

**In-Home Supportive
Services / Medi-Cal
Referral**

Fax

To: Southeast Family Resource Center

From: IHSS District Office

Attention: IHSS FRC Intake Clerk

Fax: **(619) 266-3877**

Pages

:

Phone: (619) 266-3731

Date:

Re: Income Eligible/Medi-Cal

CC:

Eligibility Determination

Urgent For Review Please Comment Please Reply Please Recycle

APPLICANTS WITH ACTIVE CDS/MEDS HISTORY

The beneficiaries listed below have applied for IHSS. A fully completed IHSS/Medi-Cal Communication form is necessary to process the IHSS application.

Case Name	Case Number	Social Security Number	SW #
Case Name	Case Number	Social Security Number	SW#
Case Name	Case Number	Social Security Number	SW#
Case Name	Case Number	Social Security Number	SW#
Case Name	Case Number	Social Security Number	SW#

Fax

To: Southeast Family Resource Center From: IHSS District Office

Attention:

Social Worker No.

IHSS FRC Intake Clerk

Fax: **(619) 266-3877**

Pages:

Phone: (619) 266-3731

Date:

Re: Income Eligible/

CC:

IHSS Recertification Due

Urgent For Review Please Comment Please Reply Please Recycle

MEDI-CAL RECIPIENTS REQUIRING AN IHSS RECERTIFICATION

The names of beneficiaries requiring a Medi-Cal recertification are circled on the Recertification Due Report attached. A completed IHSS/Medi-Cal Communication form is necessary to process IHSS eligibility.

IHSS/MEDI-CAL COMMUNICATION

Case Name [REDACTED]			Case Number [REDACTED]		SSN [REDACTED]	
Share of Cost Date	Code [REDACTED]	Linkage [REDACTED]	Source [REDACTED]	Income [REDACTED]	Deduction [REDACTED]	
Source [REDACTED]		Income [REDACTED]	Deduction [REDACTED]	Source [REDACTED]	Income [REDACTED]	Deduction [REDACTED]
Source [REDACTED]		Income [REDACTED]	Deduction [REDACTED]	Benefit Code [REDACTED]	Level [REDACTED]	[REDACTED]
Medi-Cal SOC [REDACTED]		IHSS SOC [REDACTED]			Medi-Cal Worker [REDACTED]	FRC [REDACTED]

Medi-Cal case denied on [REDACTED]
_____ (DATE)

Medi-Cal case discontinued on [REDACTED]
_____ (DATE)

Comments:

[REDACTED]

|

[REDACTED]



COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY MEDICAL SERVICES PROGRAM (CMSP)

TO APPLY FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP, complete Items 1-13 on the attached application, and sign the Certification Section (Item 19). Give the form to the welfare office. If you have a disability and need help to apply for or keep getting cash aid, benefits, and services, tell the county.

BEFORE YOU CAN GET CASH AID, FOOD STAMPS, OR MEDI-CAL/34-COUNTY CMSP, INCLUDING IMMEDIATE NEED, HOMELESS ASSISTANCE, OR FOOD STAMP EXPEDITED SERVICE, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. We use the facts you give us to figure eligibility and benefits.

FOR CASH AID AND FOOD STAMPS, the county will tell you if and when you need to be fingerprint and photo imaged in order to get benefits.

TO GET IMMEDIATE NEED AND/OR HOMELESS ASSISTANCE, you must appear to be eligible for Cash Aid. Complete the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your social security number(s), trying to get income available to you, and agreeing to cooperate with the local child support agency about child, spousal, and medical support.

FOR FOOD STAMPS, the application can be filled in and signed under penalty of perjury by either an adult household member or by an authorized representative. If you are not an adult member of the household, you must have a written note signed by the head of household or another adult household member saying that you can apply for the household, pick up their food stamps, and/or use the food stamps to buy food for the household.

FOOD STAMPS — Date of Eligibility
If you are eligible for food stamps, we will figure your benefits from the date you apply. You can apply for food stamps the first day you contact the welfare office.

CASH AID IMMEDIATE NEED

If you have an emergency, you may be able to get up to \$200 while we work on your application. You will need to tell us about your emergency situation and you will need to show that you do not have the income or money to pay for these emergencies:

- Lack of housing or lack of food
- Eviction notice
- No utilities or utility shut-off notice
- Lack of essential clothing
- Essential transportation needs not met
- Other kinds of emergencies important to health and safety.

If your Immediate Need request is turned down, you can ask for it again during the time we work on your application. Let the county know if something changes.

CASH AID HOMELESS ASSISTANCE

If you are homeless, or have received a Pay Rent or Quit Notice, and want to apply for homeless assistance, tell the county. Homeless Assistance is available once in a lifetime, with exceptions.

CalWORKs DIVERSION SERVICES

Diversion services can help applicants who need some assistance but do not want or need to go on welfare. Diversion services allow you to choose to get a lump sum cash payment or non-cash services instead of going on aid. You can only choose to get Diversion services at time of application for cash aid, and you may be eligible for Medi-Cal, child care assistance, and food stamps if you get Diversion services.

After reviewing your facts, the county will tell you if you would be eligible for Diversion services. If eligible and you choose to get a Diversion cash payment or non-cash services instead of cash aid:

- You will get a denial notice for cash aid.
- Your cash aid may be lowered or the amount of time you can get cash aid may be reduced if you go on aid later.

APPLICANTS FOR FOOD STAMPS: All you have to do the day you apply is give us your name and address, tell us you want food stamps (Item 8) and sign the application (Item 19). Before we can tell if you are eligible, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. You should be told if you are eligible within 30 days after you apply.

FOOD STAMP EXPEDITED SERVICE

You may have the right to get food stamps within three days. Your household must be eligible for the Food Stamp Program AND HAVE:

- Rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions (**see the other side of the page for definitions of income and liquid resources**),
OR
- No more than \$100 liquid resources and less than \$150 income for the month before deductions,
OR
- No more than \$100 liquid resources and at least one member who is a migrant or seasonal farmworker.

Before you can get food stamps within three days, **complete Items 1 - 17 on the attached application**; give us all the facts we ask for during your eligibility interview; and give us proof of your identity.

MEDI-CAL PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

If you are pregnant, you may get temporary Medi-Cal from certain medical providers for many prenatal care services before applying for regular Medi-Cal. Ask your doctor or clinic if they offer PE. If you apply for CalWORKs or Medi-Cal by the end of the month after the month you get a PE card, your temporary Medi-Cal will continue until aid is approved or denied. If you are getting PE, tell the county and check "YES" in both parts of Item 12.

MEDI-CAL/34-COUNTY CMSP - MEDICAL EMERGENCY/PREGNANCY

If you have a medical emergency or are pregnant AND want Medi-Cal/34-County CMSP as soon as possible, complete Items 1-13. You must also give all the facts we ask for during your eligibility interview and meet all eligibility requirements.

