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## APPLICATIONS

### General Information

Initial contact must be made with within seven calendar days of the date of application for new IHSS applications. Contact must be made with the applicant or the applicant's authorized representative, and must be noted in the case notes when updated by the Social Worker. Initial contact is made by mail using form 12-53B HHSA – *Initial Contact Letter* (Attachment). The Assignment Clerk must send form 12-53B HHSA, informing the applicant of his/her assigned Social Worker. A copy of this form must be retained in the case file. Applications are assigned to district offices based on zip code. Within each office, applications are assigned by rotation unless the application is considered confidential or secured.

All applications must be approved or denied within 30 calendar days from the date of application (MPP 30-759.2). The only exception is when an application requires a disability determination. All approvals require a face-to-face assessment by a Social Worker. When denying an application for no assessed need (NOA 443), a face-to-face assessment is required. A denial that is processed as the result of an initial telephone contact must be clearly documented in the case narrative and would be considered and documented as a withdrawal. The applicant must agree to withdraw the application.

### Social Worker Responsibilities

#### *Prior to the Home Visit*

When an application is assigned, the Social Worker will:

- Log the application on the 12-55 HHSA - *IHSS Social Worker Log* (Attachment).
- Review the MEDS QM screen (or the Meds Eligibility Information screen in CMIPS II) for the following information affecting IHSS eligibility:
  - Medi-Cal aid code
  - Medi-Cal eligibility status
  - Address
  - Conservator/Authorized Representative

If the case is status eligible, the Social Worker will review the MEDS QX screen (or the Meds Eligibility Information screen in CMIPS II) for the following information affecting IHSS eligibility:

- SSI Living Arrangement Codes indicating “Non-Medical Out-of-Home Care” (Board & Care rate) indicating the applicant is not in their own home
- SSI Living Arrangement Codes indicating “No cooking facilities rate” (ineligible to meal preparation, meal clean-up, or shopping for food)
- Marital Status (indicating a possible able and available spouse)

The Social Worker will contact the applicant (by phone or mail), record the date and method of contact as a Case Note in CMIPS II. Three attempts to contact the applicant must be made prior to any negative case action. The types of contact, along with the dates that the attempts were made must also be documented. The Social worker will complete the following actions:

- Document the name of the individual contacted and the relationship to the applicant.

- Schedule an in-home visit (or hospital visit, if appropriate) to complete the eligibility determination and a needs assessment.
- Grant or deny the application within 30 calendar days from the date of application.

***At the Home Visit***

At the home visit, the Social Worker will:

- Verify the identity of the applicant and the provider (if the provider is present) by:
  - Viewing the individual's original photo identification
  - Viewing the individual's original Social Security Card
- Explain the provider enrollment processes to the applicant and the provider (if the provider is present).
- Explain the payroll process to the applicant and the provider (if the provider is present).
- Explain the options for Blind and Visually Impaired (BVI) recipients.
- Explain the requirements and limitations to overtime, and wait time compensation for IHSS providers.
- If appropriate, refer the recipient to the Overtime Assistance Unit.
- Ensure that all required forms and actions are completed. (For the list of required forms, refer to section 2-A, Forms Completion.)

***After the Home Visit***

After completing the home visit, the Social Worker will:

- Process the application by documenting the reasons for the action taken.
- Submit the processed application for supervisory review within 30 calendar days from the date of application.
- Obtain supervisory approval when an application is pending over 30 calendar days.
- Clearly document the reason for the delay in the *Assessment Narrative*.

The Social Worker will enter evidence into CMIPS II by selecting the “*Evidence*” folder from the left navigation menu and updating the following sections:

- *Household Evidence* (new information from the home visit)
- *Service Evidence* (assessment information)
- *Program Evidence*
- *Share-of-Cost Evidence* (if applicable)

CMIPS II does not include a spell/grammar check. Narratives can be created in “ <i>Word</i> ”, edited for grammar and spelling and then pasted into the narrative screen.
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The Social Worker can create a new narrative that includes the current assessment information. The *Assessment Narrative Template* (Attachment) can be used as a tool to create the new narrative, spell check the information for edits, and then cut and paste into the *Assessment Narrative* screen. Once a narrative entry is saved, it cannot be edited.

***Conflict of Interest***

The Social Worker will immediately notify his/her supervisor *if at any time* they become aware that:

- A personal or business relationship exists between themselves and an applicant, recipient, or provider
- An applicant, recipient, or provider is an employee of the County of San Diego
- An applicant, recipient, or provider is a relative of an employee of the County of San Diego

(For detailed procedures refer to Confidential/Secured Cases, Chapter 7)

The Social Worker is responsible for knowing and following the IHSS case review requirements. All of the following categories must be submitted for supervisory review and sign off on the case narrative.

- All approvals
- All denials
- All Closing/termination of services
- All Protective Supervision – at authorization and reassessment
- All Paramedical Services – at authorization and reassessment
- An increase or decrease of 25% or more in authorized hours

In CMIPS II, cases will be submitted for review, and the supervisor approval/sign-off process will both be done within the CMIPS II system.

