

**IN-HOME SUPPORTIVE
SERVICES
SPECIAL NOTICE
ARCHIVES
2008**



IHSS SPECIAL NOTICES 2008

YEAR	NUMBER	SUBJECT (ABBREVIATED)	ISSUE DATE
2008	08-01	Reimbursement Procedures for Missed Buy-out	Issue Date 1/21/08
	08-02	Individual Provider Direct Deposit	Issue Date 3/14/08
	08-03	Medi-Cal Suspended and Ineligible Providers	Issue Date 3/24/08
	08-04	Citizenship and Identity Requirements	Issue Date 4/4/08
	08-05 <small>Issued as 08-04</small>	SCIF Guide to Workers Compensation	Issue Date 4/23/08
	08-06	Aged & Disabled FPL	Issue Date 4/28/08
	08-07	Clarification of Phase I Questions	Issue Date 5/9/08
	08-08	Working With Face-to-Face Dates and Reports	Issue Date 6/13/08
	08-09	IHSS QC Procedures	Issue Date 7/1/08
	08-10	Clerical Overpayment Processing Procedures	Issue Date 7/23/08
	08-11	Elective State Disability Insurance	Issue Date 9/12/08
	08-12	IHSS Worksheet 12-42 and Narrative 12-43A	Issue Date 10/17/08
	08-13	Social Security Benefit Information Flier	Issue Date 11/7/08
	08-14	Pace	Issue Date 12/10/08
	08-15	Paperless Distribution for Special Notices	Issue Date 12/10/08
	08-16	SSI COLA	Issue Date 12/10/08

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-16**

December 10, 2008

SUBJECT: JANUARY 2009 SOCIAL SECURITY TITLE XVI (SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTAL PAYMENT [SSI/SSP] PROGRAM) COST-OF-LIVING ADJUSTMENT

EFFECTIVE DATE: JANUARY 1, 2009

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: EBB 08015 – 2009 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 5.8% increase in their Social Security benefits effective December 1, 2008. The benefits will be payable on January 1, 2009. 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 13, 2008. Turn around documents (TADS) will be available on Monday, December 15, 2008.

III. SOC UPDATES TO CMIPS

The COLA conversion will apply the 5.8% 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 01/01/2009.
- 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.

SPECIAL NOTICE 08-16 JANUARY 2009 SUPPLEMENTAL SECURITY TITLE XVI (SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTAL PAYMENT [SSI/SSP] PROGRAM COST OF LIVING ADJUSTMENT

The new Benefit Level/Payment is as follows:

Benefit Code –	Level	\$
01		907.00
02		972.00
03		793.00
04		683.34
05		764.34
06		557.34
07		991.00
08		1579.00
09		1806.00
10		1721.00
11		1269.66
12		1496.66
13		1410.66
14		1747.00
15		789.00
16		903.00
17		860.50
18		873.50
19		634.83
20		748.33
21		705.33

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 15, 2008 at the IHSS-CMIPS Online Reports website at: <https://cmips-reports.documentportal.com>

Detailed information on IHSS CMIPS Online Reports can be found in the Users Manual in the IHSS Program Guide Chapter 8, Attachment 8-P at the following link: http://hhsa_intranet/manuals/ais/ihss/toc.pdf

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 no later than Tuesday, December 16, 2008.

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 12/13/2008 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 informational nature of this notice.

VII. FILING STATEMENT

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido (858)505-6366

Attachment: SSI/SSP Payment Standards 01/01/09 thru12/31/2009

SPECIAL NOTICE 08-16 JANUARY 2009 SUPPLEMENTAL SECURITY TITLE XVI (SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTAL PAYMENT [SSI/SSP] PROGRAM COST OF LIVING ADJUSTMENT

SSI/SSP PAYMENT STANDARDS
January 1 through December 31, 2009

	Independent Living		Reduced Needs				Non-Medical Out of Home Care (NMOHC)					
	Residing in Own Household		Household of Another With In-Kind Room and Board		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:												
<u>Aged or Disabled</u>	907.00	674.00	233.00	683.30	449.30	234.00	856.30	449.30	407.00	1086.00	674.00	412.00
-Without Cooking Facilities	991.00	674.00	317.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
<u>Blind</u>	972.00	674.00	298.00	764.30	449.30	315.00	856.30	449.30	407.00	1086.00	674.00	412.00
<u>Disabled Minor *</u>												
-Living with parent(s)	793.00	674.00	119.00	557.30	449.30	108.00	NA	NA	NA	NA	NA	NA
-Living with non-parent relative or non relative guardian	NA	NA	NA	NA	NA	NA	856.30	449.30	407.00	1086.00	674.00	412.00
Couple:												
<u>Aged or Disabled</u>	1579.00	1011.00	568.00	1269.97	674.31	595.66	1719.97	674.31	1045.66	2172.00	1011.00	1142.00
-Per couple (Both are aged or disabled)												
-Without Cooking Facilities	1747.00	1011.00	736.00	N/A	N/A	N/A	NA	NA	NA	NA	N/A	N/A
<u>Blind</u>												
-Per couple (Both are blind)	1806.00	1011.00	795.00	1496.97	674.31	822.66	1719.97	674.31	1045.66	2172.00	1011.00	1142.00
<u>Blind /Aged or Disabled</u>												
-Per couple (Couple one is blind, the other is aged or disabled)	1721.00	1011.00	710.00	1410.97	674.31	736.66	1719.97	674.31	1045.66	2172.00	1011.00	1142.00
Title XIX Medical Facility												
Individual	\$ 52.00											
Couple	\$ 104.00											
RMA (Restaurant Meal Allowance)												
Individual	\$ 86.00											
Couple	\$ 168.00											
Non-Medical Out-of-Home Care												
Minimum												
Maximum												
Room & Board												
Care & Supervision												
Personal & Incidental Needs												
Individual												
Couple												
Disabled Minor *												
Use Independent Living Arrangement for a disabled minor living in the home of his/her parents.												
Use Household of Another if the disabled minor and his/her parents live in the household of someone else, i.e. grandparents												

ATTACHMENT

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-15**

December 10, 2008

SUBJECT: In-Home Supportive Services (IHSS) Special Notices, Bulletins, and Memos

EFFECTIVE DATE: January 1, 2009

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: Health and Human Services Agency (HHS) Strategy Agenda 2009-2014

I. PURPOSE

The purpose of this Special Notice is to provide instructions on a new distribution process for IHSS Special Notices, Bulletins, and Memos.

II. BACKGROUND

Previously IHSS Policy and Procedure information has been distributed in hard-copy format, through the County of San Diego mail system. The current distribution process involves photocopying and distributing numerous copies of information to IHSS staff and to other HHS departments. In order to eliminate unnecessary use of paper and to maximize resources and efficiency, a paperless procedure is being implemented.

III. POLICY

The current HHS Strategy Agenda includes fostering continuous improvement in order to maximize efficiency and effectiveness of services through innovation and continuous improvement.

IV. PROCEDURES

1.	<p>The Program Specialist will:</p> <ul style="list-style-type: none">• Prepare updated policy and procedure information as a Special Notice, Bulletin, Memo or other appropriate format.• Submit for review to the <i>Planning and Program Support Manager</i>.• Submit for review to the appropriate designated <i>Organizational Review Committee (ORC)</i> when necessary.• Submit to the <i>Assistant Deputy Director of Operations</i> for review and sign off.• Submit to the <i>Assistant Deputy Director of Program Support</i> for review and signoff.• Scan the signed document into a Portable Document Format (PDF).• Distribute by email using the distribution list designated by Program Specialist procedures.
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2.	<p>IHSS Supervisors (Social Work Supervisors and Office Assistant Supervisors) will:</p> <ul style="list-style-type: none"> • Forward the Policy and Procedure information to all members of their unit, preferably by email. • Discuss and clarify the information with staff at unit meetings and during individual conferences. • Implement new procedures as indicated. • Contact the Program Specialist with any questions or issues, or to provide feedback.
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Planning and Program Support staff is responsible for reviewing and maintaining the distribution lists at:

S:\AIS\Planning Program Support\Planning Program Support\Program Specialists\Program Specialist Tools\P&P Distribution Lists

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. IHSS Special Notices, Bulletins, and Memos are being archived at the following link:

S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated

Wilfred Quintong
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Mary Harrison (858) 505-6952

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-14**

December 10, 2008

SUBJECT: PACE-IHSS referral

EFFECTIVE DATE: Immediately

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 eligibility criteria for St. Paul's "Program of All-inclusive Care for the Elderly", (PACE) and to encourage the use of the referral process from IHSS to PACE when appropriate.

II. BACKGROUND

St. Paul's PACE is a non-profit program that is federally funded. In 2007 PACE San Diego was established. PACE offers more extensive personal care services than IHSS, such as medical care, dental care, and physical therapy. The PACE program enables seniors age 55 years and older to continue living independently in their own homes. PACE is also a Personal Care Services Program (PCSP); recipients cannot receive services from both IHSS and PACE at the same time.

IHSS and PACE will be collaborating in referring clients to the appropriate program. A standard release of information form was created, and will be used to make referrals and exchange information. A referral may be made by either agency if a client is considered more appropriate for the other PCSP program.

III. POLICY

Before PACE or IHSS staff can share a client's personal medical information, a release of information must be signed by the applicant/recipient. The IHSS Social Worker will determine if the client meets the basic eligibility criteria before making a referral to PACE.

PACE Eligibility Guidelines

In order to refer an applicant/recipient to PACE, he/she must be:

- 55 years of age or older
- Nursing home eligible
- Live in a designated zip code area

92101	92102
92103	92104
92105	92106
92107	92108
92109	92110
92111	92113
92114	92116
92115	92117
92118	92123
92133	92134
92135	92136
92140	92155

- Potentially Medi-cal eligible or currently receiving Medi-cal.
- Able to live independently with assistance, without jeopardizing their health or safety.

The Department of Health Care Services (DHCS) must determine if the client needs a nursing home level of care before a client can receive PACE services. PACE will complete the assessment and submit it to DHCS. PACE will make a referral to Medi-cal if the applicant/recipient does not have Medi-cal.

IV. PROCEDURES

Referral Process

IHSS Social Worker Responsibilities

If the IHSS Social Worker determines that the IHSS client is more appropriate for PACE, the social worker must:

1. Review PACE's eligibility requirements to be certain that the client meets the guidelines for eligibility.
2. Explain the PACE program and get permission from the client before making a referral to PACE.
3. Have the client sign the release of information form before making a referral to PACE.
4. Contact St. Paul's PACE Marketing Director to make a referral at 619-667-3800.

5. Coordinate service dates for active recipients to avoid any duplication of services or a break in services.

Electronic copies of the attached forms can be accessed from the S drive at the following path:
S:\AIS\Operations\IHSS\Automated Forms\SW Forms or Clerical Forms

V. REVIEW STATEMENT

This Special Notice has been reviewed by IHSS and PACE management.

VI. FILING STATEMENT

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

WILFRED QUINTONG

Assistant Deputy Director



ELLEN SCHMEDING

Assistant Deputy Director



For questions contact: Gina Brown (858) 495-5554

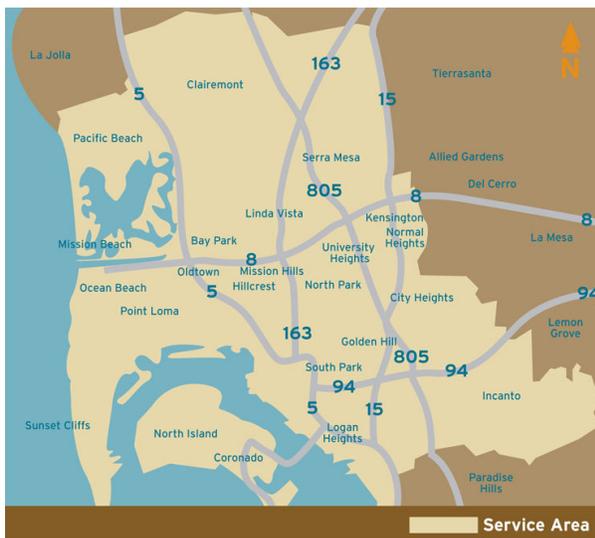
Attachments

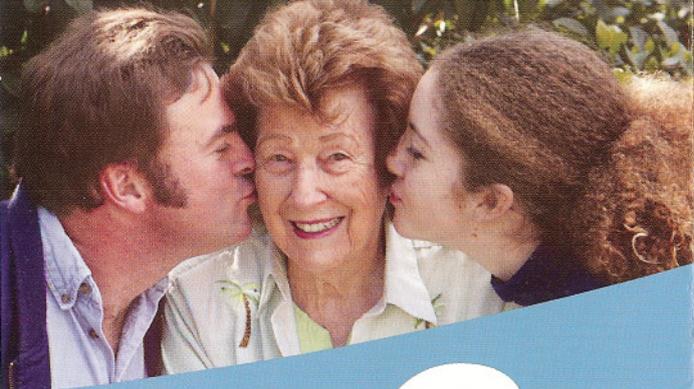
Distribution Codes 7 & 8



St. Paul's PACE Services these neighborhoods by zip:

92101	Down town	92102	Golden Hills
92103	Hillcrest	92104	North Park
92105	City Heights	92106	Pt Loma
92107	Ocean Beach	92108	Mission Valley
92109	Pacific Beach	92110	Bay Park
92111	Linda vista	92113	Barrio Logan
92114	Alta Vista/ Emerald Heights	92116	Normal Heights
92117	Claremont	92118	Coronado
92123	Serra Mesa	92133	Liberty Station
92134	Naval Medical Center	92135	NAS Naval Air Station
92136	NAVSTA Naval Station	92140	MCRD Recruit Depot
92155	NAVAL Amphib		





What is PACE?

P.A.C.E. stands for Program of All-inclusive Care for the Elderly.

PACE is now in more than 34 cities nationwide and St. Paul's PACE is the only program of its kind in San Diego.

The PACE program provides coordinated medical and social services to those who wish to continue living in their own home or community environment, (such as assisted living), despite chronic health needs. For many it is a welcome alternative to nursing home care.

Could this be you or someone you know?

St. Paul's PACE provides individualized quality care by a team of geriatric care professionals who, together with participants and caregivers, address each individual's specific needs.

www.StPaulsPACE.org

What Services are Provided?

The St. Paul's PACE program provides participants with a high level of medical care including prescription drug coverage, doctor and specialist visits, medically necessary therapies, transportation and access to the PACE Pavilion at 111 Elm Street.

St Paul's PACE services are:
(but are not limited to)

- Transportation to and from the PACE center and medical appointments
- Adult day services
- Primary medical and specialty care
- Prescription drug coverage and management
- Nutritious meals and dietary counseling
- Physical, occupational and speech therapies
- Social services
- Home care services
- Dental, podiatry, optometry and other services
- Medical equipment and supplies
- 24-hour access to the PACE care team

Services covered will be in accordance with the individualized care plan and approved by the PACE Care Team.

St. Paul's PACE
111 Elm Street Suite 100
San Diego CA 92101

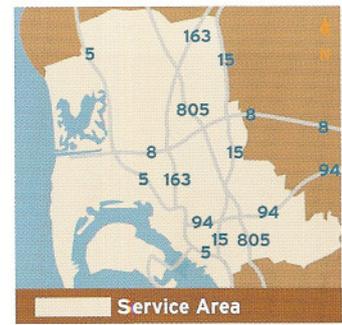
Do You Qualify for St. Paul's

PACE?

Enrollment in St. Paul's PACE is voluntary and individuals qualify if they are:

- Adults 55 years of age or older
- Living in the designated service area (see map below)
- Determined by the Department of Health Care Services as needing nursing home level of care
- Able to live in a community setting without jeopardizing their health or safety

The St. Paul's PACE service area includes these zip codes:



- 92101 92102
- 92103 92104
- 92105 92106
- 92107 92108
- 92109 92110
- 92111 92113
- 92114 92116
- 92115 92117
- 92118 92123
- 92133 92134
- 92135 92136
- 92140 92155

For a consultation on eligibility call our Enrollment Specialists. This free consultation is completely confidential and can be conducted in the privacy of your home.

619.677.3800

hearing impaired tty 800.735.2922

Who is St. Paul's?

St. Paul's Senior Homes & Services has served the elderly in San Diego for over 45-years with services such as:

- Independent Living
- Assisted Living
- Skilled Nursing Care
- Senior Day Care
- Child Day Care

St. Paul's **P A C E**

is the newest St. Paul's program.

With the addition of PACE, St. Paul's can now care for those individuals who require nursing care, yet prefer living at home rather than a nursing facility.