WHAT WE MEAN WHEN WE SAY:

- **CalWORKs:** California Work Opportunity and Responsibility to Kids Program.
- **Cash Aid:** Aid from CalWORKs and/or Refugee Cash Assistance (RCA) programs.
- **Diversion Services:** A lump sum cash payment or non-cash services instead of going on cash aid.
- **Food Stamps:** Benefits for low income households to help buy food.
- **Food Stamp Expedited Service:** Getting food stamps within 3 days.
- **Medi-Cal:** Medically necessary benefits for eligible persons.
- **Medi-Cal Presumptive Eligibility (PE):** Temporary Medi-Cal coverage from certain doctors or clinics for many out-patient prenatal care services.
- **34-County CMSP:** Medically necessary benefits for eligible adults who are not on Medi-Cal and who live in some rural counties.
- **Restricted Medi-Cal:** Medical Care for emergency and pregnancy only.
- **Restricted 34-County CMSP:** Emergency care only.
- **Authorized Representative:** A person picked by an applicant or recipient for food stamps and/or Medi-Cal, who can take care of some of their business.
- **Head of Household:** A responsible member of the food stamp household.
- **Income:** Money received or expected, such as:
 - Earnings, welfare, child/spousal support, Supplemental Security Income/State Supplementary Program (SSI/SSP), or Cash Assistance Program for Immigrants (CAPI);
 - Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI), Veterans Benefits (VA), or other disability payments;
 - Strike funds; payments from roomers and boarders; school grants and loans;
 - Cash gifts, cash winnings, any other cash payments.
- **Liquid Resources:** Money other than income, such as:
 - Cash on hand, uncashed checks; money in checking accounts, savings accounts; or saving certificates;
 - Trust deeds, notes receivable, stocks or bonds, etc.
- **Utilities:** Gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.
- **You, Anyone, Everyone:** Any and all persons who live in your home.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for cash aid, food stamps and Medi-Cal at the same time and have one interview for all.
- You have the right to fill out this form yourself or, if you ask, have someone help you.
- **OVERPAYMENTS/OVERISSUANCES:** means you got more cash aid or benefits than you should have gotten. You will have to pay it back even if the county made an error. Your cash aid or food stamps will be lowered or stopped. Your Medi-Cal/34-County CMSP share of cost may be changed.

- **FRAUD AND PERJURY:** Fraud and perjury are crimes. The law says you must sign a penalty of perjury statement on most forms to get and to keep getting cash aid, food stamps, and Medi-Cal/34-County CMSP. Perjury means that you lied when you swore under oath to give true, correct, and complete facts. If you lie about facts or **on purpose** do not give us all the facts or situations that affect your eligibility and aid payment levels, you can be charged with fraud.
- **If you are found guilty of committing fraud, you may be fined up to \$10,000 for cash aid and \$250,000 for food stamps and/or sent to jail/prison for 3 years for cash aid and 20 years for food stamps. Cash aid and/or food stamps can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years, 20 years or forever; and for Refugee Cash Assistance, 3 months and 6 months.**
- **SOCIAL SECURITY NUMBER (SSN) RULES:** We computer match SSNs against records from tax, welfare, employment, the Social Security Administration, and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also match SSNs to be sure that you are not getting aid in more than one case, or in another county or state; and for cash aid and food stamps, with law enforcement agencies for outstanding arrest warrants.

Cash aid and food stamps: You must give us the SSN for each applicant/recipient for cash aid and/or food stamps. If you refuse to give us either the SSN or proof of application for the SSN, you will not be able to get cash aid or food stamps. For cash aid, you must give us your SSN(s) or proof of application for the SSN within 30 days of application and give the SSN to the county when you get it.

Medi-Cal/34-County CMSP: Each applicant for Medi-Cal/34-County CMSP who has a SSN is asked to give it to the county. Any U.S. citizen, U.S. national, amnesty alien with a valid and current I-688, noncitizen with lawful permanent residence in the U.S. (LPR), or noncitizen permanently residing in the U.S. under color of law (PRUCOL) who refuses to give an SSN or proof of application for an SSN, will not be able to get Medi-Cal/34-County CMSP **and who is not** an amnesty alien with a valid and current I-688 or an LPR or PRUCOL, can still get restricted Medi-Cal/34-County CMSP if he/she meets all eligibility rules, including California residency.

COMPLAINTS

If you think you have been discriminated against, contact your county's civil rights representative or write to:
State Civil Rights Bureau
P.O. Box 944243
Sacramento, CA 94244-2430
or call collect (916) 654-2107
or for the hearing or speech impaired
TDD 1 - (916) 654-2098

For other kinds of complaints, contact your county first. If you and the county cannot agree, write or call to:
Public Inquiry and Response (PIAR)
744 P Street, M.S. 6-23
Sacramento, CA 95814
Phone 1 - (800) 952-5253
or for the hearing or speech impaired
TDD 1 - (800) 952-8349

STATE HEARINGS

You must ask for the hearing within 90 days of the county's action and you must tell why you want a hearing. You can ask for a State Hearing by writing to your local county appeals office or by calling one of the phone numbers listed for PIAR above, if you:

- Do not agree with any action taken by the county, or
- Are asking for a state hearing for cash aid, food stamps, Medi-Cal.

To appeal all 34-County CMSP eligibility issues, you can **only write** to your county.

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP

Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)		2. SOCIAL SECURITY NUMBER (SSN)		COUNTY USE ONLY	
3. MAIDEN OR OTHER NAME (IF ANY)		2A. DATE OF BIRTH (MM-DD-YYYY)			
4. HOME ADDRESS: NUMBER STREET		5. MAILING ADDRESS (IF DIFFERENT)		CASE NUMBER	
CITY STATE ZIP CODE		CITY STATE ZIP CODE		DATE RECEIVED	
6. TELEPHONE NUMBER(S): HOME WORK MESSAGE				TYPE OF APPLICATION:	
7. Is your home address permanent? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO HOME				CA: <input type="checkbox"/> CA <input type="checkbox"/> RCA	
8. Is anyone applying for: Cash Aid <input type="checkbox"/> YES <input type="checkbox"/> NO Medi-Cal <input type="checkbox"/> YES <input type="checkbox"/> NO		Food Stamps <input type="checkbox"/> YES <input type="checkbox"/> NO 34-County CMSP <input type="checkbox"/> YES <input type="checkbox"/> NO		FS: <input type="checkbox"/> Initial <input type="checkbox"/> Recert <input type="checkbox"/> Rest	
Any Other Program(s) <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain:				MC: <input type="checkbox"/> CMSP: <input type="checkbox"/>	
9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/34-County CMSP/Medicaid or Diversion cash or non-cash services? If "YES", list:		<input type="checkbox"/> YES <input type="checkbox"/> NO		Homeless:	
TYPE OF AID/BENEFIT		DATE(S) RECEIVED		FS: <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME(S) USED		RECEIVED WHERE? (COUNTY/STATE/COUNTRY)		CA: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CW 42	
10. The law says we must record your ethnic group, race and language. This won't affect your eligibility.					
A. ETHNICITY (Everyone must also answer B)					
Are you Hispanic or Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO					
B. RACE/ETHNIC ORIGIN - Check all boxes that apply to you. If you do not complete this question the county will do it for you.					
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White					
<input type="checkbox"/> Asian (If checked, please select one or more of the following)					
<input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian					
<input type="checkbox"/> Cambodian <input type="checkbox"/> Laotian <input type="checkbox"/> Other Asian (specify) _____					
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following)					
<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other (specify) _____					
C. PRIMARY LANGUAGE:					
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Lao <input type="checkbox"/> Tagalog <input type="checkbox"/> American Sign <input type="checkbox"/> Cantonese <input type="checkbox"/> Cambodian					
<input type="checkbox"/> Vietnamese <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify) _____					
11. Is anyone a migrant or seasonal farmworker? <input type="checkbox"/> YES <input type="checkbox"/> NO					
12. Is anyone pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", did she get a Presumptive Eligibility card? <input type="checkbox"/> YES <input type="checkbox"/> NO					
13. Does anyone have a personal emergency? If "YES", check (✓) type: <input type="checkbox"/> YES <input type="checkbox"/> NO					
<input type="checkbox"/> Immediate Medical Need <input type="checkbox"/> Pregnancy <input type="checkbox"/> Child Abuse <input type="checkbox"/> Domestic Abuse					
<input type="checkbox"/> Elder Abuse <input type="checkbox"/> Other emergency which threatens health or safety. Explain:					
IF YOU NEED: CASH AID IMMEDIATE NEED PAYMENT.....FILL IN ITEMS 14 - 18.					
FOOD STAMP EXPEDITED SERVICE.....FILL IN ITEMS 14 - 17.					
14. How much liquid resources does everyone, including children, have?		17. How much are your utilities that are not included in your rent this month? \$			
<input type="checkbox"/> Cash, uncashed checks or money orders \$ _____				YES NO	
<input type="checkbox"/> Checking/savings or credit union account(s) \$ _____		18. Do you have an eviction notice or notice to pay or quit?			
<input type="checkbox"/> Trust deeds, notes receivable, stocks or bonds \$ _____		Have your utilities been shut off or do you have a shut-off notice?			
<input type="checkbox"/> Other (explain) \$ _____		Will your food run out in 3 days or less?			
15. How much income did everyone, including children, get or will they get this month?		Do you need essential clothing, such as diapers or clothing needed for cold weather?			
Date Amount Date Amount		Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?			
_____ \$ _____					
_____ \$ _____					
16. How much is your rent or mortgage this month?					
\$ _____					
<ul style="list-style-type: none"> I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified. I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service. I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete. 					
19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE		DATE SIGNED		COUNTY OF APPLICATION	
SIGNATURE OF WITNESS TO MARK OR INTERPRETER		DATE SIGNED		COUNTY OF RESIDENCE (IF DIFFERENT)	

