STATE OF CALIFORNIA - HEALTH AND W ARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814
(916) 322-6320

April 19, 1985

ALL-COUNTY LETTER NO. 85-45

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IHSS INCOME ELIGIBLE IRWE DISREGARD

REFERENCE:

The purpose of this letter is to notify the counties of a change in the Code of Federal Regulations (CFR) impacting income eligibility determinations for In-Home Supportive Services (IHSS).

Statute (Welfare and Institutions Code (W&IC) Section 12304.5) links IHSS "income eligibles" to Title XVI of the Social Security Act income criteria. "Income eligibles" are those recipients who would qualify for Title XVI Supplemental Security Income/State Supplementary Program (SSI/SSP) payments, except for excess income. Title XVI SSI/SSP income criteria is regulated in 20 CFR - Employees' Benefits, Part 416. The Manual of Policies and Procedures (MPP) 30-770.2 refers to 20 CFR, Part 416 for the location of detailed eligibility standards.

The State Council on Developmental Disabilities has received reports that some counties have expressed reluctance to implement 20 CFR, Part 416 changes without specific instructions to do so from the State Department of Social Services (SDSS). As a reminder, MPP 30-770.2 provides counties the authority and responsibility to apply all provisions of 20 CFR, Part 416, unless specifically modified by MPP beginning with Section 30-750. Applicable portions of 20 CFR, Part 416 need not be restated by SDSS to be implemented in IHSS income eligibility determinations.

A specific change in 20 CFR, Part 416 to be implemented immediately, if you have not already done so, concerns Impairment Related Work Expenses (IRWE) as earned income disregards for disabled (not blind) under age 65 IHSS income eligibles. After applying earned income disregards in MPP 30-775.434(a), any qualifying IRWE of disabled persons, which has not already been disregarded, is to be disregarded as earned income. The IRWE in the amount of ordinary and necessary expenses related to work activity, only to the extent that they are paid, are to be disregarded (deducted) as income. Categories of IRWE are payments for:

1. Attendant care services
2. Medical devices
3. Prosthetic devices
4. Work-related equipment
5. Drugs and medical services
6. Similar items and services
7. Installing, maintaining, and repairing deductible items in 2, 3, 4 and 6 above.

This change was effective for IHSS purposes May 16, 1983. More detailed information on IRWE can be found in 20 CFR, Part 416.976. IRWE of the disabled are to be deducted in the same manner as work expenses of the blind as "other earned income deductions" on the SOC 294A (IHSS Income Eligibility - Adult) and the SOC 294C (IHSS Income Eligibility-Child). On the SOC 310 (Statement of Facts For IHSS), IRWE of the disabled can be associated with item 14 dealing with blindness and stated in item 18 as additional information (see attached examples). The SOC 310 form is currently in the process of revision and IRWE is to be added as a separate category.

Disabled income eligibles with earned income are to be made aware of IRWE disregards when completing the SOC 310. Current IHSS "income eligible" cases should be reviewed to assure disabled recipients have been granted any IRWE disregards they are entitled to.

If you have any questions regarding the IRWE income disregards for IHSS disabled income eligibles, please contact your Adult and Family Services Program Operations Consultant at (916) 322-6671.

LOREN D. SUTER
Deputy Director
Adult & Family Services Division

cc: CWDA
Jose Gonzalez, Chairperson
State Council on Developmental Disabilities

STATEMENT OF FACTS FOR IN-HOME SUPPORTIVE SERVICES

INSTRUCTIONS: Your eligibility will be decided on the information you give on this form. Using ink, complete all items. Please print.

1. APPLICANT'S NAME (FIRST, MIDDLE, LAST)	BIRTHDATE	FOR COUNTY VERIFICATION USE ONLY
HOME ADDRESS (STREET, CITY, ZIP)		
MAILING ADDRESS (IF DIFFERENT)	HOME PHONE / MESSAGE PHONE	
PLACE OF BIRTH / SOCIAL SECURITY NUMBER / RETIREMENT CLAIM NUMBER		

ARE YOU?