St. Paul's PACE is also ideal for those living in independent or assisted care, who desire a one stop health plan for all of their medical and social needs.

St. Paul's PACE does not discriminate in the delivery of PACE services based on race, ethnicity, national origin, religion, sex, sexual orientation, age, mental or physical disabilities or source of payment.

www.StPaulsPACE.org

Your Questions Answered.

How is St. Paul's PACE financed?

PACE is supported and regulated by the Centers for Medicare & Medicaid Services and the California Department of Health Care Services. St. Paul's PACE accepts Medicare, Medi-Cal and private payment. If you are entitled to Medi-Cal, you pay no premium, if you do not have Medi-Cal, contact us to determine your premium.

How do I enroll with St. Paul's PACE?

St. Paul's PACE makes the enrollment process easy. Our Enrollment Specialist will meet with you (and Caregivers/Family members if desired) at your home to provide a detailed understanding of the St. Paul's PACE program and services and do an assessment of your eligibility. A visit to the center will then be scheduled where you will meet with the doctor, nurses and other key staff. You will receive a medical evaluation at this time so your individualized care plan can be established. Upon approval from the State of California for the Nursing Home Level of Care, we complete enrollment paperwork so you may become an official participant.

Hours:

Monday-Friday 8am-4pm

tel 619.677.3800

fax 619.677.3888

tty 800.735.2922

(hearing impaired)

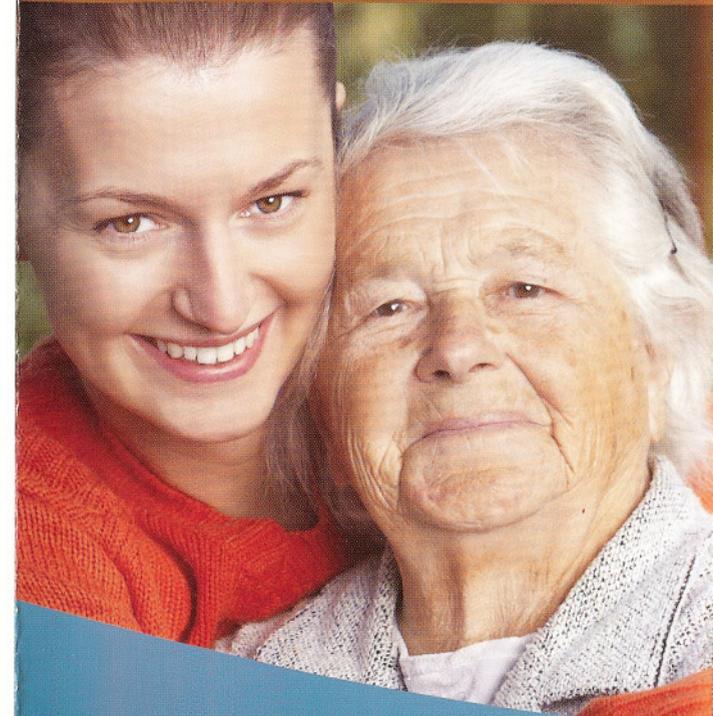
www.StPaulsPACE.org

St. Paul's PACE
111 Elm Street Suite 100
San Diego CA 92101

Attachment B-1

St. Paul's **P A C E**

Program of All-inclusive Care for the Elderly



Providing a caring network of medical and social services that promotes independence and dignity enabling San Diego's elderly to remain safely at home.

619.677.3800

hearing impaired tty 800.735.2922

IHSS Tool Box



REFERRALS TO PACE

What is PACE?

The program of All-inclusive Care for the Elderly (PACE) provides medical and social services to seniors 55 years of age and older who wish to continue living independently in their own home.

What are the PACE requirements?

In order to refer an applicant/recipient to PACE, he/she must be:

- 55 years of age or older
- Live in a designated zip code area

92101	92102
92103	92104
92105	92106
92107	92108
92109	92110
92111	92113
92114	92116
92115	92117
92118	92123
92133	92134
92135	92136
92140	92155

- Currently receiving Medi-cal, or potentially eligible to Medi-cal.
- Able to live independently with assistance, without jeopardizing their health or safety.

The Department of Health Care Services (DHCS) must determine if the client needs a nursing home level of care before a client can receive PACE services. PACE will complete the assessment and submit it to DHCS. PACE will make a referral to Medi-cal if the applicant/recipient does not have Medi-cal

What is the IHSS Social Worker responsibilities when referring IHSS clients to PACE?

If the IHSS Social Worker determines that the IHSS client is more appropriate for PACE, the social worker must:

1. Review the eligibility requirements for PACE to verify that the client meets the guidelines.
2. Explain the PACE program, and obtain the client's permission and release of information before making a referral to PACE.
3. Contact St. Paul's PACE Marketing Director, Amanda Dunkin to make the referral at 619-667-3800.
4. Coordinate service dates for active recipients to avoid any duplication of services, or a break in services.

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-13**

November 7, 2008

SUBJECT: Social Security Benefit Informational Flier

EFFECTIVE DATE: Immediately

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 that an informational flier on Social Security Benefit withholdings has been added to the IHSS Individual Provider (IP) packet. The Social Security flier will be placed on the reverse side of the 12-24 form to prevent the additional use of paper.

II. BACKGROUND

In order to clarify Social Security benefits and eligibility, a new flier has been added to the Initial Timesheet Packet that is sent to new IHSS IP's.

III. POLICY

All new individual providers will be sent standard information packets related to their employment as an IHSS Individual Provider with their initial timesheets.

IV. PROCEDURES

IHSS Clerical Responsibilities

The Senior Clerk for each IHSS district office will ensure that the Social Security Benefit informational flier is added to the reverse side of the 12-24 form in all of the IHSS IP packets.

Electronic copies of the attached forms can be accessed from the S drive. The path is:
S:\AIS\Operations\IHSS\Automated Forms\SW Forms or Clerical Forms

V. REVIEW STATEMENT

Because of 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.



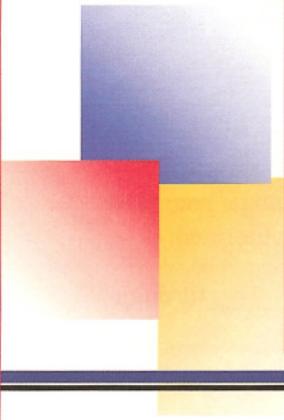
WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Gina Brown (858) 495-5545

Attachments
Distribution Codes 7 & 8



Information For IHSS Family Providers about: Social Security Benefits

Social Security Benefits

Family members providing In-Home Supportive Services (IHSS) to a relative may not be eligible for Social Security, Medicare, Federal Unemployment Tax (FUTA) withholding from their paycheck.

The following categories are not eligible for withholdings:

A spouse providing IHSS services to another spouse will not have withholdings from their paycheck for:

Social Security

Medicare

FUTA

A minor child (under the age of 21) providing IHSS services to a parent will not have withholdings from their paycheck for:

Social Security

Medicare

FUTA

A parent providing IHSS services to a minor child will not have withholdings from their paycheck for:

Social Security

Medicare

FUTA

**COUNTY OF SAN DIEGO-HEALTH AND HUMAN SERVICES AGENCY
IN-HOME SUPPORTIVE SERVICES
PROVIDER INSTRUCTIONS**

NUMBER OF HOURS

As a provider for IHSS, you are authorized to provide the services checked below. Arrange your daily work schedule with the recipient so that you do not exceed the maximum monthly hours authorized.

- You are authorized _____ prorated hours for the month of _____ beginning _____ through the end of the month.
- Monthly maximum hours: _____
- Please show all the hours worked on the timesheet.

SHARE-OF-COST

- The recipient does not have a share-of-cost.
- The recipient has a share-of-cost. You and the recipient will receive an "Explanation of IHSS Share-of-Cost" letter each pay period. The letter will indicate the amount that the recipient should pay you for the pay period. It is the responsibility of the recipient to pay the share-of-cost directly to you.

AUTHORIZED SERVICES

- Domestic services: Includes sweeping, vacuuming, picking up and dusting, washing floors, washing kitchen counters and sinks, cleaning oven and stove, cleaning and defrosting refrigerator, storing food and supplies, taking out the garbage, cleaning the bathroom, changing the bed, wheelchair upkeep, etc.
- Preparation of meals: Includes cutting food into bite-size pieces, pureeing food, reheating, etc
- Meal clean-up
- Routine laundry
- Shopping
- Other shopping and errands
- Respiration: Includes cleaning tubes and machines, assisting client with treatment
- Bowel and bladder care
- Feeding
- Routine bed baths/sponge bath
- Dressing: Includes putting on Ted hose, braces, artificial limbs
- Menstrual care
- Ambulation: Includes walking inside the home or pushing wheelchair
- Transfers: Includes moving in and out of bed, getting on and off seats & wheelchairs
- Bathing, oral hygiene and grooming
- Rubbing skin, repositioning, range of motion
- Care and assistance with prosthesis, reminding client to take medications, meds set up
- Accompaniment to medical appointments
- Protective supervision
- Paramedical services: Includes administration of insulin, g-tube feeding & cleaning, wound dressing, insertion of enemas, catheter, etc

IF YOU HAVE FURTHER QUESTIONS, PLEASE CONTACT THE CLIENT'S SOCIAL WORKER:

Social Worker Name	Worker Number	Telephone
Case Name	Case Number	Date
12-24 HHSA (06/07)		(06/09)

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-12**

October 17, 2008

**SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) 12-43A
NARRATIVE AND 12-42 WORKSHEET**

EFFECTIVE DATE: Immediately

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 that the automated Intake/Recertification Narrative form 12-43A and the IHSS Worksheet Form 12-42 have been revised.

II. BACKGROUND

As part of Quality Assurance Initiative, each county must develop standard procedures based on state program regulations for staff to carry out their functions. This includes county forms that will assist staff in doing their work accurately and efficiently.

The California Department of Social Services (CDSS) has implemented the provision of Senate Bill (SB) 1104 that calls for consistency in the authorization of IHSS services statewide. The Hourly Task Guideline (HTG) was developed in order for counties to uniformly assign time for task based on a time range.

III. POLICY

Eligibility determination must be documented by county social service staff at the time of application, at subsequent 12-month intervals, and when significant changes are reported affecting client's eligibility and authorized services. The documentation includes, but not limited to completion of required forms, and information gathered at the face-to-face interview.

County social service staff must determine the recipient's level of ability and dependence and evaluate the effects of the recipient's physical, emotional, and mental impairments on functioning. The authorized services must be based on the recipient's individual level of need to ensure health, safety, and independence. Social service staff must follow the

state time guidelines for a consistent and accurate assessment of the service needs and authorized time.

IV. CHANGES AND PROCEDURE

The revised 12-43A form (Attachment A) is now entitled Home Visit Narrative. The revised form will assist IHSS staff in documenting the intake, recertification, or reassessment interview. The revised form will be used by IHSS staff to document information on any home visit that involves an assessment of the client's needs.

The revised 12-43A form includes information that must be provided by the applicant/recipient and reviewed by the Social Worker before the IHSS case can be granted or recertified.

Step	Procedure
1.	All sections of the form must be completed and/or updated at every home visit.
2.	Additional information gathered during the interview must be written under the <i>Additional Notes</i> section of the form. Examples would include: <ul style="list-style-type: none"> • Assessment of need for Protective Supervision • Change in the service provider • Hospitalization • Reason for an increase or reduction in assessed needs

The revised 12-42 form (Attachment B) will help the Social Workers make an accurate and consistent assessment of the client's service needs. The revised 12-42 form now includes the functional index ranking on the H Line, the time range, and exceptions to the Hourly Task Guideline (HTG). The task range and the exception columns consist of drop down menus.

The Social Worker will follow the procedures below to document the recipient's functional ranking and assessed needs on the 12-42 worksheet:

Step	Procedure
1.	Assign the client a functional ranking under the H Line column.
2.	After computing the total need for each task, click on the arrow under the Range column and choose the range that corresponds to the total need on the worksheet
3.	If the functional ranking on the H Line and the Range columns are inconsistent, document the reason for the exception found on the drop down menu. <ul style="list-style-type: none"> ○ If the authorized time is outside the task range and there is no reasonable explanation for the exception, review the authorized time based on the client's need. ○ If the exception to the HTG is not listed in the options given, the SW must manually write the appropriate exception on the line opposite the task.
4.	Complete the justification column documenting the reason/need for each task

	authorized.
5.	Document the reason when hours are not needed for the task.

The Hourly Task Guidelines can be found in the State Manual of Policies and Procedures (MPP) Section 30-757, and the hierarchical five-point scale (rankings in MPP Section 30-756).

The revised automated forms are available on the S: drive. The path is:

S:\AIS\Operations\automated Forms\SW Forms.

Staff will begin using the revised versions of the automated 12-42 and 12-43A forms immediately at intake, recertification, and reassessment.

V. REVIEW STATEMENT

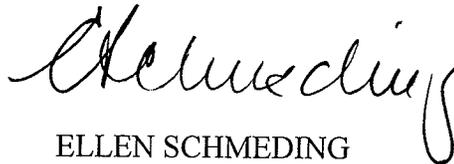
The revised 12-42 and 12-43A forms were reviewed by selected IHSS staff. This Special Notice was not reviewed by the standard review committee.

VI. FILING STATEMENT

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido at 858/505-6366

HOME VISIT NARRATIVE

CASE NAME:	CASE NUMBER:
DATE OF VISIT:	DATE OF FIRST CONTACT (Intake Only):

Medi-Cal Eligibility	<input checked="" type="checkbox"/> MEDS Print	<input type="checkbox"/> IHSS/Medi-Cal Communication
Documentation Reviewed (In File as Appropriate)	<input type="checkbox"/> Responsibility Checklist 12-58/A <input type="checkbox"/> Issuance of Civil Rights 20-44 <input type="checkbox"/> Emergency Back-up Plan SOC 827 <input type="checkbox"/> Other Document:	<input type="checkbox"/> Voter Registration <input type="checkbox"/> Language Determination Need 20-46 <input type="checkbox"/> Employment Eligibility Verification I-9
Services: <input type="checkbox"/> Authorized <input type="checkbox"/> Changed	<input type="checkbox"/> Domestic Services <input type="checkbox"/> Meal Preparation/Clean Up <input type="checkbox"/> Laundry <input type="checkbox"/> Shopping/Errands	<input type="checkbox"/> Personal Care <input type="checkbox"/> Medical Transportation <input type="checkbox"/> Paramedical Services <input type="checkbox"/> Protective Supervision

Purpose of HV:	<input type="checkbox"/> Intake <input type="checkbox"/> Renewal <input type="checkbox"/> Reassessment	<input type="checkbox"/> Protective Supervision <input type="checkbox"/> Paramedical
Location;	<input type="checkbox"/> Home <input type="checkbox"/> Hospital	<input type="checkbox"/> Other (Specify)
Participants Present:	<input type="checkbox"/> Client <input type="checkbox"/> Spouse: <input type="checkbox"/> Social Worker:	<input type="checkbox"/> HH Members: <input type="checkbox"/> Other: (Specify)
Age of client:		
Medical Diagnosis:		
Functional Limitations/ Observations:		
Alternative Resources?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (Specify below)
Health/Safety Hazards	<input type="checkbox"/> No	<input type="checkbox"/> Yes (Specify below)
Is client at risk without IHSS?	<input type="checkbox"/> No (Specify below)	<input type="checkbox"/> Yes (Specify below)
ADDITIONAL NOTES		

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-11**

September 12, 2008

SUBJECT: Elective State Disability Insurance Coverage

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 information on the application process for State Disability Insurance (SDI) coverage.

II. BACKGROUND

The Internal Revenue Service (IRS) tax code states that Individual Providers (IPs) are not automatically eligible for SDI coverage, and that SDI is not mandatory, it is elective.

Most California employees are covered by SDI; however, those who are providing IHSS services to family members may elect to participate in the SDI program by applying for Elective State Disability Insurance. Family members refer to a recipient's spouse, parent, or child (includes adopted but not a stepchild or foster child) under the age of 18. Family member provider participants may apply for State Disability Insurance benefits if they become disabled and are prevented from providing services to IHSS recipients.

III. POLICY

If a spouse, parent or child providing IHSS to a relative elects to have SDI coverage withheld from his/her paycheck, it must be requested in writing.

IV. PROCEDURES

Individual Provider Responsibilities

If a family member IP elects to have SDI Coverage withheld from his/her pay check, he/she must follow the instructions below:

- Both the IHSS recipient and the family member IP must *voluntarily agree* to the terms of the elective SDI Coverage. Please see the Elective SDI Form, SOC 409 (Attachment A).
- The IP or recipient must request the SOC 409 form from the recipient's IHSS Social Worker.