RELA Screen

Recipient Case - RELA

```

THIS RELA I 5555555555
NEXT RELB I 5555555555

CIN 96981210C4 REPRINT N
A SEQ# 008 AID 10 SSN 001 - 22 - 3324 SEX F BIRTH DATE 04181936
B LAST NAME STEVENSON FIRST BERNADINE MI
C ST 12855 OAKS AVE APT 211 CY CHINO ST CA Z 91710 3675
D PHONE # ( 909 ) 902 - 5767 DP ZZZ GUARDIAN
E ST CY ST Z

F STATUS MC AID INS DATE CTZN ETHNIC LANG OTH/COV SSNV HIC./R.R. # FBU #
E LX 2N 2 7
G SPOUSE/PARENT # HH RCP RES L/A ROOMS YARD WASH DRY STOVE REFIG
00 01 01 02 01 04 N Y Y Y Y

F U N C T I O N A L L I M I T A T I O N S
H HOUSE LNDRY SHOP MEAL MOBILITY BATH DRESS BB/M TRANSFER EAT BREATH
4 4 3 3 1 2 2 1 2 1 1

F U N C T I O N A L
H MEMORY ORIENT JUDGE INDEX HOURS W/O IHSS NEED PROV
1 1 1 2.00 63.3 3 11 1:1
DATE LAST CHANGED 08/30/2005 DATE ADDED 11/20/2003
F03=EXIT F04=CINV F05=CIN UPDATE F08=NEXT
    
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Recipient Case - RELB

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THIS RELB I 5555555555
NEXT RELC I 5555555555

                                STEVENSON, BRUCE

SOC DATE  IND  LINK  #DEP
07012005   D
I SOURCE / INCOME / DEDUCT  1 $
J 2 $ 3 $
K 4 $ 4 $
L MODE  RATE  HOURS  MODE  RATE  HOURS
IP $ 6.25 200.4 $
R
SEGMENT SELECT 1
ACT  BEG DATE  END DATE  GROSS AMT  MODE  RATE  HOURS  SHR/COST  TYPE  OPT  MEALS
M  07012005  06302006  $ 1452.90  IP  6.25 200.4  99999.00  S  R
$
N  07012004  06302005  $ 1352.70  IP  6.75 200.4  99999.00  S  R
$
O  07012003  06302004  $ 1393.20  IP  6.75 206.4  99999.00  S  R
$
P  APPLICATION DATE  REF  FACE/FACE DATE  COUNTY USE
05231998 15 05232005
***** SERVICE WORKER *****
Q DO# 01 F NAME ROBERTA L NAME JACKSON # 1234 PH# ( 999 ) 666 - 1234
F03=EXIT F08=NEXT
    
```

Recipient History Screen

Recipient Case History – RHSA

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THIS RELA I 555555555008
NEXT RELB I 555555555008

CIN 96981210C4 REPRINT N
A SEQ# 008 AID 10 SSN 001 - 22 - 3324 SEX F BIRTH DATE 04181936
B LAST NAME STEVENSON FIRST BERNADINE MI
C ST 12855 OAKS AVE APT 211 CY CHINO ST CA Z 91710 3675
D PHONE # ( 909 ) 902 - 5767 DP ZZZ GUARDIAN
E ST CY ST Z

F STATUS MC AID INS DATE CTZN ETHNIC LANG OTH/COV SSNV HIC./R.R. # FBU #
E LX 2N 2 7
G SPOUSE/PARENT # HH RCP RES L/A ROOMS YARD WASH DRY STOVE REFIG
00 01 01 02 01 04 N Y Y Y Y

F U N C T I O N A L L I M I T A T I O N S
H HOUSE LNDRY SHOP MEAL MOBILITY BATH DRESS BB/M TRANSFER EAT BREATH
4 4 3 3 1 2 2 1 2 1 1

F U N C T I O N A L
H MEMORY ORIENT JUDGE INDEX HOURS W/O IHSS NEED PROV
1 1 1 2.00 63.3 3 11 1:1
DATE LAST CHANGED 08/30/2005 DATE ADDED 11/20/2003
F03=EXIT F04=CINV F05=CIN UPDATE F08=NEXT
    
```

Recipient Case History – RHSA

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THIS RELB I 555555555008
NEXT RELC I 555555555008

                                STEVENSON, BRUCE
SOC DATE IND LINK #DEP
07012005 D SOURCE / INCOME / DEDUCT MONTHLY TOTALS
I SOURCE / INCOME / DEDUCT 1 $ CNTBLE INCOME $ 0.00
J 2 $ 3 $ BNFT LVL $ 0.00
K 4 $ IHSS SOC $ 99999.99
L MODE RATE HOURS MODE RATE HOURS MEDI-CAL SOC $ 99999.99
IP $ 6.25 200.4 $ RECOVERY AMOUNT $ 0.00
R STATE HEARING HRS 0.00

SEGMENT SELECT 1
ACT BEG DATE END DATE GROSS AMT MODE RATE HOURS SHR/COST TYPE OPT MEALS
M 07012005 06302006 $ 1452.90 IP 6.25 200.4 99999.00 S R
$ C
N 07012004 06302005 $ 1352.70 IP 6.75 200.4 99999.00 S R
$ C
O 07012003 06302004 $ 1393.20 IP 6.75 206.4 99999.00 S R
$ C
P APPLICATION DATE REF FACE/FACE DATE COUNTY USE
05231998 15 05232005
***** SERVICE WORKER *****
Q DO# 01 F NAME ROBERTA L NAME JACKSON # 1234 PH# ( 999 ) 666 - 1234
F03=EXIT F08=NEXT
    
```


