# NOTICE OF FORM CHANGE NO. 06-039

DATE: 3/21/2006

**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 (3/06)
Assessment of Need for Protective Supervision

| ORDER UNIT | | ESTIMATED PRICE | INITIAL SUPPLY SENT |
|---|---|---|---|
| MASTER ONLY | ☒ Free ☐ Sold | | ☐ Yes ☐ No |
| ☐ New ☒ Revised | DATE OF FORM: 3-2006 | REPLACES: 11/2005 | ☐ 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 3/21/2006

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

| Attending Physician's / Medical Professional's mailing address | 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. This service is <u>not available</u> in the following instances:

(1) When the need for protective supervision is caused by a physical condition rather than a mental impairment;
(2) For friendly visitation or other social activities;
(3) When the need for supervision is caused by a medical condition and the form of supervision required is medical;
(4) In anticipation of a medical emergency (such as seizures, etc.);
(5) To prevent or control antisocial or aggressive recipient behavior.

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

(Welfare and Institutions Code §12301.21)

| 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:** *COUNTY'S MAILING ADDRESS, CITY, CA,: ATTN; SW-NAME*