- The form must be completed and signed by both the IHSS recipient, and the family member IP.
- The completed form must be returned to the IHSS Social Worker.

Note:

Eligibility for elective SDI coverage does not start with the beginning date of employment. A minimum of 7 months must elapse from the beginning date of coverage, before a valid claim may be filed based solely on reportable wages under the elected coverage.

Social Worker Responsibilities

The IHSS Social Worker is responsible for:

- Providing information on SDI to the IP.
- Sending the SOC 409 form to the IP or recipient with a return envelope upon request.
- After the SOC 409 form is received the IHSS Social Worker will file a copy in the IHSS case folder.
- The IHSS Social Worker will forward the original SOC 409 to the Provider Services Specialist, Shantel Martin, at Mail Stop W-256,

Provider Services Specialist Processing

- Once the Provider Services Specialist has received the SOC 409 form, she/he will update the provider eligibility (PELG) screen under the SDI beginning date section.
- The Provider Services Specialist maintains the file containing the original, completed SOC 409.

V. REVIEW STATEMENT

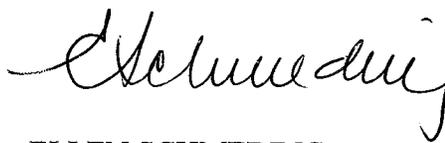
Because of the informational nature of this Special Notice it was not reviewed by the standard review committee.

VI. FILING STATEMENT

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Gina Brown (858) 495-5545

Attachments
Distribution Codes 7 & 8

IHSS/CMIPS ELECTIVE STATE DISABILITY INSURANCE (SDI) FORM

This form is for elective State Disability Insurance Coverage (Unemployment Insurance Code Section 702.5) and is only for family member providers, who receive their paychecks from the State Controller's Office. **An eligible family member is the recipient's spouse, parent, or a child (includes adopted but not a stepchild or fosterchild) under the age of 18.** This Disability Insurance is not compulsory, and, by electing to be covered, the recipient and his/her family member provider agree to have State Disability Insurance premiums deducted from the family member provider's paychecks. Do not complete this form unless both the recipient/employer and the provider/employee wish to have the provider's services voluntarily covered for Disability Insurance under the provisions of Section 702.5 of the Code.

TO BE COMPLETED AND SIGNED BY THE RECIPIENT/EMPLOYER

RECIPIENT NAME		SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ()
STREET ADDRESS	CITY	STATE	ZIP CODE

I, the undersigned, certify that the statements made in this application are true and correct to my best knowledge and belief. I hereby elect and make application to have the exempt family services considered as employment subject to the Unemployment Insurance Code for disability insurance only. **THE ELECTIVE AGREEMENT IS TO BE IN EFFECT FOR AT LEAST TWO COMPLETE CALENDAR YEARS OR UNTIL TERMINATION OF THE PROVIDER SERVICES.** The elective agreement may be terminated by filing a request for termination by January 31 of any year following two complete years of elective coverage.

RECIPIENT/EMPLOYER SIGNATURE	DATE
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TO BE COMPLETED AND SIGNED BY THE PROVIDER/FAMILY MEMBER

PROVIDER NAME		SOCIAL SECURITY NUMBER	COUNTY USE ONLY	
STREET ADDRESS	CITY	STATE	ZIP CODE	RECIPIENT CASE NUMBER
TELEPHONE NUMBER ()	RELATIONSHIP TO RECIPIENT (IF CHILD PLEASE CIRCLE) NATURAL ADOPTED (STEPCHILD OR FOSTERCHILD NOT ELIGIBLE)		DATE OF BIRTH	
1. Is the employment intended to be continuing and not intermittent or seasonal in nature? <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Are you able to perform normal and customary provider services with IHSS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Deductions for elective SDI will begin with your next warrant.				
I elect to be covered by State Disability Insurance and agree to have the contributions for this insurance deducted from my paychecks.				
SIGNATURE OF PROVIDER			DATE	
COMMENTS				

Note: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions of UI Code Sections 631, 702.5, 704 and 707.

ELIGIBILITY FOR DISABILITY INSURANCE BENEFITS UNDER THE CODE DOES NOT BEGIN WITH THE COMMENCEMENT DATE OF COVERAGE. GENERALLY, A MINIMUM OF 7 MONTHS MUST ELAPSE FROM THE COMMENCEMENT DATE OF COVERAGE BEFORE A VALID CLAIM MAY BE FILED BASED SOLELY ON WAGES REPORTABLE UNDER YOUR ELECTION.

Also note: Domestic services are not subject to Personal Income Tax Withholding, however, if a recipient and provider voluntarily agree, income tax can be withheld.

Wages and Contributions - Section 702.5: Contributions to be paid for 'Family Employment' elective coverage are to be based upon actual wages paid to covered family members for services performed up to a maximum wage limitation for the year for each family member. There is no provision in this section to permit the contributions to be based on other than actual wages paid. The amount of any disability benefits paid will also be determined on the basis of wages paid.

Social Security Number Disclosure: The disclosure of your Social Security Account Number is mandatory under the Federal Tax Reform Act of 1976. The number will be used for identification purposes and will be available only to authorized personnel within the Employment Development Department and other government agencies as permitted in Sections 322 and 1095 of the California Unemployment Insurance Code.

TERMINATION OF ELECTIVE SDI

Only the Recipient/Employer can apply to have elective SDI coverage stopped for his/her provider.
 Elective SDI coverage can only be terminated during January after two complete years of elective coverage or upon terminating employment.
 I request termination of elective SDI coverage for my provider.

SIGNATURE OF RECIPIENT	DATE
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**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-10**

July 23, 2008

SUBJECT: In-Home Supportive Services (IHSS) Overpayment Processing Procedures

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

**REFERENCE: Welfare and Institution Code (WIC) Section 12305.8
Welfare and Institution Code (WIC) Sections 12305.81-.83**

I. PURPOSE

The purpose of this Special Notice is to provide instructions to IHSS and IHSS Public Authority (PA) staff on the processing of overpayment referrals.

II. BACKGROUND

An overpayment is defined as “the amount paid by the Department of Health Care Services (DHCS) to a provider or recipient, which is in excess of the amount of services authorized or furnished.” (WIC Section 12305.8) An overpayment occurs when the IHSS recipient receives services for which he/she is not eligible, or when the Individual Provider (IP) is paid for services he/she did not perform.

III. POLICY

The State of California mandates that In-Home Supportive Services (IHSS) identify, define, and develop policies and procedures under which overpayments to IHSS are identified and recovered. If it is determined that an overpayment has occurred, IHSS is required to take the appropriate actions to recover the overpayment. All overpayments, except those that have resulted in an overpayment to a PCSP or IPW (IHSS Plus Waiver) recipient through an administrative error, must be collected. Suspected IHSS fraud is referred to the San Diego County District Attorney’s Public Assistance Fraud Division (PAFD) for investigation.

IV. PROCEDURE

IHSS Overpayment Specialist Responsibilities

A. Calculating the Overpayment

Step	Procedure
1.	Create an Overpayment Folder.
2.	Review the Overpayment Referral and any attached information for completeness.
3.	If the information is incomplete, call or e-mail the Social Worker (SW) to obtain the necessary information.
4.	If the overpayment is marked as fraud, check for the Social Work Supervisor's initials before processing. If the Supervisor's initials are missing, return the referral to the SW to obtain the needed information.
5.	Review the CMIPS records and make a print of each of the following screens as necessary: PSUM, RELA, RELB, RELC, and PELG.
6.	Obtain the correct warrant information on the pay periods in question from the WARD screen.
7.	Print the WARD screen as needed.
8.	Use the WARR screen to go to the WARD screen. Type an X before the pay period(s) where the overpayment occurred.
9.	Complete the automated 12-62A HHSA (Overpayment Calculation Worksheet). (Attachment A)
10.	When calculating the overpayment, remember to use the correct hourly wage rate for the overpayment period, and to ensure that the hours have been prorated correctly.
11.	When calculating the deductions from the overpayment, subtract from the gross amount: <ul style="list-style-type: none"> • Federal Insurance Contribution Act Tax (FICA) • MEDICARE • State Disability Insurance (SDI) Note: Union dues, share-of-cost (SOC), levy, and state and federal taxes are entered on the Overpayment Worksheet but are not used as deductions.

B. Completing the Overpayment Notification

Step	Procedure
1.	Transfer the summary of information from the automated Overpayment Worksheet to the 12-86 HHSA form.
2.	If the overpayment was made to the recipient: <ul style="list-style-type: none"> • Use form 12-86 CL HHSA, or 12-86 CL HHSA Spanish. • Complete the <i>Client Information</i> section. • Indicate only the last 4 digits of the client's Social Security number. The first 5 numbers should be X. • Send the original copy to the recipient or his/her authorized representative. • Send a duplicate copy to the Social Worker.

3.	If the overpayment was made to the provider: <ul style="list-style-type: none"> • Use form 12-86 IP HHSA, or 12-86 IP HHSA Spanish • Complete the <i>Provider Information and the Client Information</i> sections. • Indicate only the last four digits of the provider's and the client's Social Security number. The first five numbers should be x. • Send the original to the provider. • Send a duplicate copy to the Social Worker.
4.	Send a copy of the 12-86 CL HHSA or 12-86 IP HHSA to Revenue and Recovery.
5.	Retain a copy of the 12-86 CL HHSA or 12-86 IP HHSA in the Overpayment Folder.
6.	The copy sent to Revenue and Recovery, and the one in the Overpayment Folder file should indicate a complete Social Security number.
7.	Record the information on the automated 12-62B HHSA Overpayment Activity Log (Revenue and Recovery) for overpayments sent to Revenue and Recovery. (Attachment B)

C. Tracking and Recording Case Information

Step	Procedure
1.	For tracking purposes, record the fraud referrals sent to the PAFD for fraud investigation on the automated 12-50B PAFD Fraud Referrals Quarterly Report. (Attachment C)
2.	Send the fraud referral packet(s) to PAFD with a cover letter listing the name(s) of the person(s) suspected of fraud.
3.	Retain a copy of the referral packet sent to PAFD in the PAFD Referral Folder and file it in the designated case drawer.
4.	Send a copy of the cover letter listing the name(s) of the person(s) suspected of fraud to the following: <ul style="list-style-type: none"> • The AIS Assistant Deputy Director for Operations • The Department of Health Services • The IHSS Clerical Supervisor
5.	File a copy of the cover letter to PAFD in the binder labeled Fraud Referrals.
6.	Submit a monthly report (Attachment D) on the number of fraud referrals and overpayments that were received and processed, to the IHSS Operations Manager the first of every month.
7.	Record the fraud referral information on the automated 12-50A HHSA (PAFD Referral Log) sent to PAFD. (Attachment E)
8.	Send the completed 12-50A HHSA and 12-50B HHSA to the IHSS Program Manager and the IHSS Operations Manager every quarter. (Every quarter refers to the tenth (10 th) day of January, April, July, and October.)
9.	When the PAFD disposition is received and marked: Referred for Collection , or Fraud Found : <ul style="list-style-type: none"> • Process an overpayment calculation using the information in the PAFD report and the referral packet. • Complete form 12-86 CL HHSA or 12-86 IP HHSA to send to the recipient/provider, Social Worker, and Revenue and Recovery.

10.	When the PAFD disposition is received and marked: Returned, Rejected, or Allegation Unfounded , process an overpayment calculation <i>only</i> if instructed by the IHSS Program Manager.
11.	Use the information sent by PAFD to update the case status of the fraud referrals, and to obtain the statistics of pending and completed overpayments on the PAFD Referral Log.
12.	Submit the Overpayment Pending Report to the IHSS Program Manager and the AIS Assistant Deputy Director for Operations on a quarterly basis.
13.	If a PCSP eligible provider requests a supervisory review of the overpayment, send the written request with the overpayment documents to the AIS Planning and Program Support Manager at mail stop W-433.
14.	<p>If the overpayment is reversed, or if it must be recalculated:</p> <ul style="list-style-type: none"> • Complete a revised Overpayment Calculation Worksheet using the updated information. • If the overpayment is revised, type the following information on the upper center of the original 12-86 IP HHSA: <i>This is a Revision to the original Notice of Action dated _____ per _____ (Supervisory Review, Appeals, etc). Revised mo/day/year.</i> • If the overpayment is rescinded, type the following information on the upper center of the original 12-86 IP HHSA: <i>Note: Per _____ (Supervisory Review, Appeals, etc.) Rescind \$000.00 Overpayment</i> <i>By: _____</i> <i>IHSS Program Manager</i> <i>Date: _____</i> • Send the revised 12-86 IP HHSA to the provider, the Social Worker, and Revenue and Recovery. • Retain a copy of the 12-86 IP HHSA in the Overpayment Folder.

D. Processing Overpayment Recovery

Step	Procedure
1.	After receiving the monthly IHSS Overpayment Collection Summary Report from AIS Fiscal (Attachment F), the Overpayment Specialist must complete SOC 312 (Attachment G) for each payee listed on the report.
2.	Enter the payments made by the payees on the 12-62C HHSA (IHSS Overpayment Collection Summary Report). (Attachment H)
3.	Send all completed SOC 312 to the AIS Fiscal Accountant in charge of the overpayment at mail stop W433.
4.	<p>When payments are received for cases that are <u>not in collection</u>, send the following to the AIS Fiscal Accountant in charge of the overpayment for deposit at mail stop W433:</p> <ul style="list-style-type: none"> • Check • Back up documents • Completed SOC 312
5.	When the overpayment is adjusted or rescinded, send an e-mail to Revenue and Recovery to update the account record.

E. Processing Referrals from the Fraud Hotline

Step	Procedure
1.	When a fraud referral is received through the fraud hotline at 1-800-421-2252 , use the RELB screen or the SOC 311 to identify the Social Worker assigned to the case.
2.	Print the PELG, RELA, RELB, RELC, and the PSUM screens.
3.	Combine the CMIPS screen prints and the hotline fraud referral and forward them to the assigned Social Work Supervisor.
4.	The Social Work Supervisor will: <ul style="list-style-type: none">• Review the hotline fraud referral.• Forward the CMIPS screen prints and the hotline fraud referral to the assigned Social Worker with instructions to review the inconsistent information indicated in the referral.
5.	After contacting the recipient or the provider, the Social Worker will <i>either</i> make a case review referral to IHSS Quality Control <i>or</i> a fraud referral to PAFD. (Note: Refer to Special Notice 07-09 Updated Fraud/Overpayment Procedures for detailed procedures on fraud referral to PAFD.)

V. AIS FISCAL

AIS Fiscal is primarily responsible for remitting overpayments on IHSS cases to the State of California. AIS Fiscal works with the IHSS Overpayment Specialist in ensuring that supporting documents for IHSS overpayments are properly completed and account payments are accurately recorded.

VI. FILING STATEMENT

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

VII. REVIEW STATEMENT

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

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

PAFD FRAUD REFERRALS 2008		
	Month	
RECEIVED		
LEFT IN BOX		
PENDING PROCESS		
TOTAL		
OVERPAYMENTS 2008		
	Month	
RECEIVED		
LEFT IN BOX		
PENDING PROCESS		
TOTAL		

**IN-HOME SUPPORTIVE SERVICES
SPECIAL PRE-AUTHORIZED
TRANSACTIONS**

RECIPIENT

1. NUMBER		
COUNTY	CASE NUMBER	CHECK DIGIT

PROVIDER

2. NUMBER

1 - SUPPLEMENT/ EMERGENCY

3. TYPE		4. REASON		5. NOA		REASON		CODES											
				M C N															
6. FROM DATE				7. TO DATE				8. GROSS		9. HOURS	10. RATE	11. SHARE/COST							
M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y				

2 - REPLACEMENT

12. TYPE		13. REASON								
14. WARRANT#	15. WARRANT DATE				16. NET AMOUNT					
	M	M	D	D	Y	Y	Y	Y		

3 - VOID WARRANT

17. TYPE		18. REASON								
19. WARRANT#	20. WARRANT DATE				21. NET AMOUNT					
	M	M	D	D	Y	Y	Y	Y		

4 - ADJUSTMENT

22. TYPE		23. REASON		24. FROM DATE				25. TO DATE											
				M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y
26. WARRANT#	27. PAY PERIOD				28. GROSS AMOUNT		29. F.I.C.A.		30. MED										
	M	M	D	D	Y	Y	Y	Y											
31. SDI	32. FED		33. STATE		34. EIC		35. SOC		36. NET	37. HOURS									

AUTHORIZED BY

38. NUMBER

FORCE ACCEPT? 39.

