rate for that travel will be determined by the destination county.

Example: David works for two recipients, Peter and Denise, each day. Peter lives in Tulare County (with a wage rate of \$9.00 per hour), and Denise lives in Fresno County (with a wage rate of \$10.25). It takes him 45 minutes a day to drive from Peter's house to Denise's house. Because David is traveling to Fresno County from Tulare County, David gets the Fresno County wage rate of \$10.25 when determining the travel wage rate.

If the provider's claimed travel time adds up to more than seven hours per workweek, the county is required to work with the provider to rearrange the provider's work schedule to ensure his/her claimed travel time is no more than seven hours per workweek. If the provider submits a travel claim form claiming travel time of more than seven hours in a workweek, he/she will get paid for the travel time claimed but will be assessed a violation.

Once the SOC 2255 has been received by the county IHSS office and entered into CMIPS II, if information from "Part B. Travel Time" has been entered, the system will automatically generate a request for a Travel Claim Form to be sent to the provider from the Centralized Print Vendor at the Employment Development Department (EDD). After that point, each time a timesheet is sent to the provider, it will be accompanied by a Travel Claim Form. The timesheet and Travel Claim Form must be sent in a single envelope to the TPF.

Once received, the Travel Claim Form will be evaluated to ensure it conforms with the information provided by the provider in the "Part B. Travel Time" section of the SOC 2255. Payment of travel time will be made, as applicable, beginning February 1, 2016.

Wait Time

Providers will be eligible as of February 1, 2016, to receive payment for wait time associated with medical accompaniment. In order to determine whether wait time is compensable, a distinction will need to be made whether the provider is using "Wait Time—On Duty" or he/she is using "Wait Time—Off Duty."

During periods when the provider is using "Wait Time—On Duty," he/she may not be actively performing authorized services but he/she cannot effectively use the time for his/her own purposes because the time is unpredictable and of unknown duration. The provider must be paid for time he/she spends in "Wait Time—On Duty." An example of time spent in "Wait Time—On Duty" would be when a provider accompanies a recipient

to a medical appointment of unknown duration and the provider is required to remain at the medical office because, at any moment, he/she may be called upon to assist the recipient with returning to his/her home.

However, if the provider is informed in advance that he/she is relieved from performing work duties for a specified and generally longer period of time during which he/she is free to engage in his/her own personal business, he/she is considered to be using "Wait Time—Off Duty." Time spent in "Wait Time—Off Duty" is not compensable. An example of time spent in "Wait Time—Off Duty" would be when a provider accompanies a recipient to a hemodialysis treatment that is scheduled to last for three hours. In such a case, the provider would be informed that he/she is not required to remain on the premises and that he/she need not return to retrieve the recipient until the designated time. He/she could use the time to conduct his/her own personal business or engage in personal activities, and this time would not be considered work hours for which he/she would be required to be compensated.

When a recipient is authorized for medical accompaniment, if all of the following conditions are met, his/her provider will be considered to be **"Wait Time—Off Duty" (which means the time spent waiting will not be compensable and time will not be added to the service of medical accompaniment to account for this):**

- The duration of the recipient's appointment is known in advance which would allow the provider ample notification that he/she will not be needed to provide services for a specific period of time which can then be used for his/her own purposes;
- The appointment is scheduled to last a sufficient length of time for the provider to engage in personal business or activities; and
- The provider is not required to perform any other authorized service, e.g., food shopping, other shopping/errands, during the duration of the appointment.

If these conditions are met, the provider must be informed by the recipient that he/she is relieved of his/her duties until a specified time when he/she is to return to accompany the recipient home. He/she will not be paid for this time. If all of the above conditions are not met, the provider will be considered to be participating in "Wait Time—On Duty," and he/she must be paid for the time he/she spends waiting for the recipient.

Further guidelines for the authorization of wait time during authorized medical accompaniment have been set forth in ACL 14-82 (November 25, 2014). The processes and procedures outlined in that ACL must continue to be utilized by the county when authorizing wait time.

As directed in ACL 14-82, to authorize wait time, the county Social Worker will assess the recipient by phone or in person by asking how frequently he/she has medical or

other health-related appointments, the purpose of the appointments, and if accompaniment by an IHSS provider is needed during travel to or from the appointments.