☐ OVER 65 ☐ DISABLED ☐ BLIND

MARITAL STATUS — DATE

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

2. SPOUSE'S NAME	BIRTHDATE
IS SPOUSE?	
SOCIAL SECURITY NUMBER	RETIREMENT CLAIM NUMBER

3. DO YOU INTEND TO RESIDE IN CALIFORNIA? ☐ YES ☐ NO

4. ARE YOU A UNITED STATES CITIZEN? ☐ YES ☐ NO

IS SPOUSE A UNITED STATES CITIZEN? ☐ YES ☐ NO

5. ARE THERE OTHERS LIVING IN THE HOUSEHOLD? ☐ YES ☐ NO
If yes, give the information below.

NAMES	RELATIONSHIP

6. LIVING ARRANGEMENT

☐ I live in a home I am buying or own.

☐ I rent a room, apartment or house.

☐ I pay for room and board.

☐ I receive free room and board.

☐ I live in and own, or I am buying a trailer, boat or motorhome.

DESCRIPTION

ESTIMATED VALUE

$

7. DO YOU OWN REAL PROPERTY (IER THAN YOUR HOME?

If yes, give the information below. ☐ YES ☐ NO

FOR COUNTY VERIFICATION USE ONLY

ADDRESS (STREET, CITY, ZIP)

ASSESSED VALUE	AMOUNT OWED	PARCEL NUMBER	MONTHLY PAYMENT
$	$		$
MONTHLY INCOME	ANNUAL ASSESSMENTS	ANNUAL TAXES	ANNUAL INSURANCE
$	$	$	$

TAXES INCLUDED IN MONTHLY PAYMENT? ☐ YES ☐ NO

INSURANCE INCLUDED IN MONTHLY PAYMENT? ☐ YES ☐ NO

OTHER PROPERTY EXPENSES

8. WHAT IS THE VALUE OF YOUR OTHER ASSETS?

DO YOU HAVE?	CHECK IF NONE	ENTER VALUE UNDER OWNER		
		Applicant	Spouse	Both
a. Money in the house		$	$	$
b. Checking account				
c. Savings account, credit union, trust funds				
d. Checks or cash in safety deposit box				
e. Stocks or bonds (market value)				
f. Notes, mortgages, deeds, contracts (market value)				

9. DO YOU HAVE LIFE INSURANCE POLICIES? ☐ YES ☐ NO

If yes give the information below.

INSURANCE COMPANY	PERSON INSURED	POLICY OWNED BY	FACE VALUE	POLICY NUMBER	DATE ISSUED	SURR. CASH VAL.
a.						
b.						
c.						
d.						

10. DO YOU HAVE ANY IRREVOCABLE BURIAL TRUSTS? ☐ YES ☐ NO

If yes, give the information below.

NAME OF COMPANY	PURCHASE PRICE	FOR WHOM?
	$	

11. DO YOU OWN MOTOR VEHICLES (cars, trucks, motorcycles, boats, campers, trailers)? If yes, give the information below. ☐ YES ☐ NO

MAKE	MODEL	YEAR	Last License Fee Pd.		AMOUNT OWED	Check If Used For	
			Date	Amount		Work	Medical Transp.

12. ARE YOU OR YOUR SPOUSE EMPL..ED (Include self-employed)? ☐ YES ☐ NO

If yes, give the information below.

NAME OF EMPLOYER	HOW OFTEN PAID?	GROSS SALARY PER PAY PERIOD $
ADDRESS		OCCUPATION

FOR COUNTY VERIFICATION USE ONLY

13. DO YOU RECEIVE IN-KIND INCOME? ☐ YES ☐ NO

If yes, give the information below.

TYPE

FREQUENCY

14. IF YOU ARE APPLYING AS BLIND, DO YOU HAVE ANY WORK RELATED EXPENSES DUE TO BLINDNESS? Such as: DISABLED - SEE ITEM 18

SPECIAL TRANSPORTATION COST:	INCREASED HOUSEHOLD MAINTENANCE COST:

ITEMS OR SERVICES NEEDED FOR JOB PERFORMANCE COST:

15. LIST INCOME RECEIVED EACH MONTH OTHER THAN EMPLOYMENT

TYPE OF INCOME	CHECK IF NONE	ENTER AMOUNT RECEIVED BY		
		Applicant	Spouse	Both
a. Unemployment Insurance		$	$	$
b. Disability Insurance				
c. Veteran's Pension				
d. Railroad Pension				
e. Social Security				
f. Civil Service				
g. Other retirement pension				
h. Alimony (Spousal support)				
i. Payment for room and board				
j. Rents, dividends, royalties				
k. Contributions or gifts				
l. Workers' Compensation				
m. Other				
n. AFDC payments				

16. HAVE YOU APPLIED FOR OR DO YOU EXPECT TO RECEIVE DURING THE NEXT 6 MONTHS ANY OF THE BENEFITS LISTED IN ITEM 16? ☐ YES ☐ NO

If yes, give the information below.