PAYEE

40. NAME

COUNTY VALIDATION		
41. AUTHORIZATION	42. DATE	43. REMARKS
44. VALIDATION	45. DATE	46. REMARKS

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-09**

July 1, 2008

SUBJECT: IHSS QUALITY CONTROL PROCEDURES

EFFECTIVE DATE: July 1, 2008

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 instructions for new Quality Control (QC) procedures and an explanation of revised QC forms.

II. BACKGROUND

The California Department of Social Services (CDSS) promotes consistent application of policies and procedures statewide through annual CDSS Quality Assurance (QA) reviews. Mandatory QA reviews are also conducted by designated San Diego County QC staff to comply with state regulations requiring ongoing quality assurance activities. The rapid growth of the IHSS program has increased the need for streamlining the QC review process. Internal procedures and forms have been updated to simplify the processing of QC paperwork.

III. POLICY

The QA initiative requires that QC/QA workers conduct a specified number of desk reviews and home visits yearly for each allotted staff position. The completed reviews will aid in identifying trends, training needs, and potential fraud, as well as ensuring compliance with program regulations. The revised procedure and forms will become effective July 1, 2008.

IV. ASSIGNING CASES FOR QC REVIEW

The Planning & Program Support Manager or the IHSS Program Specialist is responsible for setting up and assigning case reviews monthly.

STEP	QC SUPERVISOR
1.	<ul style="list-style-type: none">• By the first of each month the QC Supervisor (or lead worker) will assign each QC Social Worker a list of case reviews.• If cases are assigned by the lead worker, a Program Specialist will assign the cases for the lead worker. The lead worker will not assign his/her own cases.• Every case that is assigned with the QC Automated Tool will be given an identification/review number for tracking purposes.

1. cont.	<ul style="list-style-type: none"> • Each SW will be assigned 10 cases for field reviews, 15 cases for phone reviews, and a minimum of 30 cases for targeted reviews monthly. • One denied case per worker, in the unit being reviewed, will be included in the review process. <ul style="list-style-type: none"> a) A field review requires that the SW complete a “cover to cover” review of the case file. In addition, the SW will conduct a home visit with the client using a QC interview guide to document the results. The QC SW will also attempt to interview the care provider. b) A phone review requires a “cover to cover” review of the case file and completion of an interview using a standardized telephone script. c) A targeted review will identify a single, specific item for review, requiring the completion of a specialized log. The subject of the targeted reviews will vary, based on program needs, identified trends and/or findings from desk reviews. d) A standard form listing correct denial procedures is used to review denied cases. • If the QC process cannot be completed (e.g., a client does not respond to request for contact) the QC Social Worker will receive credit for a ‘desk only’ review. • Reviews will not be assigned for a case in the month that the re-assessment is due, or in the month after the re-cert is due. • All reviews are to be completed by the QC SW by the last day of the month. <p>The QC Supervisor/lead worker will use the QC Automated Tool or other method to randomly select cases for the review month. The reviews will be rotated by district offices and Social Workers as follows.</p>
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QC District Review Cycle FY 2008-09				
DISTRICTS	MONTH Q1	MONTH Q2	MONTH Q3	MONTH Q4
SS10-DIST. 01 (9) SS20-DIST. 02 (9) SS50-DIST. 13 (4) SS70-DIST. 04 (9) 30	JULY	OCT.	JAN.	APR.
CS10-DIST. 08 (8) ES30-DIST. 05 (9) SS60-DIST. 03 (9) KS30-DIST. 06(6+) KS3N 2X YEARLY 32	AUG.	NOV.	FEB.	MAY
LS10-DIST. 10 (9) LS70-DIST. 04 (9) CS40-DIST. 07 (9) CS50-DIST. 11 (9) 30	SEPT.	DEC.	MAR.	JUNE

V. THE QC REVIEW PROCESS

The review of the case file will be conducted at the district office. A specific issue may require that a case be reviewed by the IHSS Program Specialist. When necessary, the case will be requested from the district office and sent to QC/Program Support at Aging & Independence Services (AIS) administrative office at mail stop W-433.

STEP	QC SOCIAL WORKER
2.	<ul style="list-style-type: none"> • At least five days prior to conducting the case reviews in the district office, the QC worker will email the Social Work Supervisor (SWS) a list of the cases to be reviewed in his/her unit. • If the case is unavailable (e.g. the case is closed, a renewal is due, the case is in leave status, in appeals, or transferred) the QC worker will be assigned, or randomly select a different case to review from the same worker. • If prior notice is received from the SWS, a new case will be assigned using the QC tool. • If no prior notice is received, the QC worker will use the “count five” method to randomly select another case to review. • For each QC field and phone review assigned, the designated QC worker will review the case file cover to cover, using a standard review guide to document the review. • Photocopies of documents in the case file will be limited to the minimum needed to document the review outcomes.
3.	<ul style="list-style-type: none"> • A contact letter or a phone call will be made to each client on the field and phone review list. • A full field visit or a full phone interview with each client (or designated representative) will be completed by the QC worker.
4.	<p>A written summary will be completed for each case reviewed. (<i>Attachment A</i>) The completed summaries will be archived in the QC folder on the S: drive. The QC worker will then email a copy of the summary to the QC Supervisor.</p> <ul style="list-style-type: none"> • The summary will include recommendations for appropriate actions, or corrections to forms and computer turn-around documents. • The district Social Worker will have 45 days to make corrections and respond to the QC review summary. • The Social Work Supervisor may submit a written disagreement with the QC findings within the 45 day period.

The QC Supervisor is responsible for logging/tracking completion of the QC review assignments and sending the review summaries to the Social Work Supervisors and other designated AIS staff.

STEP	QC SUPERVISOR
5.	The QC Supervisor will enter the QC reviews in the QC log as the reviews are completed. The log will be used to track the number of reviews, the type of review,

5. Cont.	and the review status for the completion of the SOC 824 <i>IHSS Quarterly State Report on Quality Assurance/Quality Improvement</i> . The log will also be used to track “findings” and other statistical information.
6.	<p>The completed form(s) for each unit’s QC review (<i>Attachment A</i>) will be emailed by the QC Supervisor directly to the Social Work Supervisor, with copies to:</p> <ul style="list-style-type: none"> • The IHSS Program Specialist • The AIS Administrative Secretary (Cindy Vogel) • The Planning & Program Support Manager • The IHSS Program Manager • The IHSS Operations Manager <p>All reviews are to be completed by the QC worker and then sent electronically to the QC Supervisor. All reviews for the unit for that month, will be sent to the Social Work Supervisor at the same time (not as completed) to make tracking easier.</p>

The AIS Administrative Secretary or designated AIS clerical staff will track the QC review summaries for timely return.

STEP	AIS CLERICAL
7.	<p>After receiving the monthly reviews by email from the QC Worker, the case reviews will be tracked on an automated log that includes:</p> <ul style="list-style-type: none"> • The client name. • The review number. • The date the summary was sent to the district Social Work Supervisor. • The date the completed coversheet was returned. • Any additional information needed for tracking/statistical purposes.
8.	<p>A reminder will be sent monthly to the IHSS Social Work Supervisors listing any reviews that are past the 45 day response period. The reminders will be copied to:</p> <ul style="list-style-type: none"> • The IHSS Program Specialist • The AIS Administrative Secretary (Cindy Vogel) • The Planning & Program Support Manager • The IHSS Program Manager • The IHSS Operations Manager

The IHSS Social Worker is responsible for reviewing the summary and making any necessary corrections or updates.

STEP	IHSS SOCIAL WORKER
9.	<p>The Social Worker will review each item on the QC Review Summary, make corrections as needed, and check the “corrections completed” box on the review summary coversheet. The Social Worker will:</p> <ul style="list-style-type: none"> • Print a complete copy of the QC review summary for the case file. • Sign the QC Review Summary on the indicated line. • Complete an appropriate narrative entry. • Submit the signed summary along with the case file, to the Social Work Supervisor for review and sign off.

9. Cont.	<ul style="list-style-type: none"> • A written disagreement may be submitted to the QC worker with the Social Work Supervisor's approval. • The form "Social Worker Response to IHSS Quality Control Review" will be available on the S drive at: S:\AIS\Operations\IHSS\Automated Forms\SWS Forms
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The Social Work Supervisor is responsible for ensuring that the QC Review Summaries are completed and returned within the 45 day time frame.

STEP	SOCIAL WORK SUPERVISOR PROCEDURE
10.	<p>Each Social Work Supervisor will forward the individual reviews to the Social Worker electronically, or provide him/her with a printed copy. The Social Work Supervisor will provide instructions to the worker on when to return the completed summary to the supervisor, along with the case file for review.</p> <p>The Social Work Supervisor is responsible for:</p> <ul style="list-style-type: none"> • Reviewing the QC summary, the corrections, and the response by the Social Worker. • Signing off on the completed narrative. • Signing the coversheet. • Submitting a written disagreement on the form "IHSS QC Review Response" (<i>Attachment B</i>) if appropriate. • Forwarding any disagreements directly to the assigned QC Social Worker. • Ensuring that a complete copy of the QC Review Summary is filed permanently under the QC Tab in the case folder. • Returning a copy of <u>the first page only</u> of the QC Review Summary to Program Support Administrative Secretary Cindy Vogel at MS W433.

The QC Worker is responsible for responding to the Social Work Supervisor when an "IHSS QC Review Response" form is received.

STEP	QC RESPONSE TO DISAGREEMENTS
11.	<ul style="list-style-type: none"> • The QC Worker will respond to the Social Work Supervisor about the item(s) listed on the "Social Worker Response to IHSS Quality Control Review" form within 10 days. • If further policy clarification is needed the time frame may be extended to research the issue. • If QC has adequately shown that IHSS Policy and Procedure supports the item in question, the Social Worker will need to make the correction immediately upon return of the "Quality Control Response to Social Worker" (<i>Attachment B</i>) form.

STEP	ARCHIVING
12.	<p>AIS Clerical will enter the return date of the case review responses from the Social Work Supervisor on the electronic log. At the beginning of each month starting August 1, 2008, scan the signed coversheets received in the previous calendar month and email to:</p>

	<ul style="list-style-type: none"> • The Planning and Program Support Manager • The IHSS Program Manager • The IHSS Operations Manager <p>Planning and Program Support will archive the responses electronically in the designated QC folder.</p>
--	--

VI. CHANGES AND ADDITIONS

The QC unit will no longer accept “fraud” referrals. A review of problematic cases can still be requested by the Social Worker/Supervisor to:

- Provide additional documentation for a possible appeal.
- Review/Calculate a possible over/underpayment.
- To provide additional documentation for a PAFD fraud referral.
- Other appropriate situations as discussed and agreed on by the Social Work Supervisor and the QC Supervisor/Manager.

The case will be added to a review list, a home visit conducted and a written response sent to the Supervisor. QC will also focus on special projects, e.g. caseload reconciliations, closed case reviews, and other assignments as identified by IHSS administration.

Effective immediately, the Quality Control unit will be assigned to review the Quarterly Death Match reports. These cases will be used as routine desk reviews.

VII. REVIEW STATEMENT

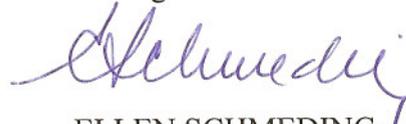
This Special Notice has been reviewed by IHSS and QC management and staff.

VIII. FILING STATEMENT

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Mary Harrison (858) 505-6952
Claire Sonnabaum Quality Control

Attachments
Distribution Codes 7 & 8



AGING & INDEPENDENCE SERVICES

COUNTY OF SAN DIEGO ■ HEALTH AND HUMAN SERVICES AGENCY

In-Home Supportive Services Quality Control Review Summary

Review #: _____

District: _____ Social Worker: _____ Mailstop: _____

Unless otherwise indicated, corrections need to be made immediately.
 Program Operation Response due to W433, Quality Control within 45 days of the date received.
 DO NOT RETURN, NO RESPONSE NECESSARY

Recipient/Provider Information

Case Name (last, first):	Aid Code/Case #:
Companion Case (last, first):	
Provider Name (last, first):	Provider #:
<input type="checkbox"/> PCSP <input type="checkbox"/> IPW <input type="checkbox"/> IHSS-R	Monthly Hours:

QC Results

Sample Month:	Review Month:
Type of Review: <input type="checkbox"/> Desk <input type="checkbox"/> Phone <input type="checkbox"/> Field	Reviewed By QCA #: TS05 QC SUP:
Primary Findings: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Results: <input type="checkbox"/> Action Items <input type="checkbox"/> Technical Errors <input type="checkbox"/> Info Items <input type="checkbox"/> Good Job	
Type(s) Of Findings:	<input type="checkbox"/> Overpayment <input type="checkbox"/> Underpayment
<input type="checkbox"/> Possible Fraud <input type="checkbox"/> Critical Incident	Hrs. _____ \$ _____
	<input type="checkbox"/> Ineligible <input type="checkbox"/> Procedural

QC Comments: _____

District Response/Action Taken:

- All corrections completed.
- Social Work Supervisor disagrees with one or more action items or findings.
A Supervisor Response form must be completed and returned with the QC Summary cover sheet.

Updates Completed By:

Social Worker: _____ Date: _____

Updates and Case File Reviewed By:

Social Work Supervisor: _____ Date: _____

Sign and return this page only to: MS W-433 Attention AIS Supervising Clerk. A copy must be filed in the QC folder along with the remaining pages of the summary and any Supervisor Response forms submitted.

CASE NAME:

CASE NUMBER:

Primary Finding: YES NO

Overpayment **Underpayment**

Definition:

An incorrect amount has been paid out for services as a result of the following:

1. A data entry or mathematical error
2. The provider/client has been collecting payment for services not rendered
3. Increase or decrease in number of days worked
4. An unreported hospitalization or absence from home
5. An unreported change in household composition
6. Client is ineligible
7. Other

Critical Incident

Definition:

The health and safety of the recipient is at risk due to inadequate service delivery or the current level of need requires immediate attention to resolve.

Ineligible

Definition:

The recipient does not meet the financial, safety/health or other required criteria to be eligible for IHSS services. IHSS regulations and policy are either not applied or are applied incorrectly, resulting in the authorization of services to persons not eligible for IHSS.

Procedural

Definition:

The recipient's eligibility is not documented in the case record, but Quality Control can verify the recipient's eligibility.

Possible Fraud

Definition:

The recipient and/or the recipient's representatives, the agency or both recipient and agency provide false information to qualify the case for IHSS. Possible fraud is considered when recipients willingly fail to provide correct information or report changes. Possible fraud is also considered when a provider knowingly accepts payment for services which are not being provided.

Explanation:

CASE NAME:

CASE NUMBER:

OTHER RESULTS:

YES

NO

Action Items

Definition:

The case does not reflect the current situation, and the case needs to be and can be corrected. This includes service changes and mandatory paperwork.

1. Missing forms
2. Missing documentation
3. Unreported change in need
4. Incorrect or incomplete information on the 293 or 311
5. Other

Technical Errors

Definition:

This is information that Quality Control discovers in the course of the review that does not affect eligibility or service but is incorrect or incomplete.

Incomplete Paperwork

Other

Information Items

Definition:

This is information that Quality Control discovers in the course of the review that does not affect eligibility or service. It is provided to the Social Worker to be used at the SW's discretion. A response to QC is not required.

Best Practice:

Case review completed by Perla Delgado TS05

Social Worker Response to IHSS Quality Control Review

Date: _____

To: _____
QC Worker

From: _____
IHSS Supervisor

Client: _____

Case Number: _____

Review Number: _____

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

District Office: _____ IHSS Supervisor: _____ IHSS Social Worker: _____

Social Worker Response: _____

Quality Control Response to Social Worker

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

Quality Control Response: _____

IHSS QC REVIEW REQUEST

Social Worker Name	Social Worker Number	Phone Number	Mailstop

Client Name: _____ Case Number: _____

Address: _____ City: _____ ZIP: _____

Provider Name: _____

Primary reason that a QC review is being requested: _____

SUPERVISOR: _____

DATE: _____

QC Worker Name	QC Worker Number	Phone Number

QC Worker Response: _____

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

June 13, 2008

SUBJECT: WORKING WITH FACE-TO-FACE DATES AND REPORTS

EFFECTIVE DATE: July 1, 2008

EXPIRATION DATE: When incorporated into the IHSS Program Guide

**REFERENCE: CALIFORNIA DEPARTMENT OF SOCIAL SERVICES (CDSS)
POLICY & PROCEDURE MANUAL 30-761.21 to .214**

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff of upcoming changes in IHSS procedures for processing annual renewals.