In order to assist the county Social Worker in collecting information needed for the authorization of medical accompaniment and wait time, counties must use the procedures established in ACL 14-82 to make telephone contact with the recipient directly or may utilize the IHSS Program Accompaniment to Medical Appointment form (SOC 2274) to obtain the required information from the recipient's Licensed Healthcare Practitioner by phone, fax, or mail. The SOC 2274 can be obtained through the CDSS website at <http://www.dss.cahwnet.gov/cdssweb/PG183.htm>.

Counties currently are in the process of reviewing IHSS cases with medical accompaniment and counties should complete the evaluation of the cases as soon as administratively feasible. As cases are reassessed and wait time is authorized under medical accompaniment, counties will be responsible for ensuring that time is authorized in compliance with the statutory maximum of 283 hours per month and that the weekly maximum limits are not exceeded.

COUNTY RESPONSIBILITIES

As of February 1, 2016, counties will be responsible for implementing and enforcing the workweek, overtime, and travel time requirements. The counties are also required to provide recipients and providers with the necessary information so that they understand their responsibility to not schedule or perform authorized IHSS work for more than the weekly maximum hours and to not exceed the limits on travel time between recipients on the same day. While consequences for violating overtime and travel time limits do not become effective until May 1, 2016, counties will need to review circumstances in which recipients and providers exceed the overtime and travel time limits and counsel recipients and providers as necessary so they can make adjustments to their workweek schedules to prevent any further occurrences. Counties must also develop a process to assist recipients and providers in preparing the workweek agreement and completing the workweek agreement forms (SOC 2255 and SOC 2256). Further, pursuant to WIC sections 12300.4(f)(5) and 12301.1(b)(2)(D), counties must provide technical assistance to recipients and providers to ensure that providers do not exceed the seven-hour per week limit on travel time and must discuss changes to the workweek agreement at reassessment and as necessary. County IHSS offices will have the capability to enter information from those forms into the CMIPS II system beginning January 25, 2016.

Required Recipient Form

Counties must establish procedures to ensure that each current recipient understands the new workweek, overtime, and travel time requirements and submits an IHSS

Program Overtime and Workweek Requirements Recipient Declaration (TEMP 3000) to that effect.

Counties are required to obtain the signed TEMP 3000 as soon as administratively feasible, but no later than the next regularly scheduled reassessment after the implementation date of February 1, 2016. Counties must provide the recipient with a copy of the signed TEMP 3000 form for his/her own records and retain the original in the recipient's case file.

Newly eligible recipients will instead complete and sign the revised IHSS Program Recipient Designation of Provider (SOC 426A) form which includes information about the new workweek, overtime, and travel time requirements similar to the TEMP 3000.

Required Provider Form

Counties must establish procedures to ensure that each currently-enrolled provider submits a newly signed Provider Enrollment Agreement (SOC 846) form. The county must provide a copy of the signed SOC 846 form to the provider for his/her own records and retain the original in the provider's file. The ability of the county IHSS office to indicate in the CMIPS II system that the SOC 846 has been received will be available on January 25, 2016.

If a currently-enrolled provider fails to submit the SOC 846 to the county postmarked by April 15, 2016, the provider shall be automatically terminated by CMIPS II effective May 1, 2016. The provider will be notified of this termination via the IHSS Notice to Applicant Provider of Provider Ineligibility, Incomplete Provider Process (SOC 851, Rev. 1/11), and the recipient will be notified via the IHSS Notice to Recipient of Provider Ineligibility, Incomplete Provider Process (SOC 855, Rev. 1/11).

A currently-enrolled provider terminated for failing to submit a newly signed SOC 846 may be reinstated if he/she submits the completed and signed form within 30 calendar days of the termination date (May 1, 2016), and he/she can be paid retroactively for any authorized services he/she provided to eligible recipients during that period he/she was terminated.

If a terminated provider submits the signed SOC 846 on or after June 1, 2016, he/she may be reinstated but will not be eligible for retroactive pay and will be paid only for authorized services provided on or after the date received.

Technical Support for Recipients with Multiple Providers and for Providers with Multiple Recipients

Counties must follow-up with recipients who employ multiple providers who fail to submit the SOC 2256 timely to determine whether these individuals understand the new workweek limits and provide any needed assistance in negotiating workweek agreements with their providers. If the recipient has failed to complete and submit the SOC 2256 to the county by March 15, 2016, he/she will be sent the IHSS Program Notice to Recipient Failure to Complete Workweek Agreement (SOC 2270) to inform him/her of the necessity to complete and submit the document to the county IHSS office. When the SOC 2256 is received, counties must provide copies of the signed form to the recipient and each of the providers.

