NOTICE OF FORM CHANGE NO. 03-111

DATE: 8/20/03

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ District Attorney
☐ Private and Public Adoption Agencies
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE

SOC 432 (8/03) Claim For Reimbursement, In-Home Supportive Services Program Contract Expenditures

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: 8/03	REPLACES: 10/02	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted

REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval

☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:

Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ OTHER:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY

☐ Use until exhausted
☒ Destroy

USE NEW FORM

☐ When supply available in DSS Warehouse
☒ Use new form effective immediately.

USE FORM IN ACCORDANCE WITH

☐ All County Letter No.
☒ Other (specify) All-County Information Notice I-46-03

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Check on the Internet to see if forms are available at www.dss.cahwnet.gov.

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

CLAIM FOR REIMBURSEMENT
IN-HOME SUPPORTIVE SERVICES PROGRAM
CONTRACT EXPENDITURES

To: Adult Programs Branch
California Department of Social Services
744 P Street, MS 19-96
Sacramento, CA 95814

FROM:
COUNTY:
ADDRESS:
CONTACT PERSON:
PHONE NUMBER: ( )

CONTRACT NUMBER	CONTRACTOR NAME	SERVICE MONTH/YEAR

WARRANT DATE_____

FISCAL YEAR/QTR. _____

CONTRACT SERVICE DELIVERY TOTALS FOR MONTH BY FUNDING SOURCE:

FUNDING SOURCE	TOTAL CASES	TOTAL HOURS	GROSS EXP.	*ADJUSTMENTS	TOTAL NET EXP.
PCSP	_____	_____	_____	_____	_____
Non-PCSP	_____	_____	_____	_____	_____
Totals	_____	_____	_____	_____	_____

* If the actual PCSP and Non-PCSP adjustment amounts are not known, please estimate the PCSP and Non-PCSP amounts based on the PCSP and Non-PCSP hours to total hours ratio.

COST REIMBURSEMENT DETAIL BY FUNDING SOURCE:

FUNDING SOURCE		FEDERAL		STATE/COUNTY		STATE		COUNTY	TOTAL NET EXPENDITURE
PCSP	(54.35%)	_____	(45.65%)	_____	(65%)	_____	(35%)	_____	_____
Non-PCSP				_____	(65%)	_____	(35%)	_____	_____
Total		_____		_____		_____		_____	_____

DO NOT PAY THIS AMOUNT

I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the Personal Care Services Program; that I have not violated any of the provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Section 1090 to 1096, inclusive of the Government Codes; that the amounts claimed herein are properly claimable as expenditures for the administration of the project as specified in accordance with all provisions of the Welfare and Institutions Codes, the rules and regulations of the State Benefits and Services Advisory Board.

SIGNATURE OF COUNTY WELFARE DIRECTOR OR CONTRACT ADMINISTRATOR	DATE

I hereby certify under penalty of perjury, that I am the official responsible for the examination and settlement of accounts, that I have not violated any provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Sections 1070 to 1096, inclusive, of the Government Code; that the expenditures claimed herein have been authorized, that a clearly delineated audit trail is in place to substantiate said expenditures, and that payments therefore have been made or expenditures otherwise incurred according to law.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

Approved by: _____ Date _____

(State IHSS Program Manager)

SECTION I OVERPAYMENTS/UNDERPAYMENTS

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
A	PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
B	CONNECTED PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
C	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

SECTION II OTHER _____ (COUNTY SPECIFIC)

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
D	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
E	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
F	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

SECTION III LIQUIDATED DAMAGES

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
G	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
H	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
I	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

SECTION IV PCSP / IHSS ADJUSTMENTS

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
J	NET ADJUSTMENT C + E + H (+ / =)	(1)	(2)	(3)	(4)	(5)	(6)
K	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
L	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

SECTION V CONTRACTOR BILLING

	SERVICE MONTH (1)	TOTAL PCSP CASES	TOTAL IHSS CASES	TOTAL PCSP HOURS	TOTAL IHSS HOURS	TOTAL PCSP GROSS	TOTAL IHSS GROSS
M							
N	INVOICE BILLED	(1)	(2)	(3)	(4)	(5)	(6)
O	NET ADJUSTMENT + / = C + E + H OR L	(1)	(2)	(3)	(4)	(5)	(6)
P	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)