STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-0181

December 16, 1981

ALL-COUNTY LETTER NO. 81-128

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IHSS NOTICE OF ACTION FOR ELIMINATION OF COMFORT

REFERENCE: MPP 30-450

This Department has developed IHSS Notices of action for recipients whose services have been or will be reduced pursuant to SB 633's elimination of comfort as a program objective. These notices were developed to be consistent with other recently adopted Notices of Action for use in implementing SB 633 actions. These notices - TEMP 1503 and TEMP 1505 - are based upon the following provisions:

1. State hearings are available to all recipients who so request within 90 days following the mailing date of these notices when properly completed.

2. Aid paid pending is available at the level the recipient would have received had the action eliminating comfort not been taken for all recipients who file a timely request for a state hearing. The two standards for timely filing are defined below.

3. Individual case assessment must be made to insure that no county action is taken that would cause recipients to be placed in a medical out-of-home care facility, become unemployed, be placed in a life-threatening situation, or be placed in a situation that would substantially threaten their health or safety. These specific exceptions appear on the notices.

4. The notices must show the type and hours of specific services being reduced or eliminated.

Following are instructions for the processing of cases and the use of each of these notices. For recipients who have requested a state hearing pursuant to the original county notice implementing "comfort reductions", see ACL 81-123 for instructions on the right to a state hearing and aid paid pending.

TEMP 1503

This notice is for severely impaired recipients who received prior "comfort reductions". This notice will reinstitute, where appropriate, reductions subsequently restored by counties pursuant to the Temporary Restraining Order in Disabled Union v. Woods. The recipient will receive aid paid pending if the hearing is requested prior to the effective date of the action. These severely impaired cases must be processed and notices must be mailed to all affected recipients no later than January 20, 1982.

This notice is also for all recipients who have not yet received those "comfort reductions' which counties are required to implement. The recipient will receive aid paid pending if a hearing is requested prior to the effective date of the action.

TEMP 1505

This notice is for non-severely impaired recipients who have received "comfort reductions". Its purpose is to ensure that these recipients are advised of hearing rights and receive a clear explanation of the nature of the county's action.

Recipients requesting a hearing within 10 days of the mailing date of the notice will receive aid paid pending the hearing as of the effective date of the county's original action. The retroactive aid will take the form of a cash payment of equivalent value to all "comfort" services the recipient would have received had the county made no reduction.

These notices must be processed and mailed to all affected recipients no later than January 20, 1982.

Although the above described forms are temporary, they are to be used until further instructions are issued. Attached are camera-ready copies for counties to reproduce. These forms will not appear in the DSS Forms Catalogue and will not be available through the DSS Warehouse. There will be no exceptions granted by the state for use of other than the attached forms and there is to be no variation in wording, printing or format. Translated notices as required by law are available upon request by contacting the DSS Language Services Unit at (916) 323-9562.

Attached are additional instructions on how to process payments for individual provider cases. If there are other questions in this matter, please contact your consultant in the Adult Services Program Operations Bureau at (916) 445-8724.

Sincerely,

Claude E. Finn

CLAUDE E. FINN
Deputy Director

Attachments

cc: CWDA

SOCIAL SERVICES

IN—HOME SUPPORTIVE SERVICES (IHSS)

NOTICE OF ACTION

NOTE: *The action described below relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security.*

Case Number: _____

Date Mailed: _____

Your In-Home Supportive Services authorization will be reduced to _____ hours ($_____) effective _____. You are currently receiving _____ hours ($ _____). The changes are as follows:

	HOURS PER MONTH BEFORE REDUCTION	HOURS PER MONTH AFTER REDUCTION
Domestic services: (Such as sweeping, garbage removal, putting away food and changing bed linen.)		
Related services: (Those services related to domestic, such as shopping, preparation of meals and cleanup and laundry.)		
Non-Medical Personal services: (such as bowel and bladder care, respiration feeding and routine bed baths.)		
Transportation: (Such as transportation to necessary medical appointments and other necessary travel.)		
Protective Supervision: (Observing behavior in order to safeguard against injury or accident.)		
Other: (specify) _____		

