Adopt Section 30-752 to read:

30-752 ELIGIBILITY FOR ALL IHSS APPLICANTS AND RECIPIENTS 30-752

.1 To be eligible for the IHSS program each applicant and recipient must:

.11 have a Medi-Cal eligibility determination, unless the conditions in Section 30-759.3 are met,

.12 submit a completed health care certification in accordance with Section 30-754,

.13 be a California resident in accordance with Section 30-770.41,

.14 physically reside in the United States in accordance with Section 30-770.46,

.15 live in his or her own home as defined in Sections 30-701(o)(1) and 30-701(o)(2).

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code and Chapter 939, Statutes of 1992.

Reference: Welfare and Institutions Code Section 12309.1.

Adopt Section 30-754 to read:

30-754 HEALTH CARE CERTIFICATION 30-754

.1 As a condition of receiving services each applicant must obtain a health care certification on a department approved form, California Department of Social Services In-Home Supportive Services Program Health Care Certification Form (SOC 873) incorporated herein by reference, signed by a licensed health care professional.

.11 The health care certification must indicate:

.111 the applicant is unable to perform some activity of daily living, for example bathing, eating, dressing etc.

.112 the applicant is at risk of out-of-home care.

.113 a description of any condition or functional limitation that has resulted in or contributed to the applicant's need for services.

.12 Counties must allow 45 calendar days for the applicant to return the completed health care certification.

.121 45 calendar days begins when the county requests the certification from the applicant.

.13 The health care certification is not required on subsequent reassessments.

.2 Counties must accept alternative documentation in lieu of a health care certification, which meets the criteria specified as follows:

.21 Alternative documentation must include all of the following elements:

.211 a statement or description indicating the applicant is unable to independently perform one or more activities of daily living,

.212 a description of the applicant's condition or functional limitation that has contributed to the need for assistance,

.213 a signature from a licensed health care professional as defined in Section 30-754.4.

.22 Alternative documentation must be dated no earlier than 60 calendar days prior to submission.

.23 Alternative documentation refers to clinical or casework documents generated for some purpose other than IHSS certification that also meets the criteria above.

.231 Some examples of alternative documentation include, but are not limited to:

(a) Hospital or nursing facility discharge plan.

(b) Minimum data set forms.

(c) Individual program plan.

.232 In the absence of such alternative documentation, the department-approved health care certification form described in Section 30-754.1 must be completed.

.3 Exceptions to authorizing services prior to receiving the health care certification:

.31 Counties may not authorize services in the absence of the health care certification except in following circumstances:

.311 When emergency services have been requested by or on behalf of an applicant who is being discharged from a hospital or a nursing home and services are needed to return safely to the community.

.312 When the county determines the applicant is at imminent risk of out-of-home placement.

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.313 An example of imminent risk of out-of-home placement:

(a) An Adult Protective Services worker advised the county that an IHSS applicant is at imminent risk of out-of-home placement without IHSS services in place. If the county determines that waiting up to 45 calendar days for the health care certification to be returned would place an IHSS applicant at risk of out-of-home placement, services can be granted temporarily pending receipt of the health care certification or alternative documentation.

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.32 Counties must request the California Department of Social Services In-Home Supportive Services Program Health Care Certification Form (SOC 873) at or before the time of the in-home assessment.

.33 Excepted applicants must return the completed California Department of Social Services In-Home Supportive Services Program Health Care Certification Form (SOC 873) within 45 calendar days from the date the county requests it.

.331 The county shall consider the heath care certification, in accordance with Section 30-754, as one indicator of need for services, but not the sole determining factor.

.34 Excepted applicants may be granted an additional 45 calendar days for good cause.

.341 Good cause means a substantial and compelling reason beyond the excepted applicant's control.

.342 Excepted applicants must notify the county of the need for a good cause extension no later than 45 calendar days from the date the county requests the certification.

.343 Counties have the discretion to determine on a case-by-case basis when good cause exists.

.4 Licensed Health Care Professional for health care certification purposes:

.41 Licensed health care professional means an individual licensed in California by the appropriate regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions code.

.411 A licensed health care professional is a licensed individual whose primary responsibilities are to diagnose and/or provide treatment and care for physical or mental impairments or conditions which cause or contribute to an individual's functional limitations.

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(a) Some examples of who is considered a "licensed health care professional" are:

(A) A physician.

(B) A physician's assistant.

(C) A regional center clinician or clinician supervisor.

(D) An occupational therapist.

(E) A physical therapist.

(F) A psychiatrist.

(G) A psychologist.

(H) An optometrist.

(I) An ophthalmologist.

(J) A public health nurse.

(K) Marriage and Family Therapist (MFT).

(J) Licensed Clinical Social Worker (LCSW).

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Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code and Chapter 939, Statutes of 1992.

Reference: Welfare and Institutions Code Section 12309.1.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
HEALTH CARE CERTIFICATION FORM

A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name: | Date of Birth:

Address:

County of Residence: | IHSS Case #:

IHSS Worker Name:

IHSS Worker Phone #: | IHSS Worker Fax #:

B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (To be completed by the applicant/recipient)

I, _____ (PRINT NAME), authorize the release of health care information related to my physical and/or mental condition to the In-Home Supportive Services program as it pertains to my need for domestic/related and personal care services.

Signature: _____ (APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR) Date: ____/____/____

Witness (if the individual signs with an "X"): _____ Date: ____/____/____

TO: LICENSED HEALTH CARE PROFESSIONAL* –

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This health care certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual's present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

**Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.*

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM HEALTH CARE CERTIFICATION FORM

Applicant/Recipient Name:	IHSS Case #:

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.

1. Is this individual unable to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)?	☐ **YES** ☐ **NO**
2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?	☐ **YES** ☐ **NO**

If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below, *and complete the rest of the form including the certification in PART D at the bottom of the form.*

If you answered "YES" to both Question #1 AND #2, respond to Questions #3 and #4 below, *and complete the certification in PART D at the bottom of the form.*

3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program:

4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months?	☐ **YES** ☐ **NO**

Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

6. How long have you provided service(s) to this individual?

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

8. Indicate the date you last provided services to this individual: ____ / ____ / ____

NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and/or certified as a Medi-Cal provider, and all information provided above is correct.

Name:	Title:
Address:	
Phone #:	Fax #:
Signature:	Date:
Professional License Number:	Licensing Authority:

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.