

COUNTY OF SAN DIEGO  
HEALTH AND HUMAN SERVICES AGENCY  
AGING & INDEPENDENCE SERVICES – IHSS

**REFERRAL FOR URGENT SERVICES**

WORKER NAME: \_\_\_\_\_

DATE OF REFERRAL: \_\_\_\_\_

RECIPIENT NAME: \_\_\_\_\_

M/S: \_\_\_\_\_ TELEPHONE: (\_\_\_\_)\_\_\_\_\_

RECIPIENT ADDRESS: \_\_\_\_\_

CMIPS CASE NO. 3 7 - \_\_\_\_\_

ADDITIONAL LOCATION INFO: (If applicable)\_\_\_\_\_

RECIPIENT TELEPHONE: \_\_\_\_\_

**INDIVIDUAL PROVIDER INFORMATION:**

NAME: \_\_\_\_\_

NUMBER: \_\_\_\_\_ HOURS: \_\_\_\_\_

NAME: \_\_\_\_\_

NUMBER: \_\_\_\_\_ HOURS: \_\_\_\_\_

**CASE STATUS: (Check all that apply)**

- Residual Program (Code 1031)
- PCSP Program (Code 1034)
- After Hours Referral
- Other: \_\_\_\_\_

**COMMENTS: (Include issues of concern)**

\_\_\_\_\_

**AUTHORIZED SERVICE:**

BEGIN ON: \_\_\_\_\_ END ON: \_\_\_\_\_

FREQUENCY OF SERVICE: \_\_\_\_\_ (times/day)

TOTAL HOURS AUTHORIZED: \_\_\_\_\_

**APPROVAL:**

\_\_\_\_\_  
(Signature-SW Supervisor) (Date)

\_\_\_\_\_  
(Print Name-SW Supervisor)

CODE	SERVICE	AUTHORIZED HOURS
AA	Domestic	
BB	Meal Prep	
CC	Meal Cleanup	
DD	Laundry	
EE	Food Shop	
HH	Respiration	
II	Bowel/Bladder	
JJ	Feeding	
KK	Bed Baths	
LL	Dressing	
MM	Menstrual	
NN	Ambulation	
OO	Move in/out bed	
PP	Bathe/groom	
QQ	Repos./Skin	
RR	Prosthesis/Meds	
	<b>TOTAL HOURS</b>	

**FAX TO: AT YOUR HOME FAMILYCARE  
858-558-6640 M/S N102**

**VENDOR VERIFICATION:**

(To be completed by the vendor after provision of services.)

BEGAN ON: \_\_\_\_\_ ENDED ON: \_\_\_\_\_

FREQUENCY OF SERVICE: \_\_\_\_\_ (times/day) TOTAL HOURS PROVIDED: \_\_\_\_\_

## How to Prepare a Referral for Urgent Services (Form 06-30)

When should this form be used:

**The County must prepare a Referral for Urgent Services (06-30 HHSA) and FAX a copy to At Your Home FamilyCare at 858-558-6640 whenever a new referral for urgent services is issued.** At Your Home FamilyCare is open for business Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. For after-hours of operation and designated holidays the After-Hours Contractor will call At Your Home FamilyCare at 877-687-4368 before faxing a copy of the referral.

Send copies of this form to:

A copy of the referral for Urgent Services (06-30) should be mailed to the IHSS Contract Unit, W433, for all **referrals**.

What information is needed:

The 06-30 must include the following:

DATE OF REFERRAL:	Date the form is completed
WORKER NAME:	Name of Social Worker
TELEPHONE NO:	Telephone number of the Social Worker
RECIPIENT NAME:	As spelled in CMIPS
CMIPS CASE NO.:	Beginning with Co. Code 37, followed by 7 numbers (note there are no alphas included in this number).
RECIPIENT ADDRESS:	To include apt. number, space number, zip code
ADDITIONAL LOCATION INFO.:	Which may include name of apartment complex, hints for finding dwelling; e.g., in back of (address).
RECIPIENT TELEPHONE:	Or number where contractor can contact client to set up service.
INDIVIDUAL PROVIDER INFO:	To include name, provider number, and hours that the provider is unable to perform and that will be provided by the contractor.
CASE STATUS:	Check all applicable information.
SERVICE TO BEGIN ON:	If other, indicate to the contractor what action they need to take.
SERVICE TO END ON:	Use when service should start on an <u>exact date</u> (e.g., when client returns from hospital).
FREQUENCY OF SERVICE:	Use when service should end.
TOTAL HOURS AUTHORIZED:	Indicate number of times per day.
COMMENTS:	Total number of hours authorized for this referral.
APPROVAL:	Can be used for any additional information (e.g., include any factors that may make it difficult to service the recipient).
	The Social Work Supervisor will sign his/her name, and date. This signifies approval. On the 2 <sup>nd</sup> line, the Social Work Supervisor will hand print his/her name. (This section is to be completed by the Social Work Supervisor only.)