**Eligibility for Institutionalized Applicants/Recipients**

Otherwise eligible applicants/recipients currently institutionalized who wish to live in their own homes will, have their needs assessed to determine if they may safely do so if IHSS is provided. IHSS services are based on the preliminary assessment of an applicant's physical needs in the acute or chronic care facility. (30-755.12)

Service delivery will commence upon the applicant's/recipient's return to their own home, except in a situation that requires the authorization of heavy cleaning prior to the applicant's/recipient's safe discharge. Heavy cleaning involves the thorough cleaning of the home to remove hazardous debris or dirt (30-757.12). Heavy cleaning is the exception, and is the only service that may be authorized prior to the individual's return home, if the service is necessary. \*

*\*The initial assessment, conducted to provide services immediately upon the applicant /recipient's return to the home, will take place in a hospital or institution. The IHSS Social Worker is also required to make a home visit to determine if an adjustment in the authorized hours is needed once the applicant/recipient has returned home.*

***Income Eligible***

An income eligible applicant/recipient will have their income eligibility reviewed on a priority basis, and if appropriate, “presumptive eligibility” will be granted. A case is presumed eligible based on the criteria outlined in MPP 30-759.3. If there is a delay in determining eligibility, and the applicant/recipient is 60 years of age or older, a referral to Home Assist/Title III In-Home services may be made.

***Status Eligible***

If the hospitalization/institutionalization of a status eligible applicant results in a conversion of his/her SSI/SSP benefits to an institutionalized rate, the rate must be returned to the “home setting” rate. The applicant must complete form SOC 810 – “*Applicant Certification of Contact with SSA to Change Status from Institutional Care to a Home Setting*”, certifying that they have contacted the Social Security Administration (SSA) indicating their transition from an institutionalized setting to independent living. (Attachment).

When IHSS cannot be granted immediately due to the applicant’s/recipient’s SSI/SSP rate, the IHSS Social Worker will:

- Contact the hospital discharge planner and request that the applicant/recipient’s physician authorize the provision of home health care through a Medi-Cal vendor until the SSI/SSP rate is converted.
- If home health services cannot be authorized, and the applicant/recipient is 60 years of age or older, complete a referral to the Home Assist/Title III in-home services until the SSI/SSP rate has been converted.
- If any safety/abuse issues are identified, complete a referral to Adult Protective Services (APS). APS will contract with an in-home service Provider to assist the applicant/recipient until the SSI/SSP rate is converted.

**Social Work Supervisor Responsibilities**

The Social Work Supervisor will:

- Review the “*Combined IHSS Referral/Intake Log*” (Attachment) as needed to determine intake assignments for direct reports.
- When prompted in CMIPS II, perform the task of case review and approve or reject the case outcome to grant or deny.
- Update and monitor the “*Combined IHSS Referral/Intake Log*” and record intakes that have been granted or denied.
- Ensure that case action is taken on all applications within 30 calendar days (unless a disability determination is pending).
- Use the “*Combined IHSS Referral/Intake Log*” to prepare monthly statistical data.

***Case Reviews***

The Social Work Supervisor is responsible for knowing and adhering to the IHSS case review requirements and ensuring that their assigned staff (including new Social Workers) is informed of the case review requirements. All of the following categories must be submitted for

supervisory review and sign off. Hard copy case file narratives must be dated and signed until CMIPS II is available.

- All approvals
- All denials
- All Protective Supervision cases must be reviewed at both application and renewal
- Paramedical Services
- Increases/Decreases of more than 25%
- Medical Transportation (more than 4x/monthly or 4 hours monthly)

### ***Intake Assignment Schedule***

The following intake assignment schedule is to be used as a guideline for new Social Workers:

- After a period of *no later* than three months, applications must be assigned at a ratio of 50% of the workload average
- After a period of *no later* than six months, applications must be assigned at 100% of the workload average
- Exceptions may be made if approved by IHSS Administration and as a part of a Performance Improvement Plan (PIP) for the individual worker.
- Other factors to consider are prior experience, condition of inherited caseload, job classification, and the abilities/strengths/expertise of the individual. The overall workload is may depend on the classification (SW I, II, III).

### ***Building a Caseload***

New staff should be managing a full caseload after a period of *no later* than three months. There is no limit on the type of cases assigned, but will be a reasonable balance of types and reassessment dates, unless designated a “specialized” caseload. As an example, a caseload will not be assigned all the Protective Supervision cases in an office or unit. While the majority of Social Workers are assigned a caseload prior to three months, factors that are to be considered are CMIPS II access, prior experience, condition of the existing caseload, job classification and the abilities/strengths/expertise of the individual.

Cases that are reassigned from other caseloads will be randomly selected by the Social Work Supervisor or clerical staff from a caseload report generated through CMIPS II or the Ad Hoc Data Base Tool.

### ***Conflict of Interest***

The Social Work Supervisor will immediately follow standard procedures outlined in Chapter 7 for confidential/secure cases if at any time he/she becomes aware that:

- A Social Worker or any other IHSS staff member (including him/herself) has a personal or business relationship with any applicant, recipient, or provider of the IHSS program.
- An applicant, recipient, or provider of IHSS services is an employee of the County of San Diego or a relative of an employee of the County of San Diego.