TYPE OF INCOME	DATE APPLIED	PLACE APPLIED
a.		
b.		
c.		

17. ARE YOU INTERESTED IN TALK[illegible] TO A SOCIAL WORKER ABOUT OTHER SERVICES WHICH MAY BE AVAILABLE. If yes, explain. ☐ YES ☐ NO

FOR COUNTY VERIFICATION USE ONLY

18. ADDITIONAL INFORMATION (Give item number. Attach additional sheet, if needed.)

ITEM NUMBER	
14	IRWE OF DISABLED (BUT NOT BLIND)

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

- I hereby state by my signature that the answers I have given are correct and true to the best of my knowledge.
- I agree to tell the County Welfare Department within 10 DAYS if there are any changes in my income, possessions or expenses or in the number of persons in my household, or if any change of address, and I agree to meet all other responsibilities explained in the "Medi-Cal Responsibilities Checklist" I have received.
- I understand that I may be asked to prove my statements, but that the county is required by law to keep them confidential.
- I understand that if I am dissatisfied with actions taken by the County Welfare Department, I have the right to a fair hearing.

I UNDERSTAND THAT THE INFORMATION I PUT ON THIS FORM MAY BE VERIFIED AND THAT MY SIGNATURE ON THIS FORM IS AN AUTHORIZATION FOR SUCH AN INVESTIGATION.

I, the undersigned, declare under penalty of perjury that the foregoing statements are true and correct.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF PERSON ACTING FOR APPLICANT — RELATIONSHIP (GUARDIAN, CONSERVATOR, ETC.)	DATE
SIGNATURE OF WITNESS (REQUIRED IF APPLICANT SIGNED BY MARK)	DATE
SIGNATURE OF PERSON HELPING APPLICANT COMPLETE FORM	DATE

State of California—Health and Welfare Agency

Department of Social Services

IHSS INCOME ELIGIBILITY – CHILD

Name _____ Case No. _____ Month _____

PARENT

A. Income deemed to a blind or disabled child living at home who is under 18 or 18 –21 and in school.

☐ Income of parent and parent's spouse where neither is aged, blind or disabled.	Unearned	Earned
1. Gross income	$	$
2. Allowance for children not blind or disabled		
a. Children's needs	$119.00 $119.00 $119.00	
b. Children's income	$ $ $	
c. Net needs (a minus b)	$ $ $	
d. Total allowance (add A2c's)	$	
3. Remaining unearned income (A1 minus A2d)	$	
4. Unmet children's needs (If A2d is greater than A1 unearned, enter the difference)		$
5. Remaining earned income (A1 minus A4)		$
6. If remaining income is EARNED only:		
a. $85 exclusion		$ 85
b. Allowance for parent and spouse (1) $476.00 (2) $714.00		$
c. Total exclusions (A6a plus A6b)		$
d. Income deemed to child (A5 minus A6c)		$
7. If remaining income is UNEARNED only:		
a. Any income exclusion	$ 20	
b. Allowance for parent and spouse (1) $238.00 (2) $357.00	$	
c. Total exclusions (A7a plus A7b)	$	
d. Income deemed to child (A3 minus A7c)	$	
8. If income is UNEARNED and EARNED:		
a. Any income exclusion	$ 20	
b. Net unearned income (A3 minus A8a)	$	
c. Unused $20 exclusion (If A8a is greater than A3, enter the difference)		$
d. Earned income exclusion		$ 65
e. Total exclusions (A8c plus A8d)		$
f. Earned income (A5 minus A8e)		$
g. Net earned income (A8f X ½)		$
h. Total income (A8b plus A8g)	$	
i. Allowance for parent and spouse (1) $238.00 (2) $357.00	$	
j. Income deemed to child (A8h minus A8i)	$	
☐ Income of parent(s) where one or both are aged, blind or disabled.		
9. Parent(s) income in excess of SSI/SSP payment		

