COUNTY OF SAN DIEGO
IN-HOME SUPPORTIVE SERVICES

OVERPAYMENT REFERRAL

DATE: _____

CASE NAME: _____

CASE NUMBER: _____

OVERPAYEE NAME: _____

OVERPAYEE SSN: _____

☐ **RECIPIENT** ☐ **PROVIDER**

OVERPAYMENT PERIOD:

FROM: _____ **TO:** _____

TYPE OF OVERPAYMENT:
(Check all that apply)

☐ **FRAUD** ☐ **NON-FRAUD** ☐ **ADMIN ERROR** ☐ **SOC**

☐ **PCSP** ☐ **IPW** ☐ **IHSS-R**

CAUSE OF OVERPAYMENT

- _____
- _____
- _____
- _____
- _____

SOCIAL WORKER _____ _____
Print Name Signature

SW# _____ **TEL#** _____

OVERPAYMENT LETTER SENT ON _____

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY
1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417
AGING & INDEPENDENCE SERVICES
P O Box 23217, SAN DIEGO CA 92193-3217
(858) 495-5858 FAX (858) 495-5080

IHSS FRAUD REFERRAL

To: PAFD Investigator	**Referral Date:**	
Social Worker Name:	Worker Number: Phone Number:	
Case Name: (Include Middle Initial)	Case Number: 37-	
Client Address:	Client Phone No.:	
Contact Person:	Language:	Relationship to Client:
Contact Address:	Contact Phone No.:	

Provider(s) Name (Include Middle Initial)	**Status** (E L T)	**Phone No.**	**Fraud Participant?**
			Yes ☐ NO ☐
			Yes ☐ NO ☐

See attached SOC 311 for additional provider information.

CASE STATUS

Date Opened:	Active ☐ Leave ☐
Provider Status:	Active ☐ Leave ☐ Closed ☐

FRAUD TYPE

Recipient ☐ Provider ☐ County Employee ☐ Other ☐
Suspected ☐ Confirmed ☐
Period of Fraud: From To (If fraud is ongoing leave date open.)
OVERPAYMENT REFERRAL STATUS: Pending PAFD results ☐ Sent ☐ Date sent:
Estimated Overpayment Amount: (Leave amount open if fraud is ongoing and dates are unclear. Do not submit a fraud referral if the resulting overpayment is less than $1500.00.)

Briefly describe the fraud occurrence and list all other parties involved. Provide all available information (name, address, SSN, phone). Automated form will allow additional pages if needed.

Reporting Party: _____
Facts: _____

SUPPORTING DOCUMENTATION

☐ **SOC 293(s)** ☐ **SOC 293A** ☐ **12-58(s)** ☐ **CMIPS RHISS** ☐ **NARRATIVE(S)** ☐ **OTHER**
☐ **SOC 311(s)** ☐ **SOC 295** ☐ **12-42(s)** ☐ **PSUM** ☐ **CLEARANCES** ☐ **WARR**

SWS SIGNATURE: _____ **DATE:** _____

PROGRAM MANAGER'S SIGNATURE: _____ **DATE:** _____

IHSS OVERPAYMENT WORKSHEET

RECIPIENT:
PROVIDER:
OVERPAYMENT:

PAY PERIOD FROM	PAY PERIOD TO	CHECK NUMBER	CHECK DATE	HOURS	SOC WITHHELD	FICA	MEDICARE	SDI	FEDERAL AND STATE TAXES	UNION DUES	GROSS DOLLARS	NET DOLLARS
		TOTAL		0.0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

D/O _____
FICA _____
SDI _____
PCSP _____

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION

Note: This notice relates ONLY to In-Home Supportive Services.
It does NOT affect your receipt of SSI/SSP or Social Security.

KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

YOUR
HOME
OFFICE

IF REQUESTING A STATE HEARING, PLEASE SEND TO:

SAN DIEGO COUNTY D.F.F.S.
APPEALS SECTION W-402
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
1 (800) 952-5253
HEARING IMPAIRED DIAL
1 (800) 952-8349

Case Number
Date Mailed

PROVIDER INFORMATION	***CLIENT INFORMATION***
NAME:	***NAME:***
DOB:	***DOB:***
SOCIAL SECURITY #:	***SOCIAL SECURITY #:***
PROVIDER #:	***CASE #:***
ADDRESS:	***ADDRESS:***
CITY/STATE/ZIP	***CITY/STATE/ZIP***
TELEPHONE #:	***TELEPHONE #:***

An overpayment referral to the Fiscal Services section of the Department of Social Services or to Revenue & Recovery, is being made based on information from your social worker. The overpayment is in the amount of $_____ and is as a result of:

_____

_____

The overpayment occurred as follows:

MONTH OF SERVICE	*HOURS OF SERVICE*	*RATE/HOUR*	*NET TOTAL*

The San Diego County Health and Human Services Agency requests that you contact:

☐ *Fiscal Services* or ☐ *Revenue & Recovery at:* _____ *to arrange repayment.*

District Office: _____ Service Worker: _____ SW#: _____ Telephone: _____

The above action(s) is supported by Federal Law (Social Security Act), State Law (Welfare and Institutions Code), Federal Regulations (Code of Federal Regulations), State Regulations (California Administrative Code and State Department of Social Services Manual of Policies and Procedures) 30-768.

D/O _____
FICA _____
SDI _____
PCSP _____

PROGRAMA DE SERVICIOS DE AYUDA EN EL HOGAR **(IHSS por sus siglas en inglés)**
NOTIFICACIÓN DE ACCIÓN- PAGO EXCESIVO

Nota: Ésta notificación se relaciona SOLAMENTE a sus Servicios de ayuda en el hogar. NO afecta el recibimiento SSI/SSP o Seguro Social.

GUARDE ESTA NOTIFICACIÓN CON SUS PAPELES IMPORTANTES.

SU OFICINA DE IHSS

SI ESTA PIDIENDO UNA AUDIENCIA ESTATAL, FAVOR DE ENVIAR AL:

SAN DIEGO COUNTY D.F.F.S
APPEALS SECTION W-402
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
1 (800) 952-5253
PERSONAS CON IMPEDIMENTOS DE OÍR MARCAR
1 (800) 952-8349

Número de caso
Fecha de envío por correo

INFORMACIÓN DE PROVEEDOR	***INFORMACIÓN DE CLIENTE***
NOMBRE:	***NOMBRE:***
FECHA DE NACIMIENTO:	***FECHA DE NACIMIENTO:***
***NÚMERO DE SEGURO SOCIAL:* XXX-XX-_____**	***NÚMERO DE SEGURO SOCIAL:* XXX-XX-_____**
NÚMERO DE PROVEEDOR:	***NÚMERO DE CASO:***
DOMICILIO:	***DOMICILIO:***
CIUDAD/ESTADO/CÓDIGO POSTAL:	***CIUDAD/ESTADO/CÓDIGO POSTAL:***
NÚMERO DE TELÉFONO:	***NÚMERO DE TELÉFONO:***

Una referencia de pago excesivo se ha hecho a la sección de Servicios Fiscales del Departamento de Servicios Sociales o al Departamento de Ingresos y Recuperación, en base a información de su Trabajador Social. El pago excesivo es en la cantidad de $_____ y es resultado de:

_____

_____

El pago excesivo ocurrió de la siguiente manera:

MES(ES) DE SERVICIO	*HORAS DE SERVICIO*	*SUELDO / HORA*	*NETO TOTAL*

La Agencia de Salud y Servicios Humanos del Condado de San Diego requiere que usted contacte a:
❑ *Servicios Fiscales o* ❑ *Ingresos y Recuperación al:* _____*para un convenio de pago.* ❑

Oficina de Distrito: _____ Trabajador Social: _____ # de TS: _____ Teléfono: _____

La(s) accion(es) anterior(es) tiene(n) fundamento en la Ley Federal (Acta del Seguro Social), Ley Estatal (Código de Bienestar e Instituciones), Reglamentos Federales (Código de Reglamentos Federales), Reglamentos Estatales (Código Administrativo de California y el Manual de Prácticas y Procedimientos del Departamento de Servicios Sociales del Estado) 30-768.

12-86 CLSP HHSA (06/07) (06/09)

D/O _____
FICA _____
SDI _____
PCSP _____

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION

Note: This notice relates ONLY to In-Home Supportive Services.