Counties must establish procedures to ensure that each provider with multiple recipients submits the SOC 2255. The county must provide a copy of the signed SOC 2255 form to the provider for his/her own records and retain the original in the provider's file. The county must review the SOC 2255 to ensure that it has been completed and signed by the provider. The county may use a web-based mapping service application (e.g., Google Maps, Bing Maps, MapQuest, etc.) and/or other methods (e.g., public transit schedules/timetables) to determine whether the travel times the provider has provided for travel between service locations are reasonable. In making this determination, the county must take into consideration the mode of transit being used; traffic patterns; seasonal issues affecting road conditions, such as snow/ice; and any other factors that may impact the amount of time required to travel between the service locations. If the county review determines that the travel time documented by the provider in the SOC 2255 will be in excess of seven hours per workweek or is not reasonable given the circumstances associated with the travel, the county should discuss alternatives with the provider to reduce his/her weekly travel time below seven hours. If a provider fails to submit the SOC 2255 to the county, the provider shall not be eligible to receive compensation for travel time until the form is submitted to the county IHSS office. If, after the SOC 2255 has been accepted by the county, a provider, on multiple occasions, submits travel time claim forms reporting actual travel times that exceed the estimated travel time he/she provided on the SOC 2255, the county must contact the provider to determine the reason the provider is claiming more travel time than he/she estimated. If, in discussing the issue with the provider, the county determines that the circumstances the provider based his/her estimated travel time on have changed, the county must require the provider to complete a new SOC 2255 with the corrected travel time information.

STATE RESPONSIBILITIES

Informing Notices to Providers

CDSS developed informational notices to provide the new workweek, overtime and travel time requirements to all current IHSS providers and recipients via an informative notice (TEMP 3001 for Providers and TEMP 3002 for Recipients). The mailing of these notices to providers and recipients began on December 5, 2015.

The TEMP 3001 included the SOC 846 and instructed providers that they must sign the revised SOC 846 and submit it to the IHSS county office for processing no later than April 15, 2016. Providers who fail to return the signed SOC 846 to the county (postmarked by April 15, 2016) will be terminated as of May 1, 2016.

The State also will be responsible for sending out the SOC 2255 and SOC 2256 notices to the appropriate providers with multiple recipients and recipients with multiple providers. These notices will be sent out with the accompanying Notifications of Maximum Weekly Hours (SOC 2271 and SOC 2271A) at the beginning of February 2016.

New and Revised Forms and Notices

CDSS has revised existing forms and developed new forms and notices for use by counties in implementing the new workweek, overtime, and travel time requirements. The attached table provides the numbers, titles and intended uses of the new and revised forms and notices.

Counties should begin using the new and revised forms as of the date of this ACL. The new and revised forms, which are designated as "Required – No Substitutes Permitted," are available in camera-ready format on the CDSS Forms/Brochures web page at:

<http://www.dss.cahwnet.gov/cdssweb/PG183.htm>

Upon completion of translations, CDSS will post Armenian, Chinese and Spanish versions of the forms on the Translated Forms and Publications web page at:

http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm

The designated Forms Coordinator for your county must distribute translated forms to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English or limited-English proficient populations, as required by the Dymally-Alatorre Bilingual Services Act (California Government Code

section 7290 et seq.) and by state regulation (CDSS Manual of Policies and Procedures Division 21, Civil Rights Nondiscrimination, section 115).

Questions about accessing the forms may be directed to the Forms Management Unit at fmudss@dss.ca.gov. Questions about translations may be directed to the Language Services Unit at LTS@dss.ca.gov.

FORTHCOMING ACLs/ACINs

This ACL is the second in a series of ACLs and ACINs that will be transmitted to provide additional information and instructions for implementing the new overtime and travel time compensation policies. In the coming months, CDSS will release ACLs/ACINs to address the following issues:

- Changes to CMIPS II system functionality
- Further guidance on implementation and tracking of violations for exceeding workweek and travel time limitations
- Release of new recipient and provider training materials, including an informational video and workbook, in addition to revised Provider Orientation materials.

Questions or requests for clarification regarding the information in this letter should be directed to the Policy and Operations Bureau, Adult Programs Division at (916) 651-5350.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Attachments

c: CWDA