

IHSS TELEPHONE REVIEW FORM

Call the recipient and identify yourself. Explain the purpose of the call by telling the recipient you are doing a follow-up review of their case. Verify that the recipient/case information is correct. If recipient response indicates clarification is needed, ask follow-up questions. Use the back of the form if additional room is needed for notes.

Social Worker Name: _____ **Worker Number:** _____

Information Verification:

Yes	No		Corrected Information
<input type="checkbox"/>	<input type="checkbox"/>	Name	_____
<input type="checkbox"/>	<input type="checkbox"/>	Address	_____
<input type="checkbox"/>	<input type="checkbox"/>	Current provider	_____

Quality Assurance

When was the last home visit from your IHSS Social Worker; do you recall the day or date?

What time was your appointment? _____ What time did the Social Worker arrive? _____

How long did the Social Worker stay? _____

How were you contacted for this visit (phone, letter, drop-by)? _____

Tell me about/what do you recall about your last visit with your Social Worker from In-Home Supportive Services. _____

Was the IHSS program explained to you? _____

Was your Social Worker courteous? _____

If you have questions or changes, do you know how to contact your IHSS Social Worker? Did he/she leave you a business card? _____

If the client is not the person answering the questions, complete the following:

Spoke with: _____ relationship to client _____

Because (e.g. client is a child) _____

Comments: _____

Case Name: _____ Case Number: _____

Reviewer: _____ Date: _____

IHSS OVERPAYMENT REFERRAL

REFERRAL DATE: *Select Date Referred*

CASE NAME: *Enter Recipient Name Enter CMIPS II Case No.*

SOCIAL WORKER NAME: *Enter SW Name* **SOCIAL WORKER NUMBER:** *Enter SW Number*

TELEPHONE NUMBER: *Enter SW Phone No.*

OVERPAYMENT INFORMATION

OVERPAYEE NAME: *Enter Name of Individual Overpaid* **OVERPAYEE SSN:** *Enter SSN No.*

RECIPIENT PROVIDER

OVERPAYMENT PERIOD: From: *Select Start Date* To: *Select End Date*

TYPE OF OVERPAYMENT

(Check all that apply)

RETURNED FROM PAFD - OVERPAYMENT REFERRAL REQUIRED

SUSPECTED FRAUD CONFIRMED FRAUD

ADMIN ERROR SOC CASE PCSP IPO IHSS-R

CAUSE OF OVERPAYMENT - *Describe How the Fraud Occured*

REFERRING PARTY INFORMATION

NAME: *Referring Party's Name* **TELEPHONE NUMBER:** *Referring Party's No*

Signature

Department/Position-*If other than IHSS line staff*

IHSS SUPERVISOR: *Name of IHSS Supervisor*

TELEPHONE NUMBER: *Supervisor's Phone No*

Signature

Date Signed

To be completed only by the designated IHSS staff

OVERPAYMENT LETTER SENT ON: _____

GROSS OVERPAYMENT AMOUNT: _____ **NET OVERPAYMENT AMOUNT:** _____

The IHSS Account Clerk must send a copy of the completed referral back to the Social Worker for the case file.

IHSS QCA CASE REVIEW SUMMARY

Case Name:

CMIPS II Case Number:

Review Month:

QCA Social Worker:

Social Worker Number:

QCA Social Worker Number:

Companion Case(s):

Desk Field

PCSP IPO Residual

- Case File is Current and Correct-** Eligibility has been established and documented appropriately in the case file. Mandated forms are completed and filed in the case.
- Overpayment/Underpayment-** An incorrect amount of services/payment has been issued, a data entry or arithmetic error has been made, and/or a provider or recipient has been collecting payment for services not rendered. See attachment for detailed computation.
- Critical Incident-** The health and safety of the recipient is at risk due to inadequate service delivery or the current assessment (neglect, abuse, provider “no show”, “harmful to self”). A critical incident requires immediate action.
- Ineligible Case-** The recipient does not meet the financial, safety/health or other required criteria to be eligible for IHSS. IHSS regulations and policy are either not applied or applied incorrectly, resulting in the authorization of services to persons not eligible for IHSS.
- Procedural-** The recipient’s eligibility is not documented in the case record, but Quality Control can verify the recipient’s eligibility.
- Suspected Fraud-** The recipient and/or the recipient’s representative, the agency or both recipient and agency provide false information to qualify the case for IHSS. Suspected fraud is considered when recipients willingly fail to provide correct information or report changes. Suspected fraud is also considered when a provider knowingly accepts payment for services that are not being provided.
- Action Items-** These items occur when the case does not reflect the current situation, and the case needs to be and can be corrected. This includes service changes and paperwork corrections.
- Other:** _____
- Comments:** _____
- _____
- _____

Updates Completed By:

IHSS Social Worker: _____ Date: _____

Updates and Case File Reviewed By:

IHSS Social Work Supervisor: _____ Date: _____

Unless otherwise indicated, corrective action needs to be made immediately. A response is due to Quality Control within 45 days of the date distributed (e-mailed). Sign and return and electronic copy of this page only to the QCA Supervisor and copy the QCA Social Worker.