☐ **IF BOX IS MARKED, YOU MAY REQUEST A REVIEW OF THIS ACTION. IF REQUESTING AN APPEAL, PLEASE SEND TO:**

KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

COUNTY OF SAN DIEGO
IN-HOME SUPPORTIVE SERVICES
780 BAY BLVD., SUITE 200
CHULA VISTA, CA 91910-5260

YOUR
HOME
OFFICE

Case Number
Date Mailed

PROVIDER INFORMATION	***CLIENT INFORMATION***
NAME:	***NAME:***
DOB:	***DOB:***
SOCIAL SECURITY #: XXX-XX-_____	***SOCIAL SECURITY #: XXX-XX-_____***
PROVIDER #:	***CASE #:***
ADDRESS:	***ADDRESS:***
CITY/STATE/ZIP	***CITY/STATE/ZIP***
TELEPHONE #:	***TELEPHONE #:***

An overpayment referral to the Fiscal Services section of the Department of Social Services or to Revenue & Recovery, is being made based on information from your social worker. The overpayment is in the amount of $_____ and is as a result of:

_____

_____

The overpayment occurred as follows:

MONTH OF SERVICE	*HOURS OF SERVICE*	*RATE/HOUR*	*NET TOTAL*

The San Diego County Health and Human Services Agency requests that you contact:

☐ *Fiscal Services* or ☐ *Revenue & Recovery at:* _____ *to arrange repayment.*

District Office: _____ Service Worker: _____ SW#: _____ Telephone: _____

The above action(s) is supported by Federal Law (Social Security Act), State Law (Welfare and Institutions Code), Federal Regulations (Code of Federal Regulations), State Regulations (California Administrative Code and State Department of Social Services Manual of Policies and Procedures) 30-767.
YOU MAY HAVE THE RIGHT TO FILE A WRITTEN REQUEST FOR APPEAL: IF THE BOX IS MARKED ABOVE, PLEASE SEND YOUR WRITTEN REQUEST TO THE COUNTY ADDRESS ON THE TOP RIGHT HAND CORNER OF THIS FORM WITHIN 90 DAYS.

CC: Fiscal Services Social Worker Overpayment File Revenue & Recovery Account Opening (M/S D-60)

12-86 IP HHSA (05/07) (05/09)

D/O _____
FICA _____
SDI _____
PCSP _____

PROGRAMA DE SERVICIOS DE AYUDA EN EL HOGAR **(IHSS por sus siglas en inglés)**
NOTIFICACIÓN DE ACCION- PAGO EXCESIVO

Nota: Esta notificación se relaciona SOLAMENTE a sus servicios de ayuda en el hogar.

☐ **SI LA CAJA ESTA MARCADA, USTED TIENE DERECHO DE SOLICITAR UNA REVISIÓN DE SUPERVISOR DE ESTA ACCION DENTRO DE 90 DIAS DE LA FECHA ENVIADA. SI USTED ESTA SOLICITANDO UNA REVISION. ENVÍE SU PETÍCION ESCRITA AL:**

COUNTY OF SAN DIEGO
IN-HOME SUPPORTIVE SERVICES

OVERPAYMENT SPECIALIST
780 BAY BLVD., SUITE 200
CHULA VISTA, CA 91910-5260

GUARDE ESTA NOTIFICACIÓN CON SUS PAPELES IMPORTANTES.

SU OFICINA DE IHSS

Numero de caso
Fecha en que se envió

INFORMACION de PROVEEDOR	***INFORMACION de CLIENTE***
NOMBRE:	***NOMBRE:***
FECHA DE NACIMIENTO:	***FECHA DE NACIMIENTO:***
SEGURO SOCIAL #: XXX-XX-_____	***SEGURO SOCIAL #: XXX-XX-_____***
PROVEEDOR #:	***CASO #:***
DOMICILIO:	***DOMICILIO:***
CIUDAD/ESTADO/CÓDIGO POSTAL:	***CIUDAD/ESTADO/CÓDIGO POSTAL:***
TELÉFONO #:	***TELÉFONO #:***