II. BACKGROUND

As part of the State Quality Assurance Initiative, the California Department of Social Services (CDSS) updated regulations that determine the date that the annual IHSS renewal is due. The date of the face-to-face (FTF) needs assessment is currently the basis in determining if an annual renewal is overdue. CDSS regulations require that no more than 10% of a county's IHSS caseload be overdue during a 12-month period. Overdue status is based on the date of the previous FTF reassessment.

III. POLICY

IHSS Social Workers are required to complete a FTF visit with the IHSS recipient in the recipient's home, and to perform a needs assessment for IHSS within twelve months of the previous face-to-face date. Cases that meet the criteria for an 18 month variable reassessment are exempted. The needs assessment must be performed *prior* to the end of the month in which the previous FTF was completed. E.g. previous FTF was 5/1/07; the renewal must be completed by 5/31/08.

IV. DEFINITIONS

Reassessment – The process of re-determining the recipient's needs for IHSS services. It may occur anytime within the twelfth month certification period. A reassessment is completed as a result of a reported change in the recipient's living situation and/or medical condition. E.g. change in household composition, change in medical condition, or a change in the number of medical appointments.

**IHSS Special Notice 08-08
Working with Face-to-Face Dates and Reports**

VI. REVIEW STATEMENT

This Special Notice has been reviewed by the standard review committee.

VII. FILING STATEMENT

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

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

ATTACHMENT A

New Application: Face-to-face occurs in the same month of the application

The application is dated April 15, 2008, and the initial FTF assessment is April 22, 2008. The SW may complete the renewal anytime prior to April 30, 2009.

- Face-to-face date on Line P, field 3 is *04/22/2008*.
- Beginning date on Line ZZ, field 3 is *04/15/2008*; or, as determined by the Social Worker.
- Ending date on Line ZZ, field 4 is *04/30/2009*.

ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
M	D								
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
N	D								
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
O	D								
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
(1) 04152008	(2)	(3) 4/22/08	(4)

D/O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

ZZ	MOR	DENL CD	RSN CD	RSN CD	RSN CD	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW
	M	N				(3) 4/15/08	(4) 4/30/09	IN Y N	R Y N
RR	MONTHLY WORKY HRS	MEAL HRS (DD-HH-CC)	MO. HRS	TOTAL	TWICE-MAL	UNET NEED			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)		

Page 2 of 2

ATTACHMENT B

New Application: Face-to-face (FTF) occurs in the month following the application

The application is dated April 30, 2008, and the initial FTF assessment is May 10, 2008. The SW may complete the renewal anytime prior to May 31, 2009.

- Face-to-face date on Line P, field 3 is *05/10/2008*.
- Beginning date on Line ZZ, field 3 is *04/30/2008*; or, as determined by the Social Worker.
- Ending date on Line ZZ, field 4 is *04/30/2009*.

ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
M	D								
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
N	D								
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
O	D								
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

P	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
(1)	04302008	(2)	5/10/2008	(4)

Q	D/O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
(1)	(2)		(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

ZZ	MCN	REN. CD.	REN. CD.	RSN. CD.	RSN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW.
(1)	MCN	(2)				(3) 4/30/08	(4) 4/30/09	(5) Y N	(6) X Y N
RR	MONTHLY WNKY TRS	MEAL TRS (DD-DC-CC)	MO. TRS	TOTAL	TUIC-ALL	UNET NEED			
(1)	(2)	(3)	(4)	(5)	(6)	(7)			

Page 2 of 2

Note: Remember to **wait 24 hours** for NOA to generate before entering the changes on the Turn Around Document (TAD).

Suppress NOA for next payment segment.

ZZ	MCN	REN. CD.	REN. CD.	RSN. CD.	RSN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW.
(1)	MCN	(2)				(3) 5/01/09	(4) 5/31/09	(5) Y N	(6) X Y N
RR	MONTHLY WNKY TRS	MEAL TRS (DD-DC-CC)	MO. TRS	TOTAL	TUIC-ALL	UNET NEED			
(1)	(2)	(3)	(4)	(5)	(6)	(7)			

Page 2 of 2

ATTACHMENT C

New Application – Share-of-Cost (SOC) Case

Face-to-face (FTF) occurs in the month following the application

The application was dated April 11, 2008. The application was reassigned to a Social Worker (SW) in the district from the SOC Specialist. The Social Worker had a FTF assessment on May 30, 2008. The SW may complete the renewal anytime prior to May 31, 2009.

- Face-to-face date on Line P, field 3 is *05/30/08*.
- Beginning date on Line ZZ, field 3 is *04/11/08*.
- Ending date on Line ZZ, field 4 is *04/30/09*.

M	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
	D									
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
	D									
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
	D									
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	

P	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
	(1) 04112008	(2)	(3) 5/30/08	(4)
Q	D/O	SERVICE WORKER NAME		SW#
	(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

ZZ	RSN. CD.	RSN. CD.	RSN. CD.	RSN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW
					(3) 4/11/08	(4) 4/30/09	(5) Y N	(6) Y N
RR	MONTHLY WKLY HRS	MEAL HRS (BB+CC+EE)	MO. HRS.	TOTAL	PURCHASE	UMET NEED		
	(1)	(2)	(3)	(4)	(5)	(6)		

Page 2 of 2

Note: Remember to **wait for 24 hours** for NOA to generate before entering the changes on the TAD.

- Change the Beginning date on Line ZZ field 3 to *5/01/09* and the Ending date on field 4 to *5/31/09* to align the FTF and Ending dates.
- Suppress NOA for next payment segment.

ZZ	NOA	RSN. CD.	RSN. CD.	RSN. CD.	RSN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW
	(1) M C N	(2)	(3)	(4)	(5)	(3) 5/01/09	(4) 5/31/09	(5) Y N	(6) Y N
aa	MONTHLY WKLY HRS	MEAL HRS (BB+CC+EE)	MO. HRS.	TOTAL	PURCHASE	UMET NEED			
	(1)	(2)	(3)	(4)	(5)	(6)			

SOC 293 (2/88) 3 PART Page 2 of 2

ATTACHMENT D

New Application – Share-of-Cost (SOC) Case
Face-to-face (FTF) occurs in the months following the application

The application was dated April 11, 2008. The application was reassigned to a Social Worker (SW) in the district from the SOC Specialist. The SW had a FTF assessment on August 13, 2008. The SW may complete the renewal anytime prior to August 31, 2009.

- Face-to-face date on Line P, field 3 is *08/13/08*.
- Beginning date on line ZZ, field 3 is *04/11/08*; or, as determined by the Social Worker.
- Ending date on Line ZZ, field 4 is *04/30/09*.

	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
M	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
N	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
O	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
P	(1) 04112008	(2)	(3) <i>8/13/08</i>	(4)

	D / O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
Q	(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

	MC#	VEN. CD.	RSN. CD.	RSN. CD.	RSN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW
ZZ	(1) MCN	(2)	(3)	(4)	(5)	(6) <i>4/11/08</i>	(7) <i>4/30/09</i>	(8) Y N	(9) Y N

	WEEKLY HOURS	MEAL (100-00-00)	MO. FREQ.	TOTAL	INITIAL	UNIT NEED
RR	(1)	(2)	(3)	(4)	(5)	(6)

Page 2 of 2

ATTACHMENT D Continued

New Application – Share-of-Cost (SOC) Case

Face-to-face (FTF) occurs in the months following the application

Note: Remember to **wait 24 hours** for the NOA to generate before entering the changes on the TAD.

- Change the Beginning date on Line ZZ field 3 to 05/01/2009 and the Ending date on field 4 to 08/31/09 to align the FTF and Ending dates.
- Suppress NOA for the next payment segment

	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
M	D	04112008	04302009							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
N	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
O	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
P	(1) 04112008	(2)	(3) 8/13/08	(4)

	D/O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
Q	(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

	MCN	REN. CD.	REN. CD.	REN. CD.	REN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW
ZZ	(1) MCN	(2)	(3)	(4)	(5)	(6) 04/11/08	(7) 4/30/09	(8) Y N	(9) Y N
						5/01/09	8/31/09		

	WCHTY								
RR	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

Page 2 of 2

ATTACHMENT E

Regular Renewal

The previous face-to-face (FTF) date was July 9, 2007. Current FTF renewal date is July 15, 2008. The next renewal may be completed anytime prior to July 31, 2009.

M	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

P	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
	(1)	(2)	(3) 7/15/08	(4)

Q	D/O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
	(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

ZZ	MCA	GEN. CD.	REN. CD.	RSN. CD.	RSN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	HEAL. ALLOW.
	MCN					(3) 8/01/08	(4) 7/31/09	(5) Y N	(6) Y N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

COUNTY INQUIRY INFO METAL INFO (DD+DD-CC) VOL. INFO TOTAL FUTURE UNEMP. NEED
 HRS (1) (2) (3) (4) (5) (6) (7)
 AUTOPAY (8) (9) (10) (11) (12) (13) (14)

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ATTACHMENT F

Early Renewal-Increase

The IHSS case is active with no break in aid. The ending date for the current certification period is 05/31/2008 since the last face-to-face (FTF) assessment was completed on 05/10/2007. Due to change in the recipient's condition, a new FTF interview is performed on April 15, 2008 (prior to the actual twelfth calendar month). The SW may complete the next renewal anytime prior to April 30, 2009.

- The FTF date on Line P, field 3 is 04/15/2008.
- Beginning date on Line ZZ, field 3 shall be determined by the Social Worker. Example: If the recipient returned home on 04/01/2008, beginning date of the new assessed benefits is 04/01/2008.
- If the change in the recipient's benefits as a result of the early reassessment has been determined effective anytime within the month (E.g. 04/05/2008, the date the recipient reported the change and, requested for an early reassessment), benefits must be prorated in the month affected (April); and another CMIPS transaction must be made to reflect the new benefits for the subsequent months.
- Ending date on Line ZZ, field 4 is 04/30/2009. Since a needs assessment was done on 04/15/2008, prior to the actual twelfth calendar month, the beginning and ending dates for the next certification period will reflect the adjusted 12-month period.

M	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
	D	06012007	05312008							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
	D	06012006	05312007							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
	D									
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

P	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
	(1)	(2)	(3) 05102007 4/15/08	(4)

Q	D / O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
	(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

ZZ	M	CN	REN. CD.	RBN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW.
					(3) 4/15/08	(4) 4/30/09	IN Y N	R Y N
RR	MONTHLY INK/INT	MEAL INT (DD+DC-CC)	MO. INT.	TOTAL	UNEMP. ALL	UNET NEED		
	(1)	(2)	(3)	(4)	(5)	(6)		

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ATTACHMENT G

Overdue Renewal-Decrease in Hours

Case renewal is *overdue*. The ending date for the current certification period is 01/31/2008 since the last face-to-face (FTF) assessment was completed on 01/25/2007. A FTF interview was completed on April 3, 2008. The SW may complete the next renewal anytime prior to April 30, 2009.

- Face-to-face date on Line P, field 3 is 04/03/2008.
- Ending date on Line ZZ, field 4 is 04/30/2008.
- Beginning date on Line ZZ, field 3 shall be determined by the Social Worker. The Social Worker must remember that a 10-day Notice of Action is required if the change will adversely affect the newly authorized total hours. He/she must also consider proration of hours as necessary.
- The SW must review the date segments on SOC 293 Lines M, N, and O to ensure that there is no break in aid and total hours are consistent. Example: Date segments 02/01/2008 03/31/2008 must be shown. The total assessed hours from the previous month (01/01/08) may be carried over to 02/01/2008 to 04/30/2008; or, the new assessed hours (except if there is a decrease) may begin on 02/01/2008.

ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
M	D	02012007	01312008						
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
N	D	02012006	01312007						
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
O	D	02012005	01312006						
(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

P	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
(1)		(2)	01252007 4/03/08	(4)

Q	D/O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
(1)	(2)		(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

ZZ	MCA	REN. CD.	REN. CD.	REN. CD.	REN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW
(1)	MCN	(2)				(3)	(4)	IN	YN
						2/1/08	4/30/08	Y	N

RR	WCHRT	WKY	LINS	MFL	IRS	DD	DC	CC	MO	TTL	TOTAL	PLNCH	WELL	UNET	NEED
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)

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Note: In order to generate a NOA, you must **wait 24 hours** before entering the changes on the TAD.

ATTACHMENT G Continued

Overdue Renewal-Decrease in Hours

New Segment Created

M	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
	D	02012008	04302008							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
	D	02012007	01312008							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
	D	02012006	01312007							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
(1)	(2)	(3) 04032008	(4)

D / O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

- On Turn-Around-Document (TAD) decrease hours, enter the new renewal period, and send timely Notice of Action (NOA).
- Change Beginning date on Line ZZ field 3 to 5/01/08.
- Change Ending date on Line ZZ field 4 to 4/30/09.

NOTE: Ensure that there is no break in aid from 02/01/2008 to 04/30/2008. A timely Notice of Action (NOA) must be sent to the recipient with the new authorized hours effective 05/01/2008.

ZZ	NOA	REN. CD.	REN. CD.	REN. CD.	REN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	HEAL. ALLOW.
	M	C	N			(3) 2/1/08	(4) 4/30/08	IN	Y N
						5/01/08	4/30/09		

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ATTACHMENT H

Overdue Renewal – Increase/No Change in Hours

The IHSS case is active with no break in aid. The ending date for the current certification period is 1/31/08. Previous FTF date is 1/25/07. The renewal should have been completed by 1/31/08 and is now overdue. A new FTF was completed on 4/3/2008.

Current Segments

M	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
	D	02012007	01312008							
(1)	(2)	(3)	(4)	(5)				(6)	(7)	(8)
	D	02012006	01312007							
(1)	(2)	(3)	(4)	(5)				(6)	(7)	(8)
	D	02012005	01312006							
(1)	(2)	(3)	(4)	(5)				(6)	(7)	(8)

APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
(1)	(2)	(3) 01252007 4/3/08	(4)

D / O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

ZZ	MCA	REN. CD.	REN. CD.	REN. CD.	REN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	HEAL. ALLOW.
	MCN					2/1/08	4/30/08	Y N X	Y N
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
RR	COUNTY INQUIRY INFO		MCA INFO (DD-MM-CC)		MO. INFO	TOTAL	UNIT/ALL	UNIT NEED	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	

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ATTACHMENT H Continued

Overdue Renewal – Increase/No Change in Hours

New segment created.

	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
M	D	02012008	04302008							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
N	D	02012007	01312008							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
O	D	02012006	01312007							
	(1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
P	(1)	(2)	(3) 04032008	(4)

	D/O	SERVICE WORKER NAME	SW#	SERVICE WORKER PHONE #
Q	(1)	(2)	(3)	(4)

R ALERT MESSAGE
NOA MESSAGE

On Turn-Around-Document enter the new renewal period.
Any increase in hours should start on the next payment segment created below .

ZZ	MCN	REN. CD.	REN. CD.	REN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW
	MCN				2/1/08	4/30/08	Y N	Y N
					5/01/08	4/30/09		
RR	AUTOMATIC							

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Increase is effective 5/1/2008, NOA will be sent automatically.

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

May 9, 2008

SUBJECT: CLARIFICATION OF PHASE ONE IHSS QUESTIONS

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: ALL COUNTY LETTER NO. 08-18

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with answers to the questions that were raised by several counties during the Phase One training of the In-Home Supportive Services (IHSS), Social Worker Training Academy (SWTA).

Question 1: Are there plans to implement an open flow of information regarding the State's Quality Assurance (QA) activities and the counties?

Answer: Yes. Currently the In-Home Supportive Services (IHSS) QA website contains meeting notes from all of the QA workgroups which were utilized in developing QA policies and implementation strategies. It also contains links to forms and other pertinent resources, tools, and program information. The website can be accessed at: <http://www.cdss.ca.gov/agedblinddisabled/>. The California Department of Social Services (CDSS) will continue to provide information regarding the State's QA activities on the website.

Question 2: Is there a minimum number of assessed hours required in order to receive IHSS?

Answer: There is no minimum number of hours required to authorize a case for IHSS. The regulations at the Manual of Policies and Procedures (MPP) Section 30-761.1 specify the conditions to be eligible for services which include meeting specific eligibility requirements and having a needs assessment to determine the services that would enable an individual to remain safely in his/her home without regard to any minimum standard of time.

**IHSS SPECIAL NOTICE 08-07
CLARIFICATION OF PHASE ONE IHSS QUESTIONS**

Question 3: Can hours be increased for services which have time per task guidelines if a social worker believes the recipient will not be safe with the hours assessed under the time guideline?