IHSS QCA CASE REVIEW SUMMARY

Case Name:

CMIPS II Case Number:

N/A Yes No

Granting

- Case granted within 45 days of application date or there is an acceptable reason for delay
 Case submitted to supervisor for review

Comments:

Reassessment

- Reassessment completely timely

Comments:

Household Evidence

- Residence Information Viewed
 Household Members Updated and Information Complete
 Proration of Household Members is Correct
 Companion Cases Identified and Linked

Comments:

Service Evidence

- Assessment Narrative
- Most recent eligibility determination narrated and current needs documented
 - Narratives for consecutive years have new information and observations
- Functional ranks consistent with assessment narrative documentation
- Service Type documentation meets requirements detailed in service type desk aid
- All service tasks authorized include a justification in the comments section
- Service times authorized are within HTG's or justification exists
- Accompaniment to Medical Appointments*
- Documentation is on file justifying assessed need (i.e. *Accompaniment to Medical Appointments Template*)
- Paramedical Services*
- Form SOC 321 – *Request for Order and Consent of Paramedical Services* is on file, current and correct
 - *Paramedical Services Form Received Date* is completed in CMIPS II
 - Documentation is on file justifying assessed need (i.e. *Paramedical Services Template*)
- Protective Supervision*
- Form SOC 821 – *Assessment of Need for Protective Supervision* is on file
 - Form SOC 825 – *Protective Supervision 24-Hours-a-Day Coverage Plan* is on file
 - Documentation is entered in CMIPS II justifying assessed need

Comments:

Program Evidence

- Authorization Start Date* and *Authorization End Date* are consistent with assessment documentation
- Home Visit Date* and *Re-Assessment Due Date* are consistent with assessment documentation
- Medical Certification
- SOC 874 – *IHSS Program Notice to Applicant of Medical Certification Requirement* or SOC 875 – *IHSS Program Notice to Recipient of Medical Certification Requirement* has been sent
 - SOC 873 – *Health Care Certification Form* is on file and recipient meets the stated eligibility requirements

Comments:

IHSS QCA CASE REVIEW SUMMARY

Case Name:

CMIPS II Case Number:

Share of Cost Evidence (if case is status eligible or treated as status eligible, check N/A)

- Current *IHSS/Medi-Cal Communication* gram is on file
 Share of Cost Evidence consistent with information reflected on communication gram
 Income Evidence consistent with information reflected on communication gram

Comments:

Medi-Cal Eligibility/ Medi-Cal Eligibility Data System (MEDS)

- INQM and INQX are on file and current
 If SSI recipient, are the *SSI Living Arrangement* and the *Marital Status* indicators on the INQX screen consistent with information in CMIPS II
 If income eligible, verification of disability is required when a person's Medi-Cal aid code does not indicate that the applicant is aged (65 or older), blind, or disabled

Comments:

Contacts

- Contacts* screen updated in CMIPS II to include emergency contact information

Comments:

Disaster Preparedness

- Disaster preparedness information consistent with assessment documentation

Comments:

Mandated Forms (On file and Current)

- 12-02 HHSA – *Voter Registration Interest/Declination*
 20-46 HHSA – *Language Needs Determination* (Form needs to be updated and signed at each recertification for any client whose primary language is not English.)
 20-49 HHSA – *Civil Rights / Interpreters*
 12-44 HHSA – *Timesheet Signature Authorization / Verification Form*
 SOC 295 – *Application for Social Services* (10/09)
 SOC 332 – *Recipient / Employer Responsibility Checklist*
 SOC 450 – *Voluntary Services Certification*
 SOC 827 – *Individual Emergency Back-Up Plan (PCSP Recipient's)*
 SOC 864 – *IHSS Program Individualized Back-up Plan and Risk Assessment (IPO Recipient's)*

Comments:

18-Month Variable Assessment

- 12-12 HHSA – *18-Month Variable Assessment Approval* form on file and all criteria met

Comments:

Provider Information (if a provider is providing services)

- 12-53A HHSA – *Letter to Recipient - Provider Enrollment* sent
 SOC 426A – *Recipient Designation of Provider* form on file
 Provider is in active status on *Case Providers* screen in CMIPS II
 Relationship to Recipient field is correct on the *Case Providers* screen in CMIPS II

Comments:

IHSS QCA CASE REVIEW SUMMARY

Case Name:

CMIPS II Case Number:

Other issues identified that affect eligibility or authorized services:

Results of home visit:

IHSS QCA HOME VISIT INTERVIEW GUIDE

Date: _____
Case Name: _____ CMIPS Case #: _____
Also Present: _____ Relationship: _____
Identification: _____ (ID, DL Senior Citizen ID) D.O.B. _____

Do you drive? Yes No
Social Security Card viewed? Yes No

Social Worker Information

Do you know who your IHSS SW is? Yes No
When was your IHSS SW here last? _____
How often do they visit you? _____
Do you know how to contact her/him? Yes No

Household Information

Who is currently living at this residence? (**Review Household Evidence Screen**)
Other household members receiving IHSS:
Name: _____ Relationship: _____
Do you have any family members or friends who work for the County of San Diego? Yes No If yes, what is their Name and Department? _____

Residence Information (Review Household Evidence Screen)

Total number of rooms in home: Bed: _____ Bath: _____ Other: _____
Sole Use Rooms: _____ Rooms shared: _____
Do you have a washer and dryer on premises? Yes No

Alternative Resources

Do you attend school, adult daycare or other program? Yes No
If so, hours: _____
Services provided: _____

Hospitalizations

Have you been hospitalized in the last year? Yes No
If so when? _____
Did you inform your Social Worker? Yes No N/A
Have there been any changes in your health/needs since then? Yes No

Are you aware that you cannot claim hours during periods when you (client) are not in the home (e.g. hospital, out-of-town, etc...)? Yes No

Health and Needs/ Physical Observations

Tell me about your health problems. What is the impact to your ability to perform the activities of daily living in your home? _____

Physical Observations:

Provider Information

Name of your provider: _____ Relationship: _____

Live-In IP: Yes No

What is your provider's schedule? _____ days per week _____ hours each day

(Review Assessed Needs):

Does your provider always work all of the authorized hours? Yes No

Do you feel that you are receiving all the services that you require? Yes No

Do you know that it is your responsibility to report if your needs change, (either increasing or decreasing) to your social worker? Yes No

If you are unable to resolve an IHSS issue with your Social Worker or their Supervisor, you can request a fair hearing before an impartial judge. The phone number is located on the back of your Notice of Action.