The determination the county has made regarding your level of services is based on a new State law which requires that the IHSS program provide only those services that will not result in your loss of employment, placement in a medical out-of-home care facility, a condition which threatens your life or a substantial threat to your health or safety. The determination regarding the number of hours authorized to you for services was based on:

_____ You are the only person counted in your household.

_____ You are receiving a pro rata share of the services allowance based on _____ people living in your household.

The action taken above was required by regulations **MPP 30-450.**

If you have any questions after reading this information or believe other facts should be considered, please immediately call your Agency Representative.

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ _____

Agency Representative Telephone Number

RIGHT TO REQUEST A STATE HEARING

1. You have the right to a conference with representatives of the county social services department to talk about this intended action. At such a conference, you may speak for yourself or be represented by a lawyer, a friend or other spokesperson. If you want a conference, contact your county department.

2. Whether you request a conference or not, you also have the right to request a State Hearing and decision by the Director of the State Department of Social Services (see form below). Your request may be written or oral but it must state that you want a hearing and why you are dissatisfied. **YOUR REQUEST FOR A HEARING MUST BE MADE WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.**

3. **IF YOU MAIL YOUR REQUEST FOR A STATE HEARING ANYTIME BEFORE THE EFFECTIVE DATE OF THE COUNTY'S PROPOSED ACTION, YOUR SERVICES MAY CONTINUE UNTIL THE HEARING.** You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request is made in good faith.

4. You may request a State Hearing on your own, or you may ask your county department for assistance. In either case, however, be sure to inform your county department worker as soon as possible.

5. At a State Hearing you have the right to be represented by an attorney or any other person (a friend, relative, or other spokesman), of your choice. You may obtain free legal advice and the services of a lawyer by contacting the nearest legal services office. You may also contact the nearest social service rights organization for assistance in presenting your claim. If free legal representation is available locally, the telephone number and/or address is listed below.

_____

_____

6. State regulations governing State Hearings for social services are available at this office of the county social services department.

7. Information Practices — The information you are requested to provide is mandatory in order to process your request for a State Hearing pursuant to W&IC 10950. A case file will be established by the Office of the Chief Referee. You have the right to examine the materials that constitute the record for decision. Any information you provide may be shared with the county social services department or the United States Department of Health and Human Services.

If you wish to make a **written** *request for a State Hearing, please send this page to:*

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

To make an **oral** *request for a State Hearing or further to obtain information about your State Hearing rights or files you may contact:*

Chief, Public Inquiry and Response
State Department of Social Services
(800) 952-5253 (toll-free number)*
TDD (800) 952-8349 * For Deaf Only

* *You may have to dial "1" first.*

REQUEST FOR STATE HEARING

NAME (LAST, FIRST, MIDDLE INITIAL)	PHONE NO.	SOCIAL SECURITY NO.
	( )	

ADDRESS	CITY	STATE	ZIP CODE

I hereby request a State Hearing before the State Department of Social Services on the action taken by the County regarding my social services. The reasons for my request are as follows:

_____

_____

_____

I have trouble understanding English, therefore I request an interpreter for my hearing in the following:	LANGUAGE	DIALECT

SIGNATURE	DATE SIGNED

AUTHORIZED REPRESENTATIVE

I have authorized the following person to act on my behalf in my appeal. I authorize the Department to release any or all information about my case to that person.

NAME OF AUTHORIZED REPRESENTATIVE

ADDRESS OF AUTHORIZED REPRESENTATIVE

SIGNATURE OF STATE HEARING APPLICANT	DATE SIGNED

INSTRUCTIONS FOR PROCESSING INDIVIDUAL PROVIDER CASE PAYMENTS ORDERED IN DISABLED UNION V. WOODS

The payrolling system has been programmed to code restoration and retroactive pay.