Answer: Yes. The social workers have the responsibility to assess hours based on the recipient's needs. In accordance with Welfare and Institutions Code (WIC) Section 12301.2, time per task guidelines can be used only if appropriate in meeting the individual's particular circumstances. Exceptions to time per task guidelines shall be made when necessary to enable the recipient to establish/maintain an independent living arrangement and/or remain safely in his/her home or abode of his/her own choosing. When an exception to a time per task guideline is made in an individual case, the reason for the exception shall be documented in the case file. Hourly task guidelines regulations, which include exception criteria, were implemented September 1, 2006. These regulations are located at MPP Section 30-757 and were transmitted to counties by All-County Letter (ACL) 06-34 which included implementing instructions and subsequent Errata.

Question 4: What is the ranking for a recipient with an "able and available spouse"? Do social workers rank as usual based on the recipient's functional ability? In the past, some have been ranked as a Rank 1 because no hours were authorized for Domestic and Related chores.

Answer: Functional Index (FI) scores should always be ranked based on the recipient's functional ability (MPP Section 30-756.1) regardless of whether the spouse is "able and available." The assessed time is listed under "Total Need" on the SOC 293. If the recipient lives with an "able and available spouse," Domestic and Related Services are shown as being met under an "Alternative Resource" and no time is listed under "Authorized to Be Purchased."

Question 5: Are Common Law Spouses considered spouses for purposes of IHSS?

Answer: In accordance with MPP Section 30-701(s) (4), a spouse is defined in accordance with the Supplemental Security Income/State Supplementary Program (SSI/SSP) definition (42 USC Section 1382c (d)). For purposes of SSI, a spouse is someone: (1) legally married under the laws of the state where the permanent home is located; (2) entitled to husband or wife's Social Security Insurance benefits as the spouse of the other; or (3) persons of the opposite sex living together in the same household holding themselves out to their community as husband and wife. Therefore, if any of the above circumstances apply, the person would be considered a spouse for purposes of IHSS. However, for purposes of determining Personal Care Services Program (PCSP) and Independence Plus Waiver

(IPW) eligibility, MPP Section 30-701(s)(4) defines a spouse more narrowly as a person legally married under the laws of the state of the couple's permanent home at the time they lived together.

Question 6: If SSI still shows a couple as married, yet the recipient has divorce documents in hand, are they considered an "able and available spouse" for IHSS purposes until they show up divorced in SSI system?

Answer: Consult with county counsel to determine if the Divorce Decree is a valid final Decree. If so, the recipient should not be considered married for IHSS purposes. Additionally, the recipient should be referred to Social Security Administration (SSA) for the SSA to make the appropriate change.

Question 7: We have a recipient who is legally married. His spouse moved out of the house, yet continues to be his IHSS provider. Do the "able and available spouse" regulations apply in this case?

Answer: No. Per MPP Section 30-763.4, the "able and available spouse" regulations under MPP Section 30-763.41 only apply in a shared-living situation where the spouses live together. If a spouse is living outside the home and still desires to be the IHSS provider, the "able and available spouse" regulations do not apply. (See MPP Sections 30-763.3 and 30-763.4.)

Question 8: Would children who are not the recipient's children living in the home that are under the age of 14 be counted in household composition?

Answer: Children who are not the recipient's children living in the home (regardless of age) would be counted in the household composition for purposes of proration for Domestic and Related services. Only children of the recipient (not grandchildren, foster children or other minor relatives for whom the recipient may have guardianship) are excluded (MPP Section 30-763.46). The CMIPS Manual, Page V-A-12, Field G2 defines Number in Household as "The total number of people living in the recipient's household, including other IHSS recipients. Exclude recipient's non-IHSS children under 14 years of age."

Question 9: Is there a written regulation addressing the issue of a parent provider signing time sheets for the minor child?

Answer: The MPP regulations do not address this particular issue. However, the CMIPS Users Manual, Section VII, Page H-2, Section D reads: "A parent provider of a minor child may sign the time sheet."

Question 10: Can Meal Preparation and Meal Cleanup be performed outside of the recipient's home?

Answer: Meal preparation and cleanup must be done in the recipient's home. It is inferred from the language of the statute and regulations that the intent is to provide these services in the home of the recipient.

Question 11: If an IHSS recipient chooses to eat meals separately from other family members residing in the home, must the IHSS recipient's needs be prorated unless the recipient has a health and safety need requiring his/her meals to be prepared separately?

Answer: No, these services do not have to be prorated. MPP Section 30-763.32 discusses when it is appropriate to prorate related services, which includes meal preparation. The regulation states that meal preparation should not be prorated, "when the service is not being provided by a housemate and is being provided separately to the recipient." This regulation does not speak to the issue of a housemate preparing separate meals. However, the intent of the regulation is to prorate hours when the needs of multiple persons are being met. When a housemate prepares food it does not automatically follow that the food prepared is meeting the needs of multiple individuals. Therefore, when a housemate prepares food separately for a recipient, the hours are not prorated because they are not meeting multiple needs. The regulation does not require that there be a health and safety reason for the recipient to eat meals separately. Consequently, the recipient may have meals provided separately in this situation solely because he/she chooses to eat separately.

Question 12: Is there a Rank 6 for Bowel and Bladder?

Answer: No. Bowel, Bladder and Menstrual Care are Ranks 1 through 5, with Rank 1 being "independent" and able to manage Bowel, Bladder and Menstrual Care with no assistance from another person. Rank 5 requires physical assistance in all areas of care (MPP Section 30-756.35). If the recipient's Bowel and Bladder needs include catheter insertion, ostomy irrigation, or a bowel program; they are assessed as Paramedical Services (MPP Section 30-757.191(c)).

Question 13: The Paramedical form (SOC 321) needs revision, as it is unclear and many doctors do not understand the IHSS definition of Paramedical services. Can the county fill out the form for the physician to sign for completion if he/she concurs?

Answer: The CDSS has modified the Paramedical form (SOC 321) for clarity. The new version was released in April 2006. Counties may have social workers identify the IHSS Paramedical services by filling out the form and then having the physician sign for completion. Additionally, some counties with Public Health Nurses (PHNs) have their PHNs contact the recipient's physician's office and speak with his/her nurse to explain the SOC 321 form and suggest timeframes for the Paramedical Services being requested. The PHN then faxes a partially completed SOC 321 to the doctor's office where she/he can review and sign it for completion. The fact the physician signs as the appropriate licensed health care professional complies with the requirements of MPP Section 30-757.19.

Question 14: Do we need a Paramedical form annually even if the recipient has no change in Paramedical needs?

Answer: At this time, renewing the Paramedical form (SOC 321) is not required annually. However, it should be a county "best practice" to insure that the Paramedical form is reviewed at each reassessment for any health changes (improvements or deteriorations). The ending dates (if any) of authorized Paramedical Services should also be noted.

Question 15: Is toenail clipping for the recipient an eligible task in the IHSS program?

Answer: No, toenail clipping is not a covered service by IHSS. According to the California Code of Regulations regulation Section 51183 (a) (2) and Section 51350 (f), grooming includes fingernail and toenail care, but excludes cutting with scissors or clipping toenails. Therefore, for consistency, the toenail care specified at MPP Section 30-757.14 (e) does not include cutting with scissors or clipping toenails. Toenail cutting or clipping is covered under Medi-Cal when performed by a Podiatrist and if it is a medical necessity.

16. Question: Is brushing teeth considered a Paramedical Service?

Answer: No, brushing teeth is considered "oral hygiene" and would be assessed under Bathing, Oral Hygiene and Grooming (MPP Section 30-780.1(a) (2)). Paramedical Services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional (MPP Section 30-757.191 (c)).

Question 17: Is crushing pills into food/liquid due to dysphasia considered Paramedical?

Answer: Yes. Paramedical Services are activities which due to the recipient's physical or mental condition, are necessary to maintain the recipient's health (MPP Section 30-757.191). The services may include administration of medications, puncturing the skin, inserting a medical device into a body orifice, activities requiring sterile procedures or other activities requiring judgment based on training given by a licensed health care professional.

Question 18: Where on the SOC 293 is time for catheter insertion authorized?

Answer: Time for catheter insertion is authorized as a Paramedical Service (MPP Section 30-757.19). The recipient's FI score would be ranked on the H Line under Bowel, Bladder and Menstrual Care. If the recipient is "independent" in bowel movements and all urination is done with the catheter, the recipient would rank a "1" in Bowel, Bladder and Menstrual Care. However, if the recipient uses intermittent catheterization and urinates between those catheterizations (number of times a day), the recipient's dependence with urination and with bowel movements would affect the recipient's FI ranking in Bowel, Bladder, and Menstrual Care.

Question 19: Can time be authorized for a provider to "shadow/follow" the recipient for ambulation if they have an unsteady gait or experience dizziness?

Answer: Yes. County staff would determine the recipient's level of ability and dependence upon verbal or physical assistance by another (MPP Section 30-756.1). If a recipient has an unsteady gait or experiences dizziness, the social worker would not assess him/her as "independent" in these tasks and time for assistance with ambulating. Per ACL 06-34, the regulations at MPP Section 30-757.14 (k), as well as the Annotated Assessment Criteria, describe "Ambulation inside" as assisting a 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. As taught in Phase One of the training, county practices should be followed in communicating with the recipient's doctor about prescribing Durable Medical Equipment (DME).

Question 20: Can the maintenance exercise of assistive walking (MPP 30-757.14(g)(2) (A)) be performed outside of the recipients home?

Answer: Yes, the maintenance exercise of assistive walking can be provided outside the recipient's home if necessary to meet the needs of the recipient. In accordance with MPP Section 30-757.14 (g) (2) (A) and MPP Section 30-780.1(a) (5) (B) "such exercises shall include the carrying out of maintenance programs, i.e., the performance of repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking." Usually, the carrying out of maintenance programs including assistive walking can be accomplished on the recipient's premises. If not, then other locations may be utilized if they are necessary and reasonable. However, if the maintenance therapy/exercise takes place away from the home, no travel time may be authorized, although time for assistance into and out of a vehicle may be authorized under MPP Section 30-757.15.

Question 21: When doctors request exercise, is it authorized under Ambulation or Paramedical?

Answer: It would depend on the type of health care professional providing the supervision of the exercise. If the exercise is assistive walking around inside the home, the services would be assessed as Range of Motion (MPP Section 30-757.14 (g) (2) (A)). However, if the provider is performing an exercise that requires the provider to receive training by a medical doctor or other medical professional authorized to do so, the service would be assessed under Paramedical. The controlling issue is the level of skill involved (MPP Section 30-757.19).

Question 22: Is time allowed to accompany recipients to medical appointments that are not local?

Answer: If the appointment is medically necessary and the health care professional is not local, the time to drive the recipient to the appointment and home would be allowed. The social worker needs to document the case file with the frequency and distance of the appointment (MPP Section 30-757.15). Providers may only claim this time when the services are actually performed.

Question 23: Are translation services for medical appointments covered under the program?

Answer: No. This service is not covered under IHSS.

Question 24: How do we assess people with seizures who are unable to do anything after they have one?

Answer: Assessing time for this service would be based on the severity and frequency of the seizures. Although the recipient is unable to do anything during and immediately after a seizure, the amount of time for recuperation varies. This is why accurate case documentation is crucial. Social workers should document the frequency of seizures, as well as the severity and duration of functional impairment following seizures. The amount of assistance required by the provider should also be documented. It is also important to note that the providers may only claim time for the service when it is actually performed.

Question 25: How and where do we assess stand-by time?

Answer: Stand-by is not allowed. For those recipients with a Functional Index rank of 2, which requires encouragement and reminding only, time to encourage and remind the recipient is allowed under the specific task where the recipient has this need (MPP Section 30-756.12). For example, if the recipient is ranked 2 in Feeding due to needing verbal assistance, such as reminding; the time would be assessed under Feeding. Remember when assessing time for encouragement and reminding, the provider can often be performing another task. Therefore, the assessed time may be minimal.

Question 26: For Teaching & Demonstration, is the provider paid by IHSS to teach the recipient skills to live independently?

Answer: The provider is paid to teach a particular task to the recipient so that once the recipient is trained IHSS assistance for that particular task will no longer be needed. Tasks are limited to instruction in Domestic and Related Services, non-medical personal care services, and Yard Hazard Abatement (MPP Section 30-757.18). Please note, Teaching and Demonstration is not an allowable task under the PCSP.

Question 27: How should the counties handle recipients who are living on the riverbanks and request IHSS? They claim this is their cultural right, but they are living in the open with no shelter.

Answer: The purpose of IHSS is to enable recipients to remain safely in their own "home." In accordance with MPP Section 30-755.11, "a person is eligible for IHSS who is a California resident living in his/her own home." Living in the open with no shelter would not be considered "living safely," and the riverbank would not be considered a "home."

Question 28: How do we deal with non-compliance (i.e., applicant/recipient will not make information available) when attempting to conduct needs assessments to determine IHSS service authorizations?

Answer: If the social worker is unable to obtain the required information, the case should be closed for non-compliance, and the applicant/recipient must be sent a Notice of Action. The applicants/ recipients must provide all pertinent information to enable the county to determine eligibility and need for services (MPP Sections 30-760.1, 30-763.11 and .12).

Question 29: When can the county close cases when there has been no provider for months?

Answer: There are no regulations that allow termination or discontinuance of IHSS/PCSP services when a recipient fails to hire a provider or there is no payroll activity. The county should determine why the recipient does not have a provider and refer the recipient to the Public Authority since the recipient has been determined to have a need for services. The key is determining if the recipient has a need for services, not whether there is a provider available. In accordance with MPP Section 30-761.219, needs assessments are performed when the county has "pertinent information which indicates a change in circumstances affecting the recipient's need for supportive services." If the recipient does not hire a provider, that may be an indication that the recipient's physical/mental condition or living/social situation has changed and the county may conduct a reassessment. The reassessment will establish the need for continued services.

Question 30: Can the provider provide services to the recipient while the recipient is temporarily absent from the home?

Answer: Yes, provided the service has been authorized, the provider is in the accompaniment of the recipient, and/or the absence is not precluded by the out-of-state absence requirements at MPP Sections 30-770.444 and .461.

Question 31: Is there a limit to the number of providers a recipient can have?

Answer: There are no regulations that limit the number of providers that a recipient can have. Time is authorized based on the recipient's needs without regard to the number of providers, and for this same reason, no additional time can be authorized on the basis of multiple providers.

Question 32: Can an individual who is not the parent of a minor have a full-time job and still work as a full-time IHSS provider?

Answer: The regulations do not prohibit a provider from working another job. However, the provider must complete and submit a timesheet (SOC 361) verifying that all of the reported service hours claimed were performed.

There may be a reason to question whether hours are actually provided or are provided appropriately to meet the needs of the recipient. It may be appropriate to evaluate the adequacy of the plan or to make appropriate referrals related to possible fraud or client neglect.

Question 33: Can counties require a yearly medical form if a recipient's condition is not likely to change?

Answer: Although some counties may request that their social workers obtain a yearly medical form, it is not a State requirement. However, as part of the reassessment, the social worker should assess whether the medical information beyond a year is sufficient to determine the recipient's condition has not changed (improvements or deteriorations) and whether or not the recipient can still remain safely in his/her home with or without specific IHSS service needs. Pursuant to MPP Section 30-761.13, social services staff must have face-to-face contact with the recipient in the recipient's home at least once every 12 months to determine the recipient's level of need which would enable the recipient to remain safely in his/her own home.

(Note: The face-to-face may be beyond 12 months if the county has opted to extend the reassessment up to six months based on the requirements of MPP Section 30-761.215 through .217.) Additionally, MPP Section 30-761.263 specifies the need for services shall be based on the "available medical information."

Question 34: How do we prorate when meals are prepared for a large group (i.e., living in a temple)?

Answer: If the recipient is living with a large group, there needs to be a determination of whether the recipient is living in a community care facility or a board and care facility and, therefore, she/he might not be eligible for IHSS. In accordance with MPP Section 30-701 (o) (2), "own home" is defined as the place in which an individual chooses to reside. An individual's "own home" does not include an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or a board and care facility. However, if this is not the case and the individual is determined to be living in his/her "own home," normal proration procedures would apply as specified in MPP Section 30-763.321: "When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the recipient's need is his/her prorated share."

Question 35: What happens when the provider claims hours after recipient's death? (Example; recipient passes away on 27th of the month and the provider claims hours up until the 30th).