Una referencia de pago excesivo se ha hecho a la sección de Servicios Fiscales del Departamento de Servicios Sociales o al Departamento de Ingresos y Recuperación. El pago excesivo es en la cantidad de $_____ y es resultado de:

_____

_____

El pago excesivo ocurrió de la siguiente manera:

MES (MESES) DE SERVICIO	*HORAS DE SERVICIO*	*SUELDO / HORA*	*CANTIDAD DE DEUDA*

La Agencia de Salud y Servicios Humanos del Condado de San Diego requiere que usted contacte a:
☐ *Servicios Fiscales o* ☐ *Ingresos y Recuperación al:* _____*para un convenio de pago.*

Oficina de distrito: _____ Trabajador Social: _____ TS#: _____ Teléfono: _____

La acción anterior tiene fundamento en la ley federal (Acta del Seguro Social) la ley estatal (Código de Bienestar e Instituciones), ordenamientos federales (Código de Ordenamientos Federales), ordenamientos estatales (Código Administrativo de California y el Manual de Practicas y Procedimientos del Departamento de Servicios Sociales del Estado) 30-767. revisión

SI USTED NO ESTA DE ACUERDO CON ESTA ACCIÓN Y LA CAJA AL PRINCIPIO DE ESTA PAGINA ESTA MARCADA, USTED TIENE EL DERECHO DE SOLICITAR UNA REVISIÓN DE SUPERVISOR. USTED DEBE HACER ESTO DENTRO DE 90 DIAS DE LA FECHA DE ESTA NOTIFICACIÓN. ENVIE SU PETICIÓN POR ESCRITO AL DOMICILIO QUE APARECE EN LA ESQUINA SUPERIOR DERECHA DE ESTA PAGINA. LOS PEDIDOS DESPUES DE 90 DIAS SOLO SERAN CONSIDERADOS SI USTED PRESENTA UNA BUENA CAUSA POR HABER EXCEDIDO LA FECHA TOPE.

CC: Fiscal Services Recipient File Overpayment File Revenue & Recovery Account Opening (M/S D-60)

12-86 IP SP HHSA (05/07) (05/09)

IHSS OVERPAYMENT ACTIVITY LOG

MONTH_____ YEAR_____

OVERPAYEE	RECIPIENT NUMBER	RECIPIENT NAME	DATE OF OP LETTER	TYPE OF OVERPAYMENT		
				FRAUD	ADMINISTRATIVE ERROR	NON-FRAUD

CONLAN II COUNTY VERIFICATION

1. DATE:	2. COUNTY NAME OR COUNTY CODE NUMBER:	
3. RECIPIENT'S NAME:		4. CLIENT INDEX NUMBER:
5. STAFF NAME:	6. SIGNATURE:	7. TELEPHONE NUMBER:

INSTRUCTIONS FOR COMPLETING THE CONLAN II COUNTY VERIFICATION

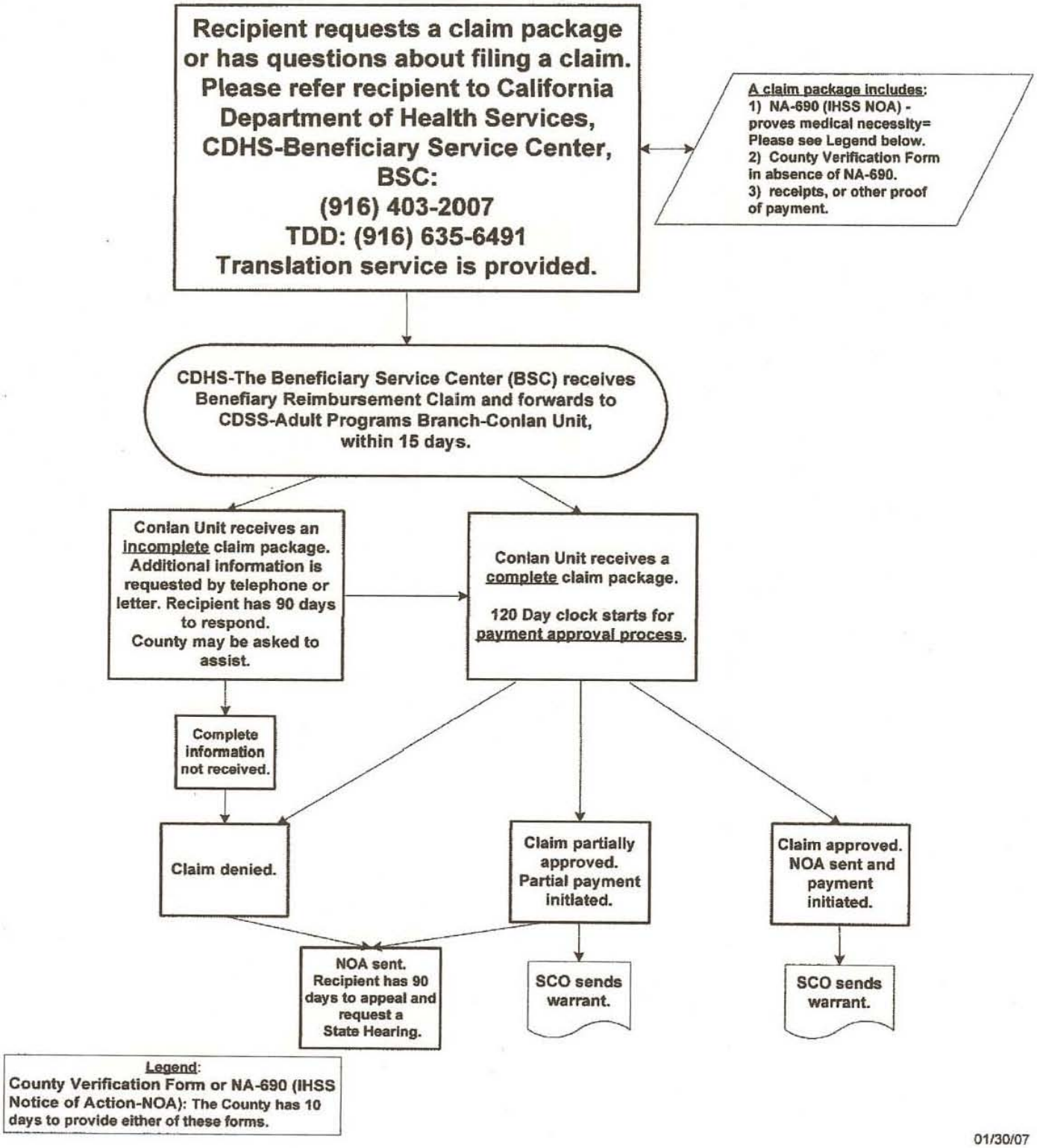
Each county office shall utilize the SOC 828, County Verification Form, in the absence of a NA-690 IHSS Notice of Action (NOA), to verify the In-Home Supportive Services (IHSS) recipient's medical necessity. The completed original should be provided to the recipient to be included with their claim package. The county should maintain a copy for their records.

1. **Date:** Required Field. Enter the date the County Verification is completed.
2. **County Name or County Code Number:** Required Field. Enter the county name or the county code number of the county completing the County Verification.
3. **Recipient's Name:** Required Field. Enter the name of the IHSS recipient/client.
4. **Client Index Number (CIN):** Required Field. Enter the CIN number for the IHSS recipient. The CIN is located on the Recipient Eligibility (REL) Screen in the Case Management, Information and Payrolling System (CMIPS).
5. **Staff Name:** Required Field. Enter the name of the staff completing the County Verification.
6. **Staff Signature:** Required Field. Enter the name of the staff signing the County Verification once printed.
7. **Telephone Number:** Required Field. Enter the telephone number of the staff completing the County Verification.

The county is unable to find the NOA for the above named recipient.