SOCD Screen

THIS SOCD I 5999995828200606
NEXT SOCD I 5999995828200606

SOC DETAIL RECORD 2 OF 4

SHARE OF COST DETAIL SCREEN

ELIG MO	MEDS ID	CIN	BIC DT	SOC	CASE NBR	FFP	MES	AID	LAST DT	T
06012006	998877665	88877777X0	12082005	01211	9999988888	N	503	67	06142006	1
MEDI-CAL SECONDARY AID CODE - 2N									NON-REVERSED SOC AMOUNT	0.00

RELATED 1938036785
IHSS CASES

INITIAL DATE	REQ AMT	APPLY AMT	MEDS SOC	IHSS SOC	IHSS AUTH	ERROR
BUY-OUT 05252006	409.00	409.00	1,211.00	802.95	1,639.30	

F03=EXIT F07=BWD F08=NEXT

F12=RETURN TO MELG

IHSS Assessment Form – Turn-Around Document – SOC 293

BIRTHDATE																																														
A	CONTY (1)	RECIPIENT #	CD (2)	SEQ # (3)	AID CODE (4)	SOCIAL SECURITY NO.	SEX (5) M F	MONTH (6)	DAY	YEAR																																				
B	(1) LAST NAME					(2) FIRST NAME				(3) MI																																				
C	(1) STREET					(2) CITY	STATE (3)	(4) ZIP CODE / CT																																						
D	(1) TELEPHONE #	(2) DIS. PRIEP.		(3)	(4)	GUARDIAN / CONSERVATOR																																								
E	(1) STREET					(2) CITY	STATE (3)	(4) ZIP CODE / CT																																						
F	STATUS (1)	PRIM DIAG. (2) IX/2N	CITIZEN (3)	ETHNIC (4)	LANG. (5)	OTH. / COV. (6)	SSNV (7)	HIC. / RPL# (8)	FBU.# (9)																																					
G	(1) SPOUSE / PARENT	(2) # HH	(3) # RCP	RES (4)	L/A (5)	# ROOMS (6)	YARD (7) Y N	WASHER (8) Y N	DRYER Y N	STOVE Y N	REFRIG. Y N																																			
H	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>(1)</td> <td>HOUSEWORK</td> <td>LABORRY</td> <td>SHOPPING & ERRANDS</td> <td>HEAL PREP & CLEANUP</td> <td>MOBILITY / WALKING</td> <td>BATHING & DRESSING</td> <td>BOUDEL & MENSTRUAL</td> <td>TRANSFER</td> <td>EATING</td> <td>RESPIRATION</td> <td>MEMORY</td> <td>ORIENTATION</td> <td>ARGUMENT</td> <td>FUNCTIONAL INDEX</td> <td>(2)</td> <td>(3)</td> <td>(4)</td> </tr> <tr> <td></td> <td>FUNCTIONAL INDEX HOURS</td> <td></td> <td>W/O IHSS</td> <td>NEED PROVIDER</td> </tr> </table>										(1)	HOUSEWORK	LABORRY	SHOPPING & ERRANDS	HEAL PREP & CLEANUP	MOBILITY / WALKING	BATHING & DRESSING	BOUDEL & MENSTRUAL	TRANSFER	EATING	RESPIRATION	MEMORY	ORIENTATION	ARGUMENT	FUNCTIONAL INDEX	(2)	(3)	(4)															FUNCTIONAL INDEX HOURS		W/O IHSS	NEED PROVIDER
(1)	HOUSEWORK	LABORRY	SHOPPING & ERRANDS	HEAL PREP & CLEANUP	MOBILITY / WALKING	BATHING & DRESSING	BOUDEL & MENSTRUAL	TRANSFER	EATING	RESPIRATION	MEMORY	ORIENTATION	ARGUMENT	FUNCTIONAL INDEX	(2)	(3)	(4)																													
														FUNCTIONAL INDEX HOURS		W/O IHSS	NEED PROVIDER																													
I	SHARE OF COST DATE (1) 03/01/2005		LINK (2) D	DEP (3)	SOURCE (4) 4	INCOME 1050.00	DEDUCT	COUNTABLE INCOME (5) 1030.00																																						
J	SOURCE (1) 1	INCOME	DEDUCT	(2) 4			BENEFIT CODE / LEVEL (3) 01 812.00																																							
K	(1) 2			(2) 5			SHARE OF COST IHSS 217.00 MEDS 12345.00																																							
L	MODE (1) IP	RATE 7.65	HOURS 145.0	(2)	MODE	RATE	HOURS	RECOVERY (3)																																						
M	ACT D	BEGINNING DATE 03/01/2005	ENDING DATE 02/28/2006	GROSS AMOUNT 1109.25	MODE IP	RATE 6.65	HOURS 145.0	SHARE OF COST 218.00	TYPE N C	PAY OPT P																																				
N	D	(2)	(3)	(4)	(5)	(6)	(7)	(8)																																						
O	D	(2)	(3)	(4)	(5)	(6)	(7)	(8)																																						
P	APPLICATION DATE (1)	REF (2)	FACE TO FACE DATE (3)	(4)	COUNTY USE																																									
Q	D / O (1)	SERVICE WORKER NAME (2)				SW.# (3)	SERVICE WORKER PHONE # (4)																																							
R	ALERT MESSAGE																																													

Sample of Provider Explanation of Share of Cost Letter (SOCL)

EAGLE COUNTY IHSS OFFICE, 01, B35F
789 BROADWAY
ANY TOWN, CA 44444

LISA REEDER
1234 ELM STREET
ANY TOWN, CA 44444

EXPLANATION OF IN-HOME SUPPORTIVE SERVICES (IHSS) SHARE OF COST

06/01/2006

CASE NAME: JOHN ROBERTS
CASE NUMBER: 1234567890 123456
SHARE OF COST OBLIGATION: \$9999.99

This notification is to inform you that the Share of Cost shown above was withheld from the warrant issued to you for service period 05/01/2006-05/15/2006 for IHSS service you performed for JOHN ROBERTS. You are responsible to collect this Share of Cost amount from JOHN ROBERTS.

Each time a timesheet is processed, the recipient's remaining Share of Cost obligation will be determined and appropriately applied for the service period. You will receive a notice telling you how much of the recipient's Share of Cost obligation has been deducted from your payroll warrant. The recipient you work for will also receive a letter similar to this one explaining the amount that is to be paid to you.

If you have questions regarding this notification, you may contact your County IHSS Social Worker or your County IHSS Payroll Office.

IHSS Payroll Department

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION-350

Note: This notice relates ONLY to your Social Services.
It does NOT affect your receipt of SSI/SSP, Social Security or Medi-Cal.

**Sample of Recipient Explanation of Share-of-Cost
Letter (SOCL)**

MONTROSE COUNTY, 01, B35F
123 OAK AVENUE
ANY TOWN, CA 99999

PENELOPE WITHERSPOON
JAMES SCOTT
5678 NORTH STREET
ANY TOWN, CA 99999

EXPLANATION OF IN-HOME SUPPORTIVE SERVICES (IHSS) SHARE OF COST

06/01/2006

CASE NUMBER: 1234567890 123456
SHARE OF COST AMOUNT TO BE PAID TO THIS PROVIDER: \$9999.99
PROVIDER: PEGGY STEVENS

This notification is to inform you that the above-indicated Share of Cost was withheld from the payment issued for service period 05/01/2006-05/15/2006. You are responsible to pay this Share of Cost to PEGGY STEVENS

Each time a payment is processed against your IHSS case, the Share of Cost obligation will be determined and appropriately applied for the service period. Your provider of service will receive a similar notice to tell him/her how much to collect from you.

If you have questions regarding this notification, you may contact your County IHSS Social Worker or your County IHSS Payroll Office.