Time Sheets

Who completes the time sheets? _____

Is it completed before or after the work is done? _____

Who signs the IHSS timesheets? _____

If you had to replace your provider, would you need assistance finding one?

Yes No

Provider Enrollment (877) 351-7744

Would you like information about the Public Authority Registry?

Yes No

Public Authority (866) 351-7722

Elder Dependent Abuse or Neglect

We are mandated reporters of abuse of any kind. Do you feel that you have been abused in any way by anyone? Yes No

If so, by whom and what is the nature of the abuse/incidents?

Emergency Back-up Plan

Did your Social Worker complete an emergency back-up plan form and provide you with a copy?

Yes No

Questions/Comments

PROVIDER INTERVIEW GUIDE

Date: _____

Case Name: _____ CMIPS Case #: _____

When did you start providing IHSS services to the client? _____

What is your schedule? _____ days per week _____ hours each day

What services do you provide? _____

(Review Service Type Details):

Who completes the IHSS timesheets? _____

Who signs the timesheets? _____

Are you aware that you cannot claim IHSS hours during periods when the client is not in the home (e.g. hospital, out-of-town, etc...)? Yes No

Do you provide any services that are not being paid for by the IHSS program?

Do you provide IHSS services to any other IHSS recipients? Yes No

Questions/Comments

IHSS QCA TARGETED CASE REVIEW SUMMARY

REVIEW ISSUE

ENTER SUMMARY OF REVIEW ISSUE

CASE NAME: _____ CMIPS II CASE #: _____

IHSS SOCIAL WORKER: _____

RESULTS

- CASE IS IN COMPLIANCE
- CASE IS NOT IN COMPLIANCE; REFER TO IHSS SOCIAL WORK SUPERVISOR
- OTHER ISSUE(S) FOUND DURING REVIEW:

QCA REVIEWER: _____ DATE: _____

CASES NOT IN COMPLIANCE MUST BE REVIEWED BY:

QCA SUPERVISOR: _____ DATE: _____

IHSS SOCIAL WORK SUPERVISOR: _____ DATE: _____

IHSS QCA DENIED CASE REVIEW SUMMARY

Date: _____

QCA Social Worker: _____

Recipient Name: _____

CMIPS II Case Number: _____

IHSS Social Worker: _____

Contact made within 7 days of application date?

YES ___ NO ___

Type of contact made?

P/C ___ H/V ___ N/A ___

If a home visit was conducted, was the SOC 295 signed by the applicant?

YES ___ NO ___ N/A ___

Reason(s) for denial clearly documented?

YES ___ NO ___

Name & relationship of person contacted clearly documented?

YES ___ NO ___ N/A ___

Action reviewed by SWS or lead worker using a CMIPS II Case Note?

YES ___ NO ___

Case denied within 45 days of application date? (SOC N/A)

YES ___ NO ___ N/A ___

If not denied within 45 days of application date:

Date of application: _____

Date application denied: _____

Results in Compliance

Training Issue

Corrective Action Required

Additional Comments:

Corrective Action Completed By:

IHSS Social Worker: _____ Date: _____

Reviewed By:

IHSS Social Work Supervisor: _____ Date: _____

Unless otherwise indicated, corrective action needs to be made immediately. A response is due to Quality Control within 45 days of the date distributed (e-mailed). Sign and return an electronic copy to the QCA Supervisor and copy the QCA Social Worker.

IHSS QCA Response From District/Reply From QCA

Date: Select Date
To: QCA Social Worker
From: Social Work Supervisor
IHSS Social Worker: Social Worker Name
Recipient: Recipient's Name
CMIPS II Case Number: CMIPS II Case Number

Social Worker Response to QCA

Please include all appropriate IHSS Program Guide, IHSS Policy & Procedure Manual, and/or California State Manual of Policies and Procedures - Division 30 references that support your position.

Social Worker Response: Detailed summary of QCA review disagreement

QCA Response to Social Worker

If QC has adequately shown that IHSS Policy and Procedure supports the item in question, the Social Worker will need to make the correction immediately upon receipt of this response.

QCA Social Worker Response: Detailed summary of QCA Worker's response

IHSS QCA CASE REVIEW REQUEST/REVIEW RESULTS

Social Worker Name	Social Worker Number	Phone Number	Mailstop

Recipient's Name: _____ CMIPS II Case Number: _____ Language: _____

Address: _____ City: _____ ZIP: _____

Provider Name: _____ Language: _____

Primary reason that a QCA review is being requested: _____

SUPERVISOR: _____

DATE: _____

IHSS QCA CASE REVIEW RESULTS

QCA Worker Name	QCA Worker Number	Phone Number

QCA Worker Results: _____

IHSS QCA IMMEDIATE ACTION/DROPPED CASE NOTICE

Date: [Select Date](#)
To: [Enter SW Supervisor Name](#)
From: [Enter QCA SW Name](#)
IHSS Social Worker: [Enter SW Name](#)
SW Telephone #: [Enter SW Telephone Number](#)
Case Name: [Enter Case Name](#)
CMIPS II Case #: [Enter CMIPS Case Number](#)

DISTRICT RESPONSE IS DUE WITHIN 30 DAYS

Immediate Action

The above case was reviewed by QCA and found to need immediate action. The reason for the immediate action is:

- Critical Incident: The recipient's health and/or safety are at risk by the service assessment or service delivery.
- IHSS Ineligibility: Recipient has been found to possibly be ineligible to IHSS services.
- Suspected Fraud: QCA review has discovered, or has been given, evidence of fraudulent activity in this case.

Dropped Case

The above case was selected by QCA for review; however, the review could not be completed for the following reason(s):

- 1. Recipient moved out of the County or State.
- 2. Recipient is unwilling to give information to complete a home call.
- 3. QCA is unable to locate recipient/whereabouts unknown.
- 4. The recipient is temporarily not in the home.
- 5. The recipient is deceased.

The IHSS Social Worker is required to immediately close the case, subject to the ten-day NOA requirement. When/if the recipient agrees to cooperate with QCA, the IHSS Social Worker needs to contact the QCA Social Worker listed above. The case cannot be reopened until the IHSS Social Worker has received notification from the QCA Social Worker that the recipient has cooperated with QCA.

Summary

Essential facts: [Enter summary of essential facts](#)

Recommendation: [Enter recommendations](#)

Applicable Regulation(s): [Enter applicable regulations](#)

District Response

Date of Case Action/Termination: [Click here to enter a date.](#)

Completed by: [Enter SW Name](#)

IHSS QCA INCOMPLETE CASE REVIEW REPORT

LIST ANY CASE THAT IS NOT EXPECTED TO BE COMPLETED AND TURNED IN FOR REVIEW BY THE LAST WORKING DAY OF THE MONTH.

DUE AT THE END OF THE MONTH

CMIPS II CASE NUMBER	CASE NAME	REASON CODE	EXPECTED DATE OF COMPLETION

REASON CODES:

A. UNABLE TO COMPLETE HOME VISIT TIMELY

1. CLIENT IN HOSPITAL/FACILITY
2. CLIENT OUT OF TOWN
3. CLIENT ILL/UNABLE TO MEET WITH QCA
4. OTHER*

B. UNABLE TO INTERVIEW PROVIDER

1. PROVIDER NOT RETURNING CALLS
2. PROVIDER TEMPORARILY OUT OF TOWN
3. OTHER*

C. UNABLE TO COMPLETE REVIEW TIMELY

1. UNEXPECTED/UNSCHEDULED TIME OFF
2. INTERRUPTED DUE TO FRAUD REFERRAL(S)
3. OTHER*

*OTHER—EXPLAIN:

QCA SOCIAL WORKER NAME/NUMBER _____



County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

AGING & INDEPENDENCE SERVICES

P.O. BOX 23217, SAN DIEGO, CALIFORNIA 92193-3217

March 18, 2013

Enter Recipient's Name

Case Number: CMIPS II Case Number

Enter Address

Enter City, State and Zip Code

The IHSS Quality Control and Assurance Section randomly selected the In-Home Supportive Services (IHSS) case for the recipient named above for review. At the home visit, the Social Worker will ask detailed questions about the assistance needed and will check for safety issues in the home.

Select Appointment and Date

- The recipient must be present during the home visit.
- Photo identification and Social Security card for the recipient must be available.
- Prior to the home visit, place pets who are not contained in another room.
- As a health and safety consideration, please refrain from smoking during the home visit.

Please contact the Social Worker below by **Select Date** to confirm or reschedule this appointment. Failure to participate in the Quality Control process could affect future services.

Thank you for your cooperation.

Name Worker Number

Social Worker

Quality Control & Assurance

(858) Phone Number

IHSS QCA TARGETED CASE REVIEW LOG TELEPHONE REVIEWS

REVIEW MONTH: Enter Month of Review

ISSUE: Telephone review on cases that have been selected through an ad hoc report that is based on a face-to-face date that is one month prior to the review month.

	SW Worker Number	Case Name (Last Name, First Name)	CMIPS II Case Number	Results/Action Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

QCA REVIEWER: Enter Name of QCA Social Worker

DATE: Select Date

APPLICATION FOR SOCIAL SERVICES**TO THE APPLICANT:** *This form is subject to verification.***NOTE:** *Retain your copy of this application.*

*** SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

		CASE NUMBER:	DATE OF APPLICATION:
1. NAME		*SOCIAL SECURITY NUMBER	
ADDRESS		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
CITY	ZIP CODE	TELEPHONE ()	BIRTHDATE
2. Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		ARE YOU A SPOUSE/CHILD OF A VETERAN? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER:
3. Do you receive SSI/SSP benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF "YES", CHECK YOUR TYPE OF LIVING ARRANGEMENT: <input type="checkbox"/> Independent Living <input type="checkbox"/> Board and Care <input type="checkbox"/> Home of Another	
SERVICES BEING REQUESTED:			
4. Have you received In-Home Supportive Services (IHSS) in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "YES", complete the following:			
DATE AND COUNTY WHERE SERVICE WAS LAST RECEIVED		TOTAL MONTHLY HOURS	NAME USED (IF DIFFERENT FROM ABOVE)
5. LIST FAMILY MEMBERS IN HOUSEHOLD		BIRTHDATE	*SOCIAL SECURITY NUMBER
NAME OF SPOUSE <input type="checkbox"/> NAME OF PARENT <input type="checkbox"/>			
CHILD/OTHER RELATIVE			
CHILD/OTHER RELATIVE			
6. The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.			
A. My ethnic origin is (see reverse side for correct code):		B. I speak and understand English: My primary language is (see reverse side for correct code):	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

- 1) Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
- 2) Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
- 3) Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
- 4) Notifying the County IHSS office when I hire or fire a provider.

In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

- 1) In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
- 2) If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
- 3) The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
- 4) I will be responsible for paying for any services I receive that are not included in my IHSS authorization.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity, I may be subject to unannounced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

SIGNATURE OF APPLICANT:	DATE:
SIGNATURE OF APPLICANT'S REPRESENTATIVE: (ONLY IF APPLICABLE)	DATE: (ONLY IF APPLICABLE)
REPRESENTATIVE'S RELATIONSHIP TO APPLICANT: (ONLY IF APPLICABLE)	REPRESENTATIVE'S TELEPHONE NUMBER: (ONLY IF APPLICABLE) ()
REPRESENTATIVE'S ADDRESS: (ONLY IF APPLICABLE)	

To report suspected fraud or abuse in the provision or receipt of IHSS services please call the fraud hotline 800-822-6222 or go to www.stopmedicalfraud@dhcs.ca.gov.

FOR AGENCY USE ONLY

INCOME ELIGIBLE: <input type="checkbox"/> YES <input type="checkbox"/> NO	STATUS ELIGIBLE: <input type="checkbox"/> YES <input type="checkbox"/> NO	VERIFICATION:	SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTATIVE:	TELEPHONE NUMBER: ()
RECIPIENT STATUS: <input type="checkbox"/> Refugee <input type="checkbox"/> Cuban/Haitian Entrant			SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS (EXPLAIN)	

A. Ethnic Codes:

1. White
2. Hispanic
3. Black
4. Other Asian or Pacific Islander
5. American Indian or Alaskan Native
7. Filipino
- C. Chinese
- H. Cambodian
- J. Japanese
- K. Korean
- M. Samoan
- N. Asian Indian
- P. Hawaiian
- R. Guamanian
- T. Laotian
- V. Vietnamese

B. Language Codes:

- | | |
|--|---------------|
| O. American Sign Language (AMISLAN or ASL) | G. Mien |
| 1. Spanish - NOA will be issued in Spanish | H. Hmong |
| 2. Cantonese | I. Lao |
| 3. Japanese | J. Turkish |
| 4. Korean | K. Hebrew |
| 5. Tagalog | L. French |
| 6. Other non-English | M. Polish |
| 7. English | N. Russian |
| 9. Spanish - NOA will be issued in English | P. Portuguese |
| A. Other Sign Language | Q. Italian |
| B. Mandarin | R. Arabic |
| C. Other Chinese Languages | S. Samoan |
| D. Cambodian | T. Thai |
| E. Armenian | U. Farsi |
| F. Ilacano | V. Vietnamese |

In-Home Supportive Services Quarterly Report On Quality Assurance/Quality Improvement (QA/QI) For Personal Care Services Program (PCSP), IHSS Plus Option (IPO) And IHSS Residual (IHSS-R) Programs				
County:				
County Code:		Reporting Quarter:		
Name/Title of Person Completing Report:				
Telephone Number:		Date Completed:		
ROUTINE SCHEDULED REVIEWS OF SUPPORTIVE SERVICES CASES				
1. Desk Reviews	PCSP	IPO	IHSS-R	
A. Number Of Desk Review Cases With No Further Action Required				
B. Number Of Desk Review Cases Requiring Additional Action				
C. Number Of Desk Review Cases Conducted (1A plus 1B)	0	0		0
2. Home Visits	PCSP	IPO	IHSS-R	
A. Number Of Home Visits With No Further Action Required				
B. Number Of Home Visits Requiring Additional Action				
C. Number Of Home Visits Conducted (2A plus 2B)	0	0		0
3. Total Number Of Desk Reviews And Home Visits Conducted	PCSP	IPO	IHSS-R	
A. Total Number Of Reviews (1C plus 2C)	0	0		0
B. Total Number Of Reviewed Cases With No Further Action Required (1A plus 2A)	0	0		0
C. Total Number Of Reviewed Cases Requiring Case Action That <u>Did Not</u> Result In A Change In Service Authorizations				
D. Total Number Of Reviewed Cases Resulting In A Change In Service Authorizations				
E. QA Cases Reviewed This Quarter Still Pending Final Determination				
F. Total Number Of Reviewed Cases With Individual Emergency Back-Up Plan (SOC 827) On File				
4. Resolution Of Cases Pended Last Quarter	PCSP	IPO	IHSS-R	
A. Cases Pended Last Quarter (CPLQ) (3E from last quarter)				
B. CPLQ Determined To Have No Further Action Required				
C. CPLQ Determined To Require Case Action That <u>Did Not</u> Result In A Change In Service Authorizations				
D. CPLQ Determined To Require Case Action Resulting In A Change In Service Authorizations				
E. CPLQ Not Yet Resolved				
5. Fraud Prevention/Detection And Over/Underpayment	PCSP	IPO	IHSS-R	
A. Number Of Cases Identified Through QA/QI Activities Requiring Further County Review				
B. Number Of Cases Identified Through QA/QI Activities Referred To California Department Of Health Care Services For Investigation				
C. Number Of Underpayment Actions Initiated As A Result Of QA/QI Activities				
D. Number Of Nonfraud-Related Overpayments Initiated As A Result Of QA/QI Activities				
E. Number Of Fraud-Related Overpayments Initiated As A Result Of QA/QI Activities				
F. Other: (specify)				

6. Critical Event/Incident Identified (Complete All That Apply)		PCSP	IPO	IHSS-R
A.	Number Of Neglect Cases			
B.	Number of Abuse Cases (Physical, Sexual, Mental, Financial, Exploitation)			
C.	Number Of Provider "No Show" Cases That Pose A Threat To The Health And Safety Of The Recipient			
D.	Number Of "Harmful To Self" Cases			
E.	Number Of Cases With More Than One Critical Event/Incident			
F.	Other: (specify)			
7. Actions Taken On Critical Events/Incidents Requiring A Response Within 24 Hours (Complete All That Apply)		PCSP	IPO	IHSS-R
A.	Adult Protective Services Referral			
B.	Child Protective Services Referral			
C.	Law Enforcement Referral			
D.	Public Authority Referral			
E.	911 Call Center Referral			
F.	Out-Of-Home Placement Referral			
G.	Other: (specify)			
8. Targeted Reviews (Complete All That Apply)		PCSP	IPO	IHSS-R
A.	Timely Assessments			
B.	Timely Reassessments			
C.	Provider Enrollment Statement (SOC 823)			
D.	Voluntary Services Certification (SOC 450)			
E.	Request For Order And Consent-Paramedical Services (SOC 321)			
F.	Protective Supervision Medical Certification Form (SOC 821)			
G.	Hours Exceed Guidelines			
H.	Able And Available Spouse			
I.	Proration Calculations			
J.	Services For Children			
K.	Provider 300+ Paid Hours Report			
L.	Other: (specify)			
9. Quality Improvement Efforts (Check All That Apply)				
A.	Developed QA Tools/Forms And/Or Instructional Materials	<input type="checkbox"/> 9A		
B.	Ensured Staff Attended IHSS Training Academy	<input type="checkbox"/> 9B		
C.	Offered County Training On Targeted Areas	<input type="checkbox"/> 9C		
D.	Established Improvement Committees	<input type="checkbox"/> 9D		
E.	Established Tools For QA/QI Fraud Prevention/Detection	<input type="checkbox"/> 9E		
F.	Conducted Corrective Action Updates (attach a brief summary)	<input type="checkbox"/> 9F		
G.	Utilized Customer Satisfaction Surveys	<input type="checkbox"/> 9G		
H.	Other: (specify)	<input type="checkbox"/> 9H		

INSTRUCTIONS FOR COMPLETING SOC 824

COUNTY INFORMATION:

County – Enter county name.

County Code – Enter county number.

Reporting Quarter – Enter the months covered in the report (Jan-Mar 08).

Name/Title of Person Completing Report – Enter name/title of person completing report.

Telephone Number – Enter the telephone number of the person completing report.

Date Completed – Enter the date the report was completed.

SECTION 1 - Desk Reviews: Case files reviewed by county QA Staff for the quarter.

- 1A. **Number Of Desk Review Cases With No Further Action Required** – For each program (PCSP, IPO, and IHSS-R), enter the number of case files reviewed during the reporting period that did not require further action. (i.e., file does not require follow up – documentation complete, forms filled out properly, etc.).
- 1B. **Number Of Desk Review Cases Requiring Additional Action** – For each program, enter the number of case files reviewed during the reporting period that required additional action to be taken.
- 1C. **Number Of Desk Review Cases Completed** – For each program, this will equal the sum of Items 1A and 1B.

SECTION 2 - Home Visits: Home visits conducted by county QA Staff for the quarter.

- 2A. **Number Of Home Visits With No Further Action Required** – For each program, enter the number of home visits conducted during the reporting period that did not require further action. (i.e., file does not require follow up – documentation complete, forms filled out properly, no fraud or APS referrals, etc.).
- 2B. **Number Of Visits Requiring Additional Action** – For each program, enter the number of home visits conducted during the reporting period that required additional action.
- 2C. **Number Of Home Visits Conducted** – For each program, this will equal the sum of Items 2A and 2B.

SECTION 3 - Total Number Of Desk Reviews and Home Visits: Desk reviewed case files and home visits completed by QA Staff for the quarter.

- 3A. **Total Number Of Reviews** – For each program, this will equal the sum of Desk Reviews and Home Visits completed during the reporting period (1C plus 2C). This must also equal the sum of 3B, 3C, 3D, and 3E.
- 3B. **Total Number Of Reviewed Cases With No Further Action Required** – For each program, this will equal the sum of Desk Reviews with no further action required, and Home Visits with no further action required completed during the reporting period (1A plus 2A). This number will ALWAYS be less than or equal to 3A.
- 3C. **Total Number Of Reviewed Cases Requiring Case Action That Did Not Result In A Change In A Change In Service Authorizations** - For each program, enter the number of Desk Reviews and Home Visits completed during the reporting period which required case action that did not result in a change in service authorizations. This number will ALWAYS be less than or equal to the difference of 3A minus 3B.
- 3D. **Total Number Of Reviewed Cases Resulting In A Change In Service Authorizations** - For each program, enter the number of Desk Reviews and Home Visits completed during the reporting period which resulted in a change in service authorizations. This number will ALWAYS be less than or equal to the difference of 3A minus 3B and 3C.
- 3E. **QA Cases Reviewed This Quarter Still Pending Final Determination** - For each program, enter the number of Desk Reviews and Home Visits completed during the reporting period for which a final determination is still pending. This number will ALWAYS be equal to the difference of 3A minus 3B, 3C, and 3D.

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- 3F. **Total Number Of Reviewed Cases With Individual Emergency Back-Up Plan (SOC 827) On File** – For each program, enter the number of cases reviewed which contained completed and signed Individual Emergency Back-Up Plans (SOC 827). This number will ALWAYS be less than or equal to 3A.

SECTION 4 – Resolution Of Cases Pended Last Quarter: The outcome of those cases from the previous reporting period which were reported as “Still Pending Final Determination.”

- 4A. **Cases Pended Last Quarter (CPLQ)** – Enter the number of cases from the previous reporting period which were reported as “Still Pending Final Determination” (3E from previous report). This number must equal the sum of 4B, 4C, 4D, and 4E.
- 4B. **CPLQ Determined To Have No Further Action Required** – From those cases on the previous report “Still Pending Final Determination” (3E), enter the number that were determined to have no further action required. This number will ALWAYS be less than or equal to 4A.
- 4C. **CPLQ Determined To require Case Action That Did Not Result In A Change In Service Authorizations** - From those cases on the previous report “Still Pending Final Determination” (3E), enter the number that were determined to require case action that did not result in a change in service authorizations. This number will ALWAYS be less than or equal to the difference of 4A minus 4B.
- 4D. **CPLQ Determined To Require Case Action Resulting In A Change In Service Authorizations** - From those cases on the previous report “Still Pending Final Determination” (3E), enter the number that resulted in a change in service authorizations. This number will ALWAYS be less than or equal to the difference of 4A minus 4B and 4C.
- 4E. **CPLQ Not Yet Resolved** - From those cases on the previous report “Still Pending Final Determination” (3E), enter the number that remain unresolved. The resolution of these cases will not be reported in future quarters. This number will ALWAYS be equal to the difference of 4A minus 4B, 4C, and 4D.

SECTION 5 - Fraud Prevention/Detection And Over/Underpayment Activities: Complete this section for each program when the county QA staff has suspected, discovered, or been given evidence of fraudulent IHSS activity.

- 5A. **Number Of Cases Identified Through QA/QI Activities Requiring Further County Review** – For each program, enter the number of case files identified during the reporting period requiring further county review due to suspected fraud.
- 5B. **Number Of Cases Identified Through QA/QI Activities Referred to Department of Health Care Services (DHCS) for Investigation** – For each program, enter the number of cases identified during the reporting period referred to DHCS for further investigation or suspected fraud.
- 5C. **Number Of Underpayment Actions Initiated as a Result of QA/QI Activities** - For each program, enter the total number of underpayments identified during the reporting period as a result of QA activities.
- 5D. **Number Of Nonfraud-Related Overpayments Initiated as a Result of QA/QI Activities** – For each program, enter the total number of nonfraud-related overpayments identified during the reporting period as a result of QA activities.
- 5E. **Number Of Fraud-Related Overpayments Initiated as a Result of QA/QI Activities** – For each program, enter the total number of fraud-related overpayments identified during the reporting period as a result of QA activities.
- 5F. **Other (specify)** - For each program, enter the number of cases reviewed during the reporting period for any other types of fraudulent overpayments and identify the types.

SECTION 6 - Critical Event/Incident Identified: Use this section to track those occasions when QA/QI activities lead to the discovery of an immediate threat, or risk to the health and safety of a recipient. Complete this section only if you became aware of any critical events/incidents, as defined here, during the quarter being reported. Complete each (A-E) that applies.

- 6A. **Number of Neglect Cases** – For each program, enter the number of cases that indicated neglect.

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- 6B. **Number Of Abuse Cases (physical, sexual, mental, financial, exploitation)** – For each program, enter the number of cases that indicated abuse.
- 6C. **Number Of Provider “No Show” Cases That Pose a Threat to the Health and Safety of the Recipient** For each program, enter the number of cases that indicated a provider “no show” which posed a threat to the health and safety of a recipient.
- 6D. **Number Of “Harmful to Self” Cases** – For each program, enter the number of cases that indicated a threat of the recipient causing harm to him/herself.
- 6E. **Number Of Cases With More Than One Critical Event/Incident** – For each program, enter the number of cases that indicated more than one critical event or incident.
- 6F. **Other Types Of Critical Events/Incidents (specify)** – For each program, enter the number of cases with any other types of critical events/incidents and identify the types.

SECTION 7 - Actions Taken On Critical Events/Incidents Requiring a Response Within 24 hours:

Enter the number and type of each case referral made during the quarter being reported.

- 7A. **Adult Protective Services (APS) Referral** – For each program, enter the number of completed case referrals.
- 7B. **Child Protective Services (CPS) Referral** – For each program, enter the number of completed case referrals.
- 7C. **Law Enforcement Referral** – For each program, enter the number of completed case referrals.
- 7D. **Public Authority (PA) Referral** – For each program, enter the number of completed case referrals.
- 7E. **911 Call Center Referral** - For each program, enter the number of completed case referrals.
- 7F. **Out-Of-Home Placement Referral** – For each program, enter the number of completed case referrals.
- 7G. **Other (specify)** – For each program, enter the number of any other types of completed cases referrals and identify the types.

SECTION 8 - Targeted Reviews: Targeted case reviews differ from routine scheduled reviews. Focus is limited to a single issue rather than the focus being on the entire case file. Identify the focused areas (A-M) of each targeted review and the number of cases reviewed during the quarter.