SOC 828 (1/07)

California Department of Social Services (CDSS)
In-Home Support Services (IHSS)
Conlan II Beneficiary Reimbursement Claims Process



01/30/07

Department of Social Services/Social Security Administration

INQUIRY/RESPONSE TO REFERRAL

Date

PROGRAM IDENTIFICATION

requesting agency completes	
For Administration Of:	
	SSI/SSP
	AFDC
	MEDI-CAL
	FOOD STAMPS
	INTERIM ASSISTANCE
	SOCIAL SERVICES
	GR (AUTHORIZATION REQUIRED)
REPRESENTATIVE PAYEE OR DSS CONSERVATOR CASE?	
☐ yes	☐ no

FROM: _____

_____

_____

(agency name and address)

TO: _____

_____

_____

RECIPIENT OR BENEFICIARY IDENTIFYING INFORMATION

name	social security #	DSS case #
address (street #)	telephone #	SS claim/medicare #
(city) (state)	(zip code)	birthdate

If unable to act on own behalf, contact:

name	
address (street)	telephone #
(city) (state)	(zip code)

REASON FOR REQUEST

☐ Information Requested ☐ Referral Information Provided

EXPLAIN SPECIFIC PURPOSE FOR WHICH INFORMATION REQUESTED WILL BE USED, OR GIVE NATURE OF REFERRAL (e.g., Need for Health Care Services, Medi-Cal Application Pending, SSI/SSP Application, etc.)

07-94 DSS(5/83) (5/91)

RESPONDING AGENCY COMPLETES/RETURN TO REQUESTING AGENCY:

☐ Information received/appropriate action taken.

☐ Information requested has been provided directly to the applicant/beneficiary.

☐ Information requested is as follows:

Status of SSA Applicant/Beneficiary:

☐ PENDING ☐ DENIED ☐ RECEIVING BENEFITS | amount $

Expected payment date: | Any Medicare Deduction? yes no

Status of Case

☐ PENDING ☐ CLOSED ☐ ACTIVE - IS RECIPIENT INCLUDED IN CASE ☐YES ☐NO

grant amount $ | grant amount excluding recipient $

Worker signature verifies that information will be used only for purpose requested.

Worker signature	Worker #	telephone #	date

DISCLOSURE AUTHORIZATION

GENERAL RELIEF PROGRAM ONLY: I authorize Social Security Administration to release information from my records to the Department of Social Services for the purpose of_____

MY AUTHORIZATION (CONSENT) IS FOR:

☐ RELEASE OF INFORMATION ON A ONE-TIME BASIS ONLY FOR THE PURPOSE STATED ABOVE.

☐ RELEASE OF ANY INFORMATION NECESSARY FOR THE ABOVE PURPOSE DURING THE PERIOD:

from_____through_____.

I further understand that the above information will be used by any authorized employee of the Department of Social Services involved in administering financial assistance or social service programs and will be entered in my Soc. Svcs. Department case record. I approve the use of the information in this manner.

signature of applicant/beneficiary or authorized representative* date

(* If authorized representative, Form SSA-1696 in File)

07-94 DSS (5/83)

IHSS QC FRAUD INVESTIGATION REQUEST

Worker Name	Worker Number	Phone	Mailstop

Client Name: _____ Case #: _____

Address: _____

City, ZIP: _____ SSN: _____

☐ PCSP ☐ IPW ☐ IHSS-R

Provider Name (if known): _____

Description of situation/issue: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SUPERVISOR: _____ DATE: _____

PROGRAM MANAGER: _____ DATE: _____

QC USE ONLY:

RECEIVED:	ASSIGNED TO:

FINDINGS/RECOMMENDATIONS

☐ Fraud discovered ☐ Fraud suspected

☐ Fraud unsubstantiated ☐ Other findings

Observations:

QC WORKER _____ DATE _____

QC SUPERVISOR _____ DATE _____

IHSS OVERPAYMENT ADJUSTMENT AGREEMENT

DATE: _____

PROVIDER INFORMATION	CLIENT INFORMATION
NAME:	NAME:
DOB: SSN:	DOB:
PROVIDER #:	CASE #:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP	CITY/STATE/ZIP
TELEPHONE #:	TELEPHONE #:

An overpayment referral to the Fiscal Services section of the Department of Social Services, is being made based on information from your social worker. The overpayment is in the amount of $_____ and is as a result of:

The overpayment occurred as follows:

MONTH OF SERVICE	HOURS OF SERVICE	RATE/HOUR	NET TOTAL

- The San Diego County, Aging & Independence Services, requests that you contact Fiscal Services at _____ within 45 days to arrange repayment. Failure to respond will result in your case being transferred to our Revenue and Recovery office for further action. You will receive no further reminders for this overpayment.

CC: Fiscal Services Social Worker Overpayment File

08-72 4/96