IHSS Payroll Department

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION-350

Note: This notice relates ONLY to your Social Services.
It does NOT affect your receipt of SSI/SSP, Social Security or Medi-Cal.

(A) IHSS PLUS WAIVER (2L)

(B) PERSONAL CARE SERVICES PROGRAM (2M)

Your IHSS calculated share of cost is shown on the front of your attached In-Home Supportive Services (IHSS) Notice of Action. You are eligible for a share-of-cost comparison between your IHSS share of cost and Medi-Cal share of cost and are only responsible for the lower share-of-cost amount. You should have received a Medi-Cal Notice of Action identifying your Medi-Cal share of cost amount.

- If your Medi-Cal share of cost is greater than your IHSS share of cost, the California Department of Social Services will pay your Medi-Cal recognized expenses equal to the difference between the two shares of cost to reduce your Medi-Cal share of cost obligation to the amount of your IHSS share of cost.
- If your Medi-Cal share of cost is less than your IHSS share of cost, then you are only responsible for obligating the amount of your Medi-Cal share of cost.

When your IHSS provider's timesheet is processed for payment, any share of cost that you have not obligated for Medi-Cal approved services will be deducted from your provider's pay warrant(s). Both you and your provider(s) will receive an "Explanation of IHSS Share of Cost" letter for each pay period telling you the amount you must pay to your provider.

(C) IHSS-RESIDUAL (2N)

Your IHSS share of cost is shown on the front of your attached In-Home Supportive Services (IHSS) Notice of Action. It is your responsibility to pay your IHSS share of cost amount directly to your provider. This IHSS share of cost amount will be deducted from your provider's pay warrant(s) until your IHSS share of cost amount has been met. If you are eligible for Medi-Cal and have a Medi-Cal share of cost, you are eligible for a share of cost comparison between your IHSS share of cost and Medi-Cal share of cost. You will only be responsible for the lower share-of-cost amount. If you are eligible for Medi-Cal and have a Medi-Cal share of cost, you can take proof of payment for the IHSS share of cost you have paid to your provider to your county Medi-Cal office to reduce your Medi-Cal share of cost obligation. For further information on how to apply these expenses, please contact your county Medi-Cal Eligibility Worker.

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING. PLEASE SEND YOUR WRITTEN REQUEST TO THE COUNTY ADDRESS ON THE TOP RIGHT HAND CORNER OF THE ATTACHED FORM.

Notice of Action Messages

Modified Boilerplate Messages

CONDITION	MESSAGE	PHASE
APPROVAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN APPROVED EFFECTIVE MM/DD/YYYY. YOU ARE AUTHORIZED TO RECEIVE SERVICES LISTED BELOW.	1
APPROVAL – ALL SERVICES TIME LIMITED	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN APPROVED EFFECTIVE THROUGH MM/DD/YYYY. <i>**** Currently there is no code in CMIPS for this Boilerplate Message.****</i>	1
DENIAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN DENIED.	1
DISCONTINUANCE	YOUR ELIGIBILITY FOR IN-HOME SERVICES WILL BE DISCONTINUED EFFECTIVE MM/DD/YYYY.	1
LEAVE	YOUR IN-HOME SERVICES HAVE BEEN TEMPORARILY SUSPENDED EFFECTIVE MM/DD/YYYY.	1
PROVISIONAL APPROVAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN PROVISIONALLY APPROVED EFFECTIVE MM/DD/YYYY. YOU ARE AUTHORIZED TO RECEIVE SERVICES LISTED BELOW.	1
REASSESSMENT CHANGE	YOUR AUTHORIZATION FOR IN-HOME SERVICES HAS BEEN CHANGED EFFECTIVE MM/DD/YYYY.	1
REASSESSMENT NO CHANGE	UPON REASSESSMENT WE FIND THERE IS NO CHANGE FROM YOUR PREVIOUS AUTHORIZATION FOR IN-HOME SERVICES EFFECTIVE MM/DD/YYYY.	1

Modified NOA Messages

CODE	MODIFIED MESSAGE	TRIGGERS	PHASE
322	YOU ARE ELIGIBLE TO RECEIVE ONLY THE ABOVE SERVICES BECAUSE YOU ARE A MINOR CHILD LIVING WITH YOUR PARENT PROVIDER, MPP 30-763	<ul style="list-style-type: none"> • ACTION = C • STATUS = I or E • Spouse Parent Code = 21, 22 or 23 <ul style="list-style-type: none"> • And current (Auth to Purchase – Unmet Need) > 0 • And current (Auth to Purchase – unmet need) ≠ previous (Auth to Purchase – unmet need) 	1
331	YOU CAN NO LONGER GET AN ADVANCE PAYMENT TO PAY YOUR SERVICE PROVIDER. THIS IS BECAUSE YOU NO LONGER MEET THE CRITERIA OF 20 HOURS OR MORE PER WEEK OF STARRED (*) AND (***) SERVICES. MPP 30-769.731	<ul style="list-style-type: none"> • STATUS = E or I • Changes from SI TO NSI 	1

CODE	MODIFIED MESSAGE	TRIGGERS	PHASE
376	YOUR IN-HOME SERVICE HOURS HAVE BEEN REDUCED. MPP 30-763	<ul style="list-style-type: none"> • ACTION = C • Previous STATUS = Current STATUS • And Current STATUS = I or E • Current Rate = Previous Rate • Current (Auth to Purchase) < Previous (Auth to Purchase) • And MEALS = Y and Current Weekly Hrs x 4.33 w/o meals ≠ Previous Weekly Hrs x 4.33 w/o meals or Current Monthly Hours ≠ Previous Monthly Hours <ul style="list-style-type: none"> ○ Or MEALS = N 	1
377	ALL OF YOUR IN-HOME SERVICE NEEDS ARE MET BY ALTERNATIVE RESOURCES AVAILABLE TO YOU FOR _____, _____, MPP 30-763.6	<ul style="list-style-type: none"> • STATUS = L, D or T • Alternate Resources > 0 • All Alternate Resources = Individual Assess Need 	1
308	YOUR HOURS OF SERVICE ARE INCREASED BECAUSE YOU RECEIVE SERVICES IN THE PERSONAL CARE SERVICES PROGRAM. MPP 30-780, MPP 30-700; W&IC 14132.95(g)	<ul style="list-style-type: none"> • ACTION = C • STATUS = I or E • NSI • PCPS changes from N to Y • MODE = IP and CC or HM (Mixed Mode) – <i>I think this was repealed with SS-00-02</i> • Unmet Need > 0 Needed Modification: • ACTION = C • STATUS = I or E • NSI • <i>MEDS Secondary Aid Code changes from 2N or 2L to 2M</i> • Previous Unmet Need > 0 	2

