NOTICE OF FORM CHANGE NO. 06-110

DATE: 8/17/2006

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: Protective Supervision 24-hours-a-day coverage plan
SOC 825 english/spanish

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
EACH	☒ Free ☐ Sold		☐ Yes ☐ No
☒ New ☐ Revised	DATE OF FORM: 6/06	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 6/06

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 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) 651-8876 or by electronic mail at LTS@dss.ca.gov.

PROTECTIVE SUPERVISION
24-HOURS-A-DAY COVERAGE PLAN

PLEASE PRINT

NAME OF IHSS RECIPIENT:	RECIPIENT'S TELEPHONE #:
ADDRESS OF IHSS RECIPIENT:	
NAME OF PRIMARY CONTACT RESPONSIBLE:	CONTACT'S TELEPHONE #:
RELATIONSHIP TO RECIPIENT:	

As the primary contact for arranging the 24-hour-a-day coverage plan for the above named Recipient, I acknowledge my understanding of the following:

- A 24-hour-a-day coverage plan has been arranged and is in place.

  The continuous 24-hour-a-day coverage plan can be met regardless of paid In-Home Supportive Service (IHSS) hours along with various alternate resources (i.e.; Adult or Child Day Care Centers, community resource centers, Senior Centers, respite centers, etc.)

- The 24-hour-a-day coverage plan will be provided at all times.

- If there is any change to the 24-hour-a-day coverage plan (i.e. hospitalization, attendance in day-care programs, travel, etc.) I will immediately **notify the IHSS social worker.**

- The above name Recipient has an established need for 24-hour-a-day Protective Supervision if he/she is to remain safely in the home. The IHSS social worker has also discussed with me the appropriateness of out-of-home care as an alternative to 24-hour-a-day Protective Supervision.

NAME OF CARE PROVIDER (1):	CONTACT PHONE #:
NAME OF CARE PROVIDER (2):	CONTACT PHONE #:
NAME OF CARE PROVIDER (3):	CONTACT PHONE #:

Describe the implementation of the Protective Supervision 24-Hour-A-Day Coverage Plan:

SIGNATURE OF PRIMARY CONTACT RESPONSIBLE:	DATE:
SIGNATURE OF IHSS SOCIAL WORKER:	CONTACT PHONE #:

SUPERVISION PROTECTORA
PLAN DE COBERTURA LAS 24 HORAS AL DIA

POR FAVOR ESCRIBA CON LETRA DE MOLDE.

NOMBRE DEL BENEFICIARIO DE SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS):	NO. DE TELEFONO DEL BENEFICIARIO:
DIRECCION DEL BENEFICIARIO DE IHSS:	
NOMBRE DE LA PERSONA DE CONTACTO PRINCIPAL RESPONSABLE:	NO. DE TELEFONO DE LA PERSONA DE CONTACTO:
PARENTESCO/RELACION CON EL BENEFICIARIO:	

Como la persona de contacto principal para los arreglos relacionados con el plan de cobertura las 24 horas al día para el beneficiario mencionado anteriormente, confirmo mi entendimiento de lo siguiente:

- Se han hecho arreglos y se ha establecido un plan de cobertura las 24 horas al día.

  Los requisitos de un plan de cobertura continua las 24 horas al día se pueden cumplir usando cualquier combinación de horas pagadas de IHSS y varios otros recursos alternativos (es decir, centros de cuidado para adultos o niños durante el día, centros de recursos comunitarios, centros para ancianos, centros para descanso temporal, etc.).

- Los requisitos de un plan de cobertura las 24 horas al día se cumplirán en todo momento.

- Si hay algún cambio al plan de cobertura las 24 horas al día (es decir, hospitalización, participación en programas de cuidado durante el día, viajes, etc.), inmediatamente **le notificaré al trabajador social de IHSS.**

- El beneficiario mencionado anteriormente tiene una necesidad establecida para supervisión protectora las 24 horas al día para poder quedarse en su hogar de una manera segura. El trabajador social de IHSS también me ha hablado acerca de lo apropiado que es el cuidado fuera del hogar como alternativa a la supervisión protectora las 24 horas al día.

NOMBRE DEL PROVEEDOR DE CUIDADO (1):	NO. DE TELEFONO DE LA PERSONA DE CONTACTO:
NOMBRE DEL PROVEEDOR DE CUIDADO (2):	NO. DE TELEFONO DE LA PERSONA DE CONTACTO:
NOMBRE DEL PROVEEDOR DE CUIDADO (3):	NO. DE TELEFONO DE LA PERSONA DE CONTACTO:

Describa la implementación del plan de cobertura las 24 horas al día para supervisión protectora:

FIRMA DE LA PERSONA DE CONTACTO PRINCIPAL RESPONSABLE:	FECHA:
FIRMA DEL TRABAJADOR SOCIAL DE IHSS:	NO. DE TELEFONO DE LA PERSONA DE CONTACTO: