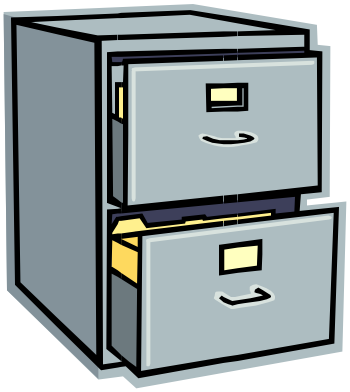
IN-HOME SUPPORTIVE SERVICES SPECIAL NOTICE ARCHIVES 2007



IHSS SPECIAL NOTICES 2007

YEAR	NUMBER	SUBJECT (ABBREVIATED)	REMARKS
2007	07-01	Protective Supervision 24 Hr Form (SOC 825)	Issue Date: 01/09/07
	07-02	IP Wage Increase	Issue Date: 01/09/07
	06-09 Add A	Correction To SN 06-09 Attachment B HTG	**Superseded**
	07-03	Individual Emergency Back-Up Plan	Issue Date: 02/19/07
	07-04	Conlan II	Issue Date 4/11/07
	07-05	Medi-Cal Referrals and CalWIN Clearance	Issue Date 4/11/07
	07-06	Conlan II Time Study Instructions	Issue Date 4/20/07
	07-07	Changes to Workers Compensation Benefits	Issue Date 5/11/07
	07-08	CMIPS Reports	Issue Date 5/23/07
	06-09 Add B	Correction to Hourly Task Guidelines	Issue Date 6/11/07
	07-09	Updated Fraud Referral/Overpayment Procedures	Issue Date 8/1/07
	07-10	Conlan II – Additional Claims	Issue Date 10/10/07
	07-11	California Paid Family Leave	Issue Date 10/15/07
	07-12	IHSS Medi-Cal Referrals & CalWIN Clearance	Issue Date 12/10/07
	07-13	Craig vs. Bonta Aid Codes	Issue Date 12/15/07
	07-14	SSI/SSP Cost-of-Living Adjustment	**Expired**
	07-15	Cost-of-Living Adjustment Affecting CAPI	Issue Date 12/24/07

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-15

December 24, 2007

SUBJECT: **JANUARY 2008 COST-OF-LIVING ADJUSTMENT (COLA)` AFFECTING THE CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI)**

EFFECTIVE DATE: January 1, 2008

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All-County Information Notice (ACIN) No. 1-75-07
All-County Information Notice (ACIN) No. 1-81-03
All-County Letter (ACL) No. 99-13

I. PURPOSE

The purpose of this Special Notice is to inform IHSS staff of the new Cash Assistance Program for Immigrants (CAPI) Payment Standards effective January 1, 2008, and June 1, 2008.

II. BACKGROUND

CAPI is a state-mandated program that provides cash assistance to aged, blind, and disabled immigrants not eligible for Supplemental Security Income/State Supplemental Payments (SSI/SSP). Welfare and Institutions Code (WIC) Section 18941 requires that CAPI payment standards are based on SSI/SSP payment standards, minus $10.00 for an individual and $20.00 for a couple. The federal Cost-of-Living Adjustment (COLA) increase for SSI recipients that is payable on January 1, 2008 affects the CAPI benefit amount. The CAPI benefit amounts from January 1, 2008 through May 31, 2008 are the result of the increase in the federal COLA for SSI. Under the provisions of Senate Bill (SB) 84 (Chapter 177, Statutes of 2007), the State SSP Cost-of-Living Adjustment (COLA) is delayed from January 1, 2008, until June 1, 2008. The CAPI payment standards effective June 1, 2008 through December 31, 2008 result from the increase in the federal COLA for SSI (effective January 1, 2008) and the State COLA for SSP (effective June 1, 2008).

III. POLICY

The CAPI Payment Standards, effective January 1, 2008, must be implemented as reflected on the attached Estimated CAPI Payment Standard Chart. All other eligibility requirements for CAPI remain the same.

IV. PROCEDURES

IHSS SOCIAL WORKER

In-Home Supportive Services (IHSS) applications received from CAPI applicants/recipients will continue to be processed as Income Eligible IHSS Residual cases. Staff may refer to Chapter 2, page 39 of the IHSS Program Guide for program definition and CAPI eligibility requirements.

V. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido (858)505-6366
Dist. Codes 7 & 8

Attachments: Attachment A - Estimated CAPI Payment Standards 01/01/08 thru 05/31/08
Attachment B - Estimated CAPI Payment Standards 06/01/08 thru 12/31/08

STATE OF CALIFORNIA
DEPARTMENT OF SOCIAL SERVICES
ADMINISTRATION DIVISION

ESTIMATES BRANCH
NOVEMBER 2007

CAPI PAYMENT STANDARDS
EFFECTIVE JANUARY 1, 2008
BASED ON JANUARY 2008 SSI/SSP STANDARDS

	INDEPENDENT LIVING			REDUCED NEEDS			NON-MEDICAL OUT-OF-HOME CARE (NMOHC)					
	RESIDING IN OWN HOUSEHOLD			HOUSEHOLD OF ANOTHER WITH IN-KIND ROOM & BOARD			HOUSEHOLD OF RELATIVE WITH IN-KIND ROOM & BOARD AND CERTIFIED NMOHC			IN LICENSED FACILITY OR HOUSEHOLD OF RELATIVE WITHOUT IN-KIND ROOM & BOARD		
	TOTAL CAPI		TOTAL SSI/SSP	TOTAL CAPI		TOTAL SSI/SSP	TOTAL CAPI		TOTAL SSI/SSP	TOTAL CAPI		TOTAL SSI/SSP
INDIVIDUAL:												
AGED OR DISABLED	**860.00**		870.00	**648.67**		658.67	**821.67**		831.67	**1,039.00**		1,049.00
- without cooking facilities (RMA) 1/	**944.00**		954.00	N/A		N/A	N/A		N/A	N/A		N/A
BLIND	**925.00**		935.00	**729.67**		739.67	**821.67**		831.67	**1,039.00**		1,049.00
DISABLED MINOR												
- living with parent(s)	**746.00**		756.00	**522.67**		532.67						
- living with non-parent relative or non-relative guardian	**746.00**		756.00	**522.67**		532.67	**821.67**		831.67	**1,039.00**		1,049.00
COUPLE:	BOTH CAPI	ONE CAPI, ONE SSI	BOTH SSI/SSP	BOTH CAPI	ONE CAPI, ONE SSI	BOTH SSI/SSP	BOTH CAPI	ONE CAPI, ONE SSI	BOTH SSI/SSP	BOTH CAPI	ONE CAPI, ONE SSI	BOTH SSI/SSP
AGED OR DISABLED												
- per couple	**1,504.00**	1,514.00	1,524.00	**1,213.00**	1,223.00	1,233.00	**1,663.00**	1,673.00	1,683.00	**2,078.00**	2,088.00	2,098.00
- without cooking facilities (RMA) 1/	**1,672.00**	1,682.00	1,692.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
BLIND												
- per couple	**1,731.00**	1,741.00	1,751.00	**1,440.00**	1,450.00	1,460.00	**1,663.00**	1,673.00	1,683.00	**2,078.00**	2,088.00	2,098.00
BLIND/AGED OR DISABLED												
- per couple	**1,646.00**	1,656.00	1,666.00	**1,354.00**	1,364.00	1,374.00	**1,663.00**	1,673.00	1,683.00	**2,078.00**	2,088.00	2,098.00

TITLE XIX MEDICAL FACILITY

	Individual	Couple
Total CAPI	$40	$80
SSI/SSP	50	100

1/ RMA - Restaurant Meals Allowance - $84 Individual; $168 Couple

ATTACHMENT A

STATE OF CALIFORNIA
DEPARTMENT OF SOCIAL SERVICES
ADMINISTRATION DIVISION

ESTIMATES BRANCH
NOVEMBER 2007

ESTIMATED CAPI PAYMENT STANDARDS
EFFECTIVE JUNE 1, 2008
BASED ON JUNE 2008 SSI/SSP STANDARDS

	INDEPENDENT LIVING			REDUCED NEEDS			NON-MEDICAL OUT-OF-HOME CARE (NMOHC)					
	RESIDING IN OWN HOUSEHOLD			HOUSEHOLD OF ANOTHER WITH IN-KIND ROOM & BOARD			HOUSEHOLD OF RELATIVE WITH IN-KIND ROOM & BOARD AND CERTIFIED NMOHC			IN LICENSED FACILITY OR HOUSEHOLD OF RELATIVE WITHOUT IN-KIND ROOM & BOARD		
	TOTAL CAPI		TOTAL SSI/SSP	TOTAL CAPI		TOTAL SSI/SSP	TOTAL CAPI		TOTAL SSI/SSP	TOTAL CAPI		TOTAL SSI/SSP
INDIVIDUAL:												
AGED OR DISABLED	**878.00**		888.00	**663.00**		673.00	**843.00**		853.00	**1,063.00**		1,073.00
- without cooking facilities (RMA) 1/	**965.00**		975.00	N/A		N/A	N/A		N/A	N/A		N/A
BLIND	**945.00**		955.00	**747.00**		757.00	**843.00**		853.00	**1,063.00**		1,073.00
DISABLED MINOR												
- living with parent(s)	**759.00**		769.00	**533.00**		543.00						
- living with non-parent relative or non-relative guardian	**759.00**		769.00	**533.00**		543.00	**843.00**		853.00	**1,063.00**		1,073.00
COUPLE:	BOTH CAPI	ONE CAPI, ONE SSI	BOTH SSI/SSP	BOTH CAPI	ONE CAPI, ONE SSI	BOTH SSI/SSP	BOTH CAPI	ONE CAPI, ONE SSI	BOTH SSI/SSP	BOTH CAPI	ONE CAPI, ONE SSI	BOTH SSI/SSP
AGED OR DISABLED												
- per couple	**1,538.00**	1,548.00	1,558.00	**1,243.00**	1,253.00	1,263.00	**1,710.00**	1,720.00	1,730.00	**2,126.00**	2,136.00	2,146.00
- without cooking facilities (RMA) 1/	**1,712.00**	1,722.00	1,732.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
BLIND												
- per couple	**1,773.00**	1,783.00	1,793.00	**1,479.00**	1,489.00	1,499.00	**1,710.00**	1,720.00	1,730.00	**2,126.00**	2,136.00	2,146.00
BLIND/AGED OR DISABLED												
- per couple	**1,685.00**	1,695.00	1,705.00	**1,390.00**	1,400.00	1,410.00	**1,710.00**	1,720.00	1,730.00	**2,126.00**	2,136.00	2,146.00

TITLE XIX MEDICAL FACILITY

	Individual	Couple
Total CAPI	$42	$84
SSI/SSP	52	104

1/ RMA - Restaurant Meals Allowance - $87 Individual; $174 Couple

ATTACHMENT B

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-14

December 24, 2007

SUBJECT: JANUARY 2008 SOCIAL SECURITY TITLE XVI (SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTAL PAYMENT [SSI/SSP] PROGRAM) COST-OF-LIVING ADJUSTMENT

EFFECTIVE DATE: JANUARY 1, 2008

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: EBB 07023 – SSI/SSP COLA AND PAYMENT STANDARDS

I. PURPOSE

This Special Notice is to inform IHSS staff of the upcoming Cost-of-Living Adjustment (COLA) and the changes to IHSS share-of-cost (SOC) cases resulting from the COLA conversion.

II. BACKGROUND

Social Security recipients will receive a 2.3% increase in their Social Security benefits effective December 1, 2007. The benefits will be payable on January 1, 2008. The COLA will update case information on SOC cases in the Case Management Information and Payrolling System (CMIPS) that meet the conversion criteria. The COLA update will take place on Saturday, December 15, 2007. Turn around documents (TADS) will be available on Monday, December 17, 2007.

III. SOC UPDATES TO CMIPS

The COLA conversion will apply the 2.3% increase to SOC cases with an income source code of 1 on fields I4, J1, J2, K1, or K2 on the RELB screen (SOC 293).

The following fields on SOC 293 will be updated:

- Line I Field 1, SOC Begin Date 01/01/2008.
- Line J Field 3, Benefit Level to the new values.
- Line K Field 3, Share-of-Cost recomputed based on the new benefit level.
- Line M Fields 2, 3, and 6, Beginning Date, Ending Date, and Share-of-Cost will show the new eligibility and SOC segment.

The new Benefit Level/Payment is as follows:

Benefit Code – 01	Level	$870.00
02		935.00
03		756.00
04		658.67
05		739.67
06		532.67
07		954.00
08		1524.00
09		1751.00
10		1666.00
11		1233.00
12		1460.00
13		1374.00
14		1692.00
15		762.00
16		875.50
17		833.00
18		846.00
19		616.50
20		730.00
21		687.00

SOC cases with providers coded 1 on line E field 3 on the SOC 311, and in E status at the time of the conversion, will show a new eligibility and SOC segment (line F fields 2, 3, and 5).

IV. EXCEPTION AND WARNING REPORTS

An "Exception Report" will list any SOC cases that do not update automatically in CMIPS. A warning report will list cases that have Veteran's Administration benefits. VA benefits are indicated on the SOC 293 with a "source" code of 2 on line I field 4, or line J field 1. The Social Workers must review and update these cases manually. The exception report will be available on Monday afternoon, December 17, 2007 at the IHSS-CMIPS Online Reports website at: https://cmips-reports.documentportal.com

V. IHSS STAFF PROCEDURES

Clerical Staff

- Print the following documents in the order of priority as follows:
  - Notice of Action (NOAs)
  - SOC 293's
  - SOC 311's
- Mail the NOAs to the IHSS recipients immediately.

IHSS Social Workers

- Log onto the IHSS-CMIPS Online Reports website.
- Click on "Annual Reports," then, click on "SOC COLA Exceptions Non-FPL" to access reports for individual Social Workers.
- Enter On or after 12/14/2007 for Cycle Date.
- The Exception Reason states why the case did not update automatically. You may refer to the online CMIPS User's Manual for additional information at: http://hhsa_intranet/ais/ihss/CMIPS2000UsersManual.pdf
- Enter the necessary updates (SOC Begin Date, Benefit Level, eligibility and SOC segments as needed) that should have been changed automatically on the SOC 293 and/or SOC 311.
- Submit the updated SOC 293 and/or SOC 311 to the designated clerical staff for data entry.

Note: The SOC COLA turnaround documents must be filed in the case folder to document the payment history for the recipient.

VI. REVIEW STATEMENT

This Special Notice was not reviewed by the standard review committee due to the immediacy of this notice.

VII. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido (858)505-6366

Attachments: Attachment A – SSI/SSP Payment Standards 01/01/08 thru 05/31/08
Attachment B – SSI/SSP Payment Standards 06/01/08 thru 12/31/08

SSI/SSP PAYMENT STANDARDS
January 1 through May 31, 2008

	Independent Living			Reduced Needs			Non-Medical Out of Home Care (NMOHC)					
	Residing in Own Household			Household of Another With In-Kind Room and Roard			Household of Relative With In-Kind Room and Board			In Licensed Facility Or Household of Relative Without In-Kind Room & Board		
	Total	SSI	SSP	Total	SSI	SSP	Total	SSI	SSP	Total	SSI	SSP
Individual:												
Aged or Disabled	870.00	637.00	233.00	658.67	424.67	234.00	831.67	424.67	407.00	1049.00	637.00	412.00
-Without Cooking Facilities	954.00	637.00	317.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blind	935.00	637.00	298.00	739.00	424.67	315.00	831.67	424.67	407.00	1049.00	637.00	412.00
Disabled Minor												
-Living with parent(s)	756.00	637.00	119.00	532.67	424.67	108.00						
-Living with non-parent relative or non relative guardian	756.00	637.00	119.00	532.67	424.67	108.00	831.67	424.67	407.00	1049.00	637.00	412.00
Couple:												
Aged or Disabled												
-Per couple (Both are aged or disabled)	1524.00	956.00	568.00	1233.00	637.34	595.66	1683.00	637.34	1045.66	2098.00	956.00	1142.00
-Without Cooking Facilities	1692.00	956.00	736.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blind												
-Per couple (Both are blind)	1751.00	956.00	795.00	1460.00	637.34	822.66	1683.00	637.34	1045.66	2098.00	956.00	1142.00
Blind /Aged or Disabled												
-Per couple (Couple one is blind, the other is aged or disabled)	1666.00	956.00	710.00	1374.00	637.34	736.66	1683.00	637.34	1045.66	2098.00	956.00	1142.00

Title XIX Medical Facility

Individual	$ 50.00
Couple	$ 100.00

RMA (Restaurant Meal Allowance)

Individual $84.00 Couple $ 168.00

Non-Medical Out-of-Home Care

	Minimum	Maximum
Room & Board	$ 450.00	$ 450.00
Care and Supervision	$ 386.00	$ 478.00
Personal and Incidental Needs	$ 121.00	$ 213.00

ATTACHMENT A

SSI/SSP PAYMENT STANDARDS
June 1 through December 31, 2008

	Independent Living			Reduced Needs			Non-Medical Out of Home Care (NMOHC)					
	Residing in Own Household			Household of Another With In-Kind Room and Roard			Household of Relative With In-Kind Room and Board			In Licensed Facility Or Household of Relative Without In-Kind Room & Board		
	Total	SSI	SSP	Total	SSI	SSP	Total	SSI	SSP	Total	SSI	SSP
Individual:												
Aged or Disabled	888.00	637.00	251.00	673.00	424.67	248.33	853.00	424.67	428.33	1073.00	637.00	436.00
-Without Cooking Facilities	975.00	637.00	338.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blind	955.00	637.00	318.00	757.00	424.67	332.33	853.00	424.67	428.33	1073.00	637.00	436.00
Disabled Minor												
-Living with parent(s)	769.00	637.00	132.00	543.00	424.67	118.33						
-Living with non-parent relative or non relative guardian	769.00	637.00	132.00	543.00	424.67	118.33	853.00	424.67	428.33	1073.00	637.00	436.00
Couple:												
Aged or Disabled												
-Per couple (Both are aged or disabled)	1558.00	956.00	602.00	1263.00	637.34	625.66	1730.00	637.34	1092.66	2146.00	956.00	1190.00
-Without Cooking Facilities	1732.00	956.00	776.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blind												
-Per couple (Both are blind)	1793.00	956.00	837.00	1499.00	637.34	861.66	1730.00	637.34	1092.66	2146.00	956.00	1190.00
Blind /Aged or Disabled												
-Per couple (Couple one is blind, the other is aged or disabled)	1705.00	956.00	749.00	1410.00	637.34	772.66	1730.00	637.34	1092.66	2146.00	956.00	1190.00

Title XIX Medical Facility
Individual $ 52.00
Couple $ 104.00

RMA (Restaurant Meal Allowance)
Individual $ 87.00 Couple $ 174.00

Non-Medical Out-of-Home Care

	Minimum	Maximum
Room & Board	$ 460.00	$ 460.00
Care and Supervision	$ 395.00	$ 489.00
Personal and Incidental Needs	$ 124.00	$ 218.00

ATTACHMENT B

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-13

December 15, 2007

SUBJECT: Craig vs. Bonta Aid Codes – New IHSS Applications and Conversion

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All County Letter 03-01 and 03-24, and clarification from The Adult Programs Operations Bureau, Operations and Technical Assistance Unit

I. PURPOSE

The purpose of this Special Notice is to inform IHSS staff of recently received clarification on the Craig vs. Bonta aid codes and the In-Home Supportive Services (IHSS) application process.

II. BACKGROUND

Effective June 30, 2007, termination of Medi-Cal benefits was prohibited for beneficiaries discontinued from Supplemental Security Income/State Supplementary Payment Program (SSI/SSP) on or after June 30, 2002, except for beneficiaries discontinued due to death or incarceration. Ongoing IHSS cases where SSI/SSP has been discontinued become conversions, and cannot be closed/denied until the Medi-cal case is re-determined or denied. Many of these cases take a very long time for the Medi-Cal eligibility to be reviewed.

III. POLICY

Craig vs. Bonta beneficiaries receive full-scope, no share-of-cost Medi-Cal benefit, until the county has completed a redetermination of eligibility. The following three MEDS aid codes were created for issuance of ongoing Medi-Cal benefits to Craig vs. Bonta beneficiaries, except for beneficiaries appealing SSA findings of "no longer disabled", or persons discontinued due to death or incarceration:

1E - Craig Continued Eligibility for the Aged
2E - Craig Continued Eligibility for the Blind
6E - Craig Continued Eligibility for the Disabled

The Craig vs. Bonta beneficiaries will remain eligible under the new aid codes until an SB 87 Redetermination is reported to MEDS.

IV. SOCIAL WORKER PROCEDURES

New Applications

A new IHSS application for services with aid codes 1E, 2E, or 6E can be granted by the Social Worker in the district office ***if otherwise eligible for IHSS services under the following conditions:***

- MEDS must indicate a zero Share-of-Cost (SOC).
- MEDS must indicate continuing Full Federal Participation (FFP) Medi-Cal - PCSP/IPW.
- The applicant's Medi-Cal is active on MEDS.

When all the above conditions are met the Social Worker in the district office must do the following:

STEP	PROCEDURE
1.	Make a home visit to assess the client's needs and determine eligibility to IHSS services.
2.	Enter the following information on CMIPS: • Aid code is 18, 28, or 68. • Income is zero or one dollar.
3.	Notify the Medi-Cal worker through e-mail that there is an active IHSS case, and provide the contact information for the assigned IHSS Social Worker.
4.	Monitor MEDS and the SOC 293 for changes in the SOC amount and the Medi-Cal aid code.
5.	When a change in the aid code and/or SOC amount is detected at anytime (except the Cost-of-Living Adjustment [COLA] conversion), the Social Worker must send a fax referral to the Southeast Family Resource Center (SEFRC) requesting an IHSS Medi-Cal Communication gram.
6.	If the Medi-Cal case closes, the Social Worker must request an IHSS/Medi-Cal Communication gram from the Medi-Cal worker of record indicating the reason for the discontinuance; ***or,*** obtain the discontinuance information from the Medi-Cal worker of record and close the IHSS case using the CalWIN screen prints and the worker's statement.
7.	Document the information in the case narrative.

Note: New applications with 999 Medi-Cal eligibility status on MEDS, and/or with pending/closed Medi-Cal or without Medi-Cal history on CalWIN are assigned to the SOC Specialist. The SOC Specialist monitors the processing of the Medi-Cal application until it is granted or denied. When Medi-Cal is active **both** on MEDS and CalWIN, the case is assigned to the district Social Worker as an intake.

Conversion

A "conversion" to income eligible from status eligible must occur when the SSI/SSP benefit of an IHSS status eligible recipient (10, 20, or 60 aid code) is discontinued. A list of IHSS cases with terminated SSI/SSP is generated and can be accessed through the CMIPS-On-Line report website as *SSI/SSP Terminations.*

If the reason for the termination is other than "death," "incarceration," or "no longer disabled," the IHSS case cannot be terminated. A Medi-Cal eligibility determination must be completed by a Medi-Cal worker to determine if the recipient qualifies as income eligible. In this situation, the Social Worker in the district office must *keep* the case in his/her caseload and complete the following steps:

STEP	PROCEDURE
1.	Clear (or request that the designated IHSS clerk clear and print) CalWIN screens to find out if a Medi-Cal case is pending.
2.	If there is a pending Medi-Cal case, notify the Medi-Cal worker of record through e-mail that there is an active Medi-cal case and provide the contact information for the assigned IHSS Social worker.
3.	If there is no Medi-Cal or CalWIN eligibility for the conversion month, complete a SAWS 1. Ensure that the application date reflects the date following the date of the status-eligible discontinuance. Example: Status eligible Medi-Cal was discontinued on 11/30/2007. The SAWS 1 application date should be 12/01/07.
4.	Submit the SAWS 1 to the designated IHSS clerk with an attached copy of the QM screen.
6.	Monitor MEDS and the SOC 293 for changes in the SOC amount and the Medi-Cal aid code.
7.	When a change in the aid code and/or SOC amount is detected at anytime (except the Cost-of-Living Adjustment [COLA] conversion), the Social Worker must send a fax referral to the Southeast Family Resource Center (SEFRC) requesting an IHSS Medi-Cal Communication gram.
8.	When/if the Medi-Cal closes or is denied, send a fax referral to the Southeast Family Resource Center (SEFRC) or to the Medi-Cal worker of record requesting an IHSS/Medi-Cal Communication gram; ***or,*** obtain the discontinuance/denial information from the Medi-Cal worker of record and close the IHSS case using the CalWIN screen prints and the worker's statement.
7.	Document the information in the case narrative.

V. REVIEW STATEMENT

This Special Notice was reviewed by the standard IHSS review committee.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido (858)505-6366

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-12

December 10, 2007

SUBJECT: IHSS MEDI-CAL REFERRALS & CALWIN CLEARANCE PROCEDURES

EFFECTIVE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

I. PURPOSE

The purpose of this Bulletin is to provide In-Home Supportive Services (IHSS) staff with instructions for CalWIN clearance and Medi-Cal referral procedures for IHSS applications.

II. BACKGROUND

With the implementation of CalWIN, clearance of IHSS cases for active Medi-cal must include the CalWIN system. All income eligible IHSS applicants must have a Medi-Cal eligibility determination completed by an IHSS Medi-Cal Worker. Before making a referral for the Medi-Cal determination, it must be verified whether or not there is an existing Medi-Cal case for the applicant.

To expedite the processing of income eligible applications, some internal procedures have changed. This includes the designation of a Share-of- Cost (SOC) Specialist Social Worker who will monitor all applications that require a Medi-Cal determination and assist applicants with the Medi-Cal application process.

III. POLICY

Medi-cal eligibility must be determined by a Medi-Cal Worker for any client that is not Status Eligible. The Medi-Cal Worker is responsible for entering the correct Medi-Cal Share-of-Cost into the Medi-Cal Data Eligibility System (MEDS).

IV. PROCEDURES

For each application received, the designated Clearance Clerk will perform the following activities:

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) & CMIPS CLEARANCE

STEP	CLERICAL PROCEDURE
1.	Download and print the following forms from the AIS Suite: • SOC 295 Application For Social Services • SOC 293A Need Assessment Face Sheet
2.	Clear CMIPS by Name (NAMR) and Social Security Number (SSNR) for existing IHSS case numbers. • Assign a case number if the case has no existing case number in San Diego County. • Use the existing CMIPS case number if the case was previously assigned a case number in San Diego County. **Note:** Do not print the NAMR & SSNR screens.
3.	If the case is active in another county, the designated clerk must do the following: • Make a telephone call to the applicant to inform him/her to contact his/her Social Worker in another county to request for an Inter County Transfer (ICT). • Keep the application until the ICT is received from the transferring county.
4.	Clear the Medi-cal Eligibility Data System (MEDS). • Print the INQM and INQX screens. • Print ONLY the INQ1 and INQ2 screens upon request by the assigned Social Worker.

5.	Clear CalWIN.
	• Select Search for Individual from the drop down menu.
	• Enter the client's Social Security Number (SSN) or County Identification Number (CIN).
	• Print the following screens:
	  o Information on Individual Results
	  o Case List
	  o Programs
	  o Case Members

NOTE:

In CalWIN minor children are sometimes listed under their parent's name. The name of the parent can be found on the "Case Listing" or "Case Members" screens. When an IHSS applicant is a minor child and he/she is listed on CalWIN under his/her parent's name, the application is treated as *pending* if Medi-Cal is not active.

Pending Medi-Cal – An application has been submitted and is entered into the CalWIN system. The application has not been approved or denied by the Medi-Cal Worker.

SOC Specialist – An IHSS Social Worker designated by the IHSS Administration to monitor Medi-Cal applications and assist applicants with the Medi-Cal application process.

The information found in the applicant's CalWIN/MEDS clearance determines the actions that must be completed next.

STEP	CLERICAL PROCEDURE
	Cases with Aid Codes 10, 20, 60, 14, 24, 64, 16, 26, 66, 6A, 6C, 6G, 6V, 1E, 2E, or 6E with Active Eligibility Status on MEDS (Not 999)
5.	The designated clerk should clear MEDS and print the following screens: • INQM • INQX
6.	Assign the case to a Social Worker in the district office.
Note:	Aid codes that are listed above (other than 10, 20, and 60) are income eligible cases but treated as status eligible as long as the client's eligibility status on MEDS is active. **A Fax Referral to SEFRC is not needed.**

STEP	CLERICAL PROCEDURE
	Cases with <u>any aid code</u> and with 999 Eligibility Status on MEDS INQM screen
7.	The designated clerk will clear CalWIN and print the following screens: • Information on Individual Results • Case List • Programs • Case Members If the Medi-Cal is approved on CalWIN, the designated clerk will: • Assign the case to the Share-of-Cost (SOC) Specialist. • Send the temporary case folder to the SOC Specialist at Mail Stop W433. • Identify the temporary case folder as *Active on CalWIN on the route slip.* If the Medi-Cal is pending on CalWIN, the designated clerk will: • Assign the case to the SOC Specialist. • Send the temporary case folder to the SOC Specialist at MS W-433. • Identify the temporary case folder as *Pending* on the route slip. If the Medi-Cal is closed or there is no history on CalWIN, the designated clerk will: • Assign the case to the SOC Specialist. • Send the temporary case folder with the copy of the SAWS 1 to the SOC Specialist at MS W-433.

STEP	CLERICAL PROCEDURE
	• Identify the temporary case folder as *SAWS 1* on the route slip. • Forward the original SAWS 1 with an attached copy of the QM screen to the SEFRC IHSS Medi-Cal Clerk at Mail Stop W69.

STEP	CLERICAL PROCEDURE
	Cases with Aid Codes *Other Than* 10, 20, 60, 1E, 2E, 6E, 14, 24, 64, 16, 26, 36, 66, 6A, 6C, 6G, or 6V with Active Eligibility Status on MEDS (not 999)
8.	The designated clerk should clear MEDS and print the following screens: • INQM • INQX
9.	Assign the case to a Social Worker in the district office.
10.	Send a Fax Referral to SEFRC

Referrals to the IHSS Share-of-Cost (SOC) Specialist

The designated district office clerk will refer to the IHSS Share-of-Cost (SOC) Specialist all IHSS applications that are waiting for a Medi-Cal determination. For each application received the designated Clearance Clerk will complete the following steps:

STEP	CLERICAL PROCEDURE – IHSS DISTRICT OFFICES
1.	After completing clearance procedures, assign income eligible applications with active Medi-cal on CalWIN and MEDS, round robin to the Social Workers in each district.
2.	Assign *SAWS 1* and *Pending* Medi-Cal cases to the SOC Specialist.
3.	Complete data entry and open the case in R status in CMIPS.
4.	Send the completed 12-52 HHSA to the IHSS applicant indicating the worker number, name, and telephone number of the SOC Specialist.
5.	If there is no existing IHSS case folder, create a temporary case folder.
6.	If there is an existing IHSS case folder: • Locate and request the case with instructions to route the case folder to the SOC Specialist at Mail Stop W-433. • Create a temporary case folder.
7.	Include the following documents in the case folder: • SOC 295 & SOC 293A • SAWS 1 (as appropriate) • CMIPS, MEDS, and CalWIN clearances • Copy of the 12-52 HHSA
9.	Identify the case that will be sent to the SOC Specialist as *SAWS 1, Pending*, or *Active on CalWIN* on the route slip.
10.	Log the cases assigned to the SOC Specialist on the district office regular intake log.

11.	Send the temporary folder or the actual case folder (as available) to the SOC Specialist at Mail Stop W-433.
12.	Batch the SAWS 1's with the attached copies of the QM screens and send them to SEFRC through the county mail daily.
13.	When a case is returned from the SOC Specialist marked *Active Medi-Cal*, assign the case to a Social Worker in the district office as a new intake, and send an Active Fax Referral to the SEFRC IHSS Medi-Cal clerk for an IHSS SOC determination.
14.	Include a copy of the fax referral in the intake packet when it is assigned to the Social Worker in the district.
15.	When a case is returned from the SOC Specialist marked *Granted*, assign the case to a Social Worker in the district as a transfer case.

The designated clerk(s) in the Hazard District Office will have the following responsibilities:

STEP	CLERICAL PROCEDURE – HAZARD DISTRICT OFFICE
1.	Print the "R" document and route to the SOC Specialist.
2.	Complete CMIPS entries for denied, closed, and granted cases.
3.	Mail the Notice of Action for denied, closed, and granted cases to the applicant.
4.	File documents in denied, closed, and granted cases.
5.	Retain denied/closed cases for 60 days and then send to Record Room.
6.	Send the granted case back to the respective district office indicating on the route slip that the case is a "transfer case."
7.	If the SOC Specialist workload increases to a significant level, additional clerical assistance may be needed on a temporary basis. This assistance may include: • Routine clearing of pending cases on MEDS, CMIPS and CalWIN. • Screen prints of MEDS, CMIPS, and CalWIN as needed.
Note:	The workload for the SOC Specialist will be evaluated monthly. Any requests for additional clerical help will be reviewed by the Hazard Social Worker Supervisor, the Planning Support Manager, and the IHSS Operations Manager.

THE SHARE-OF-COST (SOC) SPECIALIST

STEP	PROCEDURE
1.	The SOC Specialist receives all income eligible cases from the IHSS district offices if the Medi-Cal application is pending, or the Medi-Cal is not active on CalWIN or MEDS.
2.	Once the intake packet is received, the SOC Specialist inputs the case information onto the SOC Specialist Intake Log.
3.	If the applicant is ineligible to IHSS, the SOC Specialist will: • Deny the application. • Notify the appropriate staff at SEFRC.
4.	The SOC Specialist will clear the pending and inactive Medi-Cal list on a regular basis.

5.	If the Medi-Cal is approved/granted in both CalWIN and MEDS, the SOC Specialist will send the case back to the district office.
6.	If the Medi-Cal is active on CalWIN and not on MEDS, the SOC Specialist will contact the Medi-Cal "worker of record" to troubleshoot the issue.
7.	If the Medi-Cal is discontinued/denied, the SOC Specialist will: • Contact the Medi-Cal "worker of record" for denial/closing reason. • Document the activities in the case narrative. • Keep screen print copies of MEDS and CalWIN in the case. • Submit the SOC 293 for data entry to the IHSS Hazard District Office clerical. **Note:** The Hazard District Office keeps the case file for 60 days in the Closed Case drawer before sending it to the Record Library.

IHSS Share-of-Cost (SOC) Specialist Responsibilities

The Share-of Cost (SOC) Specialist is responsible for monitoring IHSS applications that are pending a SOC determination. The SOC Specialist will complete the following steps:

STEP	PROCEDURE
1.	When the IHSS/Medi-Cal application is received from the district office, the SOC Specialist will enter the case information into the SOC Specialist Intake Log.
2.	Review the following documents: • SOC 295 & SOC 293A • SAWS 1 (as appropriate) • CMIPS, CalWIN, and MEDS clearances • Copy of the 12-52 HHSA sent to the applicant
3.	Review the application and, as needed, do the following: • Initiate a telephone contact with the applicant or his/her authorized representative. • Assess applicant's situation, e.g. mental and physical impairment, terminal ailment, household composition, etc. • Evaluate and make referrals to other programs and agencies as appropriate, e.g. APS, case management, Housing Authority, or Meals-on-Wheels. • If applicant is extremely ill and isolated and needs help completing the application, evaluate the need to schedule a home visit.
4.	If necessary, assist the applicant in completing the Medi-Cal application or in identifying other persons who can help the client in completing the Medi-Cal application, e.g. family members, friends, or case management program.
5.	Complete a home call if needed to assess the need for IHSS services for terminally ill clients and/or clients with urgent needs.
6.	Transfer and file all documents from the temporary case folder to the actual case folder when it is received from the Record Room

7.	If the SOC Specialist is notified that the applicant has been determined ineligible for Medi-Cal, wishes to withdraw his/her application, or that the applicant is deceased, the SOC Specialist will: • Deny the IHSS application by completing the required forms and narrating in the case file. • Submit the entire case to the Hazard District designated clerk for data entry after review and sign off by the Planning and Program Support Manager. • Notify the Southeast Family Resource Center (SEFRC) that the application has been denied for SAWS 1 case.
8.	Review Monthly Characteristic Listing from CMIPS On-Line Reports to compare with the Specialist Log.
9.	Clear the list of pending SOC cases on MEDS, CMIPS, and CalWIN regularly.
10.	Complete case narratives and reports on any action taken on the case documenting all referrals and contacts.

SEFRC Liaison Responsibilities

The Share-of-Cost (SOC) Specialist is the IHSS SOC Liaison with the Southeast Family Resource Center (SEFRC). As the Liaison, the SOC Specialist will:

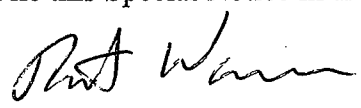
STEP	PROCEDURE
1.	Determine and mediate SOC issues with the SEFRC, Medi-cal "worker of record," or the SOC District Liaison, e.g. lobby for extension of the time needed to provide documents or verifications or expedite the applications of terminal and/or urgent cases.
2.	Send a "pending" case back to the district office when the Medi-Cal is active on CalWIN and MEDS.
3.	Send a "SAWS 1" case back to the district office when the granting gram from Medi-Cal is received from the SEFRC.
4.	Contact the Medi-Cal "worker of record" for the denial or closing reason if a Pending case is in closed or ineligible status.
5.	Document the case activities on the narrative.
6.	Complete monthly statistics to determine the number of cases assigned, denied, granted, or sent back to district, as well as any completed home visits and/or assessments.
7.	Attend quarterly SEFRC/IHSS Administration meeting.

IV. REVIEW STATEMENT

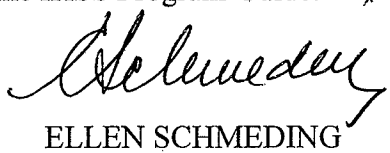
This Special Notice has been reviewed by IHSS Administration.

V. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.



RICK WANNE
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido (858)505-6366
Attachments
Distribution Codes 7 & 8

County of San Diego

JEAN M. SHEPARD
DIRECTOR

PAMELA B. SMITH
DIRECTOR

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

Dear _____
_____
_____

We have received your application for In-Home Supportive Services (IHSS); **however, your application for Medi-Cal must be approved before your IHSS application can be processed.**

I am not your Medi-Cal worker but the Social Worker assigned to be your contact person for any question related to your Medi-Cal application.

You will receive a Medi-Cal application packet in the mail from the Southeast Family Resource Center. In order to expedite your Medi-Cal application you will have to do the following:

- Complete the Medi-Cal application completely. If you are unable to complete the application, arrange to have a relative or a friend assist you.
- Have the photocopies of the following that apply to you:
  - ✓ Pension or retirement papers
  - ✓ Social Security Award Letter or Proof of Social Security Benefits
  - ✓ Disability Award Letter or Proof of Disability Benefits
  - ✓ Veteran's Benefits
  - ✓ Earnings/Self Employment Records
  - ✓ Any other source of income including gifts, loans, etc.
  - ✓ Proof of Citizenship including birth certificate or naturalization papers
  - ✓ Resident Alien Card
  - ✓ Vehicle Registrations
  - ✓ Life Insurance Policies
  - ✓ Bank Statements (Checking and Savings Accounts)
  - ✓ Burial Policies
  - ✓ Any other real and/or personal property
- Return the completed Medi-Cal application including the photocopies of the information indicated above to the Southeast Family Resource Center.

You or your authorized representative may call me directly if you have any questions.
Thank you.

Sincerely,

_____ _____ _____
IHSS Share-of-Cost Specialist Telephone Number Date

ATTACHMENT "A"

COUNTY OF SAN DIEGO
IN-HOME SUPPORTIVE SERVICES
IHSS SOC SPECIALIST ROUTE SLIP

DATE: _____

TO: **Michelle Price**
SOC Specialist
MS – W433

FROM: _____
_____ **District Office**
MS - _____

CASE NAME: _____
CASE NUMBER: _____

CASE TYPE: ☐ **PENDING** ☐ **SAWS 1** ☐ **ACTIVE on CalWIN**

SAWS sent to SEFRC on _____

RETURN ROUTE SLIP

DATE: _____

TO: _____
_____

FROM: **Michelle Price**
SOC Specialist
MS – W433

CASE NAME: _____ **CASE NUMBER:** _____

CASE STATUS: ☐ **ACTIVE MEDI-CAL**
Please assign to a District Social Worker.

☐ **GRANTED**

☐ **DENIED**

ATTACHMENT "B"

Month:_______________
Year:_______________

SOC SPECIALIST MONTHLY LOG

CASE NAME	SSN	CASE NUMBER	APPLICATION DATE	SOC REC'D DATE	AID CODE	Pending or SAWS 1	SAWS1 to SEFRC	SPEC Active FAX to SEFRC	Date from SPEC to SW	District SW #	Comments

SW=Social Worker
SPEC=SOC Specialist
SSN=Social Security Number

ATTACHMENT "C"

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-11

October 15, 2007

SUBJECT: **CALIFORNIA PAID FAMILY LEAVE (PFL) PROGRAM**

EXPIRATION DATE: **When incorporated into the IHSS Program Guide**

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff of the California Paid Family Leave (PFL) Program for IHSS Individual Providers.

II. BACKGROUND

Senate Bill 1661 implemented the California Paid Family Leave (PFL) program, (also known as California's Family Temporary Disability Insurance Act) to enhance State Disability Insurance (SDI) by creating a temporary family leave insurance program for eligible California workers.

III. POLICY

Starting January 1, 2004 all California workers covered under the SDI program contributed an additional .02 percent of their taxable wages to pay for PFL benefits. SDI eligible workers, including the IHSS-R, Personal Care Services Program (PCSP), and IHSS Plus Waiver (IPW) Individual Providers can receive partial wage replacement for up to six weeks in a 12-month period. PFL may be used when an Individual Provider takes time off from work to care for parents, children, a spouse, a registered domestic partner, or to bond with a new child. The PFL program provides protection against wage loss only. It does *not* protect the individual's job. The IHSS recipient may replace the Individual Provider to fill the position.

IV. PROCEDURES

The PFL program is administered by the Employment Development Department (EDD). EDD is responsible for answering all questions regarding program eligibility, and for processing all claims for benefits.

IHSS staff is not required to provide the PFL claim forms. Requests for applications should be referred to EDD at:

1-(877) 238-4373 (English)
1-(877) 379-3819 (Spanish)
1-(800) 563-2441 (TTY)
Employment Development Department
P.O. box 997017
Sacramento, California 95799-7017
Internet site: www.edd.ca.gov/fleclaimpfl.htm

V. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido @ 858/505-6366
Dist. Codes 7 & 8

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-10

September 25, 2007

SUBJECT: CONLAN II – ADDITIONAL CLAIMS

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All-County Letter (ACL) 07-32

I. PURPOSE

The purpose of this Special Notice is to provide staff with updated information on the Conlan II reimbursement process for In-Home Supportive Services (IHSS) recipients who have paid an excess out-of-pocket Share-of-Cost (SOC).

II. BACKGROUND

The California Department of Social Services (CDSS), Adult Programs Division (APD) has been researching the complex issues surrounding Conlan II SOC and Medically Recognized Expenses, related to the Buy-Out, with the goal of identifying the appropriate way to reimburse recipients for this expense.

III. POLICY

All recipients who believe they have paid an excess SOC must submit their claims through the Department of Health Care Services (CDHCS) Beneficiary Services Center (BSC), unless it is a Buy-Out claim for reimbursement for:

- The current eligibility month.
- One month prior to the current eligibility month.

Reimbursements for the *current month or one month prior* may be made by using the Special Pre-Authorized Transaction (SPEC) created for this purpose. Additional information on the SPEC Transaction is expected to be released in September 2007.

The BSC will then forward the claims to CDSS, APD. CDSS will review and process claims as required. The complexity of these claims requires that State staff analyze and sort through the facts associated with each claim. An additional ACL is in development that will provide the necessary instructions for the county "Buy-Out" determination process described above. It will also include examples and details on how to determine if the recipient missed the Buy-Out through **no fault of their own.** This ACL is expected to be released in September 2007.

Social workers should refer recipients who wish to file a claim to the BSC at:

(916) 403-2007
TDD (916) 635-6491

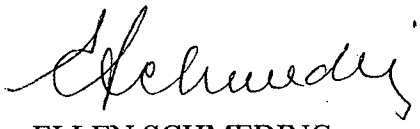
IV. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

V. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Mary Harrison (858) 505-6952

Distribution Codes 7 & 8

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-09

August 10, 2007

SUBJECT: UPDATED FRAUD REFERRAL/OVERPAYMENT PROCEDURES

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: ACIN NO: 1-04-06

I. PURPOSE

The purpose of this Special Notice is to update and clarify referral procedures for the following:

- Public Assistance Fraud Division (PAFD) fraud referrals
- Quality Control (QC) fraud referrals
- Overpayment referrals

II. BACKGROUND

There is a Memorandum of Understanding (MOU) between the Public Assistance Fraud Division of the District Attorney's office and the Health and Human Services Agency (HHSA) to investigate allegations or suspicions of fraud. Changes in the Welfare and Institutions Code (WIC) have resulted in a need for updated fraud referral procedures.

III. POLICY

In-Home Supportive Services (IHSS) staff is responsible for reviewing inconsistent and contradictory information for potential fraud. If a provider or recipient has received benefits to which he/she is not entitled and the overpayment amount is $1500.00 or more, a PAFD fraud referral must be completed. If the overpayment is less than $1500.00, only an overpayment referral will be completed. When in doubt, the fraud referral should be made and the amount of the overpayment left blank.

IV. DEFINITIONS

Overpayment

A payment made for the purchase or delivery of IHSS services in an amount to which the recipient or the provider was not entitled. (MPP 30-768 .11)

Administrative Overpayments

An administrative overpayment occurs when the action or inaction of IHSS staff results in a payment for IHSS services to which the recipient was not entitled. An administrative overpayment cannot be referred to PAFD. Any administrative overpayments greater than $5.00 occurring in an IHSS Residual (IHSS-R) case will be processed for overpayment recovery.

WIC section 12305.83 provides the authority for the collection of all IHSS overpayments (including overpayments that are not fraud related) that have been made to an IHSS provider. When an IHSS provider has received an overpayment it may be collected to the extent that is allowed under existing labor laws. In a Personal Care Services Program (PCSP), or an IHSS Plus Waiver (IPW) case, state law does not recognize *recipient* liability when an administrative error results in an overpayment to the *recipient*. An administrative overpayment made to a PCSP or an IPW eligible recipient cannot be collected.

Willful Overpayments

Willful overpayments result when a recipient or provider fails to report essential information. All overpayments will be evaluated to determine if there was willful intent to provide false, misleading, or incomplete information in order to receive benefits to which the recipient was not entitled.

Fraud

Fraud is the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. Fraud also includes any act that constitutes fraud under applicable federal or state law. WIC 12305.8 (a)

V. OVERPAYMENT REFERRAL PROCEDURES

When a County or Public Authority employee becomes aware that an overpayment for IHSS has occurred, he/she must inform the assigned IHSS Social Worker. The Social Worker will evaluate the information and if appropriate, initiate the overpayment collection process or make a referral to the PAFD unit.

The most common overpayment occurs when a provider continues to collect payment for IHSS services after the recipient is hospitalized or deceased.

SOCIAL WORKER PROCEDURE

Review the case file for the following:

- The reason the overpayment occurred.
- The start date.
- The stop date.
- The estimated overpayment amount.

When determining the dates for an overpayment resulting from a hospitalization, the Social Worker must allow for:

- Services received at home on the date the recipient was admitted to a care facility.
- Services received at home on the date the recipient returned to his/her own home.

Overpayments Under $1500.00

For overpayments that are *under* $1500.00 dollars, *a fraud referral will not be made to the PAFD unit.* When the overpayment amount is clearly less than $1500.00 dollars, and there is a confirmed beginning and end date to the period of ineligibility:

- Complete the Overpayment Referral form (Attachment A).
- Forward the form with any appropriate documentation attached to the Social Work Supervisor.
- The Social Work Supervisor will review and route to the
  IHSS Overpayment Specialist
  Mail Stop W253
  Fax No. (619) 476-6293

The Social Worker will document all of the actions taken in the case narrative. A copy of the Overpayment Referral and the information attached should be maintained in the case file under the QC tab. The Overpayment Specialist will determine the actual overpayment amount factoring in any amounts withheld from the provider's paycheck.

Overpayment Over $1500.00

When the overpayment amount is more than $1500.00 dollars or the amount is unknown or unclear:

- Complete the 12-50 HHSA IHSS Fraud Referral form (Attachment B)
- Leave the overpayment amount blank until the fraud investigators response is received.
- On the IHSS 12-50 for fraud "type", check "suspected" or "confirmed" e.g. payments submitted for an ongoing period after a recipient is deceased would be considered confirmed.
- PAFD will be responsible for the determination of intent, and if the fraud will be prosecuted by the District Attorney's Office.
- Forward the form with any appropriate documentation attached to the Social Work Supervisor for Review.
- The Social Work Supervisor will review the form for completeness and forward to the IHSS Program Manager at W253.
- The IHSS Program Manager will forward the referral to the PAFD unit at the District Attorney's Office.
- Do not complete the Overpayment Referral until the results of the PAFD referral are received.

Overpayment information is confidential and will be kept in a locked file cabinet.

OVERPAYMENT SPECIALIST PROCEDURES

1. Review the overpayment referral and the attached information for completeness. Contact the referring Social Worker (if necessary) for additional information, then create an overpayment folder.

2. Review the CMIPS records and make a print of each of the following screens:

a. RELA
b. RELB
c. RELC
d. PELG
e. PSUM

3. Calculate the amount of the overpayment by completing the automated Overpayment Worksheet (Attachment C).

4. If the overpayment was made to the recipient, complete form 12-86 CL (Attachment D) or the 12-86 CL Spanish (Attachment E). *

5. If the overpayment was made to the provider, complete form 12-86 IP (Attachment F) or the 12-86 IP Spanish (Attachment G). *

6. Complete an Overpayment Activity Log entry (Attachment H). Maintain the automated Overpayment Referral/Collections Log.

*Form 12-86 informs the recipient/provider that there has been an overpayment that they have an obligation to repay. File a copy in the overpayment folder and forward copies to the following:

- IHSS Recipient
- IHSS provider that received the overpayment
- Fiscal - Department or Revenue and Recovery
- IHSS Social Worker
- IHSS Program Manager
- Public Assistance Fraud Division (if applicable)

The following repayment methods are available:

- Balancing
- Payment Adjustment
- Voluntary Cash Recovery
- Civil Judgment
- Fiscal Collection

Additional information on repayment methods are in the IHSS Program Guide, Chapter 6.

Note:
A collection status report is received on a monthly basis from the Auditor and Controller's office.

VI. UNDERPAYMENTS

Underpayments occur when a recipient receives fewer services than he is entitled to, or when the share-of-cost paid by the recipient is greater than the correct share-of-cost. Underpayments can be corrected by increasing the service hours, or by a retroactive payment issued in an amount equal to that of the calculated underpayment. All underpayment corrections must be reviewed and approved by the Social Work Supervisor.

If an underpayment has occurred, the Social Worker will send a Notice of Action to inform the recipient of the following:

- The period during which the underpayment occurred.
- The reason for the underpayment.
- The amount of the underpayment and the calculation process to determine the underpayment amount.
- The proposed adjustment method.

VII. FRAUD REFERRALS

Before a fraud referral is initiated, the recipient/provider must be contacted to clarify the inconsistent information and/or failure to report changes. When inconsistent information cannot be clarified or resolved, a fraud referral can be made to the IHSS Quality Control Unit (QC) or to the PAFD unit. Fraud estimated at amounts greater than $1500.00 for a recipient/provider ***must*** be referred for investigation to PAFD and possible prosecution. A referral to the QC unit would be made to clarify inconsistent information or gather additional information before a referral to PAFD is made.

QUALITY CONTROL FRAUD REFERRALS

Referrals are made to the IHSS Quality Control Unit by using the form IHSS QC Fraud Investigation Request (Attachment I). When completing the referral:

- Information requested on the form should be as complete as possible.
- Include any additional information that would be helpful in conducting the review.
- On the fraud referral form the Social Worker will clearly state the intended goal of the fraud referral, e.g. "Please complete a drop-in home visit, verify house-hold composition if possible".

When determining the type of fraud referral (QC or PAFD), please remember that QC Social Workers are ***not authorized*** to do the following:

- Conduct surveillance.
- Conduct third party interviews without a client's written permission.
- Obtain any written or electronic records not already available to IHSS Social Workers.
- Conduct a home visit at the IP's home.

After completing the IHSS QC Fraud Investigation Request:

- Forward the form with any appropriate documentation attached to the Social Work Supervisor for review.
- The Social Work Supervisor will review the form for completeness and the appropriateness of the referral, and then forward it to the IHSS Program Manager at W253
- The IHSS Program Manager forwards the referral to the QC Supervisor at MS W433.

The QC Social Worker will conduct a full review of the case, including an unannounced home visit. When a case review has been completed, QC returns the referral with recommendations and observations to the IHSS Program Manager. QC will provide as much information as possible in order to make a fraud referral to PAFD (if such a referral is warranted). The district Social Worker will be responsible for completing the PAFD fraud referral packet.

PAFD REFERRALS

When the overpayment amount is more than $1500.00 dollars or the amount is unknown:

- *Do not complete* the Overpayment Referral.
- Complete the 12-50 HHSA IHSS Fraud Referral form (Attachment B), *leaving the overpayment amount blank.*
- Forward the form with any appropriate documentation attached to the Social Work Supervisor for Review.
- The Social Work Supervisor will review the form for completeness and appropriateness of the referral, and forward to the IHSS Program Manager at W253
- The IHSS Program Manager will forward the referral to the PAFD unit at the District Attorney's Office.
- When the results of the fraud investigation have been received, if appropriate follow the overpayment referral procedures.

EMPLOYEE FRAUD

Immediately refer all allegations or suspicions of employee-involved fraud to Internal Security at **(619) 338-2135.**

VIII. REVIEW STATEMENT

This Special Notice was reviewed by the following:

- IHSS Program Administration
- IHSS Social Work Supervisors
- IHSS Quality Control
- IHSS Overpayment Specialist
- Policy and Program Support
- PAFD

IX. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Mary Harrison (858) 505 6952
Attachment
Distribution Codes 7 & 8

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 _____

12-62 HHSA (05/07) (05/09)

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY
AGING & INDEPENDENCE SERVICES
9335 HAZARD WAY, SUITE 100, SAN DIEGO, CALIFORNIA 92123-1222

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 ☐
			Yes ☐ NO ☐
			Yes ☐ NO ☐
			Yes ☐ NO ☐
			Yes ☐ NO ☐

See attached SOC 311 for additional provider information.

CASE STATUS

(Note: closed cases cannot be referred to PAFD at this time.)
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.

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

PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

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

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

D/O _____
FICA _____
SDI _____
PCSP _____

NO

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: _____

' ~(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 ...digo 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.

USTED TIENE DERECHO DE PEDIR POR ESCRITO U ORALMENTE UNA AUDIENCIA ESTATAL: FAVOR DE ENVIAR SU PETICIÓN POR ESCRITO AL DOMICILIO DEL CONDADO EN LA ESQUINA SUPERIOR DERECHA DE ÉSTE FORMULARIO.

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 ACTIO IF REQUESTING AN APPEAL, PLEASE SEND TO:**

KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

YOUR HOME OFFICE

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

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)

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)

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 _____

OVERPAYMENT ACTIVITY LOG

MONTH_____ YEAR_____

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

(08/07)
(08/10)

SPECIAL NOTICE 07-09 ATTACHMENT H

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 06-09
ADDENDUM B

June 11, 2007

SUBJECT- CORRECTION TO SPECIAL NOTICE 06-09 ATTACHMENT 'B' "ANNOTATED ASSESSMENT CRITERIA"

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All-County Letter #06-34 and 06-34 Erratum

I. PURPOSE

The purpose of this Special Notice is to clarify and make a correction to Attachment B (Annotated Assessment Criteria) of Special Notice 06-09 issued September 18, 2006. This is the second correction issued.

II. BACKGROUND

Special Notice 06-09 provided standard guidelines for staff to accurately and consistently assess service needs. Corrections were made throughout the document for clarity, consistency, and to coincide with the H line of the SOC 293 form.

III. PROCEDURES

The attachment issued is to be replaced with the corrected version:

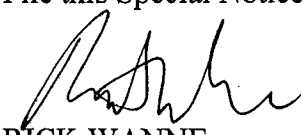
Please remove and recycle the 12/21/06 revision of Attachment B, Special Notice 06-09 Addendum A and replace it with the revision dated 04/27/06 attached with this addendum.

IV. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

V. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.



RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Gina Brown (858) 495-5554

Dist. Codes 7 & 8

ATTACHMENT B

ANNOTATED ASSESSMENT CRITERIA

Annotated Assessment Criteria is designed to assist you in the application of rankings specified in Manual of Policies and Procedures (MPP) Section 30-756 which are applied to evaluate a recipient's capacity to perform certain In-Home Supportive Services (IHSS) tasks safely. The Annotated Assessment Criteria describes each functional rank in more detail as it applies to an individual's capacity to perform certain types of tasks specified in MPP Section 30-757, and it provides sample observations you might make for each ranking, characteristics of a recipient who might be ranked at each level, and questions which might elicit the information needed to determine the appropriate rank. These samples are lists of possible indicators, not definitive standards.

General

Following are general questions that may be asked of applicants to help determine whether need exists:

* How frequently have you been seen by a doctor?
* Has the doctor limited your activities?
* When does your family come to see you and how do they feel about your condition?
* What can family/friends/neighbors do to help you?
* Who has been helping you up to this point?
* Why are you asking for help now?
* How have circumstances changed?
* How long have you been having difficulty?
* What is limiting your activities?
* How do you feel about the status of your health?
* How long do you think you will need this service?
* How would you manage if your provider called in sick one day?

Information to be given and reinforced periodically:

* A clear explanation of the recipient's responsibilities in the county's delivery system.
* IHSS is a program which provides only those services necessary for the recipient's safety which the recipient is unable to perform.

Observations

A number of observations are applicable to all functions. These involve observing the recipient getting up from a chair, ambulating, standing, reaching, grasping, bending, and carrying; and observing the recipient's endurance and mental activity. In the following text, the first eight observable behaviors above are referred to as "movement." All of these functions can usually be

observed by noting how the recipient admitted you into the housing unit and shaking his/her hand when arriving; asking the recipient to show you the housing unit; asking the recipient to show you all his/her medications; asking him/her to get his/her Medi-Cal card for you; and asking him/her to sign the application. If the above-listed functions have not been adequately demonstrated in the course of the interview, it is sometimes helpful to ask the recipient for a glass of water. Since the ranking of functioning is hierarchical, observations and questions in a lower rank are likely to apply to a higher one. Observations lead to a general assumption as to the appropriate level of functioning, and follow-up questions elicit information as to what assistance is necessary for the level of functioning observed. This listing is not all-inclusive, nor does the presence of one behavior on the list necessarily create the basis for the ranking. All your senses are involved in gaining cues to determine the recipient's functioning as a whole. Quite often, it is important to get a medical report to verify that there is a basis for observed behaviors.

General

The following are general regulatory standards that apply to all functions. The standards for each function are defined in more detail in individual scales that follow.

Rank 1: Independent: Able to perform function without human assistance although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his/her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

Rank 2: Able to perform a function but needs verbal assistance such as reminding, guidance, or encouragement.

Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.

Rank 4: Can perform a function but only with substantial human assistance.

Rank 5: Cannot perform the function with or without human assistance.

Rank 6: Paramedical Services needed.

Variable Functioning

If the recipient's functioning varies throughout the month, the functional rank should reflect the functioning on reoccurring bad days. It is not solely based on a "worst" day scenario (e.g., a recipient who suffers from arthritis will have days when pain is significant and days when pain is mild; therefore, in this case you would rank a recipient based on the reoccurring days where the frequency of pain is significant).

ATTACHMENT B

DEFINITION OF SERVICES LISTED ON THE SOC 293 "H" LINE

Domestic Services

Sweeping, vacuuming, and washing/waxing floors; washing kitchen counters and sinks; cleaning the bathroom; storing food and supplies; taking out garbage; dusting and picking up; cleaning oven and stove; cleaning and defrosting refrigerator; bringing in fuel for heating or cooking purposes from a fuel bin in the yard; changing bed linen; changing light bulbs; and wheelchair cleaning and changing/recharging wheelchair batteries.

The following is the application of functional rank specific to Domestic services with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to perform all domestic chores without a risk to health or safety. Recipient is able to do all chores though s/he might have to do a few things every day so that s/he doesn't overexert her/himself.

* **Observations:** Observe if the home is neat and tidy. Observe if the recipient's movement is unimpaired.
* **Example:** Recipient with no signs of impairment moves easily about a neat room, bending to pick up items and reaching to take items from shelves.
* **Question:** Are you able to do all the household chores yourself, including taking out the garbage?

Rank 2: Able to perform tasks but needs direction or encouragement from another person. Recipient is able to perform chores if someone makes him/her a list or reminds him/her.

* **Observations**: Observe if the recipient seems confused or forgetful and has no observable physical impairment severe enough to seem to limit his/her ability to do housework; if there is incongruity in what you observe, such as dirty dishes in cupboard.
* **Example:** Young man apparently physically healthy, but obviously confused and forgetful, is being reminded that it is time for him to sweep and vacuum.
* **Questions**: How do you manage to keep your apartment clean? Has anyone been helping you up to this time?

Rank 3: Requires physical assistance from another person for some chores (e.g., has a limited endurance or limitations in bending, stooping, reaching, etc.).

* **Observations:** Observe if the recipient has some movement problems as described above; has limited endurance; is easily fatigued; or has severely limited eyesight. Observe if the home is generally tidy, but needs a good cleaning; if it is apparent that the recipient has made attempts to clean it, but was unable to.
* **Example:** Small frail woman answers apartment door. Apartment has some debris scattered on carpet and quite-full trashcan is sitting in kitchen area. The remainder of apartment is neat.

ATTACHMENT B

* **Questions:** Have you been doing the housework yourself? What have you been doing about getting your housework done up until now?

Rank 4: Although able to perform a few chores (e.g., dust furniture or wipe counters) help from another person is needed for most chores.

* **Observations:** Observe if the recipient has limited strength and impaired range of motion. Observe if the house needs heavy cleaning.
* **Example:** Recipient walking with a cane is breathing heavily in cluttered living room. The bathtub and toilet are in need of cleansing. The recipient's activities are limited because of shortness of breath and dizziness.
* **Questions:** What household tasks are you able to perform? Has your doctor limited your activities?

Rank 5: Totally dependent upon others for all domestic chores.

* **Observations:** Observe if dust/debris is apparent; if there is garbage can odor; if the bathroom needs scouring; if household chores have obviously been unattended for some time. Observe if the recipient has obvious limited mobility or mental capacity.
* **Examples:** Bed-bound recipient is able to respond to questions and has no movement in arms or legs. Frail elderly man is recovering from heart surgery and forbidden by doctor to perform any household chores.
* **Questions:** Are there any household tasks you are able to perform? What is limiting your activities? Who has been helping you to this point?

Laundry

Gaining access to machines, sorting laundry, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry, folding and sorting laundry, mending and ironing. (Note: Ranks 2 and 3 are not applicable to determining functionality for this task.)

The following is the application of functional rank specific to Laundry services with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to perform all chores.

* **Observations:** Observe if the recipient's movement seems unimpaired; if s/he seems able to ambulate, grasp, bend, lift, and stand adequately; if s/he is wearing clean clothes.
* **Example:** Recipient is apparently physically fit. The recipient's movements during interview indicate that s/he has no difficulty with reaching, bending, or lifting.
* **Questions:** Are you able to wash and dry your own clothes? Are you also able to fold and put them away?

Rank 4: Requires assistance with most tasks. May be able to do some laundry tasks (e.g., hand wash underwear, fold and/or store clothing by self or under supervision).

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* **Observations:** Observe if the recipient has some impairment in movement, is nodding, displays forgetfulness, or has severely limited eyesight; if the recipient's clothing is stained or spotted.
* **Example:** Frail woman is unable to transfer wet wash to the dryer, particularly, sheets and towels. Housemate encourages her to help with sorting and folding, etc.
* **Questions:** Are you able to lift and transfer wet articles in the laundry? How have you handled this laundry up to now? Who has been doing your laundry for you up to this time? Has the doctor suggested that you do some simple tasks with your arms and hands?

Rank 5: Cannot perform any task, is totally dependent on assistance from another person.

* **Observations:** Observe if there are severe restrictions of movement.
* **Example:** Quadriplegic recipient is seated in wheelchair, obviously unable to perform laundry activities.
* **Questions:** Who does your laundry now? What has changed in your circumstances that resulted in your asking for help now?

Shopping and Errands

Compiling list; bending, reaching, lifting, and managing cart or basket; identifying items needed; transferring items to home and putting items away; telephoning in and picking up prescriptions; and buying clothing. (Note: Ranks 2 and 4 are not applicable to determining functionality for this task.)

The following is the application of functional rank specific to Shopping and Errands with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Can perform all tasks without assistance.

* **Observations:** Observe if movement seems unimpaired and the recipient seems oriented.
* **Example:** Social worker questions elderly man whose responses indicate that he is able to do his own shopping and can put groceries and other items away. Although his movements are a little slow, it is evident that he is capable of performing this task.
* **Question:** How do you take care of your shopping and errands?

Rank 3: Requires the assistance of another person for some tasks (e.g., recipient needs help with major shopping needed but can go to nearby store for small items, or the recipient needs direction or guidance).

* **Observations:** Observe if the recipient's movement is somewhat impaired; if the recipient has poor endurance or is unable to lift heavy items; if s/he seems easily confused or has severely limited eyesight; if there is limited food on hand in refrigerator and cupboard.
* **Example:** Recipient goes to corner market daily to get a few small items. Someone else makes a shopping list.

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* **Questions:** Do you have difficultly shopping? What are the heaviest items you are able to lift? Do you usually buy the items you planned to purchase? Do you have any difficulty remembering what you wanted to purchase or making decisions on what to buy? (Ask recipient's significant other whether the recipient has difficulty making decision on what to buy or if recipient's mental functioning seems impaired.)

Rank 5: Unable to perform any tasks for self.

* **Observations:** Observe if movement or mental functioning is severely limited.

* **Example:** Neighbors help when they can. Teenaged boy comes to recipient's door and receives money and list from recipient to purchase a few groceries.
* **Questions:** Has someone been shopping for you? How do you get your medications?

Meal Preparation/Meal Cleanup

Meal Preparation includes such tasks as planning menus; removing food from refrigerator or pantry; washing/drying hands before and after meal preparation; washing, peeling, and slicing vegetables; opening packages, cans, and bags; measuring and mixing ingredients; lifting pots and pans; trimming meat; reheating food; cooking and safely operating stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-size pieces.

Meal Cleanup includes loading and unloading dishwasher; washing, rinsing, and drying dishes, pots, pans, utensils, and culinary appliances and putting them away; storing/putting away leftover foods/liquids; wiping up tables, counters, stoves/ovens, and sinks; and washing/drying hands.

Note: Meal Cleanup does not include general cleaning of the refrigerator, stove/oven, or counters and sinks. These services are assessed under Domestic services.

The following is the application of functional rank specific to Meal Preparation/Meal Cleanup with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Can plan, prepare, serve, and cleanup meals.

* **Observations:** Observe if the recipient's movement seems unimpaired.
* **Example:** Recipient cooks and freezes leftovers for reheating.
* **Questions:** Are you able to cook your own meals and cleanup afterwards? Are you on a special diet? If yes, describe.

Rank 2: Needs only reminding or guidance in menu planning, meal preparation, and/or cleanup.

* **Observations:** Recipient seems forgetful. There is rotten food, no food in refrigerator, or a stockpile of Twinkies®, only. Recipient's clothes are too large, indicating probable weight loss. There are no signs of cooking.

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* **Example:** Elderly recipient is unable to plan balanced meals, has trouble knowing what to eat so eats a lot of desserts and snacks, sends granddaughter to purchase fast foods. Recipient leaves dishes near the sofa where s/he eats; s/he reuses dirty dishes if not reminded to wash and dry them.
* **Question:** Are you able to prepare and cleanup your own meals?

Rank 3: Requires another person to prepare and cleanup main meal(s) on less than a daily basis (e.g., recipient can reheat food prepared by someone else, can prepare simple meals, and/or needs some help with cleanup but requires another person to prepare and cleanup with more complex meals which involve, peeling, cutting, etc., on less than a daily basis).

* **Observations:** Observe if the recipient's movement is impaired; if s/he has poor strength and endurance or severely limited eyesight; if s/he appears adequately nourished and hydrated.
* **Example:** Recipient can reheat meals, make a sandwich, and get snacks from the package. Recipient has arthritis that impairs her/his grasp; s/he is unable to wash dishes because s/he cannot hold on to dishes.
* **Questions:** What type of meals are you able to prepare for yourself? Can you lift casserole dishes and pans? Can you reheat meals that were prepared for you ahead of time? Are you able to wash dishes? Can you wipe the counter and stove?

Rank 4: Requires another person to prepare and cleanup main meal(s) on a daily basis.

* **Observations:** Recipient has movement and endurance problems and has very limited strength of grip.
* **Example:** Recipient is unable to stand for long periods of time. Recipient can get snacks from the refrigerator like fruit and cold drinks, can get cereal, or make toast for breakfast, etc.
* **Questions:** Can you stand long enough to operate your stove, wash, dry, and put away dishes and/or load/unload the dishwasher?

Rank 5: Totally dependent on another person to prepare and cleanup all meals.

* **Observations:** Observe if the recipient has severe movement problems or is totally disoriented and unsafe around the stove.
* **Example:** Recipient has schizophrenia. Recipient believes that when s/he gets wet the water has the power to enable people to read her/his mind. Provider cuts up food in bite-sized portions and carries tray to bed-bound recipient.
* **Questions:** Are you able to prepare anything to eat for yourself? Does your food and drink need to be handled in any special way? Can you wash dishes?

*If all of the recipient's ingestion of nutrients occurs with tube feeding, the recipient shall be ranked "1" in both Meal Preparation and Eating because tube feeding is a Paramedical service. (MPP 30-756.41)

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Ambulation

Assisting the recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving and retrieving assistive devices, such as a cane, walker, or wheelchair, etc.; and washing/drying hands before and after performing these tasks. Ambulation also includes assistance to/from the front door to the car **(including getting in and out of the car)** for medical accompaniment and/or alternative resource travel.

The following is the application of functional rank specific to Ambulation with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Requires no physical assistance though recipient may experience some difficulty or discomfort. Completion of the task poses no risk to his/her safety.

* **Observations:** Observe if the recipient is steady on feet, able to maneuver around furniture, etc. Observe if the recipient needs to grab furniture or walls for support. Have the recipient show you the home and observe ambulation.
* **Questions:** Do you ever have any difficulty moving around? Have you ever had to use a cane or walker? Do you feel safe walking alone in your home?

Rank 2: Can move independently with only reminding or encouragement (e.g., needs reminding to lock a brace, unlock a wheelchair or to use a cane or walker).

* **Observations:** Observe if the recipient can use his/her walker or cane of his/her own volition; if recipient can rely appropriately on an appliance; if there is an assistive device visible in a corner rather than right beside the recipient when s/he is sitting; how well the recipient is able to move about with an assistive device; if there is any modifications observable in the home such as grab bars, etc.
* **Questions:** Do you ever have trouble handling your device? Are there times when you forget and get somewhere and need help getting back or do not wish to use your device? What happens then? Have you experienced any falls lately? Describe.

Rank 3: Requires physical assistance from another person for specific maneuvers (e.g., pushing wheelchair around sharp corner, negotiating stairs or moving on certain surfaces).

* **Observations:** Observe if the recipient needs to ask you for assistance; if the recipient appears to be struggling with a maneuver that could put her/him at risk if unattended; if recipient appears strong enough to handle the device; if there are architectural barriers in the home.
* **Questions:** Are there times when you need to rely on someone else to help you get around the house? What kind of help do you need and when? What happens when there is no one to help you? Are there certain times of day or night when movement is more difficult for you? Are all areas of your home accessible to you?

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Rank 4: Requires assistance from another person most of the time. Is at risk if unassisted.

* **Observations:** Observe if the recipient is able to answer the door; get back safely to his/her seat; if there is clutter on the floor, scattered rugs, or stairs; if there is obvious fatigue or labored breathing; if there are bruises, scabs, bumps, or burns (signs of falls) on the recipient.
* **Questions:** Is there someone in the home helping you now? If so, what is the level of assistance?

Rank 5: Totally dependent upon others for movement. Must be carried, lifted, or assisted into a wheelchair or gurney at all times.

* **Observations:** Observe if the recipient appears to be immobile; if s/he appears to be uncomfortable or in pain; if s/he has any fears related to being moved; if s/he makes needs known.
* **Questions:** Who is available to help you when you need to be moved? Do you feel s/he is able to do so without causing you undue pain or discomfort? Is there anything that needs to be changed to make you more comfortable?

Bathing, Oral Hygiene, and Grooming/Routine Bed Bath

Bathing (Bath/Shower) includes cleaning the body in a tub or shower; obtaining water/supplies and putting them away; turning on/off faucets and adjusting water temperature; assistance with getting in/out of tub or shower; assistance with reaching all parts of the body for washing, rinsing, drying, and applying lotion, powder, deodorant; and washing/drying hands.

Oral Hygiene includes applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

Grooming includes combing/brushing hair; hair trimming when the recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care (excluding toenail clipping) when these services are not assessed as Paramedical services for the recipient; and washing/drying hands.

Note: Bathing, Oral Hygiene, and Grooming does not include getting to/from the bathroom. These tasks are assessed as mobility under Ambulation services.

Routine Bed Bath includes cleaning basin or other materials used for bed sponge baths and putting them away; obtaining water and supplies; washing, rinsing, and drying body; applying lotion, powder, and deodorant; and washing/drying hands before and after bathing.

The following is the application of functional rank specific to Bathing, Oral Hygiene, and Grooming/Routine Bed Baths with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to bathe, brush teeth, and groom self safely without help from another person.

* **Observations:** Observe if the recipient's mobility is unimpaired; if the recipient is clean and well groomed; if there is assistive equipment in the bathroom.
* **Questions:** Do you ever require any assistance with Bathing, Oral Hygiene, or Grooming? Are you able to get in and out of the tub or shower safely? Have you ever fallen?

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Rank 2: Able to bathe, brush teeth, and groom self with direction or intermittent monitoring. May need reminding to maintain personal hygiene.

* **Observations:** Observe if the recipient has body odors, unwashed hair, dirt or grime on body, un-manicured fingernails; if the recipient is unshaven, displays a lack of oral hygiene or general poor grooming habits; if the recipient is unaware of his/her appearance.
* **Questions:** Are there times when you forget to bathe, brush your teeth, and groom yourself, or it seems just too much bother? Does anyone help you organize your bath or shower?

Rank 3: Generally able to bathe and groom self, but needs assistance with some areas of body care (e.g., getting in and out of shower or tub, shampooing hair, or brushing teeth).

* **Observations:** Observe if the recipient has weakness or pain in limbs or joints; difficulty raising arms over head, frailty, general weakness, unsteady gait indicating a safety risk; if the bathroom is not set up to meet the recipient's safety needs (e.g., grab bars, tub bench); if recipient's grooming indicates an unaddressed need.
* **Example:** Recipient has fear associated with lack of movement.
* **Questions:** Are there areas of bathing, oral hygiene, or grooming that you feel you need help with? What? When? How do you get into the shower or tub? Do you ever feel unsafe in the bathroom? Have you ever had an accident when bathing? What would you do if you did fall?

Rank 4: Requires direct assistance with most aspects of bathing, oral hygiene, and grooming. Would be at risk if left alone.

* **Observations:** Observe if the recipient requires assistance with transfer; has poor range of motion, weakness, poor balance, fatigue; skin problems (e.g., indications of a safety risk). Determine how accessible and modified the bathroom is to meet the recipient's needs.
* **Questions:** How much help do you need in taking a bath and washing your hair? If there were no one to help you, what would be left undone? Do you experience any loss of sensation to your body? Do you have any fears related to bathing? Have you fallen when getting into or out of the tub or shower? What would you do if you did fall?

Rank 5: Totally dependent on others for bathing, oral hygiene, and grooming.

* **Observations:** Observe if there is any voluntary movement and where; if the recipient exhibits good skin color, healthy, clean skin and hair; if bathing schedules/activities are appropriate for the recipient's specific disability/limitations.
* **Questions:** Are you satisfied with your bathing, oral hygiene, and grooming routines? Does anything frighten or scare you when you are bathed?

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Dressing/Prosthetic Devices:

Dressing/Prosthetic Devices: Putting on/taking off, fastening/unfastening, buttoning/unbuttoning, zipping/unzipping, and tying/untying of garments, undergarments, corsets, elastic stockings, braces, and prosthetic devices; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.

The following is the application of functional rank specific to Dressing/Prosthetic Devices with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to put on, fasten, and remove all clothing. Clothes self appropriately for health and safety.

* **Observations:** Observe if the recipient is appropriately dressed; if clothing is buttoned, zipped, laced; if the recipient has no difficulty with small hand movements as demonstrated by his/her ability to sign the application.
* **Questions:** Do you ever have any difficulty getting dressed (e.g., buttoning or zipping clothing, etc.).

Rank 2: Able to dress self; but requires reminding or direction.

* **Observations:** Observe the appropriateness of the recipient's dress for room temperature or if the recipient's clothing is bizarre (e.g., wearing underwear outside of clothing); if the clothing is buttoned, zipped, laced; if the clothing is relatively clean, is mended if necessary, is the correct size for recipient; if the recipient is blind; if the recipient is alert and aware of his/her appearance.
* **Questions:** Are there times when it seems just too much of a bother to get dressed for the day? Does anyone ever comment to you on how you are dressed? Are you warm enough or too warm? Could you use some help in getting your clothes organized for the day?

Rank 3: Unable to dress self completely without the help of another person (e.g., tying shoes, buttoning, zipping, putting on hose, brace, etc.).

* **Observations:** Observe if the recipient's clothes are correctly fastened; if the recipient apologizes or seems embarrassed about the state of his/her dress; if the recipient asks you for any assistance; if the recipient is disabled in his/her dominant hand; if the recipient has impaired range of motion, grasping, small hand movement; if the recipient needs special clothing.
* **Questions:** Are there any articles of clothing you have difficulty putting on or fastening? Do you need help with clothing items before you feel properly dressed? Do you need to use a special device in order to get dressed? Do you use Velcro® fastening?

Rank 4: Unable to put on most clothing items by self. Without assistance the recipient would be inappropriately or inadequately clothed.

* **Observations:** Observe if the recipient's range of motion and other movements are

impaired. Observe if the recipient is dressed in bed clothes, robe, and slippers rather than street clothes; if the recipient appears too cold or too warm for the room temperature; if the recipient seems willing to try to adapt to alternate methods of dressing.

* **Questions:** Do you feel unable to get out or have people visit because you are unable to get adequately dressed? Do you ever feel too hot or too cold because you cannot put on or take off the necessary clothing to make you feel more comfortable? Has your health ever been affected because you have not been able to dress appropriately for the weather or temperature?

Rank 5: Unable to dress self at all, requires complete assistance from another.

* **Observations:** Observe if the recipient is capable of voluntary movement? If the recipient's clothing appears comfortable and clean; if the recipient appears satisfied with the degree of dress. Determine if the recipient would prefer a dress and shoes rather than a robe and slippers all of the time.
* **Questions:** How do you change your clothing? Do you ever feel too warmly or too coolly dressed? Is your clothing comfortable and clean enough? Do you get changed as often as you feel necessary?

Bowel, Bladder, and Menstrual Care

Bowel, Bladder, and Menstrual Care: Assisting with using, emptying, and cleaning bedpans/bedside commodes, urinals, ostomy, enema, and/or catheter receptacles; application of diapers; positioning for diaper changes; managing clothing; changing disposable barrier pads; putting on/taking off disposable gloves; wiping and cleaning recipient; assisting with getting on/off commode or toilet; and washing/drying hands. Menstrual care is limited to the external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes, using and/or disposing of barrier pads, managing clothing, wiping, cleaning, and washing/drying hands.

Note: This task does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program, or colostomy irrigation. These tasks are assessed as Paramedical services. In assessing Menstrual care, it may be necessary to assess additional time in other service categories such as Laundry, Dressing, Domestic, Bathing, Oral Hygiene, and Grooming. Also, if a recipient wears diapers, time for menstrual care should not be necessary

The following is the application of functional rank specific to Bowel, Bladder, and Menstrual care with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to manage Bowel, Bladder, and Menstrual care with no assistance from another person.

* **Observations:** Observe if recipient's movement is unimpaired and odor of urine present; if the recipient has had colon cancer, observe if the recipient wears a colostomy or ostomy bag or if there are ostomy or colostomy bags present.
* **Questions:** Do you need any help when you have to use the toilet? Do you also use a bedside commode, urinal, or bedpan? Do you have any problems getting to the bathroom on time?

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Rank 2: Requires reminding or direction only.

* **Observations:** Observe if the recipient seems disoriented or confused; if urine smells are detectable; if furniture is covered with barrier pads or plastic; if adult diapers are in the recipient's bedroom or bathroom; if the recipient takes diuretics such as Lasix®; if the recipient's clothing is stained, indicating that there is an incontinence problem.
* **Questions:** In the past month, have you had difficulty getting to the toilet/commode on time? If yes, how often? Does someone remind you?

Rank 3: Requires minimal assistance with some activities but the constant presence of the provider is not necessary.

* **Observations:** Observe if there are moderate movement impairments; if there is severe limitation of use of the recipient's hands; if the recipient needs a boost to transfer.
* **Questions:** Do you have any problems using the bathroom or managing your clothes? Does anyone help you? If yes, what kind of assistance do you need and how often? Are you able to empty your urinal/commode (if used)? Do you have accidents? How often do the accidents occur? Are you able to cleanup after them?

Rank 4: Unable to carry out most activities without assistance.

* **Observations:** Observe the severity of the recipient's movement problems; if the recipient is unable to transfer unassisted; the recipient's or provider's statement as to the quantity or frequency of daily laundry and any indication that hand laundry is done daily. Observe if there is a large amount of unwashed laundry with the odor of urine or fecal matter. Observe if there are meds such as stool softeners visible.
* **Questions:** Who helps you? How? Is s/he available every time you need help? Do you need more help at certain times of the day/night?

Rank 5: Requires physical assistance in all areas of care.

* **Observations:** Observe if the recipient has any voluntary movement; if the recipient is bedfast or chair bound; if the recipient is able to make her/his needs known.
* **Questions:** Who helps you? What is your daily routine? Do you also need assistance with activities we classify as Paramedical Services?

Transfer

Transfer: Assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, couch, wheelchair, walker, or other assistive device generally occurring within the same room.

Note: Transfer does not include assistance on/off toilet. This task is assessed as part of Bowel, Bladder, and Menstrual Care. Care of pressure sores (skin and wound care). This task is assessed as part of Paramedical services.

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The following is the application of functional rank specific to Transfer with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to do all transfers safely without assistance from another person though recipient may experience some difficulty or discomfort. Completion of task poses no risk to his/her safety.

* **Observations:** Observe if the recipient's movement is unimpaired; if s/he is able to get out of a chair unassisted when s/he shows you the house; if s/he shifts weight while sitting.
* **Questions:** Do you ever need a boost to get out of bed or out of the chair? When? How often? Do you ever have difficulty moving around?

Rank 2: Able to transfer, but needs encouragement or direction.

* **Observations:** Observe if the recipient seems confused and has trouble getting out of a chair (probably more problematic in getting out of bed). Determine if the recipient is bed bound on bad days.
* **Questions:** Does anyone help you get out of bed in the morning? How does s/he help you?

Rank 3: Requires some help from another person (e.g., routinely requires a boost).

* **Observations:** Observe the length of time it takes the recipient to answer door; the sounds heard as the recipient comes to door; if the recipient asks you for a boost when s/he gets up to get medications, or is shaky when using assistive device; if the recipient is obese and has a great deal of difficulty getting up.
* **Questions:** Do you always have difficulty getting out of a chair? Who helps you? How? How often? Do you also have trouble getting out of bed? What kind of help do you need? (Expressing interest in how the recipient has solved one problem usually encourages her/him to tell you ways s/he have solved other problems.)

Rank 4: Unable to complete most transfers without physical assistance. Would be at risk if unassisted.

* **Observations:** Observe if the recipient uses an assistive device for mobility; if the recipient's joints are deformed from arthritis or some other disease; if the recipient is wearing a cast or brace; if someone in house assists the recipient to get up if s/he uses a walker or is in a wheelchair; if there are bruises, scabs, or bumps or burns on the recipient.
* **Questions:** Who helps you? How? How often? Both in getting into and out of bed, in and out of chair/wheelchair? Do you need more help at certain times of the day/night?

Rank 5: Totally dependent upon another person for all transfers. Must be lifted or mechanically transferred.

* **Observations:** Observe if the recipient appears to be immobile; if s/he appears to be uncomfortable or in pain; if s/he has any fears related to being moved; if the recipient makes needs known.

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* **Questions:** Who is available to help you when you need to be moved? Do you feel they are able to do so without causing you undue pain or discomfort? Is there anything that needs to be changed to make you more comfortable?

Eating

Assisting with consumption of food and assurance of adequate fluid intake consisting of eating or related assistance to recipients who cannot feed themselves or who require other assistance with special devices in order to feed themselves or to drink adequate liquids. Eating task includes assistance with reaching for, picking up, and grasping utensils and cup; cleaning face and hands; and washing/drying provider's hands.

Note: This does not include cutting food into bite-sized pieces or puréeing food, as these tasks are assessed in Meal Preparation services.

The following is the application of functional rank specific to Eating with suggestions that may help inform the determination as to rank:

Rank 1: Independent: Able to feed self.

* **Observations:** Observe if there is no impairment in grasp indicated when the recipient signs the application or handles medicine bottles; if there is a cup or glass next to the recipient's chair; observe how the recipient takes a drink.
* **Questions:** Do you need any help eating? (Since deterioration usually occurs in a hierarchical manner and feeding oneself is the last function to lose, questions may not be necessary if the recipient is able to dress self and scores 1 in Bowel and Bladder Care except in cases where the recipient seems mentally impaired.)

Rank 2: Able to feed self, but needs verbal assistance such as reminding or encouragement to eat.

* **Observations:** Observe if the recipient appears depressed, despondent, or disoriented; if the recipient's clothes seem large for the recipient, indicating possible recent weight loss; if there is rotten food, no food in refrigerator, or a stockpile or Twinkies®, only; if there are not any signs of cooking.
* **Questions:** What have you eaten today? How many meals do you eat each day? Do you have trouble with a poor appetite? What is the difficulty? Are there times you forget to eat? Does it sometimes seem like it takes too much effort to eat? Do you have trouble deciding what to eat?

Rank 3: Assistance needed during the meal (e.g., to apply assistive device, fetch beverage or push more food within reach, etc.), but constant presence of another person is not required.

* **Observations:** Observe if manual dexterity is impaired, particularly of dominant hand; if there are straws or cups with spill-proof lids; if the recipient has difficulty shaking hands; if s/he has severely limited eyesight.

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* **Questions:** Do you need help in feeding yourself? Do you need to use special utensils to feed yourself? Do you feel that you get enough to eat? Do you have difficulty reaching food on your plate or reaching your glass?

Rank 4: Able to feed self some foods, but cannot hold utensils, cups, glasses, etc., and requires constant presence of another person.

* **Observations:** Food stains on clothing; shakiness of hands; deformity of hands with limitation in ability to grasp or hold trays, towels, bibs.
* **Questions:** Does someone help you eat? How? How often? Do you eat with the rest of the family? Can you feed yourself finger foods? Are you able to use a fork or spoon? Do you have difficulty chewing or swallowing? If so, how do you deal with the problem?

Rank 5: Unable to feed self at all and is totally dependent upon assistance from another person.

* **Observations:** Observe if the recipient has no use of upper extremities; if there are trays, towels, bibs, etc., near the recipient.
* **Questions:** What is your daily routine for eating meals?

*If all of the recipient's ingestion of nutrients occurs with tube feeding, the recipient shall be ranked "1" in both Meal Preparation and Eating because tube feeding is a Paramedical service. (MPP 30-756.41)

Respiration

Respiration is limited to non-medical services such as assistance with self-administration of oxygen and cleaning oxygen equipment and IPPB machines.

The following is the application of functional rank specific to Respiration with suggestions that may help inform the determination as to rank:

Rank 1: Does not use respirator or other oxygen equipment or is able to use and clean independently.

* **Observations:** Observe the oxygen equipment present; if the recipient coughs or wheezes excessively or if breathing is labored.
* **Question:** Are you able to clean and take care of the equipment yourself?

Rank 5: Needs help with self-administration and/or cleaning.

* **Observations:** Observe the same things above and if when the recipient ambulates if s/he has difficulty with breathing or breathing is laborious. Observe the recipient's meds; if the recipient has weakness or immobility in conjunction with breathing problems; if there is a referral from an oxygen supplier indicating the recipient is not taking care of the equipment properly.

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* **Questions:** Are you able to clean and take care of the equipment yourself? If not, how does it get done? How often do you use the equipment? Have you had difficulty administering your own oxygen or using your breathing machine? (If yes, refer for Paramedical service.) Who cleans equipment after you use it?

*If all the recipient's needs for human assistance in Respiration are met with Paramedical services of tracheostomy care and suctioning, the recipient should be ranked a "1" because this care is Paramedical service rather than Respiration. (MPP 30-756.42).

ATTACHMENT B

MENTAL FUNCTIONING

Memory

Recalling learned behaviors and information from distant and recent past.

The following is the application of functional rank specific to Memory with suggestions that may help inform the determination as to rank:

Rank 1: No problem: Memory is clear. Recipient is able to give you accurate information about his/her medical history; is able to talk appropriately about comments made earlier in the conversation; has good recall of past events. The recipient is able to give you detailed information in response to your questions.

* **Observations:** Observe if recipient's responses to your questions indicate that s/he has good recall; knows his/her doctors' names; knows his/her own telephone number or the number of a close friend; is clear about sources of income and assets; knows who close relatives are and where they live. Observe if the recipient is mentally capable of following through on activities of daily living; if s/he has good social skills; if recipient's thought process seems clear and s/he is able to keep track during a conversation.
* **Example:** An elderly women living alone in her home responds quickly and confidently to your questions to establish her eligibility for IHSS and determine her need for services. The recipient is reasonably organized. His/her medications are in place. There are stamped bills in the mailbox. The trash appears to be picked up regularly. There is a grocery list ready for the IHSS provider.
* **Questions:** Who is your doctor? What medicine do you take regularly? What is your address and telephone number? When were you born? Where were you born? What is the date today? How long have you lived in this house? Where did you live before you lived here? What serious illnesses or surgeries have you had? How long ago was each illness or surgery?

Rank 2: Memory loss is moderate or intermittent: Recipient shows evidence of some memory impairment, but not to the extent where s/he is at risk. Recipient needs occasional reminding to do routine tasks or help recalling past events.

* **Observations:** Observe if the recipient appears forgetful and has some difficulty remembering names, dates, addresses, and telephone numbers; if the recipient's attention span and concentration are faulty; if the recipient fidgets, frowns, etc., possibly indicating a struggle to recall; if the recipient repeats statements and asks repetitive questions; if recipient occasionally forgets to take medication or cannot recall when s/he last took medication and if the problem is corrected with the use of a Medi-Set (pill distribution box) set up by someone else. Observe if the recipient may become bewildered or appears overwhelmed when asked about details; if the recipient's recall process aggravates mental confusion or causes intermittent memory loss; if the recipient becomes moderately confused when daily routine is altered.
* **Example:** Elderly man has to be prompted occasionally by his wife when he tries to respond to your questions. He apologizes for or tries to conceal memory lapses.

ATTACHMENT B

* **Questions:** What year were you born? How old are you now? How old were you when your first child was born? What medicines do you take? Tell me what you usually do during the day. Who telephones or comes to see you often? What do you have to eat for dinner tonight?

Rank 5: Severe memory deficit: Recipient forgets to start or finish activities of daily living that are important to his/her health and/or safety. Recipient cannot maintain much continuity of thought in conversation with you.

* **Observations:** Observe if the recipient has a blank or benign look on her/his face most of the time; if s/he is continually placing and replacing objects in the room to avoid answering your questions; if s/he gives inappropriate responses to questions; if the recipient's voice and/or train of thought trails off in middle of conversations; if s/he starts an activity and forgets to finish it; if the recipient consistently forgets to take medications or takes them inappropriately, even with a Medi-Set. Determine if the recipient has a history of leaving stove burners on or the water running in the sink and/or tub causing overflows. Observe if the recipient cannot remember when s/he ate last or what s/he ate; if s/he is unable to remember names of close relatives; has loss of verbal ability; is impaired intellectually; displays abnormal and potentially dangerous behavior.
* **Example:** Middle-aged man suffering from Alzheimer's disease is totally unable to respond to your questions. He becomes very agitated for no good reason; arises from chair as if to leave room and stares in bewilderment; needs to be led back to his chair. He seems unconcerned with events in daily life and cannot articulate his need for services. His daily routine follows a set, rigid pattern. He relates to the situation on a superficial basis.
* **Questions:** What are the names and relationships of your closest relatives? Did you eat breakfast today? What did you eat? Can you tell me what I'm holding in my hand? How old are you? What is your birth date? Ask housemate: What happens when the recipient is left alone? Does s/he remember any events from the previous day, hour, or minute? Does s/he remember who you are? Does s/he remember how to operate the stove, shave self, or perform other tasks safely?

Orientation

Awareness of time, place, self, and other individuals in one's environment.

The following is the application of functional rank specific to Orientation with suggestions that may help inform the determination as to rank:

Rank 1: No problem: Orientation is clear. Recipient is aware of where s/he is and can give you reliable information when questioned about activities of daily living, family, etc.; is aware of passage of time during the day.

* **Observations:** Observe if the recipient appears comfortable and familiar with his/her surroundings. Recipient makes and keeps good eye contact with you. His/her facial expression is alert and is appropriate to the situation. The recipient is spontaneous and direct. The recipient shows interest in maintaining a good personal appearance. The

recipient is obviously in touch with reality; is aware of time and place; readily responds to questions about his/her living arrangement, family, etc.; is fully aware of the reason for your visit. Determine if the recipient is physically able to leave home unassisted and if the recipient can find his/her way back without getting lost and can get around using public transportation.

* **Example:** Recipient is ready and waiting for your visit. S/he initiates social amenities such as offering coffee, a chair to sit on, etc. The recipient introduces family members and/or is able to identify family pictures when asked and has the documents ready that you asked him/her to locate.
* **Questions:** Do you have relatives living close by? Why are you asking for help at this time? How have you managed to care for yourself until now? Do you have someone who helps around the home?

Rank 2: Occasional disorientation and confusion is apparent but recipient does not put self at risk: Recipient has general awareness of time of day; is able to provide limited information about family, friends, age, daily routine, etc.

* **Observations:** Observe if the recipient appears disheveled and the surroundings are chaotic. Observe if objects are misplaced or located in inappropriate places; if there is moldy food in and out of kitchen; if the recipient does not notice that the home is over heated or under heated until you mention it; if the recipient appears to be less confused in familiar surroundings and with a few close friends; if the recipient is able to maintain only marginal or intermittent levels of social interaction; if the recipient is able to provide some information but is occasionally confused and vague; if the recipient is not always aware of time, surroundings and people; if the recipient is able to respond when redirected or reminded.
* **Example:** Twice in the past year the recipient has called her daughter at 2:00 a.m. and was not aware that it was the middle of the night. When told what time it was, the recipient apologized and went back to bed. When you enter the recipient's apartment, the elderly woman asks, "Why are you here today? You said you'd be here Tuesday." You respond, "This is Tuesday." The recipient seems unprepared for your visit and has difficulty settling down for the interview. She participates with some difficulty. She is not comfortable outside of her immediate environment and rarely ventures out. Her mail is left unopened occasionally, and her clothing and some perishable food items are not properly stored.
* **Questions:** What day is today? How many rooms do you have in your home? Where is the closest grocery store? Do you know who I am and why I am here? Do you go out alone? Do you ever get lost when you go out of the house alone? Do you know the name of the bus you take when you go to the store and where the bus stop is to go home? What month, year, season, holiday, etc.?

Rank 5: Severe disorientation which puts recipient at risk: Recipient wanders off; lacks awareness or concern for safety or well being; is unable to identify significant others or relate safely to environment or situation; has no sense of time of day.

* **Observations:** Observe if the recipient shuffles aimlessly throughout house; if s/he

exhibits inappropriate behaviors such as giggling or making comments that are irrelevant to the conservation; if s/he handles objects carelessly; appears unkempt, displays poor personal hygiene; has a manner of dress that is inappropriate or bizarre; if when the social worker attempted to shake the recipient's hand, s/he tried to bite social worker's hand. Observe if the recipient is very confused, unaware of time, place, and/or individuals; goes to the mailbox and cannot find her/his way back to the apartment; does not recognize the apartment manager when the manager tries to help the recipient find her/his way back to the apartment and the recipient becomes highly agitated. Observe if the recipient appears to be disoriented and experiences hallucinations and displays a dazed and confused state of mind; is unable to answer simple questions appropriately; if the recipient's sleep-wake cycle may be abnormal; if the recipient confuses immediate living relatives (son/daughter) with dead relatives (husband, etc); if emotional instability is present.

* **Example:** Family member or friend must answer door, as recipient is unable to maneuver in home without wandering. The recipient must be directed to chair. The recipient exhibits no awareness of the purpose of the social worker's visit. The recipient is unable to concentrate; s/he either does not respond to questions or speaks unintelligibly.
* **Questions:** What is your name? Where do you live? What is the date today? What year is it? Where are you? Where are you going? If the recipient is unable to respond or responds inappropriately, ask housemate: What is the nature of ___'s mental problem? What can the recipient do for self? What does the recipient do if left alone?

Judgment

Making decisions so as not to put self or property in danger. Recipient demonstrates safety around stove. Recipient has capacity to respond to changes in the environment (e.g., fire, cold house). Recipient understands alternatives and risks involved and accepts consequences of decisions.

The following is the application of functional rank specific to Judgment with suggestions that may help inform the determination as to rank:

Rank 1: Judgment unimpaired: Able to evaluate environmental cues and respond appropriately.

* **Observations:** Observe if home is properly maintained, and in safe repair; if recipient's responses show decision-making ability is intact; if recipient dresses appropriately for the weather; if recipient is able to form correct conclusions from knowledge acquired through experience; if recipient is capable of making independent decisions and is able to interact with others.
* **Example:** Recipient takes pride in managing his/her own affairs and does so appropriately. The recipient has a list of numbers to call in case of emergency; takes measures to guard safety such as locking doors at night, not allowing strangers into home, etc.
* **Questions:** Do you have a list of numbers to call in case of an emergency? Do you have friends or family who could help out in a crisis situation? What would you do if your provider were unable to come to work one day?

ATTACHMENT B

Rank 2: Judgment mildly impaired: Shows lack of ability to plan for self; has difficulty deciding between alternatives, but is amenable to advice; social judgment is poor.

* **Observations:** Observe if the home is in disrepair (leaking faucets, broken appliances, inadequate lighting, etc.); if debris has been allowed to accumulate in walk-way areas; if food in the home is of poor nutritional value; if the recipient is unable to recognize that there are alternatives or unable to select between them and is unable to plan or foresee consequences of decisions. Observe if the recipient is not capable of making decisions without advice from another, is able to understand options when explained, makes correct choices; knows enough to turn stove and heat on and off.
* **Example:** Recipient wastes money on useless items while allowing needed repairs to go unattended. The recipient "makes do" with the condition of home even if it is inconvenient for the recipient. The recipient appears to be a "collector," has difficulty throwing anything out even though access through home is limited. The recipient can't decide which provider s/he wants. The grocery list to provider contains mostly junk food. The recipient stopped homebound meals when s/he decided they weren't tasty rather than add salt. S/he refuses to use walker or cane.
* **Questions:** Who would you call in case of emergency? If someone you did not know came to your door at night, what would you do? What are you able to do for yourself? Do you need anyone to help you? Who would you depend on to assist you if you needed a household repair done such as if your heater did not work?

Rank 5: Judgment severely impaired: Recipient fails to make decisions or makes decisions without regard to safety or well-being.

* **Observations:** Observe if safety hazards are evident: clothing has burn holes; faulty wiring, leaking gas, burned cookware, etc. Observe if utilities may be shut off; food supply is inadequate or inedible. If the recipient is a pet owner, observe if there are animal feces in home. Observe if the recipient is obviously unaware of dangerous situations, not self-directing, mentally unable to engage in activities of daily living; goes outside with no clothing on; if neighbors saw smoke from apartment several times; if they entered and extinguished fires on stove; if someone from the community calls to report that the recipient is defecating or urinating on the front yard. Observe if the recipient cannot decide to eat, dress, or take medications; if the recipient seems preoccupied, confused, or frightened; if the recipient is unaware or too frail or feeble to make decisions to maintain self safely at home; if s/he takes a shower with clothes on; drinks spoiled milk, etc.
* **Example:** Recipient has open access to home to anyone who approaches. The recipient seems unaffected by stench or odors due to garbage, feces, urine, etc; exhibits no concern over obvious safety hazards (e.g., debris piled on stove, papers scattered near heater, etc.); lets injuries such as burns go unattended. In the past year, the recipient has recurrently started dinner and fell asleep and awoke to a smoke-filled kitchen.
* **Questions:** What would you do if you saw something on fire in your house? If you needed to get to the doctor what would you do? Ask Housemate: What happens when __ is left alone? Can s/he recognize situations that would lead to danger? Is s/he capable of making rational decisions?

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-08

May 23, 2007

SUBJECT: PROCEDURES FOR CMIPS ONLINE REPORTS - UPDATED

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: EBB 07007

I. PURPOSE

The purpose of this Special Notice is to remind In-Home Supportive Services (IHSS) staff of the policy, procedures, and use of the Case Management Information and Payrolling System (CMIPS) reports on-line. Included in this notice will be information on the Individual Provider (IP) Social Security Number (SSN) verification process and the resulting report generated by CMIPS.

II. BACKGROUND

Beginning May 18, 2007, CMIPS will begin sending IP information to the Social Security Administration (SSA) to verify that the Social Security number (SSN) and the associated personal information provided by the IP agree with the SSA information.

III. POLICY

Effective January 1, 2005 IHSS Staff started monitoring CMIPS reports online. The reports are utilized for IHSS caseload management. The specific conditions of the policy change were as follows:

1) IHSS Staff authorized to use the CMIPS reports online will be assigned worker specific login identification and a password.

2) **Passwords are never to be shared**; users are restricted to using their own codes to access the system (Privacy & Security Information Notice HHSA-F-5).

3) Every user will be assigned to a document access group; this entitles the user to see a menu of documents that are associated with their job functions.

4) IHSS Staff will be notified via e-mail when the CMIPS reports have been updated (Attachment A).

5) Initial accessibility to the reports will require the use of the assigned User Identification Number and Password. Ongoing accessibility requires the maintenance of a current password.

SOCIAL WORK SUPERVISOR

The Social Work Supervisor will use the CMIPS online reports to monitor work performance as follows:

- Understand and review CMIPS online reports to identify problem areas
- Adjust caseloads
- Complete management reports
- Monitor productivity.
- Train the Social Workers in his/her unit on how to use the CMIPS online reports.
- Ensure that eligibility determinations are processed in a timely manner.

SOCIAL WORKER

The IHSS Social Worker is responsible for accessing the CMIPS on line reports generated by their assigned caseload, and making any corrections/updates indicated by the reports. The reports include but are not limited to the following:

- Application/Approval/Denial/Termination Listing
- Assessment Due Report
- CMIPS Warning Alert Listing
- Monthly Characteristics Listing
- No Timesheet Activity For 60 Days
- Out of State Warrants
- Overdue Assessment Listing
- Provider 300+ Paid Hours Report
- Rate Change Reports
- SSI/SSP Terminations
- IHSS+ Waiver/PCSP Adjustment Report
- Daily Response Exception Report
- Monthly Renewal Exception Report
- Weekly Statutory Max Report

The Social Worker will use the CMIPS online reports to maintain his/her assigned workload within established guidelines as follows:

- Utilize CMIPS online reports to organize and complete casework accurately and timely.
- Review CMIPS online reports and ensure that the data is consistent with the assessed needs, recipient demographics and budgets.
- Process CMIPS online alerts and make corrections as necessary.
- Follow all specified timelines as outlined in the IHSS Program Guide and/or IHSS Policy and Procedures Handbook regarding the promptness in completing assignments.
- Adhere to established policies regarding conflict of interest and confidentiality.
- If participating in a telecommuting agreement, ensure confidentiality is maintained when using the CMIPS online reports at an off-county site work environment.
    - To avoid third party interception of e-mails, use only the County e-mail server.
    - Secure all documents and materials containing IHSS recipient and Individual Provider information.
    - Ensure that confidential information is not available to individuals not connected to County operations.
    - Shred all documents before putting them in the trash.

Unauthorized disclosure of information obtained during the course of county employment is a misdemeanor under the State of California Civil Code 56.

CMIPS will alert all users via e-mail when an update has been made to the online reports.

ACCESS

The CMIPS Online Reports can be accessed at the following Internet address:

https://cmips-reports.documentportal.com/servlet/data

Navigation

- When you first open the CMIPS Online Reports, the user identifier screen appears (Attachment A). This screen prompts the user to enter the User ID and Password.
- To launch the software, enter the User ID and Password, then click on Login or press enter.
- A retrieval screen will appear (Attachment B). Every user has been assigned to an access group that will determine the list of reports that will appear in the selection box labeled "Choose Group".
- The selection box contains an alphabetical list of the groups; you may use the scroll bar to view all of the options available.
- Select a group from the options; this will automatically build a document list. A selection box labeled "Choose Document Type" will appear on the screen (Attachment C).
- Use the scroll bar to view the documents available. Select the document that you wish to view, and press enter.
- A search criteria dialogue box will appear on your screen (Attachment D and E). The document that you select to view will determine the data that will be required to set the retrieval parameters.

Cycle Date- Identifies the period for a report; the number of digits will differ depending on the document selected. For this example the cycle date format is "not empty". Note: Using "not empty" option will expand the amount of data retrieved.

County- Two-digit code that identifies the county. For San Diego County the code is 37.

District Office- Two-digit number identifying the specific IHSS unit. The code is found on the IHSS Telephone Roster or in the reference table below.

IHSS UNIT	DISTRICT OFFICE CODE
CS10	08
CS40	07
CS50	11
ES30	05
KS10	06
LS10	10
LS70	04
SS10	01
SS20	02
SS60	03
SS70	12

Social Worker- Four-digit number assigned by the county that identifies the assigned Social Worker.

- Enter the appropriate data requested to set the retrieval parameters.
- Click on the search button at the bottom of the screen, the document(s) generated will depend on the retrieval parameters.
- To print a document, click on the print document button at the bottom of the screen.
- To logout of the retrieval system, click on the logout button at the bottom of the screen. This will send you back to the login screen.

V. ADDITIONS TO CMIPS

THE FOLLOWING PROCEDURES HAVE BEEN ADDED TO CMIPS:

- A weekly batch file that includes all unverified IP SSNs
- A new field on the Provider Eligibility (PELG) screen–Social Security Number Verification (SSNV)
- A provider SSN verification report

NEW PELG SCREEN

The new SSNV field will display at the extreme right of the H3 line on the PELG screen. This field will be system generated.

NOTE:

The SOC 311 will not be modified to include the new fields, but will be viewable in CMIPS on the PELG screen.

NEW CMIPS PROCEDURE

The new weekly process will submit the IP's name, SSN, date of birth and gender to SSA for any provider record with a blank SSNV field. The SSA will send a response which will be posted to CMIPS the following week.

The valid SSNV field indicators are as follows:

- Blank - not yet submitted to SSA for verification
- s - sent to SSA for verification
- v - verified
- 1 - SSN not on file
- 2 - name and DOB match; gender code does not match
- 3 - name and gender code match; DOB does not match
- 4 - name matches; DOB and gender does not match
- 5 - name does not match; DOB and gender not checked
- d - deceased

The SSNV field will be reset to "blank" and the provider record will be resubmitted for verification, when a change is made to one of the following fields on the PELG:

- Social Security number
- Name (last, first or middle initial)
- Date of birth
- Gender

The new "Provider SSN Verification Report" will list any providers that have been reported by the SSA as having an *unverified SSN for reasons 1 through 5 and d above* (attachment F). The report will be:

- Created weekly.
- Sorted by county, district office and social worker.
- Will appear under the "caseload detail" group on the CMIPS Online Report website.

IP SOCIAL SECURITY NUMBER MISMATCH

Detailed instructions on IP Social Security number mismatches are pending.

PLEASE NOTE:

A mismatch is not a basis in and of itself, to take any adverse action against an IHSS provider, such as:

- laying off
- suspending
- firing
- discriminating

Using the mismatch of SSA records to take inappropriate adverse action against a worker *may violate state or federal law*. The information you receive from Social Security number verification service (SSNVs) does not make any statement regarding a worker's immigration status. Further information can be found on the SSNVs website at: www.SSA.gov/employer/SSNV.htm.

VI. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

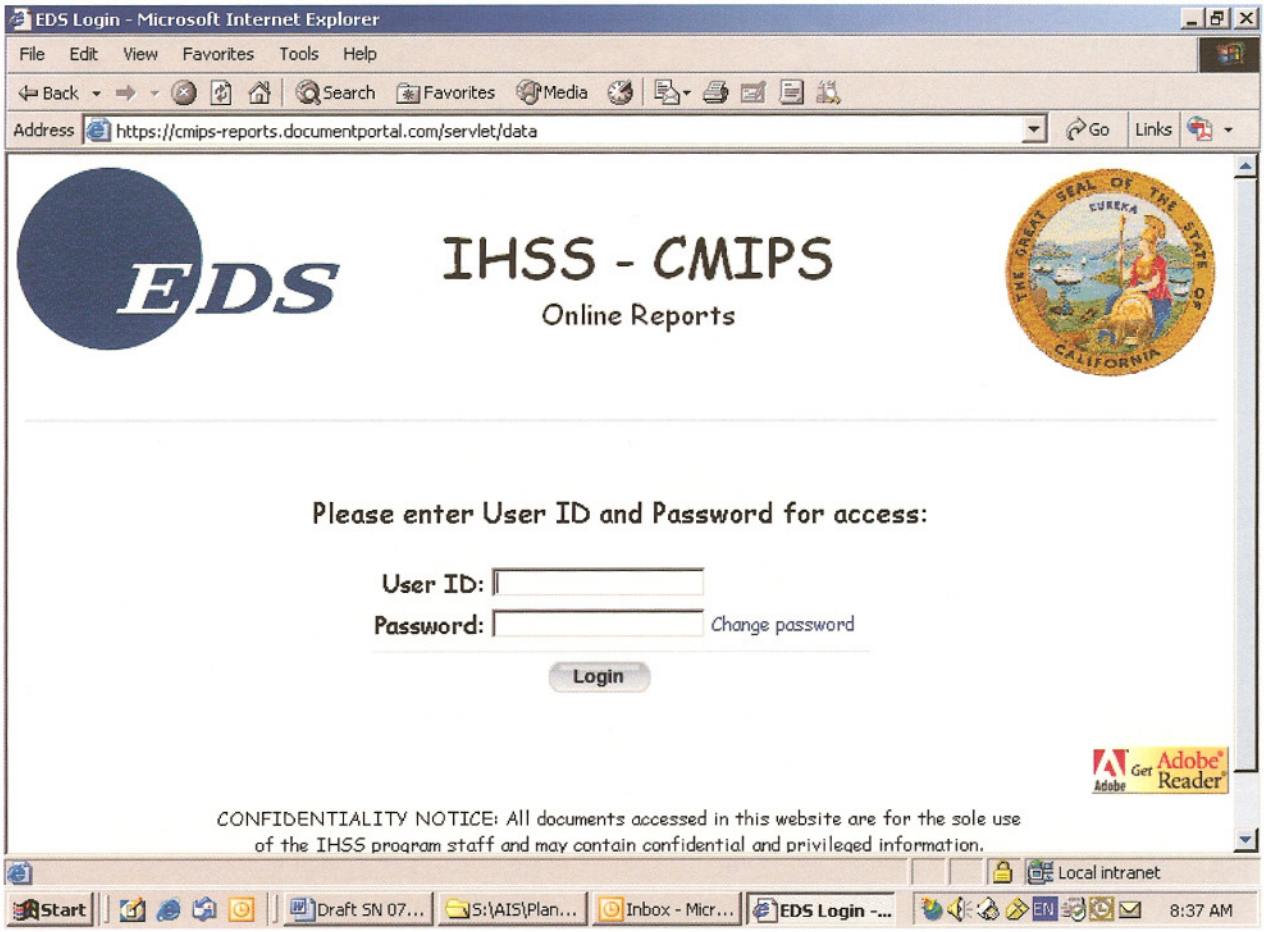
VII. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Mary Harrison (858) 505-6952
Attachments
Distribution 7 & 8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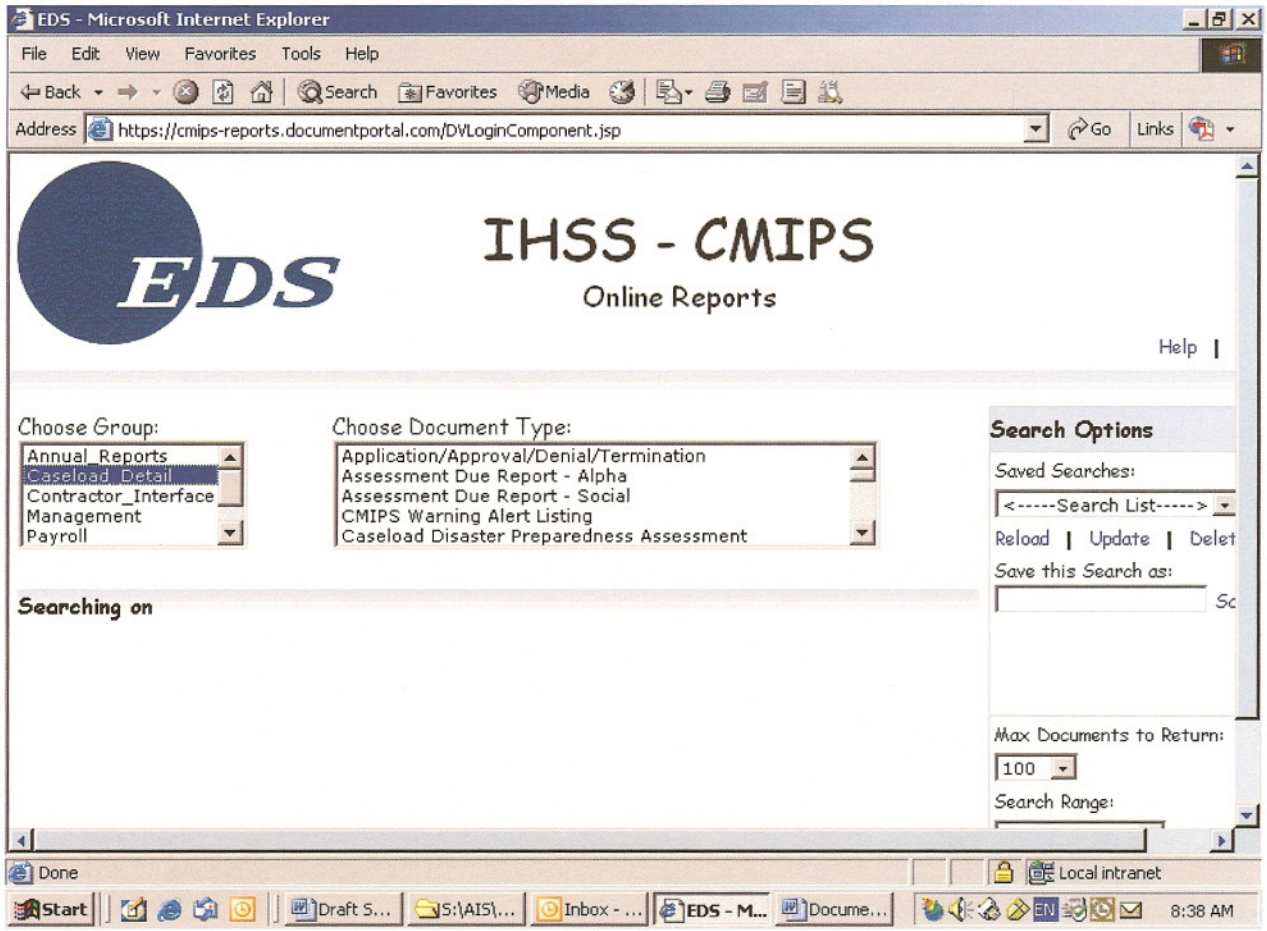
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Assessment Due Report - Social
CMIPS Warning Alert Listing
Caseload Disaster Preparedness Assessment
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Caseload_Detail
Contractor_Interface
Management
Payroll

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Assessment Due Report - Social
CMIPS Warning Alert Listing
Caseload Disaster Preparedness Assessment

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IHSS SPECIAL NOTICE 07-09
ATTACHMENT C

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IHSS SPECIAL NOTICE 07-09
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IHSS - CMIPS

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- Annual_Reports
- Caseload_Detail
- Contractor_Interface
- Management
- Payroll

Choose Document Type:

- Office Caseload
- Overdue Assessment Listing - Alpha
- Overdue Assessment Listing - Social
- Provider 300+ Hour Report
- Provider SSN Verification Report

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IHSS SPECIAL NOTICE 07-08
ATTACHMENT F

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-07

May 11, 2007

SUBJECT: CHANGES TO WORKERS COMPENSATION BENEFITS

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: ALL-COUNTY LETTER 06-03

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with information and procedures on changes to Workers Compensation benefits affecting IHSS Individual Providers (IPs).

II. BACKGROUND

Senate Bill (SB) 899 (Chapter 34, Statutes of 2004) enables employees to pre-designate a physician of their choice for treatment of on the job injuries, and for the establishment of a medical provider network (MPN) to provide medical treatment to injured employees.

III. POLICY

The State Compensation Insurance Fund (SCIF) has established two MPN's, Kaiser Permanente Alliance and the Preferred Provider Network (PPN). An MPN physician may be found by calling 1-888-222-3211 or through SCIF's MED finder program at www.scif.com. If a physician is not pre-designated, the IP is limited to treatment within the network for the life of the claim. This does not affect the referral process for immediate treatment already in place.

New regulations apply to injuries occurring on or after January 1, 2005. Welfare and Institutions Code (W&I Code) sections 12302.2 and section 12302.21 require the State to provide workers' compensation coverage for IHSS providers in the IP mode.

The IHSS Program is responsible for distributing the "New Employees Guide to Workers' Compensation" (Attachment C) which contains the "Physician/Chiropractor Pre-designation Form" (Attachment A&B) to all new IHSS IP's and upon request to existing IHSS IP's. The form is maintained in the IHSS case file with other provider documentation.

Contact: Mary Harrison 858-505-6952

IV. NEW PROCEDURES

IHSS CLERICAL STAFF

- Clerical staff will include the "New Employees Guide to Workers Compensation Benefits" in the initial timesheet packet sent to every new IP.
    - If the "Physician/Chiropractor Pre-designation Form" is returned to IHSS Public Authority along with the W-4 form, it will be forwarded to the assigned IHSS Social Worker.

- Upon request, clerical staff will mail the "New Employees Guide to Workers Compensation Benefits" to any existing IP that requests one, along with a return envelope for the "Physician/Chiropractor Pre-designation Form". The assigned Social Workers' worker number will be included on the return envelope.

IHSS SOCIAL WORKER PROCEDURES

- The IHSS Social Worker is responsible for retaining the "Physician/Chiropractor Pre-designation Form" in the case file along with the IP's other documentation.
- The form will be filed under the "Application" divider in the case file.

IHSS PUBLIC AUTHORITY RESPONSIBILITY

- Public Authority staff will mail a copy of the "New Employees Guide to Workers Compensation Benefits" to any existing IP that requests one, along with a return envelope for the "Physician/Chiropractor Pre-designation Form".

- Any "Physician/Chiropractor Pre-designation Forms" received by Public Authority will be forward to the assigned IHSS Social Worker.

V. REVIEW STATEMENT

Due to the informational need for this Special Notice, it was not reviewed by the standard review committee. IHSS Workers Compensation Procedures are pending review and update by a Policy and Program Support Workgroup.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Attachment
Distribution Codes 7&8

Contact: Mary Harrison 858-505-6952

In Order to use your own doctor when you are injured at work, ***prior to being injured***, you must complete and return this form to IHSS Public Authority 780 Bay Blvd. Chula Vista CA 91910

Employee's Predesignation of Personal Physician Form

- In order for an employee to predesignate a personal physician, the employer must offer group health insurance.
- The employee may use the predesignation of personal physician form to name a medical doctor or doctor of osteopathic medicine if all other requirements are met.
- The physician is not required to sign this form, but in lieu of a signature, other documentation of the physician's agreement is required.

For the employee:

If I am injured on the job, I wish to be treated by my **personal physician**, who meets all the following requirements: (1) is my regular physician; (2) is my primary care physician; (3) is licensed per Business & Professions Code; (4) has previously provided my treatment; (5) retains my records; (6) agrees to be my predesignated physician.

Or, I wish to be treated by my **personal chiropractor or acupuncturist**, who has treated me before and has my records. I understand my identification of a personal chiropractor or acupuncturist is allowed only if there is no medical provider network (MPN) applicable. If the MPN is not applicable, my *personal chiropractor or acupuncturist may treat my injury* during the first 30 days of the employer's medical control, but I must first be evaluated by my employer's physician before I may request a change to my personal chiropractor or acupuncturist.

EMPLOYEE'S INFORMATION:

NAME

ADDRESS

CITY STATE ZIP

YOUR DOCTOR'S INFORMATION:

DOCTOR

ADDRESS

CITY STATE ZIP

PHONE

DOCTOR'S SIGNATURE

EMPLOYEE'S SIGNATURE DATE

Formulario de Designación del Doctor Personal del Empleado

- Para que un empleado pueda designar su médico personal, el empleador debe ofrecer seguro médico de grupo.
- Si se han cumplido todos los otros requerimientos, el empleado puede utilizar el formulario de designación del médico personal para nombrar a un doctor médico o un doctor de medicina osteopática.
- No se requiere la firma del médico en este formulario, pero en lugar de una firma, otra documentación del acuerdo del médico es requerida.

Para el empleado:

Si me lesiono en el trabajo, deseo que me atienda mi **doctor personal**, quien llena todos los siguientes requisitos: 1) Es mi médico regular; 2) Es mi médico primario de cuidado; 3) Tiene una licencia de aprobación del Business & Professions Code; 4) Me ha proporcionado tratamiento médico anteriormente; 5) Tiene y mantiene mi historial médico; 6) Acepta ser mi médico designado.

Ó, deseo que me atienda mi **quiropráctico o acupunturista personal**, quien es el que me ha atendido anteriormente y tiene mi historial. Estoy por entendido que identificar a un quiropráctico o acupunturista solamente es permitido cuando la medical provider network (MPN) no es aplicable. Si la MPN no aplica, mi quiropráctico o acupunturista personal podrá ofrecerme tratamiento durante los primeros 30 días del control médico del empleador, pero un doctor asignado por mi empleador deberá *examinarme primero antes de solicitar que me cambien* a mi quiropráctico o acupunturista personal.

INFORMACIÓN DEL EMPLEADO:

NOMBRE

DIRECCIÓN

CIUDAD ESTADO CÓDIGO POSTAL

INFORMACIÓN DE SU DOCTOR:

DOCTOR

DIRECCIÓN

CIUDAD ESTADO CÓDIGO POSTAL

TELÉFONO

FIRMA DEL DOCTOR

FIRMA DEL EMPLEADO FECHA

Employer Name: _____.
(Client you are working for.)

Case Number: _____.

Social Worker _____.

Retain in IHSS case folder with employment documentation

ATTACHMENT A
IHSS SPECIAL NOTICE 07 - 07
CHANGES TO WORKERS COMPENSATION BENEFITS

STATE
COMPENSATION
INSURANCE
FUND

A nuestros asegurados:

La legislación del Estado de California obliga a los empleadores a suministrar un formulario en el que los empleados pueden indicar el nombre de su médico personal o de su acupunturista o quiropráctico personal. El formulario debe entregarse al nuevo empleado en el momento de la contratación o al finalizar el primer período de pago.

Un representante del State Fund le entregará este formulario sin costo alguno. Siempre tenga formularios a la mano. Documente los registros personales, indicando cuándo se le entregó este formulario y cuándo se le ha devuelto.

LEA AL DORSO

Después de que el empleado haya completado el formulario, conserve el original en el archivo personal del empleado y entréguele una copia.

STATE
COMPENSATION
INSURANCE
FUND

To our policyholders:

California law requires employers to provide a form on which employees may indicate the name of their personal physician or personal chiropractor. The form must be provided to new hires either at the time the employee is hired or by the end of the first pay period.

This form is available from your State Fund representative at no cost to you. Keep a supply on hand. Document personnel records, indicating when this form was provided and when it was returned to you.

PLEASE SEE REVERSE SIDE

After completion by employee, keep original in the employee's personnel file, and provide a copy to your employee.

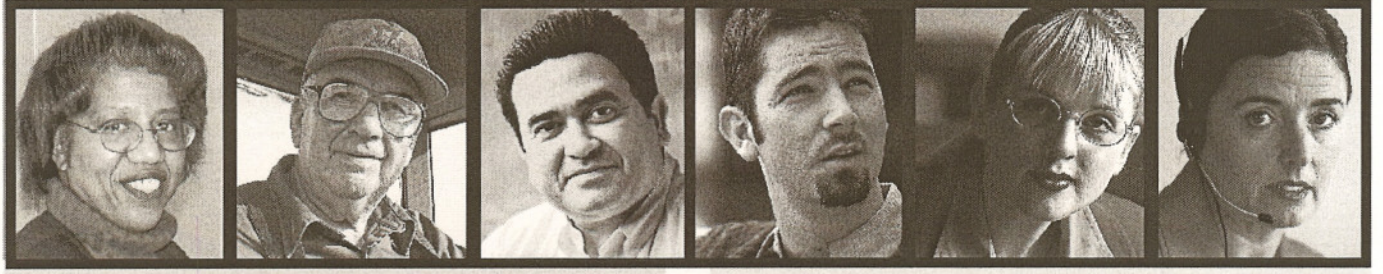
STATE COMPENSATION INSURANCE FUND

new employee's guide to WORKERS' compensation

Helpful information you should know if you are injured on the job or become ill due to your job.

guía para nuevos empleados SOBRE LA compensación A LOS TRABAJADORES

Información útil en caso de que sufra alguna lesión en el trabajo o se enferme a causa de su trabajo.



Questions & Answers

What is workers' compensation?

At no cost to you, it is insurance that the law requires your employer to carry to help you if you are injured on the job or if you become ill due to your job.

What is a workers' compensation injury or illness?

An injury or illness that occurs due to employment is considered a workers' compensation injury or illness. Under workers' compensation law, you will receive help if you are injured, no matter who was at fault.

Workers' compensation covers various types of events, injuries, and illnesses. You could get hurt by one event at work, such as hurting your back in a fall, or by repeated exposures at work, such as hurting your wrist from doing the same motion over and over.

What is State Compensation Insurance Fund?

We are the insurance carrier your employer has chosen to provide its workers' compensation coverage. We have more than 90 years of experience providing workers' compensation throughout California.

Is workers' compensation the same as State Disability Insurance?

No. Workers' compensation is only for injuries or illnesses that occur due to employment. State Disability Insurance (SDI) is for injuries or illnesses that are not work-related, and it is a benefit that the Employment Development Department provides.

Preguntas y respuestas

¿Qué es la compensación a los trabajadores?

Es un seguro que su empleador debe contratar, por ley y sin ningún costo para usted, para ayudarlo en caso de que sufra alguna lesión en el trabajo o se enferme a causa de su trabajo.

¿Qué es una enfermedad o lesión susceptible de compensación a los trabajadores?

Toda lesión o enfermedad causada por el trabajo es considerada lesión o enfermedad susceptible de compensación a los trabajadores. De acuerdo con la legislación vigente en materia de compensación a los trabajadores, usted recibirá ayuda si sufre una lesión,indep endientemente de quién sea el culpable. La compensación a los trabajadores cubre diferentes tipos de acontecimientos, lesiones y enfermedades. En el trabajo, usted puede lesionarse por un acontecimiento, (por ejemplo, lastimarse la espalda por una caída), o bien, por la reiteración de una determinada actividad, (por ejemplo, lastimarse la muñeca por la repetición constante de un movimiento).

¿Qué es State Compensation Insurance Fund?

Somos la compañía de seguros que ha elegido su empleador para suministrar la cobertura de compensación a los trabajadores. Contamos con más de 90 años de experiencia en el suministro de seguros por accidentes o enfermedades laborales en el estado de California·

¿Es la compensación a los trabajadores lo mismo que el Seguro Estatal por Incapacidad?

No. La compensación a los trabajadores es sólo para lesiones o enfermedades que ocurren debido al trabajo. El Seguro Estatal por

How does this coverage affect my own health insurance?

Workers' compensation is separate from personal health-care insurance. Workers' compensation insurance covers work-related injuries and illnesses only. There is no deductible—the insurance carrier pays all approved medical bills. It is important to let the treating doctor know if your injury is work-related.

How do I file a claim?

If you are injured on the job, as soon as you can, tell your supervisor that you have been hurt. Except for first-aid injuries, your employer will provide you with a claim form on which you can describe your injury, as well as how, when, and where it occurred. Return the completed form to your employer, who will send it to us. We will then get in touch with you to explain the benefits to which you may be entitled.

What are my benefits and rights?

Within one day after an employee files a claim form, the law requires the employer to authorize medical treatment as required and limited by the law, until the claim is accepted or rejected, up to a limit of $10,000 in total. All medical treatment is provided in accordance with the medical treatment utilization schedule.

If State Fund accepts your claim, State Fund will pay all approved medical care that is reasonable, necessary, and supported by evidence-based treatment guidelines. This care may include doctors, hospital services, physical therapy, lab tests, x-rays, medicines, and related reasonable transportation expenses. For injuries on or after January 1, 2004, there are limits on the number of chiropractic, occupational therapy, and physical therapy visits.

State Fund pays for all authorized treatment so you should not receive any bills. The law states that you are not responsible for copayments or balance-due bills after we have paid the provider. If you receive any bills, or a medical provider or pharmacy demands payment up-front, contact your claims representative right away to direct you elsewhere.

We will also pay a portion of your lost wages if you cannot work due to the injury. This benefit is called temporary disability. If your injury or illness results in a permanent impairment that diminishes your future earning capacity, we will also pay you permanent disability benefits. In the event of a work-related death, we will pay death benefits to your qualified surviving dependents.

As of January 1, 2004, the Labor Code allows State Fund to review medical-treatment requests from your physician through a utilization review (UR) process. This review process involves doctors and other health consultants reviewing your medical-treatment needs by following medical-treatment guidelines approved by the administrative director of the Division of Workers' Compensation (DWC). There are time limits to approve, modify, delay, or deny treatment requests from your physician.

How is temporary disability calculated?

The weekly temporary disability rate is two-thirds of your average weekly earnings, subject to minimum and maximum amounts that the California Legislature determines. The minimum and

Incapacidad (SDI) cubre lesiones o enfermedades que no están relacionadas con el trabajo. Es un beneficio que brinda el Departamento de Desarrollo del Empleo.

¿De qué manera afecta esta cobertura al seguro de salud?

La compensación a los trabajadores es independiente del seguro de salud personal. El seguro de compensación a los trabajadores sólo cubre lesiones y enfermedades relacionadas con el trabajo. No existe deducible, ya que la compañía de seguros paga todas las facturas médicas aprobadas. Es importante comunicar al médico tratante que su lesión está relacionada con el trabajo.

¿Cómo presento un reclamo?

Si se lesiona en el trabajo, comuníquele a su supervisor tan pronto como pueda que ha sufrido una lesión. Excepto en lesiones de primeros auxilios, su empleador le entregará un formulario de reclamos, en el que deberá describir su lesión y aclarar cómo, cuándo y dónde se produjo. Una vez completado el formulario, devuélvalo a su empleador para que nos lo envíe. De este modo, nos pondremos en contacto con usted para explicarle los beneficios a los que puede acceder.

¿Cuáles son mis derechos y beneficios?

Hasta tanto se acepte o rechace el reclamo, la legislación vigente obliga al empleador a autorizar tratamiento médico por un valor máximo de $10,000 en total dentro de las 24 horas posteriores a la presentación del formulario de reclamos, conforme a las disposiciones y limitaciones de la legislación. Todo tratamiento médico se realiza conforme a su correspondiente programa de utilización.

Si State Fund acepta su reclamo, pagará toda la atención médica aprobada que resulte razonable y necesaria y que esté sustentada por las pautas de tratamiento basadas en las pruebas. Esta atención puede incluir los gastos para médicos, servicios hospitalarios, terapia física, pruebas de laboratorios, radiografías, medicamentos y transporte relacionado. En el caso de lesiones posteriores al 1ro de enero de 2004, existen restricciones en la cantidad de sesiones de terapia ocupacional, física y quiropráctica.

State Fund pagará todo el tratamiento autorizado para que usted no reciba ninguna factura. La ley establece que usted no es responsable de las facturas con saldos pendientes o copagos después de que hayamos pagado al proveedor. Si recibe alguna factura o el proveedor de servicio de salud o de la farmacia le exige pago por adelantado, póngase en contacto de inmediato con el representante de reclamos para que lo derive a otro lugar.

También pagaremos parte del salario perdido si no puede trabajar debido a la lesión. Este beneficio se denomina discapacidad temporal (TD). Si su lesión o enfermedad ocasionara un problema permanente que redujera su capacidad de trabajo en el futuro, también le pagaremos beneficios por discapacidad permanente. Ante una muerte relacionada con el trabajo, pagaremos los beneficios garantizados en caso de muerte a las personas a su cargo que cumplan con los requisitos correspondientes.

A partir del 1ro de enero de 2004, el Código Laboral le permite a State Fund de revisar cada solicitud de tratamiento de su médico mediante el proceso denominado revisión de utilización (UR). Este proceso de revisión involucra a médicos y otros especialistas de la

maximum amounts that are in effect depend upon your date of injury, as shown on the following table:

TD Rates	2002	2003	2004	2005	2006
Minimum	Actual Wages	$126	$126	$126	$126*
Maximum	$490	$602	$728	$840	$840*

* For injuries on or after 01/01/07, the minimum and maximum temporary disability rates will increase to reflect the percentage increase in the state average weekly wage (published annually by the U.S. Department of Labor).

We recalculate temporary disability payments made two or more years after the injury to reflect the rates in effect at the time of payment.

When does temporary disability start and stop?

If you are unable to work for more than 3 calendar days, we will pay you temporary disability. This 3-day "waiting period" will qualify for payment as of the fourth day of medically authorized lost time from work when you are unable to work for more than 14 calendar days, or if you are hospitalized as an inpatient. You will receive temporary disability (TD) payments every two weeks during the time you qualify for this benefit. Generally, temporary disability stops when you return to work, or when the treating physician releases you for work or says that your injury has reached a point of maximum improvement. TD payments will not be extended beyond 104 compensable weeks within two years after the initial TD payment. (Exempt are certain injuries that typically take longer to heal; they are subject to a cap of 240 weeks within a five-year period.) After the termination of the 104 weeks of TD payments, a timely Employment Development Department filing may result in your qualifying for additional state disability benefits.

How is permanent disability calculated and paid?

Your examining physician will report on any permanent impairment that may be considered a permanent disability. Under workers' compensation law, a permanent disability rating involves the use of a specialized formula. This formula considers your age and occupation at the time of your injury or illness, diminished future earning capacity, plus any permanent impairments that the examining physician may indicate. The permanent disability rating yields a specific dollar amount. The exact amount depends on the date of injury, the percentage of disability, and your average weekly earnings at the time of injury. Once permanent disability payments begin, you receive payments every two weeks at your permanent disability rate. This rate is equal to two-thirds of your average weekly wages at the time of injury, subject to the established minimum and maximum rates. The following table lists the maximum permanent disability payments for each percentage range.

Maximum Permanent Disability Payments

Rating	07/01/96-12/31/02	2003	2004	2005	2006-2007
Up to 14.75%	$140	$185	$200	$220	$230
15% to 24.75%	$160	$185	$200	$220	$230
25% to 69.75%	$170	$185	$200	$220	$230
70% to 99.75%	$230	$230	$250	$270	$270
Minimum per week:	$ 70	$100	$105	$105	$130

salud, que examinarán su necesidad de recibir tratamiento médico en función de pautas para tratamientos médicos aprobadas por el director administrativo del Division of Workers' Compensation (DWC). Existen plazos para aprobar, modificar, retrasar o rechazar las solicitudes de tratamiento de su médico.

¿Cómo se calcula la discapacidad temporal (TD)?

El coeficiente semanal de discapacidad temporal es dos tercios de sus ingresos medios semanales y está sujeto a cantidades mínimas y máximas determinadas por la Legislatura de California. Las cantidades mínimas y máximas en vigencia dependen de la fecha en que ocurrió la lesión, como se muestra en la tabla siguente:

Tasas de TD	2002	2003	2004	2005	2006
Minimo	Salario Actual	$126	$126	$126	$126*
Maximo	$490	$602	$728	$840	$840*

* Para las lesiones occurridas en o después de 01/01/07, la mínima y máxima tasa de discapacidad temporal aumentará reflejando el porcentaje de aumento del salario semanal promedio estipulado por el estado (el cual es publicado anualmente por el Department of Labor de los Estados Unidos).

Nosotros volvemos a calcular los pagos por discapacidad temporal realizados en un período mínimo de dos años a partir de la lesión para que reflejen los coeficientes en vigencia en el momento del pago.

¿Cuándo comienza y cuándo finaliza la discapacidad temporal?

Si está imposibilitado de trabajar durante más de 3 días consecutivos, le pagaremos por discapacidad temporal. Este "período de espera" de tres días le permitirá recibir el pago a partir del cuarto día de tiempo laboral perdido con autorización médica, si no puede trabajar durante más de 14 días consecutivos o si se lo debe hospitalizar. Recibirá pagos por discapacidad temporal cada dos semanas mientras reúna los requisitos para recibir este beneficio. Generalmente, la discapacidad temporal termina cuando regresa al trabajo o cuando el médico tratante permite que vuelva a rabajar o señala que su lesión ha alcanzado el punto de mejoramiento máximo. Los pagos por TD no se extenderán más allá de las 104 semanas indemnizables dentro de los dos años posteriores al pago inicial por TD. (Quedan exceptuadas ciertas lesiones que demoran más tiempo en curarse. El límite máximo en estos casos es de 240 semanas dentro de un período de cinco años.) Luego del término de las 104 semanas de pagos TD, puede que oportunamente resulte un archivo del Departamento de Desarrollo de Empleo de su calificación para beneficios adicionales estatales de discapacidad.

¿Cómo se calcula y se paga la discapacidad permanente?

El médico que lo atiende informará todo problema permanente que pudiera considerarse discapacidad permanente. De acuerdo con la legislación vigente en materia de indemnizaciones por accidentes o enfermedades laborales, el cálculo de una discapacidad permanente requiere el uso de una fórmula especializada. Esta fórmula considera la edad y ocupación en el momento de la lesión o enfermedad y la reducción de la capacidad de trabajo en el futuro, además de todos los problemas permanentes que podría indicar el médico que lo revise. El cálculo de la discapacidad permanente da como resultado una cantidad específica de dólares. La cantidad exacta depende de la fecha de la lesión, el porcentaje de discapacidad y sus ingresos semanales medios en el momento de la lesión. Una vez iniciados los pagos, los recibirá

When does permanent disability start and stop?

Generally, if we accept your claim and your treating physician has determined that you have permanent disability, payments begin within 14 days after the termination of temporary disability. If we know the extent of your permanent disability, we will continue the payments every two weeks until we have paid the full benefit. If we do not know the extent of your permanent disability, payments will continue every two weeks until we have paid a reasonable estimate of your permanent disability indemnity due.

How are death benefits calculated and paid?

The total death benefit is contingent on the number of surviving partial and total dependents at the time of injury or illness resulting in death. Once we determine the dependency, we pay the death benefit in installments at the decedent's temporary disability rate. However, the rate must be no less than $224 per week until we have paid the total death benefit, or, if dependency involves a minor child, until the minor child is 18 years old. For injuries on or after January 1, 2003, benefits will be paid to a dependent child for life when physically or mentally incapacitated from earning. The next table shows the distribution of maximum death benefits.

Death Benefit Maximums

	07/01/96-12/31/05	2006 - NEW BENEFITS
Single total dependent	$125,000	$250,000
No total dependents and one or more partial dependents	$125,000	$250,000
Single total dependent and one or more partial dependents	$145,000	$290,000
Two total dependents	$145,000	$290,000
Three or more total dependents	$160,000	$320,000

Effective 01/01/04, if no dependents exist, $250,000 will be paid to the employee's estate.

What is the role and function of the primary treating physician?

Your treating doctor will decide what type of medical care you'll get for your injury or illness, determine when you can return to work, help identify the kinds of work you can do safely while recovering, refer you to specialists, if necessary, and write medical reports that will affect the benefits you receive.

Where do I get medical treatment?

If your injury or illness is due to employment, the State Fund Medical Provider Network will provide authorized medical treatment.

What is the State Fund Medical Provider Network?

State Fund's Medical Provider Network (MPN) is made up of a group of physicians and other medical service providers within the state of California, some who primarily treat occupational injuries and other providers who specialize in general areas of medicine. If necessary, the MPN will provide specialists to treat your injury or illness.

cada dos semanas de acuerdo con su tasa de discapacidad permanente. Esta tasa equivale a dos tercios de su salario medio semanal en el momento de la lesión y está sujeto a los coeficientes mínimos y máximos establecidos. La siguiente tabla señala los pagos máximos por discapacidad permanente para cada rango de porcentajes.

Pago Máximo Por Discapacidad Permanente

Clasificación	Tasas 07/1/96-12/31/02	2003	2004	2005	2006-2007
Hasta 14.75%	$140	$185	$200	$220	$230
De 15% a 24.75%	$160	$185	$200	$220	$230
De 25% a 69.75%	$170	$185	$200	$220	$230
De 70% a 99.75%	$230	$230	$250	$270	$270
Mínimo por semana:	$ 70	$100	$105	$105	$130

¿Cuándo comienza y cuándo finaliza la discapacidad permanente?

Generalmente, si aceptamos su reclamo y su médico tratante ha determinado que usted padece de discapacidad permanente, los pagos comienzan dentro de los 14 días posteriores a la terminación de la discapacidad temporal. Si conocemos la duración de su discapacidad permanente, continuaremos los pagos cada dos semanas hasta que hayamos abonado la totalidad del beneficio. Si no conocemos la duración de su discapacidad permanente, los pagos continuarán cada dos semanas hasta que hayamos pagado una tasa razonable en función de una valoración de la indemnización por discapacidad permanente.

¿Cómo se calculan y se pagan los beneficios en caso de muerte?

El beneficio total garantizado en caso de muerte está supeditado a la cantidad de personas total o parcialmente dependientes de usted en el momento de la lesión o enfermedad que provoca la muerte. Una vez que determinemos quiénes son dependientes, pagaremos en plazos el beneficio en caso de muerte, de acuerdo con el coeficiente de discapacidad temporal del difunto. Sin embargo, la cantidad no será inferior a $224 por semana hasta que hayamos pagado el beneficio total en caso de muerte o, si la dependencia involucrara a un menor, hasta que haya cumplido los 18 años de edad. En el caso de lesiones posteriores al 1ro de enero de 2003, el niño dependiente recibirá los beneficios de por vida si tiene una discapacidad física o mental para trabajar en forma remunerada. La tabla siguiente muestra la distribución de los beneficios máximos garantizados en caso de muerte.

Beneficios Máximos En Caso De Muerte

	01/07/96-31/12/05	NUEVOS BENEFICIOS 2006
Una persona totalmente dependiente	$125,000	$250,000
Sin personas totalmente dependientes y una o más personas parcialmente dependientes	$125,000	$250,000
Una persona totalmente dependiente y una o más personas parcialmente dependientes	$145,000	$290,000
Dos personas totalmente dependientes	$145,000	$290,000
Tres o más personas totalmente dependientes	$160,000	$320,000

En vigencia a partir del 01/01/04, si no hay dependientes, se pagará $250,000 a los herederos del empleado.

If your injury or illness is due to employment, the State Fund MPN physicians and other medical providers will provide authorized medical treatment. These medical providers will provide quality medical treatment based on the utilization schedule developed by the administrative director of the DWC.

To meet medical access standards, an MPN must have at least three physicians of each specialty expected to treat common injuries experienced by injured employees on the basis of the type of occupation or industry in which the employee is employed. An MPN must have a primary treating physician and a hospital for emergency health-care services or a provider of all emergency health-care services within 30 minutes or 15 miles of each covered employee's residence or workplace. An MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of a covered employee's residence or workplace.

How do I get medical treatment?

After filing a claim, your employer will refer you to an MPN facility for initial treatment within 3 business days for non-emergency services.

If you are temporarily working outside the geographical service area of the Medical Provider Network, and you are injured on the job, you should seek emergency treatment at the nearest emergency room. If you are injured on the job, but it is not an emergency, you should notify your adjuster, State Fund's Claims Reporting Center, or your primary treating physician. You must contact State Fund or your employer if additional treatment is needed and continue authorized treatment with an available MPN physician.

How do I get emergency medical treatment?

If it's a medical emergency, call 911 or go to an emergency room right away. Your employer may advise you where to go for treatment. Tell the health-care provider who treats you that your injury or illness is job-related, and, if possible, give your employer's workers' compensation carrier information.

Can I change my doctor?

Yes, after the initial medical evaluation with an MPN doctor, you have the right to choose another primary treating physician or subsequent physician from the MPN.

How do I choose a doctor?

You may obtain a regional-area listing of MPN doctors by going to MEDfinder MPN Search at www.scif.com. You may also obtain a regional-area listing by telephoning or sending a written request to your claims adjuster, if one has been assigned to you, or by calling State Fund's Claims Reporting Center at (888) 222-3211. If you wish to obtain a complete hard-copy list of all MPN providers, contact the State Fund MPN by sending an e-mail to scifmpn@scif.com, or by calling (866) 436-0204, or by sending a written request to:

State Compensation Insurance Fund
Attention: State Fund Medical Provider Network
900 Corporate Center Dr.
Monterey Park, CA 91754

¿Cuál es la función del médico tratante primario?

Su médico tratante decidirá qué tipo de atención médica recibirá por su lesión o enfermedad, determinará cuándo podrá regresar al trabajo, ayudará a identificar las clases de trabajo que usted puede realizar sin riesgos mientras se recupera, lo referirá a especialistas (en caso de ser necesario) y redactará informes médicos que condicionarán los beneficios que recibirá.

¿Dónde obtengo tratamiento médico?

Si su lesión o enfermedad se debe al trabajo, la State Fund Medical Provider Network le proporcionará tratamiento médico autorizado.

¿Qué es la State Fund Medical Provider Network?

La State Fund Medical Provider Network (MPN) está compuesta por un grupo de médicos y otros proveedores de servicios médicos en el estado de California unos quiénes principalmente tratan lesiones ocupacionales, así como otros proveedores especialistas en áreas generales de medicina. Si es necesario, la MPN proporcionará especialistas para tratar su lesión o enfermedad.

Si su lesión o enfermedad se debe al empleo, los médicos y otros proveedores de la MPN le brindarán tratamiento médico autorizado. Estos proveedores médicos proporcionarán tratamiento médico de calidad basado en el programa de utilización desarrollado por el director administrativo de la Division of Workers' Compensation (DWC).

Para cumplir los estándares de acceso médico, una MPN debe contar con un mínimo de tres médicos de cada especialidad esperada para tratar lesiones comunes experimentadas por empleados, con base en el tipo de ocupación o industria en la cual trabaja el empleado. Una MPN debe contar con un médico de atención primaria y un hospital para servicios de atención médica de emergencia, o un proveedor de todos los servicios de atención médica de emergencia a una distancia no mayor de 30 minutos o 15 millas de la residencia o lugar de trabajo de cada empleado cubierto. Una MPN debe tener proveedores de servicios y especialistas de salud ocupacional a una distancia no mayor de 60 minutos o 30 millas de la residencia o lugar de trabajo de cada empleado cubierto.

¿Cómo obtengo tratamiento médico?

Si no se trata de una emergencia, luego de que presente el reclamo, su empleador lo enviará a un centro de la MPN para el tratamiento inicial, dentro de los 3 días hábiles siguientes. Si está trabajando temporalmente fuera del área geográfica de servicios de la Medical Provider Network y se lesiona en su trabajo, debe solicitar tratamiento de urgencia en la sala de emergencias más cercana. Si usted necesita tratamiento médico no de emergencia, debe comunicarse con su ajustador de reclamos, el Centro de Atención de Reclamos las 24 horas de State Fund, o su médico de atención primaria. Si es necesario un tratamiento adicional y continuar el tratamiento autorizado con un médico disponible de la MPN, deberá ponerse en contacto con State Fund o con su empleador.

¿Cómo obtengo tratamiento médico de emergencia?

En caso de emergencia médica, llame al 911 o diríjase a una sala de emergencias de inmediato. Su empleador puede sugerirle dónde acudir para recibir tratamiento. Comuníquele al médico que lo atienda que su lesión o enfermedad está relacionada con el trabajo y, si es posible, dele información acerca de la compañía de seguros a cargo de la compensación a los trabajadores de su empleador.

After you receive a regional-area listing of MPN doctors, you may select a treating doctor (or any subsequent doctor) on the basis of the physician's specialty or recognized expertise in treating your particular injury or condition.

If there are less than three primary treating physicians within 15 miles of your location in a specialty appropriate to treat your injury, you may choose your own doctor or provider outside the MPN network. For assistance you may contact your adjuster, if one has been assigned to you, or the State Fund Claims Reporting Center.

Am I able to predesignate a personal physician?

Yes, provided that you have predesignated the doctor before you are injured and your employer offers group health coverage (HMO/PPO/HCO). Your predesignated physician must meet the following requirements:

- Must be your regular physician.
- Must be your primary care physician.
- Must be licensed per Business & Professions Code.
- Must have previously provided your treatment.
- Retains your medical records, including medical history.
- Agrees to be your predesignated physician.

To predesignate, you must give your employer the name and address of your physician *in writing*, before you are injured. **If you do not predesignate**, your employer will arrange your initial treatment with a physician within the MPN. After this initial treatment, you will be able to choose your physician within the MPN.

Can I predesignate a personal chiropractor or acupuncturist?

No. But, if the MPN is not applicable and you have identified a personal chiropractor or acupuncturist in writing prior to the date of your injury, you may request a change from the employer's physician to your personal chiropractor or acupuncturist. This request for a change of physician may be made at any time after the initial treatment provided by your employer.

What do I do if I disagree with my doctor's diagnosis or treatment?

It is your responsibility to advise your adjuster of the dispute and request a second opinion. You will need to select a doctor or specialist from the list of MPN providers. You need to make an appointment with the selected doctor within 60 days. If you do not make the appointment within the 60-day period, you will not be allowed to have a second opinion with regard to this disputed diagnosis or treatment by this treating physician. (For more details on this MPN process, see *Employee's Guide to the State Fund Medical Provider Network*, form 13176.)

How can I return to work as soon as possible?

To help you return to work as soon as possible, you should actively communicate with your treating doctor, claims representative, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

¿Puedo cambiar mi doctor?

Sí; después de la evaluación médica inicial con un doctor de la MPN, usted tiene el derecho a elegir a otro médico de atención primaria o médico subsecuente de la MPN.

¿Cómo elijo un doctor?

Usted puede obtener una lista regional de médicos de la red MPN mediante el buscador "MEDfinder MPN Search" en www.scif.com. También puede obtener una lista regional llamando por teléfono o enviando una petición por escrito a su ajustador de reclamos, si se le ha asignado uno, o llamando al Centro de Atención de Reclamos las 24 horas de State Fund al (888) 222-3211. Si usted desea obtener una copia de la lista completa de todos los proveedores de la MPN, comuníquese con la MPN de State Fund enviando un correo electrónico a scifmpn@scif.com, llamando al (866) 436-0204, o enviando una petición por escrito a:

State Compensation Insurance Fund
Attention: State Fund Medical Provider Network
900 Corporate Center Dr.
Monterey Park, CA 91754

Después de que reciba una lista de los doctores de la MPN en el área regional, usted puede seleccionar a un doctor que brinde tratamiento (o a cualquier doctor subsecuente) basado en la especialidad de éste o su experiencia reconocida en el tratamiento de su lesión o enfermedad particular.

Si existen menos de tres médicos de atención primaria dentro de un radio de 15 millas de donde usted se encuentre, que tengan la especialidad que usted selecciona, es posible que se le permita elegir a su propio medico o proveedor fuera de la red MPN. Comuníquese con su ajustador de reclamos, si es que se le ha asignado uno, o al Centro de Atención de Reclamos las 24 horas de State Fund para obtener ayuda.

¿Puedo previamente designar un médico personal?

Sí, siempre que previamente designe al médico antes de sufrir una lesión y su empleador le ofrezca cobertura médica de grupo (HMO/PPO/HCO). El médico designado por usted debe cumplir con los siguientes requisitos:

- Debe ser su médico de cabecera.
- Debe ser su médico de atención primaria.
- Debe tener licencia conforme al Código de Negocios y Profesiones.
- Debe haberlo atendido previamente.
- Conserva sus registros médicos, incluida la historia clínica.
- Está de acuerdo en ser su médico previamente designado.

Para designar previamente un médico, debe darle a su empleador el nombre y la dirección del médico *por escrito*, antes de sufrir una lesión. **Si no designa ningún médico,** su empleador acordará su tratamiento inicial con un médico de la MPN. Luego de este tratamiento inicial, podrá elegir un médico de la MPN.

¿Puedo previamente designar un quiropráctico o acupunturista personal?

No. Sin embargo, si la MPN no correspondiera por algún motivo y usted hubiera designado por escrito un quiropráctico o acupunturista personal antes de la fecha de su lesión, puede solicitar que se sustituya el médico elegido por su empleador por el quiropráctico o acupunturista personal de su elección. La solicitud para cambiar de médico puede realizarse en cualquier momento después del tratamiento inicial suministrado por su empleador.

May I file a workers' compensation claim if an injury occurs outside of work?

Your employer or your employer's carrier may not be liable for the payment of workers' compensation benefits for an injury resulting from your voluntary participation in any off-duty recreational, social, or athletic activity which is not part of your work-related duties.

Note: Workers' compensation fraud laws make it a felony for anyone to file a false or fraudulent statement or to submit a false report or any other document for the purpose of obtaining or denying workers' compensation benefits. Anyone caught performing these illegal acts will be prosecuted. If convicted, the person can face up to 5 years in prison and/or up to a $150,000 fine.

What if I have a recurrence and require further medical care?

If you need more medical care for your injury after your original treatment has ended, you have one full year after your last treatment to notify us of your request for more medical care.

What if I have to change my line of work because of a workers' compensation injury?

For injuries before January 1, 2004, if you are unable to return to your job due to a workers' compensation injury, you may qualify for vocational rehabilitation benefits. Your rehabilitation plan may be as simple as a modification of your current job to accommodate any limitations you have suffered, or it may involve training for a new job. Our vocational rehabilitation counselors will help you obtain any needed services.

For injuries before January 1, 2004, a represented employee may agree to settle his or her right to future vocational rehabilitation with a one-time payment which cannot be more than $10,000.

For injuries on or after January 1, 2004, if your injury results in permanent disability, and you are unable to return to work within 60 days after the last payment of temporary disability, and your employer does not offer modified or alternative work, a non-transferable voucher for education-related costs is payable to a state-approved school. The voucher can be up to $10,000 depending on the level of your permanent disability. This benefit is called a Supplemental Job Displacement Benefit (SJDB). The following table shows the specific ranges of the benefit.

Supplemental Job Displacement Benefits (SJDB)

Permanent Disability Level	SJDB Voucher Amount
Less than 15%	Up to $4,000
15% to 25%	Up to $6,000
26% to 49%	Up to $8,000
50% to 99%	Up to $10,000

¿Qué debo hacer si no estoy de acuerdo con el diagnóstico o tratamiento de mi médico?

Es su responsabilidad notificar al mediador de la situación y solicitar una segunda opinión. Deberá seleccionar un médico o especialista de la lista de la MPN. Debe fijar una cita con el médico seleccionado dentro de los 60 días. Si no fija la cita en el período de 60 días, no se le permitirá obtener una segunda opinión con respecto a este diagnóstico o tratamiento por este médico tratante en disputa. (Para obtener más detalles sobre este proceso de la MPN, consulte la *Guía del Empleado para la State Fund Medical Provider Network*, formulario 13176).

¿Cómo puedo volver a trabajar lo antes posible?

Para ayudarlo a regresar a su trabajo lo antes posible, se debe comunicar en forma activa con el médico tratante, el representante de reclamos y el empleador para conocer los tipos de trabajo que puede realizar mientras se recupera. Ellos podrán coordinar esfuerzos para que pueda regresar y realizar una tarea modificada o bien pueda encargarse de otro trabajo acorde a su salud. Este trabajo nuevo o modificado podrá ser temporal o extenderse durante cierto tiempo, según la naturaleza de su lesión o enfermedad.

¿Puedo presentar un reclamo de compensación a los trabajadores si la lesión se produce fuera de mi trabajo?

El empleador puede quedar exento del pago de los beneficios de compensación a los trabajadores en el caso de lesiones que se produjeran por la participación voluntaria del empleado en actividades recreativas, sociales o deportivas fuera del horario laboral que no formasen parte de las tareas de su trabajo.

Nota: la legislación en materia de fraude en la compensación a los trabajadores considera delito grave presentar una declaración falsa o fraudulenta o enviar un informe o cualquier documento falso con el propósito de obtener o rechazar beneficios de compensación a los trabajadores. A los culpables de tales ilícitos se les iniciará un procedimiento criminal. En caso de ser declarada culpable, la persona puede enfrentar una condena de hasta 5 años de prisión y/o una multa de hasta $150,000.

¿Qué ocurre si los síntomas reaparecen y necesito continuar con la atención médica?

Si necesita más atención médica por su lesión una vez que ha terminado su tratamiento original, tiene un año entero a partir de su último tratamiento para notificarnos que necesita más atención médica.

¿Qué ocurre si debo modificar mi línea de trabajo debido a la lesión susceptible de compensación a los trabajadores?

En el caso de lesiones anteriores al 1ro de enero de 2004, si no puede regresar a su trabajo debido a la lesión susceptible de compensación a los trabajadores, puede acceder a los beneficios de rehabilitación vocacional. Su plan de rehabilitación puede ser simple, como la modificación de su trabajo actual para adaptarlo a la limitación que haya sufrido, o puede consistir en la capacitación para un nuevo trabajo. Nuestros asesores en rehabilitación vocacional lo ayudarán a obtener todos los servicios que sean necesarios.

En el caso de lesiones anteriores al 1ro de enero de 2004, el empleado representado puede aceptar saldar su derecho a la futura rehabilitación vocacional con un pago único que no superará los $10,000.

What are my protections against discrimination for filing a workers' compensation claim?

It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or for testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state. If you believe you have experienced discrimination because of your injury, you should discuss your rights with an information and assistance officer of the DWC or with an attorney.

What if I have not received the benefits that I think I should have?

If you have not received the benefits you think you should have, ask for an explanation from your State Fund claims representative. Misunderstandings and errors sometimes do occur, but you can resolve most of them by talking with your claims representative. If you are not satisfied with your claims representative's answers, you have several options. You have the right to consult with and be represented by an attorney. You can consult with an information and assistance officer of the DWC. You can also file an Application for Adjudication of Claim with the Workers' Compensation Appeals Board (WCAB) to resolve your claim formally. The information and assistance officer can help you file the Application for Adjudication of Claim.

Are there time limits for filing a claim?

Yes. Generally, the law requires you to provide your employer with notice of your injury within 30 days of the date of injury. In addition, should you disagree with any of our actions, in order to protect your rights you must commence proceedings before the WCAB by filing an Application for Adjudication of Claim within one year of the date of injury, or one year from the last furnishing of indemnity or medical-treatment benefits by your employer or State Fund. It is very important that you act promptly so as not to risk losing your benefits because you waited too long.

En el caso de lesiones posteriores al 1ro de enero de 2004, si la lesión le produce una discapacidad permanente, no puede regresar a su trabajo dentro de los 60 días posteriores al último pago recibido por discapacidad temporal y su empleador no le ofrece un trabajo alternativo o modificado, se le otorgará un vale no transferible para cubrir costos relacionados con su educación, que será pagadero a una escuela con autorización estatal. El vale no podrá superar los $10,000 y dependerá del nivel de discapacidad permanente. Este beneficio se denomina Beneficio Complementario Por Sustitución De Trabajo (SJDB). La siguiente tabla muestra las escalas específicas del beneficio.

Beneficios Complementarios Por Sustitución De Trabajo (SJDB)	
Nivel de discapacidad permanente	**Monto del vale de SJDB**
Inferior al 15%	Hasta $4,000
De 15% a 25%	Hasta $6,000
De 26% a 49%	Hasta $8,000
De 50% a 99%	Hasta $10,000

¿Qué me protege contra la discriminación por presentar un reclamo de compensación a los trabajadores?

Es ilegal que su empleador lo sancione o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por prestar declaración en un caso de compensación a los trabajadores de un tercero. En caso de comprobarse alguna de estas infracciones, podrá recibir los salarios perdidos, la reincorporación al trabajo, beneficios adicionales y los costos y gastos hasta los límites establecidos por el estado. Si considera que ha sido discriminado a causa de su lesión, deberá analizar sus derechos con un funcionario de información y asesoramiento del Division of Workers' Compensation del estado o bien con un abogado.

¿Qué ocurre si no recibo los beneficios que considero que debo recibir?

Si no ha recibido los beneficios que considera que debería recibir, solicite una explicación al representante de reclamos de State Fund. A veces se producen malentendidos y errores, aunque podrá resolver la mayoría de ellos hablando con su representante de reclamos.

Si no queda satisfecho con las respuestas del representante de reclamos, cuenta con diversas opciones. Tiene el derecho de consultar y ser representado por un abogado. Puede consultar a un funcionario de información y asesoramiento de Division of Workers' Compensation. También puede presentar una solicitud de arbitraje de reclamo, denominada Application for Adjudication of Claim, ante el Workers' Compensation Appeals Board (WCAB), para resolver su reclamo formalmente. El funcionario de información y asesoramiento puede ayudarlo a presentar esta solicitud de reclamo.

¿Existe algún límite de tiempo para presentar un reclamo?

Sí. Según la ley, el plazo del que normalmente dispone para notificar la lesión al empleador es de 30 días a partir de la fecha de dicha lesión. Además, en caso de que no esté de acuerdo con alguna de nuestras medidas, para proteger sus derechos debe iniciar una demanda ante el Workers' Compensation Appeals Board presentando una solicitud de arbitraje de reclamo antes de cumplirse un año de la fecha de la lesión o de la última indemnización o beneficio de tratamiento médico que le haya proporcionado su empleador o State Fund. Es muy importante actuar de inmediato para no arriesgarse a perder los beneficios por demorarse demasiado.

DIVISION OF WORKERS' COMPENSATION
INFORMATION AND ASSISTANCE OFFICERS

ANAHEIM	714/738-4038	RIVERSIDE	951/782-4347
BAKERSFIELD	661/395-2514	SACRAMENTO	916/263-2741
EUREKA	707/441-5723	SALINAS	831/443-3058
FRESNO	559/445-5355	SAN BERNARDINO	909/383-4522
GOLETA	805/968-4158	SAN DIEGO	619/767-2082
GROVER BEACH	805/481-3380	SAN FRANCISCO	415/703-5020
LONG BEACH	562/590-5240	SAN JOSE	408/277-1292
LOS ANGELES	213/576-7389	SANTA ANA	714/558-4597
OAKLAND	510/622-2861	SANTA MONICA	310/452-1188
OXNARD	805/485-3528	SANTA ROSA	707/576-2452
POMONA	909/623-8568	STOCKTON	209/948-7980
REDDING	530/225-2047	VAN NUYS	818/901-5374

(800) 736-7401 (Recorded information only)

This pamphlet has been approved by the administrative director of the Division of Workers' Compensation.

STATE FUND LOCATIONS

BAKERSFIELD
Policy (661) 664-4000
Claims (661) 664-4000

EUREKA
Policy (707) 443-9721
Claims (707) 443-9721

FRESNO
Policy (559) 433-2600
Claims (559) 433-2700

LOS ANGELES
Policy (877) 405-4545 toll-free
Claims (818) 291-7000

OAKLAND
Policy (510) 577-3000
Claims (510) 577-3000

OXNARD
Policy (805) 988-5200
Claims (805) 988-5300

REDDING
Policy (530) 223-7135
Claims (530) 223-7000

RIVERSIDE
Policy (951) 656-8300
Claims (951) 656-8300

SACRAMENTO
Policy (916) 924-5072
Claims (916) 924-5100

SAN BERNARDINO
Policy (909) 384-4560
Claims (909) 384-4500

SAN DIEGO
Policy (858) 552-7000
Claims (858) 552-7100

SAN FRANCISCO
Policy (415) 974-8100
Claims (415) 974-8200

SAN JOSE
Policy (408) 363-7600
Claims (408) 363-7400

SANTA ANA
Policy (714) 565-5995
Claims (714) 565-5000

SANTA ROSA
Policy (707) 573-6400
Claims (707) 573-6500

SOUTH ORANGE
Policy (714) 347-5445
Claims (714) 347-5400

STOCKTON
Policy (209) 476-2600
Claims (209) 476-2600

CUSTOMER SERVICE CENTER

Policy Services & Certificates of Insurance
(877) 405-4545 toll-free
(800) 268-3635 toll-free fax

Certificates of Insurance
(866) 266-2071 toll-free fax

24-Hour Claims Reporting Center
(888) 222-3211 toll-free
(800) 371-5905 toll-free fax

Fraud Hot Line
(888) 786-7372 toll-free

DIVISION OF WORKERS' COMPENSATION
FUNCIONARIOS DE INFORMACIÓN Y ASESORAMIENTO

ANAHEIM	714/738-4038	RIVERSIDE	951/782-4347
BAKERSFIELD	661/395-2514	SACRAMENTO	916/263-2741
EUREKA	707/441-5723	SALINAS	831/443-3058
FRESNO	559/445-5355	SAN BERNARDINO	909/383-4522
GOLETA	805/968-4158	SAN DIEGO	619/767-2082
GROVER BEACH	805/481-3380	SAN FRANCISCO	415/703-5020
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LOS ANGELES	213/576-7389	SANTA ANA	714/558-4597
OAKLAND	510/622-2861	SANTA MONICA	310/452-1188
OXNARD	805/485-3528	SANTA ROSA	707/576-2452
POMONA	909/623-8568	STOCKTON	209/948-7980
REDDING	530/225-2047	VAN NUYS	818/901-5374

(800) 736-7401 (Sólo información grabada)

Este folleto ha sido aprobado por el director administrativo del Division of Workers' Compensation (DWC).

OFICINAS DEL STATE FUND

BAKERSFIELD
Póliza (661) 664-4000
Reclamos (661) 664-4000

EUREKA
Póliza (707) 443-9721
Reclamos (707) 443-9721

FRESNO
Póliza (559) 433-2600
Reclamos (559) 433-2700

LOS ANGELES
Póliza (877) 405-4545 línea gratuita
Reclamos (818) 291-7000

OAKLAND
Póliza (510) 577-3000
Reclamos (510) 577-3000

OXNARD
Póliza (805) 988-5200
Reclamos (805) 988-5300

REDDING
Póliza (530) 223-7135
Reclamos (530) 223-7000

RIVERSIDE
Póliza (951) 656-8300
Reclamos (951) 656-8300

SACRAMENTO
Póliza (916) 924-5072
Reclamos (916) 924-5100

SAN BERNARDINO
Póliza (909) 384-4560
Reclamos (909) 384-4500

SAN DIEGO
Póliza (858) 552-7000
Reclamos (858) 552-7100

SAN FRANCISCO
Póliza (415) 974-8100
Reclamos (415) 974-8200

SAN JOSE
Póliza (408) 363-7600
Reclamos (408) 363-7400

SANTA ANA
Póliza (714) 565-5995
Reclamos (714) 565-5000

SANTA ROSA
Póliza (707) 573-6400
Reclamos (707) 573-6500

SOUTH ORANGE
Póliza (714) 347-5445
Reclamos (714) 347-5400

STOCKTON
Póliza (209) 476-2600
Reclamos (209) 476-2600

CENTRO DE ATENCIÓN AL CLIENTE

Servicios de pólizas y Certificados de seguros
(877) 405-4545 línea gratuita
(800) 268-3635 fax en línea gratuita

Certificados de seguros
(866) 266-2071 fax en línea gratuita

Centro de atención de reclamos las 24 horas
(888) 222-3211 línea gratuita
(800) 371-5905 fax en línea gratuita

Linea de asistencia para fraude
(888) 786-7372 línea gratuita

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SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-06

April 20, 2007

SUBJECT: CONLAN II TIME STUDY INSTRUCTIONS

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All County Letter (ACL) 07-11, County Fiscal Letter (CFL) 06/07-34

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with claiming instructions for Conlan II activities performed by county staff that are eligible for reimbursement from the Department of Health Services (DHS).

II. BACKGROUND

This information applies to the Conlan II court orders requiring that Medi-Cal recipients are reimbursed by DHS for any out-of-pocket expenses, paid for during the following periods:

- The retroactive period – Three months prior to application for Medi-Cal.
- The evaluation period – The time between the date of application and the date of approval for Medi-Cal.
- The post approval period – The time period after the recipient was approved for Medi-Cal.

Those clients eligible for reimbursement may include recipients of the Personal Care Services Program (PCSP) and IHSS Plus Waiver (IPW).

III. POLICY

To capture Conlan II related activities a new Time Study Code (TSC) will be included on the upcoming May 2007 time study. This will be an ongoing procedure since the Conlan II claims process will also be ongoing.

IV. SOCIAL WORKER AND SOCIAL WORK SUPERVISOR PROCEDURES

IHSS staff will claim the following activities under the new time study code:

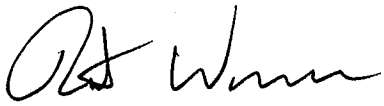
- Referring clients as needed to the DHS Beneficiary Service Center.
- Providing copies of the Notice of Action (NOA) form (NA-690) that shows medical necessity.
- Providing the SOC 828 County Verification Form.
- Responding to questions and/or providing documentation for State Hearings when requested by State staff.

V. REVIEW STATEMENT

Due to the immediacy of this Special Notice, it was not reviewed by the standard review committee.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.



RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Mary Harrison (858) 505-6952
Attachment
Distribution Codes 7 & 8

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-05

April 11, 2007

SUBJECT: IHSS MED-CAL REFERRALS & CALWIN CLEARANCE PROCEDURES

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with CalWIN clearance and Medi-Cal referral procedures for IHSS applications. The Case Data System (CDS) is no longer available for clearing purposes.

II. BACKGROUND

With the implementation of CalWIN, clearance for IHSS cases for active Medi-Cal must now be done through the CalWIN system. All income eligible applicants must have a Medi-Cal eligibility determination completed by an IHSS Medi-Cal Worker. Before making a referral for the Medi-Cal determination it must be verified whether or not there is an existing, active Medi-Cal case for the IHSS applicant.

III. POLICY

Medi-Cal eligibility must be determined by a Medi-Cal Worker for any client that is not Status Eligible. The Medi-Cal Worker is responsible for entering the correct Medi-Cal Share-of-Cost into the Medi-Cal Data Eligibility Screen (MEDS).

IV. PROCEDURES

For each IHSS application received, the designated Clearance Clerk will perform the following activities:

STEP	CLERICAL PROCEDURE
1.	Download & print the following forms from the AIS Suite: • SOC 295 Application For Social Services • SOC 293A Need Assessment Face Sheet
2.	Clear the Medi-Cal Eligibility Data System (MEDS), and print the following screens: • INQM • INQX

3.	Clear the CalWIN system and print out the Medi-Cal information as follows: **<u>Status Eligible</u>** a) Log on to CalWIN and click on the "Search" tab. From the drop down menu select: • "Search for Individual". b) Enter applicant's Social Security number or CIN number if available. When the applicant's information is found check the following client information • Name • CIN number • Date of birth. • Print the screen for the intake packet. c) Click on "Action" • Click on "Case List" • Print out this screen. d) Under Action click on "Case Details". Print out the following tabs: • Programs • Case Members If "No records found" is indicated print the screen and include in the intake packet. e) Enter the following information on the SOC 295: • Referral type • Language • Ethnicity Codes for the above information are available in the CMIPS Manual. **<u>Income Eligible (Share-of-Cost Applications)</u>** a) Log on to CalWIN and click on the "Search" tab. From the drop down menu select: • "Search for Individual". b) Enter applicants Social Security number or CIN number if available. When the applicant's information is found check the following client information • Name • CIN number • Date of birth. • Print the screen for the intake packet. c) Click on "Action" • Click on "Case List" • Print out this screen. d) Under Action click on "Case Details". Print out the following tabs: • Programs

3. cont.	• Case Members e) Under the Programs tab, if Medi-Cal is indicated as pending* notify the designated IHSS/Medi-Cal SOC liaison.** *Pending Medi-Cal - Application has been submitted and is entered into the CalWIN system. The application has not been approved or denied. ** The IHSS/Medi-Cal SOC liaison will be designated by the IHSS administration.
Note:	In CalWIN minor children are sometimes listed under their parent's name. The name of the parent can be found on the "Case Listing" or "Case Members" screens. When an IHSS applicant is a minor child as described above, but is not active on Medi-Cal the application is treated as "pending". • The assigned clerk will notify the designated IHSS/Medi-Cal SOC liaison. • The IHSS/Medi-Cal SOC liaison will hold and monitor the application until the Medi-Cal case is active in CalWIN. • Once the Medi-Cal case is active, a fax referral is sent to the SEFRC Intake Clerk requesting an IHSS SOC determination.
4.	The designated Clearance Clerk will attach all clearance forms and screen prints to the IHSS Referral Packet.

The information found in the applicant's CalWIN/MEDS clearance determines the actions that must be completed next.

STEPS	CLERICAL PROCEDURE
5.	If a case is ***active*** on CalWIN, but ***not active*** on MEDS: The assigned clerk will send the IHSS/Medi-Cal Referral Fax Coversheet to the Southeast Family Resource Center. (Attachment A) Attention: IHSS Intake Clerk (619) 266-3877
	If a case is ***not active*** on CalWIN, but ***active*** on MEDS: • The IHSS Social Work Supervisor will contact the IHSS Family Resource Center (FRC) district liaison. (Attachment B) • The IHSS FRC district liaison will notify the district worker of record to correct the case status. • The IHSS FRC District Liaison will notify the IHSS/Medi-Cal SOC Liaison once the Medi-Cal case is active. • The IHSS/Medi-Cal liaison will then refer to SEFRC via Fax referral.
	If a case is ***pending*** Medi-Cal on CalWIN at the time of application for IHSS: • The assigned clerk will notify the designated IHSS/Medi-Cal SOC liaison. • The IHSS/Medi-Cal SOC liaison will hold and monitor the application until the Medi-Cal case is active in CalWIN. Once the Medi-Cal case is active, a fax referral is sent to the SEFRC Intake Clerk requesting an IHSS SOC determination.

5. cont.	SEFRC staff will send an Inter-Department Memo (Attachment A) to the originating IHSS clerk if the Medi-Cal case status has changed in the middle of the referral process.

Applicants Without CalWIN/MEDS History

The table below shows the procedures for IHSS Clerical to follow when processing a referral, where there is ***no*** CalWIN/MEDS history. The lack of history indicates that the applicant ***is not*** receiving Medi-Cal.

STEP	CLERICAL PROCEDURE
1.	From the AIS Suite print the following: • SOC 295 Application for Social Services • SOC 293A Need Assessment Face Sheet
2.	• Review the SOC 293A and SOC 295 for completeness. • Enter the Social Worker's full name on the lower left corner of the SOC 293A. • enter the Social Worker's first initial of their first name and full last name on the lower right corner. Note: The date entered in the "Date of Application" box by the Call Center Specialist is the actual date of IHSS application.
3.	Use the information available on the SOC 293A, and the SOC 295 to complete the following fields on the SAWS 1 form: • Field1 – Name of Applicant • Field 2 – Social Security Number • Field 2A – Date of Birth • Field 3 – Maiden or Other Name • Field 4 – Home Address • Field 5 – Mailing Address (if different) • Field 6 – Telephone Number(s) • Field 8 – Check "Yes" for Medi-Cal • Field 10A – Ethnic Group • Field 10B – Language • Field 19 – The designated clerk must sign and use the IHSS application date • In the County Use Section of the SAWS 1 indicate if client has a spouse and if the spouse has IHSS or is requesting IHSS. • Place the worker number for the assigned Social Worker on the bottom of the SAWS 1 form.
4.	Make two (2) copies of the SAWS 1 form. One (1) copy is for clerical records and one (1) copy to be included with the Social Worker's intake packet.

5.	Within two (2) business days of completing the SAWS 1: • Batch all SAWS 1 forms • Send via county mail to the SEFRC Mail stop W69 Attention: IHSS Intake Clerk. Note: • The completed SAWS 1 is no longer faxed to the SEFRC. • If the case status has changed by the time the SAWS1 is received by the SEFRC, an Interdepartmental Memo will be faxed, requesting corrected information on the Medi-Cal referral. (Attachment C)

Applicants With CalWIN/MEDS History

The following table shows the procedures to be used when processing a referral where there ***is*** CalWIN/MEDS history that indicates the applicant ***is currently*** receiving Medi-Cal.

STEP	CLERICAL PROCEDURE
1.	Complete the following fields found on the IHSS/Medi-Cal Referral Fax Coversheet: • Pages • Date • Case Name • Case Number • Social Security Number
2.	On a daily basis: • Fax the In-Home Supportive Services/Medi-Cal Referral fax coversheet to SEFRC Attention: IHSS Intake Clerk Fax number (619) 266-3877.

Inter-County Transfer (ICT)

STEP	SOCIAL WORKER PROCEDURE
	When an IHSS ICT is received that needs a Medi-Cal SOC determination the IHSS Social Worker will: • Send the IHSS ICT fax form (Attachment D) to the SEFRC IHSS Intake Clerk. • Advise the client to request a Medi-Cal ICT from the Medi-Cal worker in the transferring county. If the case is active on Medi-Cal ***only*** in another county: • The Social Worker will still send the ICT fax form to the SEFRC IHSS Intake Clerk. • The SEFRC will request an ICT for the Medi-Cal case. • The Social Worker will advise the client to request a Medi-Cal ICT from the Medi-Cal worker in the transferring county.

Recertification

Medi-Cal Workers at the SEFRC will maintain the case files of adult-only Medi-Cal cases with IHSS companion cases. If there are children in the family budget unit the case will remain in the appropriate district FRC with the assigned worker.

The table below shows the procedures to be followed by the IHSS Social Worker when requesting an IHSS SOC re-determination and the recipient's case is ***not*** part of the IHSS Medi-Cal granted caseload in the SEFRC.

STEP	SOCIAL WORKER PROCEDURE
1.	By the 1st of each month : Identify the income-eligible cases listed on the "Assessment Due Report" for that month.
2.	Review the MEDS printouts for the income-eligible cases.
3.	Using the MEDS printout identify if the Medi-Cal case has a SEFRC IHSS Medi-Cal Worker (indicated by a worker number beginning with "SX").
4.	• Circle any cases on the report that are ***not*** maintained in the SEFRC IHSS Medi-Cal Unit. • Write the current Medi-Cal worker's number next to the circle. Example: • The worker number listed on the MEDS printout begins with MX, MW, SC, SA, etc. • The client's actual Medi-Cal case is physically located in a different District Office or • Is assigned to a worker who is not in the IHSS SEFRC unit.
5.	• The Social worker will give their Assessment Due list to the designated IHSS clerk. • IHSS clerical will batch and send the unit's listings by county mail to the granted SEFRC IHSS/Medi-Cal supervisor by the 5th of each month. Currently: Mary Ann Gonzales MS W-69

Communication With SEFRC

	MEDI-CAL WORKER RESPONSIBILITY
	The Medi-Cal Worker will send the IHSS Social Worker the following information: • Medi-Cal SOC. • IHSS SOC. • All applicable CMIPS coding for the SOC 293. This information will be transmitted by email using the IHSS/Medi-Cal Communication form. (Attachment E)

	SOCIAL WORKER RESPONSIBILITY
	The Social Worker will notify the assigned Medi-Cal Worker by email of any changes affecting eligibility for active/ongoing cases. These include, but are not limited to the following: • IHSS case grantings. • Any changes in the income or property of the recipient or household. • Change of address, telephone number, household composition, or the marital status of the recipient. • Any extended absence of the recipient from the home such as hospitalization. • Any change in circumstances that may affect the SOC amount. • Case closings. All emails must include the client's name and Social Security number.

Changes To Pending IHSS Cases

	CHANGES TO PENDING CASES
Example 1.	A Medi-Cal case becomes "active" three months or more after the actual IHSS application date. The following procedures will be followed. • The Social Work Supervisor will contact the IHSS FRC district liaison at the office where the Medi-Cal case is active. • The IHSS FRC district liaison will inform the Medi-Cal Worker that a retroactive determination is needed covering the missing months. • The IHSS FRC district liaison will report back on the Medi-Cal determination status. • If the case is confirmed as active the assigned IHSS clerk will send an active fax referral to the SEFRC IHSS Intake Clerk. • If the Medi-Cal case is denied the IHSS Social Worker will deny the IHSS application. • If a referral to State Programs-Disability and Adult Programs Division (SP-DAPD) is needed the IHSS Social Worker will complete the referral.
Example 2.	A case becomes status eligible (aid code 10, 20, or 60) or Medi-Cal eligible after the original IHSS and IHSS Medi-Cal application date. Status Eligible: • Clear MEDS. • Check the INQX screen "Title XVI – SSI/SSP Information" • In the "Other Information" section of this screen check the "DISABL-BLD-ONSET" field. • The date displayed is the effective date that the client was determined disabled. o If there is no disability determination date then a Disability Evaluation Packet must be forwarded to the State Programs-Disability and Adult Programs Division (SP-DAPD) covering the time period in question.

Example 2. Cont.	Active Medi-Cal: • The assigned Medi-Cal worker completes a Medi-Cal determination using the IHSS application date. • If the case is past the three month retroactive period: • This would be processed by the Medi-Cal Worker at the SEFRC if it is past the three month retroactive period. • If an SP-DAPD is required the IHSS Social Worker is responsible for obtaining the completed referral.

Out-of-Pocket Expenses For IHSS Applicants

	CONLAN II CLAIMS
	An IHSS applicant will need to file a Conlan II claim for reimbursement if he/she has paid out-of-pocket for IHSS/Medi-Cal covered expenses during the following time periods: • Retroactive Time Period -Three months prior to date of application. • Evaluation Period – The time period between the application date and the date the application is approved. • Post Approval – For excess co-pay or excess Share-of-Cost. For out-of-pocket expenses from June 27, 1997 to November 16, 2006 a completed Conlan II claim form must be received no later than November 16, 2007. For out-of-pocket expenses after November 16, 2006 the applicant has 1 year from receipt of services to file a Conlan II claim, or 90 days from receipt of Medi-Cal card (whichever period is longer).
	To request a claims packet the recipient must call or write to: California Department of Health Services Beneficiary Services P.O. Box 138008 Sacramento CA 95813-8008 (916) 403-2007 TDD (Hearing impaired) (916) 635-6491 The toll free number for Conlan II claims information is 1-877-508-1327
	The Social Worker is responsible for assisting the client by: • Providing a copy of the granting Notice of Action NA-690. • If the Notice of Action is not available providing form SOC 828 verifying the applicant's medical necessity. • If requested by the applicant, assisting with completion of the claims packet. • If the applicant's Conlan II claim is denied, assisting with the appeal procedure.

V. REVIEW STATEMENT

This Special Notice has been reviewed by IHSS and SEFRC Administration.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Mary Harrison (858) 505-6952
Attachments
Distribution Codes 7 & 8

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 of Fax:**

Re: Income Eligible/Medi-Cal Eligibility Determination **CC:**

☐ **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	Application Date	Case Number	Social Security Number	SW #
Case Name	Application Date	Case Number	Social Security Number	SW#
Case Name	Application Date	Case Number	Social Security Number	SW#
Case Name	Application Date	Case Number	Social Security Number	SW#
Case Name	Application Date	Case Number	Social Security Number	SW#
Case Name	Application Date	Case Number	Social Security Number	SW#
Case Name	Application Date	Case Number	Social Security Number	SW#
Case Name	Application Date	Case Number	Social Security Number	SW#

Attachment A

FAMILY RESOURCE CENTERS
LIAISON FOR IHSS PROGRAM

OFFICE	MS	ADDRESS	FRC MANAGERS	LIAISON
CENTRE CITY	W248 **C***	1255 Imperial Ave. San Diego, CA 92101	Deni Gradwohl/Reba Baldwin (619) 237 - 8457	Margaret Dick (619) 338 - 2145
EL CAJON	W99 **L***	220 S. First Street El Cajon, CA 92019	Donna Rafenstein/Charley Khoury (619) 401 - 6026/27	Tami Gaines (619) 401 - 6011
ESCONDIDO	N85 **E***	620 E. Valley Pkwy Escondido, CA 92025	Dominic Camplisson (760) 740 - 4240	Barb Hagood (760) 740 - 4078
KEARNY MESA	W92 **H***	5201 Ruffin Rd., Ste. K San Diego, CA 92123	Mark Silvia (858) 495 - 5744	Craig Maze (858) 694-2528
LEMON GROVE	W260 **G***	7065 Broadway Lemon Grove, CA 91945	Sylvia Melena (619) 668 - 3800	Julie Hinman (619) 668 - 3964
MISSION VALLEY	W431 **M***	7947 Mission Center Ct. San Diego, CA 92108	Deanna Zotalis (619) 767 - 5000	Jennifer Young (619) 767 - 5006
NORTHEAST	W89 **N***	5001 73rd Street San Diego, CA 92115	Karen Bebb (619) 589 - 4501	Jaime Mendez (619) 668 - 5569
OCEANSIDE	N106 **K***	1315 Union Plaza Court Oceanside, CA 92054	Leslie Henderson/Marcia James (760) 754 - 5899	Vickie Liles (769) 754 - 3552
SOUTHBAY	W97 **V***	690 Oxford St. Ste #E Chula Vista, CA 91911	Josie Frelke (619) 409 - 3243	Teresa Barajas (619) 409 - 3269
SOUTHEAST	W69 **S***	4588 Market St. San Diego, CA 92102	Pat Lopez/Othella Burns (619) 266 - 3701	Tiffani Bolden (619) 266 - 3719
HEALTHCARE ACCESS (HOS, CMS)	O557D **HS***	8840 Complex Dr., #235 San Diego, CA 92123	Julie Steidl (858) 492 - 2217	Jennifer Davis (858) 492 - 2295

* WORKERS DESIGNATOR

County of San Diego
INTER-DEPARTMENT MEMO

Date: _____

Case Number: _____

Case Name: _____ Social Worker #: _____

☐ Fax referral sent erroneously, please send a SAWS 1. 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

Attachment C

In-Home Supportive Services / Medi-Cal Referral

Fax – IHSS Inter-County Transfer

To: Southeast Family Resource Center **From:** IHSS District Office

Attention: IHSS FRC Intake Clerk

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

Phone: (619) 266-3731 **Date of Fax:**

Re: IHSS Inter-County Transfer **CC:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

INTER- COUNTY TRANSFER (ICT) APPLICANTS

The beneficiaries listed below have applied for IHSS in San Diego County through the IHSS ICT process. A Medi-Cal ICT must be initiated and processed as well. A fully completed IHSS/Medi-Cal Communication form is necessary to process the IHSS application. The effective date for San Diego County benefits is noted below.

1. Case Name	Effective Date	Case Number	Social Security Number	SW #
Current Address		Social Worker Name (Transferring County)	Social Worker Phone No. (Transferring County)	
2. Case Name	Effective Date	Case Number	Social Security Number	SW#
Current Address		Social Worker Name (Transferring County)	Social Worker Phone No. (Transferring County)	
3. Case Name	Effective Date	Case Number	Social Security Number	SW#
Current Address		Social Worker Name (Transferring County)	Social Worker Phone No. (Transferring County)	

Attachment D

IHSS/MEDI-CAL COMMUNICATION

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

☐ Medi-Cal case denied on _____ (DATE)

☐ Medi-Cal case discontinued on _____ (DATE)

Comments:

_____

_____

_____

_____

_____

10/05

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-04

April 11, 2007

SUBJECT- Conlan II Implementation Settlement

EFFECTIVE DATE: Immediately **EXPIRATION DATE: When incorporated into the IHSS Program Guide**

REFERENCE: All-County Letter #07-11

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) with updated information and instructions on the Conlan II Claims process.

II. BACKGROUND

The Conlan v. Bonta and Conlan v. Shewry lawsuits resulted in the issuance of two separate decisions by the First District Court of Appeal. The first decision is referred to as Conlan I and was issued on September 30, 2002. The second decision, referred to as Conlan II, was issued on August 15, 2005. These court decisions directed California Department of Health Services (CDHS) to adopt and implement procedures to ensure reimbursement to Medi-Cal beneficiaries for covered medical services received and paid for by a beneficiary during the following periods.

- Retroactive Period: The three-month period prior to applying for Medi-Cal.
- Evaluation Period: The period when the Medi-Cal application is pending.
- Post Approval: The denial period between a beneficiary's application for Medi-Cal eligibility and reversal of that decision. Reimbursement to Medi-Cal beneficiaries also includes excess co-payment and excess Share-of-Cost (SOC) expenses.

The Medi-Cal application date, not the IHSS application date, is used to determine eligibility to reimbursement for IHSS expenses.

III. POLICY

The CDHS implementation plan will allow eligible Medi-Cal clients (including IHSS recipients) to request reimbursement for covered services, and be informed of the procedures for requesting and submitting a claims packet to CDHS.

IV. PROCEDURES

Social Worker Responsibility

IHSS staff will (if requested by the recipient) assist with the following:

- Providing a copy of the granting Notice of Action NA 690.
  - The notice must be provided to the recipient within 10 business days.
- If the Notice of Action is not available, form SOC 828 (Attachment B) verifying the recipient's medical necessity must be provided instead.
  - Form SOC 828 is only used to verify medical necessity and not to provide case information.
- If requested, assist the recipient with completion of the claims packet.
- If the recipient's Conlan II claim is denied, assist with the appeal procedure.
  - The recipient has 90 days from receipt of the denial notice to request an appeal.

Claim Processing

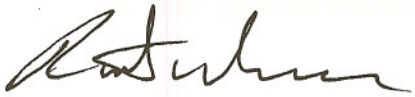
- For out-of-pocket expenses from June 27, 1997 to November 16, 2006:
  A completed Conlan II claim form must be received no later than November 16, 2007 or 90 days from the receipt of the Medi-Cal card (whichever period is longer).
- For out-of-pocket expenses after November 16, 2006:
  The applicant has one year from receipt of services to file a Conlan II claim or 90 days from receipt of Medi-Cal card (whichever period is longer).
- Claims are submitted to CDHS, Benefits Service Center (BSC). BSC will forward the claim to California Department of Social Services-Adult Programs Division (CDSS-APD) within 15 days.
- CDSS-APD has 120 days (four months) to deny/approve or partially deny/approve a claim.
- Recipients may receive more information on claims reimbursement by calling toll free at 1-(877) 508-1327. The phone number listed on Attachments D and E are not toll free.

V. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.



RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Gina Brown (858) 495-5554

Dist. Codes 7 & 8

Attachments:

A. Frequently Asked Questions
B. SOC 828 Conlan II County Verification
C. Conlan II Claims Process
D. Conlan II Recipient Notification (English)
E. Conlan II Recipient Notification (Spanish)

Frequently Asked Questions

Q1: **What does the California Department of Social Services (CDSS) have to do with Conlan II if litigation was filed with the California Department of Health Services (CDHS)?**

A 1: The CDSS is responsible for administering the In-Home Supportive Services (IHSS) Program including the Medi-Cal Personal Care Services Program (PCSP) and IHSS Plus Waiver (IPW). The CDHS is the Medi-Cal Single State Agency responsible for the administration and implementation of the Medi-Cal Program. The CDHS, through an interagency agreement, has authorized the CDSS to implement and administer the PCSP/IPW programs.

Because the PCSP/IPW programs are a Medi-Cal benefit and recipients are determined eligible under Medi-Cal eligibility rules, they would be considered part of the class of individuals eligible to receive reimbursement for any out-of-pocket medical expenses in accordance with Conlan II.

Q2: **What is a Beneficiary Reimbursement (Conlan) claim?**

A2: A claim filed by recipients of I HSS services who are requesting Medi-Cal reimbursement for out-of-pocket expenses paid for the IHSS service(s) received. Monetary reimbursement will be provided to any individual with a valid claim for services received on or after June 27, 1997.

Q3: **What is the statute of limitations to file a claim for retroactive services?**

A3:

A) Claims for services provided June 27, 1997, through November 16, 2006, must be received by CDHS by November 16, 2007, or within 90 days after issuance of the Medi-Cal card, whichever is longer.

B) Claims for services provided on or after November 16, 2006, must be submitted within one year of receipt of services or within 90 days after issuance of the Medi Cal card, whichever is longer.

Q4: **What is the earliest date an individual can file a claim with all the appropriate documentation?**

A4: A Beneficiary Reimbursement (Conlan) claim for IHSS can be filed with dates of service back to June 27, 1997.

QS: Which application date would be used to determine the recipient's eligibility for reimbursement of IHSS covered services?

A5: The date the recipient applied for Medi-Cal, not the date the recipient applied for IHSS.

***Q6:* What documentation does an individual need to submit with their claim?**

A6: Proof of medical necessity (Le. NA-690) and proof of payment for the service (e.g.; cancelled check, provider receipt).

***Q7:* What happens if the recipient does not have a copy of their NA-690 IHSS Notice of Action (NOA)?**

A7: The recipient may ask for a copy of the NA-690 from their County Office. The county must provide a copy, within 10 business days, or use the **SOC** 828, County Verification Form (1/07). The county must provide the recipient with the completed original SOC 828 and maintain a copy for their records.

Q8:* What is the purpose of the SOC 828, County Verification Form *(1/07)?

A8: The SOC 828 is to be used by the county when they are unable to find the NA-690 in their immediate records. The SOC 828 is used only to verify medical necessity and not to detail any recipient case information such as hours and/or services. The **SOC** 828 will be available electronically via the CDSS external Webpage.

***Q9:* What impact will the implementation of Conlan II have on counties?**

A9: To minimize the impact on counties CDSS has the substantial workload for implementation. However, if county efforts are necessary, counties will be able to claim Conlan II costs through the County Expense Claim process. Based upon current law cited in Welfare and Institutions Code (WIC) Section 12306, CDSS shares the annual cost of services with the counties.

Q10: Will the County Offices be provided with claim packages for distribution to recipients?

A 10: No. The CDHS Beneficiary Reimbursement Center (BSC) will log and distribute Beneficiary Reimbursement claim packages.

***Q11:* What is the difference between the "retroactive period," the "evaluation period," and the "post-approval period"?**

A 11: The *retroactive period* is up to three months prior to the time of application for Medi-Cal.
The *evaluation period* includes the time between the dates that an application for Medi-Cal eligibility was submitted and approved.
The *post-approval period* is the time period after the recipient was approved for Medi-Cal.

012: Who would an individual contact to obtain information about filing a claim?

A 12: The SSC at (916) 403-2007 or TDD (916) 635-6491.

013: Is there a toll free (800) number to refer individuals seeking additional information about filing a claim?

A 13: Yes. The number is 1-877-508-1327.

014: What happens if the claim is denied?

A 14: The recipient will be notified in writing via a Notice of Action letter that will explain the reason for the denial. The letter will also include a notice of the recipient's rights and instructions for requesting a State Hearing.

015: Where can an individual find detailed information about the types of services covered under the IHSS program?

A 15: The CDSS regulations, Manual of Policies and Procedures, Division 30, Chapters 30-700 and 30-780; and WIC sections 12300 et. seq., and 14132.95 et seq.

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

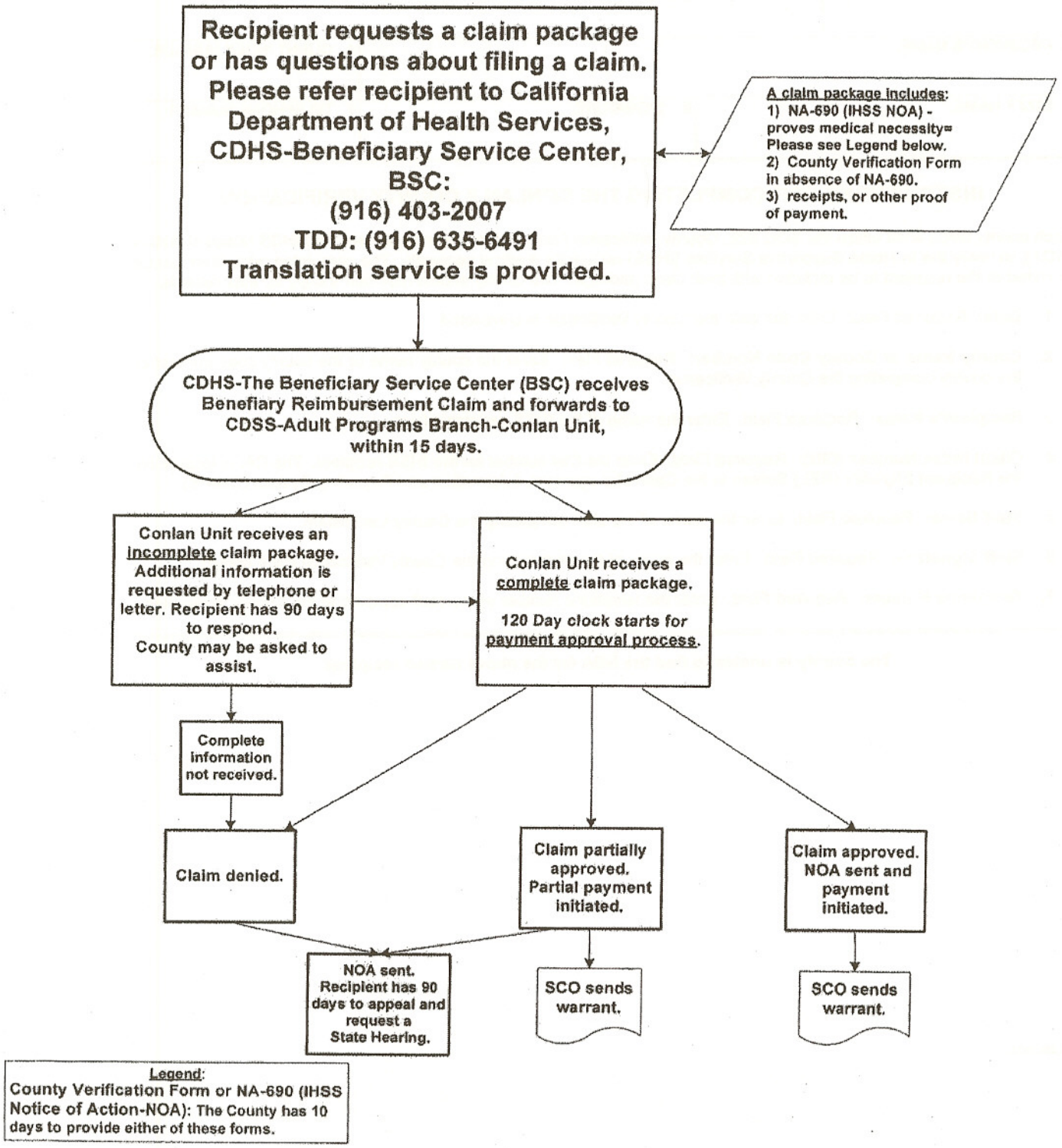
Each county office shall utilize the SOC 828, County Verification Form, in the absence of a NA-690 IHSS Notice of Action (NOA), to verify the In-Home Supportive Services (IHSS) recipient's medical necessity. The completed original should be provided to the recipient to be included with their claim package.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

ATTACHMENT B

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



ATTACHMENT C

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

IF YOU WERE ELIGIBLE FOR MEDI-CAL ANYTIME SINCE JUNE 27, 1997, OR ARE ELIGIBLE NOW, MEDI-CAL MAY REIMBURSE YOU FOR MEDICAL OR DENTAL BILLS YOU PAID

Conlan v. Bontá; Conlan v. Shewry

As the result of two court decisions, you may be able to be repaid for some medical expenses you paid. The California Department of Health Services (CDHS) will assist you in getting your money back if all criteria below are met:

1. You received a medically necessary medical or dental service during one or all of these time periods:
   - ✓ The 3-month period prior to the month you applied for the Medi-Cal program,
   - ✓ From the date you applied for the Medi-Cal program until the date your Medi-Cal card was issued,
   - ✓ After your Medi-Cal card was issued (includes excess co-payment and excess share of cost charges).
2. You paid for your medical or dental service; or another person paid for your medical or dental service on your behalf. You will be asked to provide proof that the medical or dental service was paid for by you or the other person.
3. You received the medical or dental service from a Medi-Cal enrolled provider (note: you do not need to have received the service from a Medi-Cal enrolled provider if you received the medical or dental service during the 3-month period prior to applying to Medi-Cal, or you received the services on or after June 27, 1997 but before February 2, 2006 and you had applied for Medi-Cal but not yet received a Medi-Cal card).
4. For those Medi-Cal services that were provided and would have required Medi-Cal authorization, you have documentation from the medical or dental provider that shows medical necessity for the service.
5. You were Medi-Cal eligible to receive that specific medical or dental service.
6. The medical or dental service was a benefit under the Medi-Cal program.
7. The medical or dental service was provided on or after June 27, 1997.
8. After you received your Medi-Cal card, you contacted your provider and showed your provider your Medi-Cal card and the provider would not give you your money back.

Important dates and time frames:

- For services received June 27, 1997 through November 16, 2006, you must submit your claim by November 16, 2007, or within 90 days after issuance of the Medi-Cal card, which ever is longer.
- For services received on or after November 16, 2006, you must submit your claim within one year of receipt of services or within 90 days after issuance of the Medi-Cal card, which ever is longer.

For more information or to file a claim, you MUST call or write to Medi-Cal at:

For Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims:	For Dental Claims:
California Department of Health Services **Beneficiary Services** **P.O. Box 138008** **Sacramento, CA 95813-8008** **(916) 403-2007 TDD: (916) 635-6491**	**Denti-Cal** **Beneficiary Services** **P.O. Box 526026** **Sacramento, CA 95852-6026** **(916) 403-2007 TDD: (916) 635-6491**

-- DON'T FORGET TO KEEP ALL RECEIPTS FOR THE MEDICAL AND DENTAL CARE YOU RECEIVE --

Medi-Cal will review your claim for repayment and send you a letter with a check or a denial letter that tells you the reason for denial. If Medi-Cal denies your request for payment, you may ask for a state hearing. The denial letter will tell you how to ask for a state hearing.

Medicare/Medi-Cal Coverage: Starting January 1, 2006, medications covered under Medicare Part D will not be a covered benefit under the Medi-Cal Program and are not eligible for reimbursement. For questions regarding Medicare Part D contact 1-800-Medicare.

ATTACHMENT D

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

SI USTED ERA ELEGIBLE PARA MEDI-CAL EN CUALQUIER MOMENTO DESDE EL 27 DE JUNIO DE 1997, O AHORA ES ELEGIBLE, ES POSIBLE QUE MEDI-CAL LE REEMBOLSE POR CUENTAS MÉDICAS O DENTALES QUE USTED HAYA PAGADO

Conlan v. Bontá; Conlan v. Shewry

Como resultado de dos decisiones de la corte, es posible que usted pueda ser reembolsado/a por algunos costos médicos que usted pagó. El Departamento de Servicios de Salud de California (California Department of Health Services-CDHS) le asistirá en conseguir el reembolso de su dinero si satisface todos los requisitos mencionados abajo:

1. Si usted recibió un servicio médico o dental que fue médicamente necesario durante estos períodos:
   - ✓ En el período de 3 meses antes del mes que usted solicitó para el programa de Medi-Cal,
   - ✓ A partir de la fecha que usted solicitó el programa de Medi-Cal hasta que su tarjeta de Medi-Cal fue expedida,
   - ✓ Después de que se expida su tarjeta médica (incluye exceso del pago parcial y exceso de cargos de parte del costo).
2. Si usted pagó por su servicio médico o dental, u otra persona pagó por su servicio médico o dental de parte suya. Usted va ser requerido que provea pruebas del servicio medico o dental, que fue pagado por usted u otra persona.
3. Si usted recibió el servicio médico o dental de un proveedor inscrito en Medi-Cal (nota: usted no necesita haber recibido el servicio de un proveedor inscrito en Medi-Cal si usted recibió el servicio médico o dental durante el período de tres meses antes de solicitar Medi-Cal).
4. Si usted tiene, una autorización de un proveedor médico o dental, y tienes documentación del proveedor medico o dental que enseña que los servicios fueron necesarios.
5. Si usted tenía elegibilidad de Medi-Cal para recibir ese servicio específico médico o dental.
6. El servicio médico o dental fue un beneficio bajo el programa de Medi-Cal.
7. El servicio médico o dental fue proporcionado en o después del 27 de junio de 1997.
8. Después de que usted recibió su tarjeta de Medi-Cal, usted contactó a su proveedor y le mostró a su proveedor su tarjeta de Medi-Cal y el proveedor no le reembolsó su dinero.

Fechas y horarios importantes:

- Para los servicios recibidos el 27 de junio de 1997 al 16 de noviembre del 2006, usted debe presentar su reclamo antes del 16 de noviembre del 2007, o en el plazo de 90 días después de que se recibió la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.
- Para los servicios recibidos en o después del 16 de noviembre del 2006, usted debe presentar su reclamo dentro del plazo de un año de la fecha que recibió los servicios, o en el plazo de 90 días después de que se recibió la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.

Para más información o presentar un reclamo, usted DEBE llamar o escribir a Medi-Cal a las siguientes direcciones:

Para Reclamos Médicos, de Salud Mental, de Drogas y Alcohol, y de Servicios de Casa y Cuidado Personal (Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Service Claims):	Para Reclamos Dentales (Dental Claims):
California Department of Health Services **Beneficiary Services** **P.O. Box 138008** **Sacramento, CA 95813-8008** **(916) 403-2007 TDD: (916) 635-6491**	**Denti-Cal** **Beneficiary Services** **P.O. Box 526026** **Sacramento, CA 95852-6026** **(916) 403-2007 TDD: (916) 635-6491**

--NO SE OLVIDE GUARDAR TODOS LOS RECIBOS DEL LOS SERVICOS MÉDICO Y DENTAL QUE USTED RECIBIO--

Medi-Cal revisará su reclamo para el reembolso y le enviará una carta con un cheque o una carta de negación que le explicará la razón del porqué fue negado. Si Medi-Cal niega su petición de pago, usted puede pedir una Apelación al Estado. La carta de negación le dirá cómo pedir la Apelación al Estado.

Cobertura de Medicare/Medi-Cal: Empezando el 1° de Enero del 2006, los medicamentos cubiertas bajo Medicare Parte D no serán un beneficio cubierto bajo el programa de Medi-Cal y estos medicamentos no son elegibles para el reembolso. Para preguntas sobre Medicare Parte D llame al 1-800-Medicare.

ATTACHMENT E

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-03

February 19, 2007

SUBJECT: INDIVIDUAL EMERGENCY BACK-UP PLAN

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All-County Letter # 07-08

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff of form SOC 827 Individual Emergency Back-Up Plan

II. BACKGROUND

The California Department of Social Services (CDSS) is mandated to promote the enhancement of service options and service delivery methods that include Person-Centered Planning. CDSS developed the Individual Emergency Back-up Plan as a component of Person-Centered Planning. Participants must have and understand their own individual emergency back-up plan in the event their service provider(s) are not available, and they experience a critical incident.

III. POLICY

Effective immediately, the attached form SOC 827 should be completed at every initial assessment and annual re-assessment for all clients.

IV. SOCIAL WORKER PROCEDURES

- Form SOC 827 is available on the S drive in the "Automated Forms" folder. The link is: S:\AIS\Operations\IHSS\Automated Forms

- The Social Worker will complete as much information as possible prior to the home visit. Information not available may be added during the home visit.

- Print two copies to be finalized and signed during the home visit. The form is completed and signed by the participant or his/her authorized representative at the home visit. One copy is to be left with the recipient and displayed in an appropriate place in the

recipient's house. The other copy is to be retained in the case file under the miscellaneous tab.

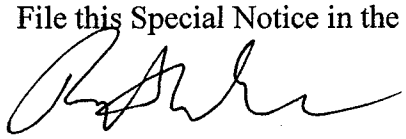
- The new "Senior/Disabled Resource List" 12-96 form should be included with the SOC 827.

V. REVIEW STATEMENT

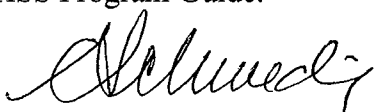
Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.



RICK WANNE
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Mary Harrison (858) 505-6952
Susan Pullido IHSS Quality Control

Attachment
Distribution Codes 7 & 8

In-Home Supportive Services (IHSS) Program

INDIVIDUAL EMERGENCY BACK-UP PLAN

Participant Name: _____ Date: _____

Case #: _____ Declined to participate: ☐

If your Care Provider does not arrive and you need assistance, call:

Family Member: _____

Friend: _____

Neighbor: _____

County Social Services Worker: _____

County IHSS Social Services Office: _____

Public Authority: _____

If you need to report abuse and/or neglect of elderly or disabled individuals, call:

Adult Protective Services: _____

Other important numbers:

Doctor's Office: _____

Medi-Cal Office: _____

Advocacy Group(s): _____

Police Department: _____

Fire Department: _____

Other: _____

If you have an emergency, call 911

Social services staff discussed the above information with the recipient and/or his/her Authorized Representative and all parties are aware of what to do in case of an emergency.

Signature of Participant: _____ Date: _____

Signature of: _____ Date: _____

Authorized Representative, if applicable

Signature of: _____ Date: _____

County Social Services Staff

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 06-09
ADDENDUM A

January 12, 2007

SUBJECT- CORRECTION TO SPECIAL NOTICE 06-09 ATTACHMENT 'B' "ANNOTATED ASSESSMENT CRITERIA"

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All-County Letter #06-34 and 06-34 Erratum

I. PURPOSE

The purpose of this Special Notice is to clarify and make a correction to Attachment B (Annotated Assessment Criteria) of Special Notice 06-09 issued September 18, 2006.

II. BACKGROUND

Special Notice 06-09 provided standard guidelines for staff to accurately and consistently assess service needs. The word "**main"** was inadvertently left out of Attachment B, Page 7, where it states: "Rank 4: Requires another person to prepare meal(s) and cleanup on a daily basis."

III. PROCEDURES

This line is to be replaced with the corrected version:

"Requires another person to prepare and cleanup **main** meal(s) on a daily basis."

Please note the word "meal" was also moved in this version and placed after the word "main" for consistency. Please remove and recycle the 9/5/06 revision of Attachment B, Special Notice 06-09 and replace it with the revision dated 12/21/06 included with this addendum.

IV. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

V. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.

RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Matt McKay (858) 505-6366

Dist. Codes 7 & 8

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-02

January 9, 2007

SUBJECT – INDEPENDENT PROVIDER WAGE INCREASE AND CHANGES IN HEALTH CARE BENEFITS

DATE: February 1, 2007 **EXPIRATION DATE: When incorporated into the IHSS Program Guide**

I. PURPOSE

The purpose of this Special Notice is to inform IHSS staff of a wage increase for independent providers (IPs) effective February 1, 2007.

II. BACKGROUND

Assembly Bill (AB) 1682 required all counties to establish an Employer of Record for IHSS Programs. In response to this 1999 State mandate, the Board of Supervisors for San Diego County approved an ordinance to establish the County of San Diego In-Home Supportive Services Public Authority (Public Authority) as the Employer of Record. The ordinance also established the Board of Supervisors as the Public Authority Governing Body.

The Public Authority is the employer of record for more than 21,000 IPs. In October of 2001, the United Domestic Workers of America (UDW) was elected to represent the IPs in negotiations for a Memorandum of Understanding (MOU) between the Public Authority and the UDW. The initial MOU increased wages and added health benefits for IPs authorized to work 80 hours a month or more.

The current MOU between the Public Authority and the UDW is for the period of January 12, 2005 to January 31, 2008.

III. POLICY

Effective February 1, 2007, the current MOU allows for all individual providers in San Diego County to receive a wage increase. The specific conditions of the agreement are as follows:

- The IP wage will increase from $9.00 per hour to $9.25 per hour.

IV. PROCEDURES

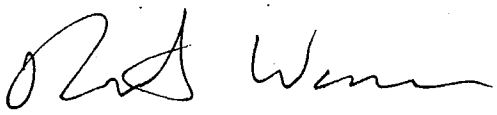
Case Management, Information and Payrolling System (CMIPS) will implement the rate increase. Turn around documents will be generated for all affected cases. An exception report will be generated for any cases that cannot be automatically changed to the new rate.

V. REVIEW STATEMENT

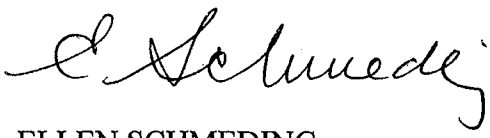
Due to the immediacy of this information, the standard review committee did not review this Special Notice.

VI. FILING STATEMENT

Please file this Special Notice in the Special Notice section of the IHSS Program Guide.



RICK WANNE
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Matt McKay (858) 505-6366

Dist. Codes 7 & 8

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 07-01

January 9, 2007

SUBJECT- PROTECTIVE SUPERVISION 24-HOURS-A-DAY FORM (SOC 825)

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All-County Information Notice #1-97-06

I. PURPOSE

The purpose of this Special Notice is to inform In Home Supportive Services (IHSS) staff of the new Protective Supervision 24-Hours-A-Day form SOC 825 for optional use (Attachment A). This form is available in English and Spanish and can be accessed on the S drive or at the State website address: http://www.dss.cahwnet.gov/pdf/SOC825.PDF.

II. BACKGROUND

The Protective Supervision 24-Hours-A-Day Coverage Plan form was developed by California Department of Social Services in conjunction with the California Welfare Directors Association and various other stakeholders. The SOC 825 form was designed as an optional tool to be utilized by the IHSS Social Worker to identify how the 24-Hours-A-Day Coverage Plan will be attained in order for the recipient to remain safely in his/her home.

III. POLICY

The SOC 825 form is an additional way of documenting that Protective Supervision eligibility requirements for a case are being met. The IHSS Social Worker has the option of using the State's SOC 825 form or the county's 12-89 HHSA form. One of these two forms must be completed for each Protective Supervision case. If it is determined that Protective Supervision is required for any client, a 24/7 Care Plan must be completed before any hours can be authorized for this task.

IV. PROCEDURES

IHSS SOCIAL WORKER

When Protective Supervision is required for the recipient to remain safely in his/her home, the IHSS Social Worker will discuss a plan or schedule of 24 hours a day coverage for the recipient with the care provider(s). An SOC 825 (or 12-89 HHSA) form must be completed and signed by the primary contact and the IHSS Social Worker. Detailed

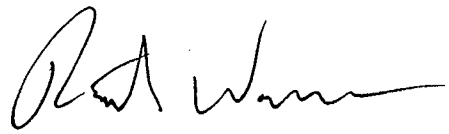
instructions for completing the form are included on the back of the SOC 825. The original SOC 825 will be retained in the case file under the Misc. tab and a copy sent to the primary contact.

V. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by the standard review committee.

VI. FILING STATEMENT

File this Special Notice in the Special Notice section of the IHSS Program Guide.



RICK WANNE
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Matt McKay (858) 505-6366

Dist. Codes 7 & 8

PROTECTIVE SUPERVISION
24-HOURS-A-DAY COVERAGE PLAN

PLEASE PRINT

NAME OF IHSS RECIPIENT:	RECIPIENT'S TELEPHONE #:
ADDRESS OF IHSS RECIPIENT:	
NAME OF PRIMARY CONTACT RESPONSIBLE:	CONTACT'S TELEPHONE #:
RELATIONSHIP TO RECIPIENT:	

As the primary contact for arranging the 24-hour-a-day coverage plan for the above named Recipient, I acknowledge my understanding of the following:

- A 24-hour-a-day coverage plan has been arranged and is in place.

  The continuous 24-hour-a-day coverage plan can be met regardless of paid In-Home Supportive Service (IHSS) hours along with various alternate resources (i.e.; Adult or Child Day Care Centers, community resource centers, Senior Centers, respite centers, etc.)

- The 24-hour-a-day coverage plan will be provided at all times.

- If there is any change to the 24-hour-a-day coverage plan (i.e. hospitalization, attendance in day-care programs, travel, etc.) I will immediately **notify the IHSS social worker.**

- The above name Recipient has an established need for 24-hour-a-day Protective Supervision if he/she is to remain safely in the home. The IHSS social worker has also discussed with me the appropriateness of out-of-home care as an alternative to 24-hour-a-day Protective Supervision.

NAME OF CARE PROVIDER (1):	CONTACT PHONE #:
NAME OF CARE PROVIDER (2):	CONTACT PHONE #:
NAME OF CARE PROVIDER (3):	CONTACT PHONE #:

Describe the implementation of the Protective Supervision 24-Hour-A-Day Coverage Plan:

SIGNATURE OF PRIMARY CONTACT RESPONSIBLE:	DATE:
SIGNATURE OF IHSS SOCIAL WORKER:	CONTACT PHONE #:

ATTACHMENT A

INSTRUCTIONS

The IHSS Protective Supervision 24-Hours-A-Day Coverage Plan (SOC 825) is an optional form for County use. The SOC 825 is intended to ensure that recipients who need Protective Supervision have the 24-hours of care needed for their health and safety 24 hours a day. The recipient's social service worker and the IHSS care provider(s), whether a family member, friend, or no relation at all, should discuss together a plan or schedule of 24 hours a day of coverage for the recipient.

NAME OF IHSS RECIPIENT: Enter the full name of the IHSS recipient.

RECIPIENT'S TELEPHONE NUMBER: Enter the contact telephone number for the recipient.

ADDRESS OF IHSS RECIPIENT: Enter the recipient's home address where the majority of the 24-hours-a-day coverage will be performed.

NAME OF PRIMARY CONTACT RESPONSIBLE: Enter the name of the person with primary responsibility for coordinating the recipient's 24-Hours-A-Day Coverage Plan.

PRIMARY CONTACT'S TELEPHONE NUMBER: Enter the telephone number for the primary contact responsible.

RELATIONSHIP TO RECIPIENT: Enter the relationship of the primary contact to the recipient, (i.e., family member, IHSS care provider, friend, etc.).

NAME OF CARE PROVIDER(S) (1), (2), (3), and CONTACT TELEPHONE NUMBER(S): Enter the name(s) of each care provider responsible for the recipient's care during the 24 hours a day of coverage. Enter a contact telephone number for each care provider.

If more than three (3) care providers are responsible for this recipient, an additional sheet of paper can be attached with name(s) and contact telephone number(s).

Describe the implementation of the Protective Supervision 24-Hours-A-Day Coverage Plan:

Enter the planned schedule, or explanation of the plan in which the above provider(s) will ensure the recipient is cared for the entire 24-hour period. An additional sheet of paper can be attached if more space is needed to describe the 24-Hours-A-Day Coverage Plan.

SIGNATURE OF PRIMARY CONTACT RESPONSIBLE and DATE: Once the 24-Hours-A-Day Coverage Plan is developed, the primary contact responsible will sign and date the form when the Plan is discussed with the social worker authorizing the need for Protective Supervision.

SIGNATURE OF IHSS SOCIAL WORKER and CONTACT TELEPHONE NUMBER: When the 24-Hours-A-Day Coverage Plan is discussed and signed and dated by the primary contact, the county social service worker will sign the form and add their contact telephone number.

A copy of the form is to be provided to the primary contact and retained in the County case file.