CODE	MODIFIED MESSAGE	TRIGGERS	PHASE
309	YOUR HOURS OF SERVICE ARE DECREASED BECAUSE YOU ARE NO LONGER ELIGIBLE FOR THE PERSONAL CARE SERVICES PROGRAM. THE IHSS MAXIMUM FOR THE NON-SEVERELY IMPAIRED IS 195 HOURS A MONTH. MPP 30-765; W&IC 12303.4	<ul style="list-style-type: none"> • ACTION = C • STATUS = I or E • PCSP from Y to N • Unmet Need > 0 Needed Modification: <ul style="list-style-type: none"> • ACTION = C • STATUS = I or E • <i>MEDS Secondary Aid Code changes from 2M to 2L or 2N</i> • NSI • Current Auth to Purchase Hours < Previous Auth to Purchase Hours • And current Auth to Purchase Hours = 195 	2
354	THE CHANGE IN YOUR SHARE OF COST SHOWN ABOVE IS EFFECTIVE #####. PLEASE SEE THE ATTACHED FORM FOR INFORMATION SPECIFIC TO YOUR CASE. MPP 30-755.233	PLUG - ##### = CURRENT SOC DATE <ul style="list-style-type: none"> • ACTION = C • Previous 293 STATUS#R, D, or T or J (Old Judgment Status) • Aid Code = 18, 28 or 68 • STATUS = E or I <ul style="list-style-type: none"> • Current Countable Income #Prev Countable Income or • Current Benefit Lvl #Prev Benefit Lvl or • Current SOC Start Dt #Prev SOC Start Dt Needed Modification: <ul style="list-style-type: none"> • ACTION = C • Previous 293 STATUS#R, D, or T Aid Code = 18, 28 or 68 • STATUS = E or I <ul style="list-style-type: none"> • Current Countable Income #Prev Countable Income or • Current Benefit Lvl #Prev Benefit Lvl or • Current SOC Start Dt #Prev SOC Start Dt or • Current SOC #Prev SOC 	2

CODE	MODIFIED MESSAGE	TRIGGERS	PHASE
373	YOUR SHARE OF COST OF \$ #####.## (K3) EXCEEDS THE ASSESSED IHSS-RESIDUAL COST OF #####.# (AA6) HOURS X \$ ###.## (L1&L2) PER HOUR WHICH EQUALS \$ #####.##. W&IC 12304.5, MPP 30-753(b)(2), MPP 30-764.12 and MPP 30-775	<ul style="list-style-type: none"> • ACTION = C • Current STATUS = D, L or T • Current AID CODE = 18, 28 or 68 • GROSS AMT and IHSS SOC > 0 • GROSS ≤ SOC • MEALS = N <p>Needed Modification:</p> <ul style="list-style-type: none"> • ACTION = C • MEDS Secondary Aid Code = 2N • Current STATUS = D, L or T • Current AID CODE = 18, 28 or 68 • GROSS AMT and IHSS SOC > 0 • GROSS ≤ SOC • MEALS = N 	2
379	YOUR SHARE OF COST OF \$ #####.## (K3) EXCEEDS THE ASSESSED IHSS-RESIDUAL COST OF #####.# HOURS X \$###.## PER HOUR PLUS THE RESTAURANT MEAL ALLOWANCE OF \$ ### WHICH EQUALS \$ #####.##. W&IC 12304.5, MPP 30-753(b)(2), MPP 30-764.12, MPP 30-755 and MPP 30-757.134	<ul style="list-style-type: none"> • Action = C • STATUS changes from I or E to D, L or T • Aid Code = 18, 28 or 68 • SOC and GROSS > 0 • GROSS ≤ SOC • MEALS = Y <p>Needed Modification:</p> <ul style="list-style-type: none"> • Action = C • STATUS changes from I or E to D, L or T • Aid Code = 18, 28 or 68 • MEDS Secondary Aid Code = 2N • SOC and GROSS > 0 • GROSS ≤ SOC • MEALS = Y 	2
386	THE STATUTORY MAXIMUM NUMBER OF HOURS OF ###.## DECREASES THE NUMBER OF YOUR AUTHORIZED HOURS TO ###.##. THEREFORE, YOU HAVE AN UNMET NEED OF ###.## SERVICE HOURS. W&IC 12303.4		2

CODE	MODIFIED MESSAGE	TRIGGERS	PHASE
387	THE STATUTORY MAXIMUM NUMBER OF IN-HOME SERVICE HOURS IS ###.##. THEREFORE, YOU HAVE AN UNMET NEED OF ###.## SERVICE HOURS. W&IC 12303.4	<ul style="list-style-type: none"> • Action = C • STATUS = I or E Plugs <ul style="list-style-type: none"> • If NSI (195.00) and unmet need > 0 • If SI (283.00) and unmet need > 0 Needed Modification: <ul style="list-style-type: none"> • Action = C • STATUS = I or E • If unmet need > 0 • <i>MEDS Secondary Aid Code = 2M</i> • If NSI (283.00) • If SI (283.00) • <i>MEDS Secondary Aid Code = 2L or 2N</i> • If NSI (195.00) • If SI (283.00) 	2

CODE	MODIFIED MESSAGE	CONDITIONS?	PHASE
408	YOUR REQUEST FOR SERVICES WAS ERRONEOUSLY DENIED AND IN-HOME SERVICES HAVE BEEN APPROVED. (No new application date is required.) MPP 30-755.1	Status: changes from D to I or E Boilerplate Message: Approval or Approval – All Time Limited Services	1
415	YOUR APPLICATION FOR DIRECT DEPOSIT BY ELECTRONIC FUNDS TRANSFER HAS BEEN DENIED BECAUSE YOU HAVE NOT BEEN A RECIPIENT OF IHSS FOR AT LEAST ONE YEAR AND/OR YOU ARE NOT ELIGIBLE FOR ADVANCE PAY. W&IC 12304.3	Status = E	1
422	YOU ARE RESIDING IN THE HOME OF RELATIVES AND RECEIVING A BOARD AND CARE PAYMENT. MPP 30-701 and MPP 46-140.11(b)	Status = E or I Boilerplate Message: Approval, Provisional Approval, Reassessment Change, Reassessment No Change	1

CODE	MODIFIED MESSAGE	CONDITIONS?	PHASE
462	YOU HAVE BEEN AUTHORIZED ADDITIONAL IN-HOME SERVICES AND YOU HAVE CONDITIONALLY WITHDRAWN A REQUEST FOR STATE HEARING. MPP 22-054	Status = E Boilerplate Message: Approval, Reassessment Change	1
470	YOU ARE TEMPORARILY INELIGIBLE FOR IN-HOME SERVICES BECAUSE YOU ARE HOSPITALIZED. MPP 30-701	Status = L Boilerplate Message: Leave	1
471	YOU ARE TEMPORARILY INELIGIBLE FOR IN-HOME SERVICES BECAUSE YOU ARE STAYING IN A SKILLED NURSING FACILITY. MPP 30-701	Status = L Boilerplate Message: Leave	1
472	YOU ARE TEMPORARILY INELIGIBLE FOR IN-HOME SERVICES BECAUSE YOU ARE STAYING IN AN INTERMEDIATE CARE FACILITY. MPP30-701	Status = L Boilerplate Message: Leave	1
473	YOU ARE TEMPORARILY INELIGIBLE FOR IN-HOME SERVICES BECAUSE YOU ARE STAYING IN A COMMUNITY CARE FACILITY. MPP 30-701	Status = L Boilerplate Message: Leave	1
474	YOU ARE TEMPORARILY SUSPENDED FROM RECEIVING CALIFORNIA PAID IN-HOME SERVICES BECAUSE YOU HAVE BEEN ABSENT FROM THE STATE FOR A PERIOD EXCEEDING SIX MONTHS. IN-HOME SERVICES SHALL NOT BE RESUMED UNTIL YOU HAVE RETURNED TO CALIFORNIA AND A REASSESSMENT OF NEED HAS BEEN COMPLETED. MPP 30-770.45	Status = T Boilerplate Message: Discontinuance	1
521	YOU ARE NO LONGER ELIGIBLE FOR AN IN-HOME SERVICE RESTAURANT MEAL ALLOWANCE BECAUSE YOU ARE ELIGIBLE TO RECEIVE THAT ALLOWANCE FROM THE SOCIAL SECURITY ADMINISTRATION. MPP 30-757.134	Status = E or I Boilerplate Message: Reassessment Change	1
540	AS A RESULT OF REASSESSMENT OF YOUR NEED FOR IN-HOME SERVICES OF LAUNDRY, FOOD SHOPPING, AND OTHER SHOPPING/ERRANDS, THE CHANGES SHOWN ABOVE HAVE BEEN MADE IN YOUR AUTHORIZATION FOR IN-HOME SERVICES IN ACCORDANCE WITH STATEWIDE STANDARDS. MPP 30-758	Status = E or I Boilerplate Message: Reassessment Change	1
554	PLEASE CONTACT YOUR COUNTY SOCIAL WORKER WHEN YOU SELECT AN INDIVIDUAL PROVIDER. MPP 30-767.1	Status = E or I Boilerplate Message: Approval, Approval – All Time Limited Services, Provisional Approval, Reassessment Change, Reassessment No Change	1

