# NOTICE OF FORM CHANGE NO. 05-133

DATE: 11/9/2005

**TO:**
County Welfare Director
Supply Clerk / Forms Coordinator

**FROM:**
Forms Management Unit
(916) 657-1907

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

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 821 (11/05) - ASSESSMENT OF NEED FOR PROTECTIVE SUPERVISION FOR IN-HOME SUPPORTIVE SERVICES PROGRAM

| ORDER UNIT | | ESTIMATED PRICE | INITIAL SUPPLY SENT |
|---|---|---|---|
| MASTER ONLY | ☒ Free ☐ Sold | | ☐ Yes ☐ No |
| ☒ New ☐ Revised | DATE OF FORM: 11/2005 | REPLACES | ☐ 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 11/8/2005

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

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 forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov.

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

☐ Release of Information Attached

| | | |
|---|---|---|
| | PATIENT'S NAME: | PATIENT'S DOB: / / |
| | MEDICAL ID#: (IF AVAILABLE) | COUNTY ID#: |
| | IHSS SOCIAL WORKER'S NAME: | |
| | 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.

Protective Supervision is not available when: (1) the need for supervision is caused by a physical condition rather than a mental impairment;
(2) prevention or control of antisocial or aggressive behavior is necessary (including self-destructive behavior, destruction of property, or harming others); or
(3) a medical emergency (such as seizures, etc.,) is anticipated.

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

| | |
|---|---|
| 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:**