### CHART COLUMN HEADINGS

AUTHORIZED HOURS: Enter the number of hours authorized per day per service.

TOTAL HOURS: Enter the total number of hours authorized for the referral.

VENDOR VERIFICATION (To be completed by the vendor after provision of services.)

SERVICE BEGAN ON:	Use to verify the <u>exact date</u> that urgent services were started.
SERVICE END ON:	Use to verify the last date that urgent services were provided.
FREQUENCY OF SERVICE:	Indicate number of times per day that services were provided.
TOTAL HOURS PROVIDED:	Total number of hours of urgent services that were provided.



**A. RECIPIENT**

NAME:	IHSS CASE NO: 37-	TELEPHONE NO: (    )
ADDRESS:	CITY:	ZIP CODE:
EMERGENCY CONTACT NAME:	RELATIONSHIP TO RECIPIENT:	TELEPHONE NO: (    )

**B. REPORTING PARTY**

NAME:	RELATIONSHIP TO RECIPIENT:	TELEPHONE NO: (    )
ADDRESS:	CITY:	ZIP CODE:

**C. COMPLAINT INFORMATION**

NAME OF PROVIDER:	DATE OF OCCURANCE:	REPORT RECEIVED BY:
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NATURE OF COMPLAINT: (✓ Check all that apply)

ASSAULT   
  FINANCIAL   
  PERSONAL CARE   
  HEALTH AND SAFETY HAZARD  
 OTHER

REPORTER'S COMPLAINT STATEMENT:

**D. IHSS SOCIAL WORKER**

NAME:	WORKER NO:	MAIL STOP:	TELEPHONE NO: (    )
ACTIONS TAKEN TO RESOLVE COMPLAINT:			

**E. IHSS SOCIAL WORK SUPERVISOR**

NAME:	WORKER NO:	MAIL STOP:	TELEPHONE NO: (    )
ACTIONS TAKEN TO RESOLVE COMPLAINT:			

**F. IHSS CONTRACT ADMINISTRATOR**

INVESTIGATIVE FINDINGS:			
CORRECTIVE ACTION:			
NAME:	SIGNATURE:	TELEPHONE NO: (858)	DATE:

FAX TO: AT YOUR HOME FAMILYCARE (858) 558-6640

MAIL TO: SOCIAL WORKER AND PROGRAM MANAGER

## INSTRUCTIONS FOR COMPLETING THE PURCHASE OF SERVICES REPORT

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### When should the form be used?

The County must use the form as a report for Fiscal tracking of expenditures for the provision of urgent services to ongoing IHSS recipients.

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### Who should receive copies of the form?

On a monthly basis, the Social Work Supervisor will submit a unit summary to the Program Manager. IHSS Management will send a monthly summary report to AIS Fiscal at mail stop W433. The report will be a synopsis of information from all the reports submitted by the Social Work Supervisors and the After Hours Vendor. The report is due to AIS Fiscal on the first of the month following the month in which services were provided.

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### What information must be contained in the form?

**RECIPIENT NAME:** Enter the name of each IHSS recipient who received urgent services.

**CASE NUMBER:** The County assigned seven-digit number that represents a specific recipient.

#### PROGRAM CODE:

##### Code 1031

Place a check mark in this column if the services were purchased for a Residual Program case.

##### Code 1034

Place a check mark in this column if the services that are being purchased are for a PCSP Program case.

**BEGIN DATE:** The date that the provision of services initiated.

**END DATE:** The date that the provision of services was terminated.

**SOCIAL WORKER:** The County assigned number to identify the recipient's Social Worker.

**INDIVIDUAL PROVIDER NAME /NUMBER:** Enter the name and provider number for the individual provider of record. For multiple providers, make an entry for each and enter the portion of the urgent services that the provider would have been scheduled to work.

**UNITS REFERRED:** The total number of hours authorized to be purchased for the recipient.

**UNITS PROVIDED:** The total number of hours verified as provided by the contractor on the turn around 06-30 HHS.A.

**TOTAL COST:** The number of hours authorized multiplied by the hourly rate (\$16.37).

**SUPERVISOR'S SIGNATURE:** The supervisor must sign and date the completed Purchase of Services Form.





4. Findings/Conclusions) \_\_\_\_\_  
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5. Corrective Action Taken (if applicable) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Comments:

Reviewed by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Upon completion of review a copy will be returned to case manager's supervisor.

J:\Shared\Contract Operations\PO\Contract\Vendor Complaint