CODE	MODIFIED MESSAGE	CONDITIONS?	PHASE
586	WE WILL CONTINUE TO AUTHORIZE SERVICES AS YOUR ELIGIBILITY FOR IN-HOME SERVICES HAS BEEN TRANSFERRED FROM THE COUNTY OF _____ EFFECTIVE _____. W&IC 11102	Status = E or I	1
444	TO THE ESTATE OF ##### (B1): WE HAVE BEEN NOTIFIED OF THE DEATH OF ##### (B2) # (B3) ##### (B1). MPP 30-763.1	Status = T Boilerplate Message: Discontinuance	2
477	YOU ARE TEMPORARILY INELIGIBLE FOR IHSS-RESIDUAL BECAUSE YOUR SOC EXCEEDS ASSESSED NEEDS FOR IHSS. W&IC 12304.5	Status = T Secondary Aid Code = 2N SOC must be > 0	2
532	PAY YOUR SHARE OF COST FOR IHSS-RESIDUAL TO YOUR INDIVIDUAL PROVIDER. MPP 30-755.233	Status = E or I Secondary Aid Code 2N	3
534	PAY YOUR SHARE OF COST FOR IHSS-RESIDUAL TO THE AGENCY WHO PROVIDES YOUR SERVICES. MPP 30-755.233	Status = E or I Secondary Aid Code 2N	3
535	YOU ARE NOT ELIGIBLE TO RECEIVE IHSS-RESIDUAL BECAUSE YOU HAVE NOT PAID YOUR OBLIGATED SHARE OF COST FOR IN-HOME SERVICES. MPP Section 30-755.233(a)	Status = T	3
539	YOU ARE NOT ELIGIBLE TO RECEIVE IHSS-RESIDUAL BECAUSE YOU STATED YOU WILL NOT PAY YOUR SHARE OF COST FOR IN-HOME SERVICES. MPP Section 30-755.233(d)	Status = T	3

New NOA Messages

CODE	NEW NOA MESSAGE	BEFORE CONDITION	AFTER CONDITION	NOA PLUG	PHASE
409	YOU HAVE ELECTED TO DISCONTINUE YOUR PARTICIPATION IN THE IN-HOME SERVICE WAIVER PLUS PROGRAM.	STATUS = I, E or L	STATUS = T	None	1
445	THE IN-HOME SUPPORTIVE SERVICES PROGRAM HAS BEEN NOTIFIED THAT YOU ARE NOT ELIGIBLE FOR FEDERALLY-FUNDED MEDI-CAL.	STATUS = R, I, E or L	STATUS = T or D	None	1

CODE	NEW NOA MESSAGE	BEFORE CONDITION	AFTER CONDITION	NOA PLUG	PHASE
310	EFFECTIVE MMDDYYYY YOUR ELIGIBILITY HAS BEEN TRANSFERRED FROM THE IHSS PLUS WAIVER PROGRAM TO PERSONAL CARE SERVICES PROGRAM. YOU MAY BE ELIGIBLE TO RECEIVE ADDITIONAL HOURS OF SERVICE PER MONTH DEPENDING UPON YOUR ASSESSED NEED.	STATUS = I, E or L MEDS Secondary Aid Code = 2L	STATUS = I, E or L MEDS Secondary Aid Code = 2M	MEDS Aid Code Effective Date	2
311	EFFECTIVE MMDDYYYY YOUR ELIGIBILITY HAS BEEN TRANSFERRED FROM THE IHSS PLUS WAIVER PROGRAM TO THE IHSS-RESIDUAL PROGRAM.	STATUS = I, E or L MEDS Secondary Aid Code = 2L	STATUS = I, E or L MEDS Secondary Aid Code = 2N	MEDS Aid Code Effective Date	2
312	EFFECTIVE MMDDYYYY, YOUR ELIGIBILITY HAS BEEN TRANSFERRED FROM THE PERSONAL CARE SERVICES PROGRAM TO IHSS PLUS WAIVER PROGRAM.	STATUS = I, E or L MEDS Secondary Aid Code = 2M	STATUS = I, E or L MEDS Secondary Aid Code = 2L	MEDS Aid Code Effective Date	2
313	EFFECTIVE MMDDYYYY YOUR ELIGIBILITY HAS BEEN TRANSFERRED FROM THE PERSONAL CARE SERVICES PROGRAM TO THE IHSS-RESIDUAL PROGRAM.	STATUS = I, E or L MEDS Secondary Aid Code = 2M	STATUS = I, E or L MEDS Secondary Aid Code = 2N	MEDS Aid Code Effective Date	2
314	EFFECTIVE MMDDYYYY YOUR ELIGIBILITY HAS BEEN TRANSFERRED FROM THE IHSS RESIDUAL PROGRAM TO IN-HOME SERVICES PLUS WAIVER PROGRAM.	STATUS = I, E or L MEDS Secondary Aid Code = 2N	STATUS = I, E or L MEDS Secondary Aid Code = 2L	MEDS Aid Code Effective Date	2
315	EFFECTIVE MMDDYYYY YOUR ELIGIBILITY HAS BEEN TRANSFERRED FROM THE IHSS RESIDUAL PROGRAM TO PERSONAL CARE SERVICES PROGRAM. YOU MAY BE ELIGIBLE TO RECEIVE ADDITIONAL HOURS OF SERVICE PER MONTH DEPENDING ON YOUR ASSESSED NEED.	STATUS = I, E or L MEDS Secondary Aid Code = 2N	STATUS = I, E or L MEDS Secondary Aid Code = 2M	MEDS Aid Code Effective Date	2
316	EFFECTIVE MMDDYYYY YOU HAVE BEEN APPROVED TO PARTICIPATE IN THE IHSS PLUS WAIVER PROGRAM BECAUSE YOU RECEIVE ADVANCE PAY OR RESTAURANT MEAL ALLOWANCE, OR YOU RECEIVE SERVICES FROM YOUR SPOUSE OR YOU ARE UNDER THE AGE OF 18 AND RECEIVE SERVICES FROM A PARENT.	STATUS = R, T or D	STATUS = I or E MEDS Secondary Aid Code = 2L	MEDS Aid Code Effective Date or Case Effective Date whichever is greater	2