Answer: No services can be claimed after a recipient has passed away, as the purpose of the program is to allow recipients to remain safely in their own home. If payment for services is received after the death of the recipient, overpaid compensation is to be collected from the provider in accordance with MPP Section 30-769.9.

Question 36: Can we accept mental health diagnoses from other medical professionals or should it be diagnoses provided by mental health professionals only?

Answer: A mental health diagnosis can only be made by a mental health professional. To be eligible for Social Security Disability on the basis of a mental disorder, a variety of documentation consisting of symptoms, signs, and laboratory findings (including psychological test findings) is analyzed.

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.



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Verónica Hernández

Distribution Codes 7 & 8

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-06**

April 28, 2008

**SUBJECT: NEW LIMITS AND DISREGARDS FOR THE AGED AND
DISABLED FEDERAL POVERTY LEVEL (A&D FPL) PROGRAM
FOR 2008**

EFFECTIVE DATE: April 1, 2008

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All County Welfare Directors Letter (ACWDL) No. 08-06

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff of the 2008 income limits and disregards for the Aged and Disabled Federal Poverty Level (A&D FPL) Program.

II. BACKGROUND

Assembly Bill (AB) 2877, Chapter 93 Statutes of 2000, amended the Welfare and Institution Code (WIC) and authorized funding for a Medi-Cal benefit with no share-of-cost (SOC) for qualified medically needy aged and disabled persons.

The formula to determine the income limit for the Aged and Disabled Federal Poverty Level (A&D FPL) Program for individual and couples would be 100 percent of the FPL for one person plus the standard disregard for an individual. In compliance with the WIC Section 14005.40(1) requirement that an A&D FPL couples income limit should not be less than SSI/SSP, a different formula is used to compute the income disregard for couples.

III. POLICY

IHSS Personal Care Services Program (PCSP) and IHSS Plus Waiver Program (IPW) recipients with income at or below the FPL plus a disregard amount, must be evaluated for a zero SOC. The evaluation must be done by a Medi-Cal Human Services Specialist (HSS) in any of the following circumstances:

- Annual case renewal/reassessment
- Changes in the recipient's A&D FPL Program eligibility
- Changes in the FPL

IV. NEW INCOME LIMITS AND DISREGARDS

Effective April 1, 2008, the effective income limit for an A&D FPL individual is \$1097. This income limit is equal to the 100% of the FPL of \$867 and the \$230 standard disregard.

The effective income limit for A&D FPL couples is \$1524 for determinations from January 1, 2008 to March 31, 2008. This income limit is equal to 100 percent of the FPL of \$1141.00 plus the \$383 disregard. (The disregard is equal to the SSI/SSP couple payment standard of \$1524 effective January 1, 2008 minus 100 percent of the FPL for two [\$1141] effective April 1, 2007 through March 31, 2008.)

The effective income limit for A&D couples is \$1524 for determinations for April 1, 2008 and May 2008. The income limit is equal to 100 percent of the FPL of \$1167 plus the \$357 disregard. (The disregard is equal to the SSI/SSP couple payment standard of \$1524 from January 1, 2008 minus 100 percent of the FPL for two [\$1167] effective April 1, 2008 through March 31, 2009.)

The effective income limit for A&D couples is \$1558 for determinations from June 2008 through December 2008. The income limit is equal to 100 percent of the FPL \$1167 plus the \$391 disregard. (The disregard is equal to the SSI/SSP payment standard of \$1558 effective June 2008 minus 100 percent of the FPL for two [\$1167] effective April 1, 2008 through March 31, 2009.)

V. PROCEDURES

IHSS SOCIAL WORKER

Social Workers will submit the following information to update the A & D FPL in CMIPS.

- The SOC 293 indicating the changes on the IHSS/Medi-Cal Communication sent by the Human Services Specialist (HSS).
- The SOC 311, if necessary, for cases with more than one provider.

Social Workers will update the case narrative to indicate the change to a zero SOC with effective date (“Case is \$0.00 SOC effective [date] due to A&D FPL.”)

If the start date of zero SOC is retroactive, the Social Workers must evaluate for an underpayment.

CLERICAL STAFF

Notices of Action (NOAs) must be mailed to all affected recipients.

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.



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido (858) 505-6366

Distribution Codes 7 & 8

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-05**

April 23, 2008

SUBJECT: NEW EMPLOYEES GUIDE TO WORKERS COMPENSATION BOOKLET

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 inform In-Home Supportive Services (IHSS) Clerical staff of an improved, printable version of the State Compensation Insurance Fund (SCIF) "New Employee Guide to Workers Compensation" booklet.

II. BACKGROUND

The IHSS Program is responsible for distributing the "New Employees Guide to Workers Compensation" booklet (Attachment A & B) to all new IHSS IP's and upon request to existing IHSS IP'S upon their request.

III. POLICY

The 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. When the SCIF, "New Employee Guide to Workers Compensation" booklet is not available, clerical staff will maintain and print copies to be distributed as required by SCIF. The printable version is available at:

S:\AIS\Operations\IHSS\Automated Forms\Clerical Forms

IV. 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 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".

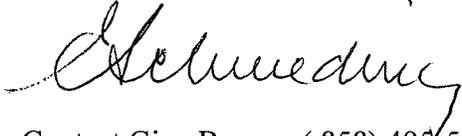
V. REVIEW STATEMENT

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.

ELLEN SCHMEDING
Assistant Deputy Director



Contact Gina Brown: (858) 495-5554

Distribution Codes 7&8

New employees guide to workers' compensation



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

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.

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 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

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 Benefits Maximum		
	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.

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

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.

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 that 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 nontransferable 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	
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

What protects me from 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.

DIVISION OF WORKERS' COMPENSATION **INFORMATION AND ASISTANCE OFFICERS**

Anaheim	(714) 738-4038	Redding	(530) 225-2047
Bakersfield	(661) 395-2514	Riverside	(951) 782-4347
Eureka	(707) 441-5723	Sacramento	(916) 263-2741
Fresno	(559) 445-5355	Salinas	(831) 443-3058
Goleta	(805) 968-4158	San Bernardino	(909) 383-4522
Grover Beach	(805) 481-3380	San Diego	(619) 767-2082
Long Beach	(562) 590-5240	San Francisco	(415) 703-5020
Los Angeles	(213) 576-7389	San Jose	(408) 277-1292
Marina Del Rey	(310) 482-3820	Santa Ana	(714) 558-4597
Oakland	(510) 622-2861	Santa Rosa	(707) 576-2452
Oxnard	(805) 485-3528	Stockton	(209) 948-7980
Pomona	(909) 623-8568	Van Nuys	(818) 901-5374

(800) 736-7401 (Recorded information only)

STATE FUND LOCATIONS

Bakersfield	(661) 664-4000	Sacramento	(916) 924-5100
Eureka	(707) 443-9721	San Bernardino	(909) 384-4500
Fresno	(559) 433-2700	San Diego	(858) 552-7100
Los Angeles	(818) 291-7000	San Jose	(408) 363-7400
Oxnard	(805) 988-5300	Santa Ana	(714) 565-5000
Pleasanton	(925) 523-5200	Santa Rosa	(707) 573-6500
Redding	(530) 223-7000	South Orange	(714) 347-5400
Riverside	(951) 656-8300	Stockton	(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

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.

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 or the personal physician's integrated multispecialty medical group 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 or my personal physician's integrated multispecialty medical group, who meets all the following requirements:

(1) is my regular physician; (2) is my primary care physician or integrated multispecialty medical group; (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.

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.

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, independientemente 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 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, comuníquelo 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 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 ley. Las cantidades mínimas y máximas en vigencia dependen de la fecha en que ocurrió la lesión, como se muestra en la tabla siguiente: 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 trabajar 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 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 01/7/96-31/12/02	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	2006 – 2007
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

¿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. Comuníquese 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.

¿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 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 brined 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 médico 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 o a un grupo médico de multiespecialidades de doctores titulados en medicina u osteopatía (MDs or DOs) que provean un servicio médico completo principalmente a lesiones que no sean adquiridas en el trabajo y enfermedades que se hayan presentado antes de la 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 o el grupo médico de multiespecialidades del médico.
- 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, usted debe darle a su empleador el nombre y dirección de su médico personal o su grupo personal de doctores de multiespecialidades médicas *por escrito*, antes de sufrir una lesión.

Si no designa previamente 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.

¿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 future rehabilitación vocacional con un pago único que no superará los \$10,000.

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 ultimo 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.

Nivel de discapacidad permanente Monto del vale de SJDB

Inferior al 15%
De 15% a 25%
De 26% a 49%
De 50% a 99%
Hasta \$4,000
Hasta \$6,000
Hasta \$8,000
Hasta \$10,000

Division of Workers' Compensation

FUNCIONARIOS DE INFORMACIÓN Y ASESORAMIENTO

Anaheim	(714) 738-4038	Redding	(530) 225-2047
Bakersfield	(661) 395-2514	Riverside	(951) 782-4347
Eureka	(707) 441-5723	Sacramento	(916) 263-2741
Fresno	(559) 445-5355	Salinas	(831) 443-3058
Goleta	(805) 968-4158	San Bernardino	(909) 383-4522
Grover Beach	(805) 481-3380	San Diego	(619) 767-2082
Long Beach	(562) 590-5240	San Francisco	(415) 703-5020
Los Angeles	(213) 576-7389	San Jose	(408) 277-1292
Marina Del Rey	(310) 482-3820	Santa Ana	(714) 558-4597
Oakland	(510) 622-2861	Santa Rosa	(707) 576-2452
Oxnard	(805) 485-3528	Stockton	(209) 948-7980
Pomona	(909) 623-8568	Van Nuys	(818) 901-5374

(800) 736-7401 (Sólo información grabada)

OFICINAS DEL STATE FUND

Bakersfield	(661) 664-4000	Sacramento	(916) 924-5100
Eureka	(707) 443-9721	San Bernardino	(909) 384-4500
Fresno	(559) 433-2700	San Diego	(858) 552-7100
Los Angeles	(818) 291-7000	San Jose	(408) 363-7400

Oxnard	(805) 988-5300	Santa Ana	(714) 565-5000
Pleasanton	(925) 523-5200	Santa Rosa	(707) 573-6500
Redding	(530) 223-7000	South Orange	(714) 347-5400
Riverside	(951) 656-8300	Stockton	(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

Línea de asistencia para fraude

(888) 786-7372 línea gratuita

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.

Médico Personal del Empleado

- Para que un empleado pueda previamente 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 previa del médico personal para nombrar a un doctor médico o un doctor de medicina osteopática o el grupo de médicos de multiespecialidades integradas de su médico personal.
- 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 o el grupo de médicos de multiespecialidades integradas de mi doctor personal, quien llena todos los siguientes requisitos: 1) Es mi médico regular; 2) Es mi médico primario de cuidado o grupo médico de multiespecialidades; 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 **quiropático o acupunturista personal**, quien es el que me ha atendido anteriormente y tiene mi historial. Estoy por entendido que identificar a un quiropático o acupunturista solamente es permitido cuando la medical provider network (MPN) no es aplicable. Si la MPN no aplica, mi quiropático 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 quiropático o acupunturista personal.

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-04**

April 4, 2008

**SUBJECT: CITIZENSHIP AND IDENTITY REQUIREMENTS FOR MEDI-CAL
APPLICANTS AND RECIPIENTS**

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: Medi-Cal Program Guide Letter #631

I. PURPOSE

The purpose of this Special Notice is to provide IHSS staff with information about the new Federal requirements to provide proof of citizenship and identity for all Medi-Cal applicants/recipients. This Special Notice also provides information on the identification and processing of acceptable citizenship and identity documentation.

II. BACKGROUND

State Assembly Bill 1807 provides the California Department of Health Care Services (DHCS) with the authority to implement the new requirements for documentation of citizenship and identity. Under the new Federal Deficit Reduction Act (DRA) regulations, citizens and non-citizens must provide satisfactory evidence of citizenship and identity in order to receive full scope Medi-Cal benefits. In October 2007, DHCS began mailing informational notices to recipients who were due for a redetermination for Medi-Cal benefits. Recipients with redetermination dates in June 2008 and beyond will be required to provide evidence of citizenship and identity, if they have not previously provided satisfactory documentation.

III. POLICY

All applicants of Medi-Cal must provide satisfactory proof of citizenship and identity prior to the granting of full-scope Medi-Cal. Beginning with redetermination dates in June 2008, all current recipients of Medi-Cal must also provide proof of citizenship and identity. Recipients of Medi-Cal will be given a reasonable amount of time to submit the required documentation, provided that they are making a good faith effort to obtain such documentation.

**IHSS SPECIAL NOTICE 08-04
CITIZENSHIP AND IDENTITY REQUIREMENTS FOR MEDI-CAL**

IV. PROCEDURES

The new citizenship and identity requirements will affect income eligible IHSS applicants/recipients only, Medi-care recipients and Social Security income recipients are exempt. The assigned Medi-Cal Worker has the primary responsibility to obtain satisfactory proof of citizenship and identity, and to document the verification of citizenship in the case file. In order to assist IHSS applicants/recipients, the IHSS Social Worker will:

- Provide the "Acceptable Citizenship and Identity Documents Form" (DHCS 0007) to applicants/recipients when information on documentation is requested.

If an IHSS applicant/recipient submits documentation to an IHSS Social Worker, the IHSS Social Worker will:

- Make copies of the citizenship and/or identity documents.
- Retain copies of all documents in the IHSS case file.
- Complete a "Receipt of Citizenship or Identity Documents Form" (DHCS 0005), make a copy and give the original to the applicant/recipient.
- Forward copies of all documents to the assigned Medi-Cal Worker.

The Medi-Cal Worker will determine if the citizenship and/or identity documents are acceptable.

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.



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Verónica Hernández (858) 495-5131
Attachments

Acceptable Citizenship and Identity Documents

A new law says *most* Medi-Cal applicants and beneficiaries who are U.S. citizens or nationals must show proof of citizenship *and* proof of identity. This form provides a list of acceptable documents.

The easiest way for U.S. citizens or nationals to provide *both* proof of citizenship and identity is with **one** of these documents:

- U.S. Passport issued without limitation (expired ones are acceptable)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of U.S. Citizenship (N-560 or N-561)

— OR —

If you do not have one of the documents above, provide...

One citizenship document from this column

- | | |
|---|--|
| <ul style="list-style-type: none"> ❖ U.S. Birth Certificate ❖ Certification of Report of Birth (DS-1350) ❖ Report of Birth Abroad of a U.S. Citizen (FS-240) ❖ State Department Certification of Birth (FS-545 or DS-1350) ❖ U.S. Citizen Identification Card (I-197 or I-179) ❖ American Indian Card (I-872) ❖ Northern Marianas Card (I-873) ❖ Final adoption decree showing a U.S. place of birth ❖ Proof of adoption of a child born outside U.S. and in the legal/physical custody of the U.S. citizen parent (IR-3 or IR-4) ❖ Proof of U.S. civil service employment before June 1, 1976 ❖ U.S. military service record showing a U.S. place of birth ❖ U.S. hospital record established at the time of the person's birth * ❖ Life, health, or other insurance record * ❖ Religious record recorded in the U.S. within 3 months of birth showing U.S. place of birth and birth date or age ❖ Early school record showing a U.S. place of birth, date of admission, birth date, names and places of birth of parents | <ul style="list-style-type: none"> ❖ Federal or State census record that shows the applicant's age and U.S. citizenship or place of birth ❖ Seneca Indian tribal census record * ❖ Bureau of Indian Affairs Navajo Indians tribal census record * ❖ U.S. State Vital Statistics birth registration notification* ❖ An amended U.S. public birth record (amended more than 5 years after the person's birth) * ❖ Statement signed by doctor or midwife present at the birth * ❖ Roll of Alaska Natives from the Bureau of Indian Affairs ❖ Admission papers from a nursing or skilled care facility, or other institution that shows a U.S. place of birth ❖ Medical record (not an immunization record) * <p>* <i>Must be dated at least 5 years before your 1st Medi-Cal application and show a U.S. place of birth.
You must provide a document as high on the list as you can.</i></p> |
|---|--|

If you cannot provide any of these citizenship documents... Ask two adults to fill out and sign an Affidavit of Citizenship. Both adults must have proof of their own identity and U.S. citizenship, and only one of them may be related to you.