1. Use the SOC 311 for restoration actions. Enter Reason Code 633 (increase due to restoration per court order). This code applies to:

   a) Severely impaired recipients restored by the Temporary Restraining Order.

   b) Non-severely impaired recipients who, upon receipt of special SB 633 renotices, file timely hearing requests and thereby receive aid paid pending from the effective date of the county's original SB 633 action. Code 633 will apply to the increase in service level required for "continuing" aid paid pending.

2. Use the SOC 312 for payments of retroactive restoration or retroactive aid paid pending. Issue payment using the Emergency Transaction Code and enter Reason Code X-09 (court ordered payment). Since this payment will be paid to IHSS recipients only, taxes will not be deducted.

These instructions incorporate and expand upon those provided with ACL 81-110.

If you have any questions, please contact your IHSS Payroll Consultant at (916) 323-0270 or ATSS 473-0270.

Your Right to Appeal This Action

If you are dissatisfied with the County's original action, you may request a state hearing before a Hearing Officer of the State Department of Social Services even though your original notice may have led you to believe otherwise. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. If you decide to request a state hearing, you may do so within **90 DAYS OF THE MAILING OF THIS NOTICE.**

IF YOU ASK FOR A HEARING WITHIN 10 DAYS OF THE MAILING DATE OF THIS NOTICE, YOU WILL RECEIVE AID PAID PENDING THE STATE HEARING, AT THE LEVEL OF SERVICES YOU RECEIVED BEFORE THE COUNTY'S ORIGINAL ACTION.

Aid paid pending will be effective as of the date of the County's original action.

You will not be liable for repayment of services or monies received pending the hearing, even if the result is a denial.

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

TDD (800) 952-8349* For the Deaf Only

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to In-Home Supportive Services

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.

IN—HOME SUPPORTIVE SERVICES (IHSS)
NOTICE OF ACTION

NOTE: *The action described below relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security*

Case Number: _____

Date Mailed: _____

SPECIAL NOTICE

This is a special notice which is being sent to you concerning your In-Home Supportive Services. On _____ you were sent a notice from the county welfare department which either reduced or terminated your In-Home Supportive Services due to a change in State law. **That notice may not have properly and completely informed you of your right to request a state hearing and of your right to receive aid paid pending the state hearing,** PLEASE CAREFULLY READ ALL OF THE FOLLOWING NOTICE WHICH WILL GIVE YOU INFORMATION ON THE NATURE OF THE COUNTY WELFARE DEPARTMENT'S ACTION AND ITS EFFECT ON YOUR IN-HOME SUPPORTIVE SERVICES. If you have any questions after reading this information or believe other facts should be considered, please immediately call your Agency Representative.

Your In-Home Supportive Services (IHSS) were redueed to _____ hours ($ _____) effective _____ . Prior to this reduction, you received _____ hours ($ _____). The changes are as follows:

	HOURS PER MONTH BEFORE REDUCTION	HOURS PER MONTH AFTER REDUCTION
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Related services: (Those services related to domestic, such as shopping, preparation of meals and eleanup and laundry.)		
Non Medical Personal services: (Such as howel and bladder care, respiration, feeding and routine bed baths.)		
Transportation: (Such as transportation to necessary medical appointments and other necessary travel.)		
Protective Supervision: (Observing behavior in order to safeguard against injury or accident.)		
Other: (specify) _____		
_____		
_____		
_____		

The determination the county has made regarding your level of services is based on a change in State Law which requires that the IHSS program provide only those services that will not result in your loss of employment, placement in a medical out-of-home care facility, a condition which threatens your life or a substantial threat to your health or safety. The determination regarding the number of hours authorized to you for services was based on:

____ You are the only person counted in your household.

____ You are receiving a pro rata share of the services allowance based on ____ people living in your household.

The action taken above was required by regulations MPP 30-450.

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE THE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ Agency Representative

_____ Telephone Number