- 8A. **Timely Initial Assessments** - For each program, enter the number of targeted case files reviewed for timely initial assessments.
- 8B. **Timely Reassessments** – For each program, enter the number of targeted case files reviewed for timely reassessments.
- 8C. **Provider Enrollment Form (SOC 426)** – For each program, enter the number of targeted cases files reviewed focusing on the Provider Enrollment Form.
- 8D. **Voluntary Services Form (SOC 450)** – For each program, enter the number of targeted case files reviewed focusing on the Voluntary Services Form.
- 8E. **Request For Order And Consent-Paramedical Services (SOC 321)** – For each program, enter the number of targeted case files reviewed focusing on the Paramedical Services Form.
- 8F. **Protective Supervision Medical Certification Form (SOC 821)** – For each program, enter the number of targeted case files reviewed focusing on the Protective Supervision Medical Certification Form.
- 8G. **Hours Exceed Guidelines** – For each program, enter the number of targeted case files reviewed for hours exceeding applicable time guidelines.
- 8H. **Able And Available Spouse** – For each program, enter the number of targeted case files reviewed for appropriate applications of Able and Available Spouse.
- 8I. **Proration Calculations** - For each program, enter the number of targeted case files reviewed for proration calculations.
- 8J. **Services For Children** – For each program (PCSP, IPW, and IHSS-R), enter the number of targeted case files reviewed for services authorized appropriately for children.
- 8K. **Over-300-Hours Report** – For each program, enter the number of targeted case files reviewed that were generated by a review of the Over-300-Hours Report.

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8L. **Other (specify)** – For each program, enter the number of case files reviewed for any other targeted areas and identify the types.

SECTION 9 - Quality Improvement Efforts: Quality Improvement efforts initiated during the quarter. For each (A-H) check all that applies.

- 9A. **Developed QA Tools/Forms And/Or Instructional Materials** – Check box if any tools, forms, and/or other instructional materials were developed for QA activities.
- 9B. **Ensured Staff Attended IHSS Training Academy** – Check box if staff attended IHSS Training Academy.
- 9C. **Offered County Training on Targeted Areas** – Check box if training was offered for county staff on targeted areas.
- 9D. **Established Improvement Committees** – Check box if QA/QI committees were established.
- 9E. **Established tools for QA/QI Fraud Prevention/Detection** – Check box if any tools, forms and/or other materials were developed for fraud prevention/detection.
- 9F. **Conducted Corrective Action Updates (attach a brief summary)** – Briefly describe any corrective action updates developed as part of State or County QA review efforts.
- 9G. **Utilized Customer Satisfaction Surveys** – Check box if customer satisfaction surveys were utilized.
- 9H. **Other (specify)** – Check box if any other Quality Improvement efforts occurred and identify the types.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER ENROLLMENT AGREEMENT

I, _____, UNDERSTAND I AM REQUIRED TO ATTEND THE IHSS PROVIDER
(PRINT NAME)

ORIENTATION TO BE ELIGIBLE TO PROVIDE IHSS. HOWEVER, IF I HAVE BEEN A PROVIDER (ON OR BEFORE OCTOBER 31, 2009), I HAVE THE OPTION TO ATTEND AN IHSS ORIENTATION OR I MAY RECEIVE THE PROVIDER ORIENTATION INFORMATION DIRECTLY FROM THE COUNTY IHSS OFFICE.

1. During the required orientation for IHSS providers:
 - I was given the requirements to be an eligible IHSS provider and a description of the IHSS program. I was informed of my responsibilities as an IHSS provider.
 - I was informed of the consequences of committing fraud in the IHSS program.
 - I was given the Medi-Cal toll-free telephone fraud hotline number, 1-800-822-6222 and Internet Web site, <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx> for reporting suspected fraud or abuse in the IHSS program.
2. I received a demonstration of, and understand, how to complete my timesheet. If I have been a provider (on or before October 31, 2009), I received information on the new timesheet and understand how to complete it.
 - I understand the timesheet should indicate only the authorized services I performed for the recipient and the time needed to perform those authorized services. I understand that my signature on my timesheet verifies that the information I reported on it is true and correct.
 - I understand that, if I am convicted of fraudulently reporting information on my timesheet, in addition to any criminal penalties, I may be required to pay civil penalties of at least \$500, and not more than \$1,000, for each violation of fraud.
 - I understand that when required, it will be necessary for me to place my fingerprint on my timesheet in order to be paid.
3. I understand that I am required to complete Form I-9, a form kept on file by the recipient, which states that I have the legal right to work in the United States.
4. I understand I have the option to submit Form W-4 to request federal income tax withholding and/or Form DE 4 to request state income tax withholding from my wages. I understand that if I do not submit Form W-4 and/or DE 4, no withholding will be taken out of my wages.
5. I understand services cannot be performed when the recipient is away from his/her home (for example, when the recipient is in the hospital or away on vacation). I will contact the recipient's social worker for approval of any services that may be performed when the recipient is away from the home.
 - I understand that, in the future, I will receive an information sheet that names the recipient and the services I am authorized to perform for that recipient.
6. I will cooperate with state or county staff to provide requested information related to the evaluation of a recipient's IHSS case.

I UNDERSTAND THE IHSS PROGRAM RULES EXPLAINED AT THE PROVIDER ORIENTATION OR BY THE PROVIDER ORIENTATION INFORMATION GIVEN TO ME BY THE COUNTY IHSS OFFICE. I ACCEPT THE RESPONSIBILITY TO FOLLOW ANY INFORMATION PROVIDED BY THE COUNTY. I UNDERSTAND THAT FAILURE TO FOLLOW THE REQUIREMENTS PROVIDED TO ME MAY RESULT IN BEING TERMINATED AS AN IHSS PROVIDER.

Provider's Signature

Date