CODE	NEW NOA MESSAGE	BEFORE CONDITION	AFTER CONDITION	NOA PLUG	PHASE
317	EFFECTIVE MMDDYYYY YOU HAVE BEEN APPROVED TO PARTICIPATE IN THE PERSONAL CARE SERVICES PROGRAM. YOU MAY BE ELIGIBLE TO RECEIVE ADDITIONAL HOURS OF SERVICE PER MONTH DEPENDING ON YOUR ASSESSED NEED.	STATUS = R, T or D	STATUS = I or E MEDS Secondary Aid Code = 2M	MEDS Aid Code Effective Date or Case Effective Date whichever is greater	2
318	EFFECTIVE MMDDYYYY YOU HAVE BEEN APPROVED TO PARTICIPATE IN THE IHSS-RESIDUAL PROGRAM.	STATUS = R, T or D	STATUS = I or E MEDS Secondary Aid Code = 2N	Case Effective Date	2
319	EFFECTIVE MMDDYYYY, YOU HAVE BEEN PROVISIONALLY APPROVED FOR THE IHSS-RESIDUAL PROGRAM PENDING YOUR MEDI-CAL ELIGIBILITY DETERMINATION. IF THE MEDI-CAL ELIGIBILITY DETERMINATION INDICATES YOU ARE ELIGIBLE FOR OTHER PROGRAMS YOU WILL RECEIVE AN ADDITIONAL NOTICE OF ACTION.	STATUS = Blank, R, T or D MEDS Secondary Aid Code	STATUS = I or E No MEDS Secondary Aid Code for eligibility segment	Case Effective Date	2
345	YOUR SHARE OF COST IS \$####.##. PLEASE SEE ATTACHED FORM FOR INFORMATION SPECIFIC TO YOUR CASE.	STATUS = Blank, R, T or D Or MEDS SOC ≤ IHSS SOC Or MEDS Secondary Aid Code = 2N	STATUS = I or E MEDS SOC > IHSS SOC MEDS Secondary Aid Code = 2L or 2M	Next Buy-Out Date or MEDS Aid Code Effective Date, whichever is later	2

NOA Messages to be Discontinued – These NOA Messages will be removed from the CMIPS User's Manual

CODE	MESSAGE	PHASE
346	Effective mmdyyy, the California Department of Social Services will pay your Medi-Cal recognized expenses to reduce your Medi-Cal share of cost obligation to the amount of your IHSS soc.	
350	You are entitled to receive a no share of cost Medi-Cal card. MPP 30-755.3	1
351	You have a share of cost for IHSS. If you pay your IHSS share of cost, you are entitled to receive a no share of cost Medi-Cal card. MPP 30-755.3	1
378	You are no longer eligible for a Medi-Cal card based on your IHSS eligibility. Contact our Medi-Cal unit who will determine if you are eligible for Medi-Cal only. MPP 30-755.3 and CCR 50201	1
380	An increase in service provider cost increases your authorized IHSS cost beyond the state payment maximum of \$####.##. Therefore, you have an unmet need of ###.## service hours. W&IC 12303.4	1
381	The cost of your IHSS authorized hours exceeds the state payment maximum of \$####.##. Therefore, you have an unmet need of ###.## (aa7) service hours. MPP 30-765	1
382	Your unmet need for IHSS is decreased because the state payment maximum has been increased to \$####.##. Your unmet need is now ###.## service hours. MPP 30-765	1
383	You no longer have an unmet need for IHSS because the increased state payment maximum of \$####.## will cover the cost of your authorized need for service. MPP 30-765	1
560	Because of a change in law that required your services to shift from IHSS to PCSP on April 1, 1999, you are receiving \$_____. This is the difference between your PCSP Medi-Cal share of cost and your former IHSS share of cost. Receipt of this payment could affect your or your family members, continued Medi-Cal eligibility. You should immediately contact your Medi-Cal eligibility worker to see if it does.	1
595	You are no longer eligible for the Personal Care Services Program (PCSP) because you are no longer considered a categorically needy Medi-Cal beneficiary. However, you may be eligible for services under the IHSS program. CCR 51350	1
597	You are no longer eligible for the Personal Care Services Program (PCSP) because you are no longer authorized to receive any personal care services (non-medical personal, or paramedical services). However, you may be eligible for services under the IHSS program. CCR 51350	1
355	The share of cost indicated above is the Medi-Cal share of cost calculated by your Medi-Cal Eligibility Worker. Please refer to your Medi-Cal Notice of Action for the share of cost calculation and other information.	2
392	Effective MMDYYYY, you are eligible for the Personal Care Services Program which may allow up to a maximum of 283 hours per month. If you become ineligible for the Personal Care Services Program in the future, your service hours may be reduced. MPP 30-780, MPP 30-700, W&IC 12303.4 and W&IC 14132.95(g)	2
529	You are not eligible for the Medi-Cal Aged & Disabled Federal Poverty Level (A&D FPL) Program of W&I Code 14005.40 at this time because you do not meet the following A&D FPL eligibility requirement(s): _____. You will receive a second NOA shortly letting you know your new monthly Medi-Cal Share-of-Cost. Contact your County Social Worker if you have any questions.	3

CODE	MESSAGE	PHASE
530	You have been approved for the Medi-Cal Aged & Disabled Federal Poverty Level (A&D FPL) Program because you currently meet all eligibility requirements of W&I Code 14005.40. Disregard the Share-of-Cost amount on the top of this form. Your Medi-Cal Share-of-Cost payment for PCSP Services has been reduced to zero (\$0.00) effective _____. You County Social Worker can provide you with additional information. Notify your County Social Worker when your provider, services or eligibility status changes.	3
531	Effective _____, you must pay your IHSS/PCSP provider the Share-of-Cost calculated at the top of this form in accordance with W&I Code 14005.70. Your eligibility for the Medi-Cal Aged & Disabled Federal Poverty Level (A&D FPL) Program of W&I Code 14005.40 will stop because you do not meet the following A&D FPL eligibility requirement(s): _____. Verify your income amounts and contact your county social worker within 10 days if you have any questions.	3
533	Pay your share of cost for IHSS-Residual to the County Welfare Department.	3
536	Pay \$_____ share of cost to your Individual Provider and pay \$_____ share of cost to the county social services department. MPP Section 30-755.233(b)(2)	3
537	Pay \$_____ share of cost to your contract provider and pay \$_____ share of cost to your county social services department. MPP Section 30-755.233(b)(2)	3
538	Pay \$_____ share of cost to your Individual Provider and pay \$_____ share of cost to your contract provider. MPP Section 30-755.233(b)(2)	3
541	Effective _____ you will no longer have an IHSS/PCSP share-of-cost. You have been approved for the Medi-Cal 250% Working Disabled Program because you currently meet all eligibility requirements of W&I Code 14007.9. You receive your supportive services under the Personal Care Service Program (PCSP) W&I Code 12300(f) and 14132.95. PCSP is a Medi-Cal benefit. This means that your share-of-cost for PCSP is zero (\$0.00). You must maintain your eligibility for the Medi-Cal 250% Working Disabled Program in order to receive zero share-of-cost. You must notify your county social worker when your provider, PCSP service needs, or 250% Working Disabled Program eligibility status changes.	3
542	Effective _____ you must pay your IHSS/PCSP share-of-cost calculated at the top of this form in accordance with W&I Code 14005.7 or 12304.5. You have been determined ineligible for the 250% Working Disabled Program W&I Code 14007.9. To continue to receive supportive services you must pay your IHSS/PCSP share-of-cost.	3



County of San Diego

INTER-DEPARTMENT MEMO

Date: _____

Case Number: _____

Case Name: _____

Social Worker #: _____

Fax referral sent erroneously, please send a SAWS1. Date of Application: _____

SAWS1 sent erroneously, please send Fax Referral. Date of Application: _____

SAWS1/Fax Referral pending, please send Fax Referral when Case is Active.

MC denied/discontinued

Comments: _____

Thank you,