### **Income & Disability Requirements**

Individuals applying for IHSS who are *not* receiving SSI/SSP must over the age of 65, blind, or disabled and meet Medi-Cal eligibility requirements. In order to qualify for IHSS, an applicant

must meet the income requirements established by the Medi-Cal program, and be approved for Medi-Cal. An individual may receive Medi-Cal through their SSI benefits or through an application filed at a Family Resource Center (FRC).

***Status Eligible Applications***

An application is considered status eligible when the IHSS applicant is receiving Supplemental Security Income/State Supplemental Payment (SSI/SSP) through the Social Security Administration. This means that the financial, age, and disability factors of eligibility have already been determined by the Social Security Administration and are accepted by IHSS. An applicant receiving SSI/SSP is eligible to full scope, zero share-of-cost (SOC) Medi-Cal. Medi-Cal aid codes for status eligible cases are 10, 20, and 60.

***Income Eligible/Share-of-Cost (SOC) Applications***

An application is considered income eligible when the applicant is within the allowed IHSS income and property limits but is not eligible to, or receiving, SSI/SSP. These limits are the same as the Medi-Cal and SSI/SSP limits. Income over the allowed limit may become a share-of-cost for the recipient.

Before IHSS services can be approved, applicants must complete a Medi-Cal eligibility determination. The assigned Medi-Cal Worker determines Medi-Cal eligibility and calculates the Medi-Cal and IHSS SOC amounts. Once completed the information is returned by e-mail through an *IHSS/Medi-Cal Communication Gram* (Attachment). Designated liaisons for each Family Resource Center (FRC) office (Attachment) may be contacted to resolve issues related to the Medi-Cal case.

Cases without active Medi-Cal are assigned to the IHSS SOC Specialist (see SOC Specialist procedures) until the Medi-Cal has been processed and is showing active in the Medi-Cal Eligibility Determination System (MEDS). Cases with active Medi-Cal need to be evaluated based on the Medi-Cal aid code located on the MEDS QX screen.

**Active Medi-Cal**

Individuals 19 through 64 years of age are no longer required to be blind or disabled in order to receive Medi-Cal. Eligibility for full or restricted-scope Medi-Cal can be established based on the MAGI category under the Affordable Care Act (ACA). There are a number of MAGI aid codes, and the Department of Health Care Services is responsible for the Medi-Cal [Aid Codes Master chart](#). This link goes directly to a document that includes all Medi-Cal aid codes. Many MAGI-eligible individuals are considered categorically needy, and those eligible for full-scope Medi-Cal with Federal Financial Participation (FFP) will be evaluated for IHSS under MPP 30-780.2(b), as stated below.

IHSS staff must determine disability for Medi-Cal IHSS for categorically-needy Medi-Cal recipients pursuant to MPP 30-780.2(b).

Personal care services may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12

consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without IHSS services.

### Social Worker Responsibilities

IHSS Social Workers are responsible for determining eligibility to IHSS services. For applicants who are not considered “status eligible” (aid codes 10, 20, and 60), the following evaluation process is to be followed.

The eligibility process for all Medi-Cal IHSS programs consists of three parts:

1. Does the client have full-scope Medi-Cal with FFP?
  - Many clients who meet Medi-Cal through MAGI have full-scope Medi-Cal with FFP.
  - Full-scope Medi-Cal with FFP can be verified for clients on the CMIPS II Medi-Cal Eligibility screen.
2. Is the client aged, blind, or disabled?
  - For those clients with a MAGI aid code (which indicate they have **not** been determined aged, blind, or disabled based on the Medi-Cal definitions), the client must meet the disability criteria found in MPP 30-780.2(b).
3. Does the client have an assessed IHSS need?
  - MAGI clients must go through the assessment of needs process in the same manner as all IHSS applicants.

MAGI Medi-Cal has no impact on the IHSS-Residual program. Anyone who does not have full-scope Medi-Cal with FFP can be evaluated for the IHSS-R program, if appropriate.

Cases with the following Medi-Cal aid codes (located on the MEDS “QX” screen or the “Meds Eligibility Information Screen” in CMIPS II) do not require an IHSS SOC Determination or an *IHSS/Medi-Cal Communication Gram*:

- 14, 24, 64,
- 16, 26, 66,
- 1E, 2E, 6E, 1X
- 6A, 6C, 6G, 6V

**Note:**

*The above list is not all inclusive. Each aid code must be evaluated for Medi-Cal type and IHSS eligibility.*

### ***IHSS SOC Determination***

Income eligible cases (other than those with the aid codes listed above) require an HHSA 14-140 *IHSS/Medi-Cal Communication gram* (Attachment). When an IHSS application is entered into CMIPS II and the applicant does not have active Medi-Cal, CMIPS II sends an electronic request

to CalWIN and starts the Medi-Cal application process. Once the application has been processed, the IHSS Social Worker will receive a CMIPS II notification indicating if the case was approved or denied. The Social Worker will grant or deny the IHSS application within five working days of the receipt of the HHS 14-140.