RECIPIENT

B. IHSS share of cost computation for blind or disabled child who is under 18 or 18 – 21, in school and living at home.

	Unearned	Earned
1. Income deemed to child (from A6d, A7d, A8j or A9)**	$	
2. Unearned income (list) (Do not show exempt income)		
a.	$	
b.	$	
c.	$	
3. Total unearned income (B1 plus B2)	$	
4. Any income exclusion	$ 20	
5. Net unearned income (B3 minus B4)	$	
6. Earned income (Do not show exempt income)		$
7. Unused $20 exclusion (If B4 is greater than B3, enter the difference)		
8. Earned income exclusion		$ 65
9. Total exclusions (B7 plus B8)		$
10. Remaining earned income (B6 minus B9)		$
11. Net earned income (B10 X ½)		$
12. Other earned income deductions ✓		$
13. Total net earned income (B11 minus B12)		$
14. Total countable income (B5 plus B13)	$	
15. SSI/SSP payment level	$	
16. IHSS share of cost (B14 minus B15)	$	

** Note: If more than 1 eligible child, divide deemable income equally among them, except that if one child has excess income, it is deemed to other eligible children.

_____ Worker

_____ Date

SOC 294 C (7/80)

State of California--Health and Welfare Agency

Department of Social Services

IHSS INCOME ELIGIBILITY – ADULT

Name _____ Case No. _____ Month _____

RECIPIENT

A. Income of aged, blind or disabled individual or couple (if individual has spouse not aged, blind or disabled, also complete Part B)

	UNEARNED	EARNED
1. Unearned income (list) (Do not show exempt income)		
a.	$	
b.	$	
c.	$	
2. Total unearned income (A1a to A1c)	$	
3. Any income exclusion	$20	
4. Net unearned income (A2 minus A3)	$	
5. Earned income (Do not show exempt income)		$
6. Unused $20 exclusion (If A3 is greater than A2, enter the difference)		$
7. Earned income exclusion		$65
8. Total exclusions (A6 plus A7)		$
9. Remaining earned income (A5 minus A8)		$
10. Net earned income (A9 X ½)		$
11. Other earned income deductions		$
12. Total net earned income (A10 minus A11)		$
13. Total countable income (A4 plus A12)	$	

** If there is also a blind or disabled child in the family, the share of cost shown in Line C3 is not paid. Enter this amount on Form SOC 294C, Line A9. The share of cost will be the amount determined in SOC 294C, Line B16.

SPOUSE

B. Income of aged, blind or disabled individual and spouse who is not aged, aged, blind or disabled.

				UNEARNED	EARNED
1. Income of client's spouse*				$	$
2. Allowance for children not blind or disabled.					
a. Children's needs					
b. Children's income*	$	$	$		
c. Net needs (a – b)	$	$	$		
d. Total allowance (add B2 c's)				$	
3. Remaining unearned income (B1 minus B2d)				$	
4. Unmet children's needs (If B2d is greater than B1 unearned, enter the difference)					$
5. Remaining earned income (B1 minus B4)					$
6. Net income of spouse (B3 plus B5) – *If equal to or less than* , A13 is entered in C1 – If greater than , complete B7 through B20				$	
7. IHSS client's income (From A2 and A5)				$	$
8. Income of couple (B3 plus B7 unearned, B5 plus B7 earned)				$	$
9. Any income exclusion				$20	
10. Net unearned income (B8 minus B9)				$	
11. Unused $20 exclusion (If B9 is greater than B8 unearned, enter the difference)					$
12. Earned income exclusion					$65
13. Total exclusions (B11 plus B12)					$
14. Remaining earned income (B8 *minus* B13)					$
15. Net earned income (B14 X ½)					$
16. Other earned income deductions					$
17. Total net earned income (B15 minus B16)					$
18. Total countable income (B10 plus B17)				$	
19. Needs of spouse					
20. Net countable income (B18 minus B19)				$	

C. **SHARE OF COST**

1. Countable income (higher of A13 or B20)	$
2. SSI/SSP payment level	$
3. IHSS share of cost (C1 minus C2)**	$

Worker _____ Date _____

SOC 294A (7/81)