NOTICE OF FORM CHANGE NO. 05-133

TO: County Welfare Director
    Supply Clerk / Forms Coordinator

FROM: Forms Management Unit
      (916) 657-1907

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

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

<table>
<thead>
<tr>
<th>FORM NUMBER AND TITLE</th>
<th>ORDER UNIT</th>
<th>MASTER ONLY</th>
<th>ESTIMATED PRICE</th>
<th>INITIAL SUPPLY SENT</th>
<th>REPLACES DATE OF FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOC 821 (11/05) - ASSESSMENT OF NEED FOR PROTECTIVE SUPERVISION FOR IN-HOME SUPPORTIVE SERVICES PROGRAM</td>
<td>New</td>
<td>☑ Free</td>
<td>☐ Sold</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11/2005</td>
</tr>
</tbody>
</table>

REQUIRED FORM:
☑ No Change Permitted
☐ 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

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.
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.

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<table>
<thead>
<tr>
<th>MEMORY</th>
<th>ORIENTATION</th>
<th>JUDGMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>- No deficit problem</td>
<td>- No disorientation</td>
<td>- Unimpaired</td>
</tr>
<tr>
<td>- Moderate or intermittent deficit (explain below)</td>
<td>- Moderate disorientation/confusion (explain below)</td>
<td>- Mildly Impaired (explain below)</td>
</tr>
<tr>
<td>- Severe memory deficit (explain below)</td>
<td>- Severe disorientation (explain below)</td>
<td>- Severely Impaired (explain below)</td>
</tr>
</tbody>
</table>

**Explanation:**

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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? __________________________

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**CERTIFICATION**

I certify that I am licensed to practice in the State of California and that the information provided above is correct.

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**RETURN THIS FORM TO:**