— AND —

One identity document from this column

- | | |
|--|--|
| <ul style="list-style-type: none"> ❖ Driver's license issued by a U.S. State or Territory with a photograph or other identifying information ❖ School Identification card with a photograph ❖ U.S. Military I.D. card or draft record ❖ Federal, state or local government I.D. card with same identifying information as a driver's license | <ul style="list-style-type: none"> ❖ U.S. Military dependent identification card ❖ A U.S. passport (issued with limitation) ❖ Certificate of Degree of Indian Blood or other U.S. American Indian/Alaska Native Tribal document ❖ U.S. Coast Guard Merchant Mariner Card |
|--|--|

Continued on back

- ❖ Three or more confirming documents, such as employee ID cards, high school or college diplomas, marriage licenses, divorce decrees, and property deeds/titles
- ❖ Clinic, doctor, or hospital records for a child under 16
- ❖ School, nursery school, or daycare records, including report cards, for a child under 16. The county will verify with the school.
- ❖ For people with disabilities who live in a residential care facility, an Affidavit signed by the facility's director or administrator

For a **child under 16** who did not provide an *Affidavit of Citizenship*, you may submit:

- ❖ An Affidavit of the child's identity signed by the child's parent, guardian, or caretaker relative with date and place of birth
- ❖ A Medi-Cal application or the Healthy Families/Medi-Cal joint application that shows the child's date and place of birth, and is signed by the child's parent, guardian, or caretaker relative.

For a **child under 18**, an Affidavit of the child's identity signed by the child's parent, guardian, or caretaker relative may be used if school ID cards or driver licenses are not available.

Note: Expired identity documents are acceptable proof of identity.

Receipt of Citizenship or Identity Documents

Instructions to County/DSH/FQHC Staff: When you receive citizenship and/or identity document(s) for an applicant or beneficiary, you must fill out this form.

Citizenship/Identity document for Applicant or Beneficiary:

_____ Date of birth: _____
First Middle Last

Address: _____
Street City State Zip Code

Name of parent if Applicant or Beneficiary is a child: _____
First Middle Last

Applicant or Beneficiary BIC/CIN: _____

<p>Name of the citizenship/identity document you saw: _____ </p> <p>The document you saw was <i>(check one)</i>:</p> <p><input type="checkbox"/> An original (not a photocopy or a notarized copy) <input type="checkbox"/> A copy that was certified by the issuing agency</p> <p>This document was received <i>(check one)</i>:</p> <p><input type="checkbox"/> By mail <input type="checkbox"/> In person <i>(from the applicant or beneficiary)</i> Name: _____ <input type="checkbox"/> In person <i>(from a guardian, authorized representative, or caretaker relative)</i> <i>(Name and relationship to applicant or beneficiary)</i> _____</p>	<p>Name of the citizenship/identity document you saw: _____ </p> <p>The document you saw was <i>(check one)</i>:</p> <p><input type="checkbox"/> An original (not a photocopy or a notarized copy) <input type="checkbox"/> A copy that was certified by the issuing agency</p> <p>This document was received <i>(check one)</i>:</p> <p><input type="checkbox"/> By mail <input type="checkbox"/> In person <i>(from the applicant or beneficiary)</i> Name: _____ <input type="checkbox"/> In person <i>(from a guardian, authorized representative, or caretaker relative)</i> <i>(Name and relationship to applicant or beneficiary)</i> _____</p>
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Make a photocopy of the citizenship and/or identity document received from the applicant or beneficiary, return the original document(s) to the bearer and provide a copy of the signed receipt to the bearer. Once the document is received by the eligibility worker, the county social services office will notify the applicant or beneficiary of this receipt if the document(s) provided are acceptable. DSH/FQHC staff must send this receipt and copies of the document(s) to the appropriate county social services office.

County/DSH/FQHC Staff reads and signs below.

I declare under penalty of perjury under the laws of the State of California that the information above is true and correct.

_____ Date: _____
Signature of County/DSH/FQHC Staff

Name of County/DSH/FQHC Staff *(print)*: _____
First Middle Last

Information: _____
Name of agency County Telephone number E-mail

County fills out this box	
Case No: _____	Case Name: _____

**SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-03**

March 24, 2008

SUBJECT: MEDI-CAL SUSPENDED AND INELIGIBLE (S&I) PROVIDERS

EFFECTIVE Immediately
DATE:

EXPIRATION When incorporated into the IHSS Program Guide
DATE:

REFERENCES: Welfare and Institution Code (WIC), Section 14123
Welfare and Institution Code (WIC), Section 12305.81
Penal Code, Section 273a
Penal Code, Section 368

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with clearance procedures and instructions for terminating suspended and ineligible IHSS Individual Providers.

II. POLICY

Welfare and Institution Code (WIC), Section 14123 mandates that the California Department of Health Services (CDHS) suspend a Medi-Cal provider when he/she has been (a) convicted of a crime involving fraud or abuse of the Medi-Cal program or (b) suspended from the federal Medicare program for any reason.

Suspension is automatic when either of the above events occurs. Suspended Medi-Cal providers, including IHSS Individual Providers, are not entitled to a hearing under the *California Administrative Procedures Act*. Additionally, WIC Section 12305.81 provides for a ten-year ineligible period for providing IHSS services when certain crimes against the elderly, disabled adults, and children have been committed.

III. BACKGROUND

IHSS Administration receives regular reports from the San Diego County District Attorney's Office documenting convictions of IHSS recipients and providers for IHSS fraud. This information is sent to the State of California in order to place the convicted providers on the

Medi-Cal Suspended and Ineligible (S&I) Provider List. The list is updated regularly and is available to the public on the internet.

IHSS Administration also reviews elder abuse conviction reports to ensure those convicted are not IHSS providers.

IV. PROCEDURES

IHSS Program Specialist

Step	PROCEDURE
1.	The IHSS Program Specialist will monitor the California Department of Health Care Services (DHCS) monthly publication of the Medi-Cal S&I Provider List. The list can be accessed from http://www.medi-cal.ca.gov/ <ul style="list-style-type: none"> • Select the References tab. • Scroll down and click on <i>Suspended and Ineligible List (susp U)</i>.
2.	The IHSS Program Specialist will e-mail the current Medi-Cal S&I Provider List to the Senior Office Assistant quarterly. (Attachment A)

Clerical

Step	PROCEDURE
1.	When the Senior Office Assistant receives the Medi-Cal S&I List from the IHSS Program Specialist, he/she will clear the list using the CMIPS SSNP screen.
2.	If a suspended or ineligible provider is currently providing services to any San Diego County IHSS recipient(s), the Senior Office Assistant will: <ul style="list-style-type: none"> • Write the provider information on the IHSS S&I Provider log book. (Attachment D) • E-mail the Medi-Cal S&I List to the assigned Social Worker, cc: <ul style="list-style-type: none"> ○ Social Work Supervisor, ○ Public Authority (PA) Provider Services Manager, and ○ PA Registry Manager.
3.	When the Senior Office Assistant receives a response from the Social Worker indicating the action taken, he/she will: <ul style="list-style-type: none"> • Enter the date the 12-97 HHSA (S&I Letter to Recipient) and the 12-97A HHSA (S&I Letter to Provider) [Attachments B & C] were sent to the recipient and IP, and the date the services were terminated on the IHSS S&I Log. • Send a copy of the S&I Log to the IHSS Program Manager and the IHSS Operations Manager quarterly.

Social Worker

Step	PROCEDURE
	When the Social Worker receives the name(s) of the provider(s) on the Medi-Cal S&I Provider List from the Senior Office Assistant, he/she will:
1.	Send the recipient(s) the 12-97 HHSA informing them that the provider is terminated. A separate letter, 12-97A HHSA, is sent to the IP or Individual Provider. The letters should be sent within 10 calendar days from the date the e-mail is received from the Senior Office Assistant.
2.	Terminate the Individual Provider immediately . A Notice of Action is not required. The IHSS case remains open.
3.	Complete a narrative entry on the 12-43 or 12-43A. The entry should include the reason for terminating the IP, and the effective date of service termination.
4.	Indicate on Line E, Field 1 of the County Use Section of the SOC 311 "Suspended/Ineligible Provider effective _____."
5.	Contact the Senior Office Assistant by e-mail and indicate the date that the 12-97 HHSA/12-97A HHSA was sent and the date that the Individual Provider was terminated.

V. REVIEW STATEMENT

This Special Notice has been reviewed by IHSS Administration.

VI. FILING STATEMENT

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



ELLEN SCHMEDING
Assistant Deputy Director

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

Medi-Cal Suspended and Ineligible Provider List

<u>Dental Clinic Employee</u>	<u>Provider Number</u>	<u>Suspension Status</u>	<u>In-Home Health Service</u>	<u>Provider Number</u>	<u>Suspension Status</u>
Perez, Emma 480 Kenwood Drive Lemoore, California		Suspended indefinitely effective 6/4/99.	McCoy, Dorothy Mae 1041 Grand Avenue Sacramento, California		Suspended 5/20/99 for 5 years.
Perez, Hector 480 Kenwood Drive Lemoore, California		Suspended indefinitely effective 6/4/99.	Morris, Brenda Sue aka: Brenda Smith Brenda Sue Sowell Brenda Sue Ball 10499 Mills Tower Drive, #31 Rancho Cordova, California		Suspended 7/20/99 for 5 years.
<u>Nursing Home Administrator</u>					
David, Emmanuel T., Jr. 1002 Oregon Trail Banning, California	5479	Suspended indefinitely effective 6/18/98.	Patrick, Sharon Lewis 8139 Sunset Avenue, Apt.# 250 Fair Oaks, California		Suspended 5/20/99 for 5 years.
Payumo, Romeo aka: Romeo Bucalan Payumo 506 Hanover Street Daly City, California		Suspended indefinitely effective 1/22/99.	Wilson, Sylvia Merino aka: Sylvia Rameriz Sylvia Renteria Sonja Merino Cornell 1522 W. Tuolumne Fresno, California		Suspended indefinitely effective 10/2/99.
<u>Billing Service</u>					
Alexander, Leroy 5361 Annie Laurie Lane Bonita, California		Suspended indefinitely effective 09/20/00.	<u>In-Home Support Services Provider</u>		
<u>Holistic Health</u>					
Holistic Health Center 1254 Irvine Boulevard, Suite 100 Tustin, California		Suspended indefinitely effective 10/19/00.	Abaya, Gerald Rudolfo aka: Abaya, Julio P.O. Box 4 Biola, California		Suspended indefinitely effective 8/20/2007.
<u>In Home Care Provider</u>					
Santer, Marjorie Ann aka: Marjorie Santer 475 West Sierra, #162 Fresno, California	00308121	Suspended 2/20/00 for 5 years.	Allen, Edward Anthony aka: Edward, Anthony Allen 515 C Street Fresno, California		Suspended 5/18/2006.
<u>In-Home Health Service</u>					
Ackerman, Valerie Smith P.O. Box 246052 Sacramento, California		Suspended 5/20/99 for 5 years.	Armendariz, Joseph Michael 315 South Garden Avenue, #139 Fresno, California		Suspended indefinitely effective 7/19/2007.
Ansiello, Lisa 2501 Ivy Drive, Apt. #7 Oakland, California		Suspended 5/20/99 for 5 years.	Andrade, Ramon aka: Andrade, Juan Ramon 4794 East Liberty Avenue Fresno, California		Suspended indefinitely effective 10/18/2007.
Belmonte, Derek Edmund Federal Medical Center Fort Worth, Texas		Suspended indefinitely effective 6/17/99.	Andrews, James 1734 North Clark Street Fresno, California		Suspended indefinitely effective 5/20/2007.
Kelly, Varval 1820 W. Oleander Avenue Fresno, California		Suspended 5/20/99 for 5 years.	Arroyo, Angelina aka: Angelina Claudio Arroyo Angelina Arroya Claudio Olga Arroyo Claudio 5416 Watt Avenue, #A North Highlands, California		Suspended indefinitely effective 3/1/00.
McCastel, Maryann 3325 1 st Avenue, Apt. #2 Sacramento, California		Suspended 5/20/99 for 5 years.	Birley, Jeana Renon 25600 Horseshoe Lane Tehachapi, California		Suspended indefinitely effective 9/20/2007.
			Blackwell, Anita 520 S. Modoc Street Fresno, California		Suspended indefinitely effective 9/20/2007.

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<u>In-Home Support Services Provider</u>	<u>Provider Number</u>		<u>In-Home Support Services Provider</u>	<u>Provider Number</u>	
Bravo, Theresa Marie aka: Bravo, Maria T. 12506 Caminito de La Gallard San Diego, California		Suspended indefinitely effective 12/20/2005.	Gomez, Jeri Patricia aka: Bailey, Jeri Patricia 3540 North Wilson Avenue Fresno, California		Suspended indefinitely effective 8/20/2007.
Brown, Glenn Thompson 445 W. Nees, #208 Fresno, California		Suspended indefinitely effective 7/19/2007.	Harp, Angie Renee 1330 North 8th Street, #124 Fresno, California		Suspended indefinitely effective 9/20/2007.
Bumgarner, Tammy Lynn aka: Miller, Tammy 6296 Oakway Paradise, California		Suspended indefinitely effective 11/29/2007.	Hiley, Latrice M. aka: Clark, Latrice Michelle 2895 Herrington Avenue, Apartment A San Bernardino, California		Suspended indefinitely effective 5/13/2007.
Calip, Hermelina Villena 320 Merganser Drive, #20 Suisun City, California		Suspended indefinitely effective 9/20/2005.	Howden, James M. 14423 Helm Court Healdale, California		Suspended indefinitely effective 4/5/2007.
Camacho, Angelica Lopez aka: Lopez, Veronica Torrez 905 West Griffith Way Fresno, California	93705	Suspended indefinitely effective 6/20/2007.	Jackson, Betty Jo 5445 East Belmont Avenue, #208 Fresno, California		Suspended indefinitely effective 5/20/2007.
Carter-Myles, Latasha 1570 North Delno Fresno, California		Suspended indefinitely effective 7/19/2007.	Jones, Debra aka: King, Debra 4547 North Feland Avenue Fresno, California		Suspended indefinitely effective 2/20/2006.
Clark, Shirley Ann aka: Johnson, Shirley A. Miller, Shirley Ann 2275 Sacramento Street Vallejo, California		Suspended indefinitely effective 10/20/2005.	Kee, Linda Joyce 1444 East Palo Alto Avenue Fresno, California		Suspended indefinitely effective 3/20/2006.
Condra, Bernice aka: Fusilier, Bernice 937 Drake Avenue Marin, California		Suspended indefinitely effective 9/20/2006.	Lima, Patrice Louise 2881 East Huntington Boulevard Fresno, California		Suspended indefinitely effective 09/09/00.
Cooper, Antoinette Lashelle 4342 West Harvard Avenue Fresno, California		Suspended indefinitely effective 7/19/2007.	Ludan, Delia Correa aka: Correa, Delia Abenes 820 Lomita Avenue Millbrae, California		Suspended indefinitely effective 9/20/2006.
Dansby, Rocheryl aka: Harmon, Juliette Marie Green, Sherry Wilson, Quinnette Rojers, Jennifer Davis, Sherry Davis, Mary Rogers, Jenifer Shepard, Sherri Woods, Barbara Roberts, Treva Ann 927 E. Byrd Avenue Fresno, California		Suspended indefinitely effective 5/20/2007.	Major, Jeffery Allan aka: Jeffery Allen Majors Allan Jeffery Major Jeff Allan 6900 23rd Street Sacramento, California		Suspended indefinitely effective 09/09/00.
Escoto, Eulalia 2972 East Black Horse Drive Ontario, California		Suspended indefinitely effective 4/20/2006.	Manning, Fionna Nichole aka: Fionna, Manninti Nichole Manning, Nichole 4661 East Church Avenue Fresno, California		Suspended indefinitely effective 10/18/2007.
Field, Joyce Marie 415 Buckeye Terrace, #4 Redding, California		Suspended indefinitely effective 06/20/00.	McGrue, Phyllis Marie 182 West Kaviland Avenue Fresno, California		Suspended indefinitely effective 5/20/2007.
Garcia, Generosa 1023 East Nevada Avenue Fresno, California		Suspended indefinitely effective 7/19/2007.	Moreno, Tina Louise aka: Louise, Tina 2258 Knobcone Avenue Anderson, California		Suspended indefinitely effective 10/4/2007.
			North, Carlene 14729 Magnolia Drive Magalia, California		Suspended indefinitely effective 11/29/2007.

<u>In-Home Support Services Provider</u>	<u>Provider Number</u>		<u>In-Home Support Services Provider</u>	<u>Provider Number</u>	
Orozco, Leonard aka: Orozco, Leandro P.O. Box 1045 Fresno, California		Suspended indefinitely effective 2/20/2007.	Walton, Wanda Denise 122 Louisiana Street Vallejo, California		Suspended indefinitely effective 9/20/2005.
Packard, Earl 3052 West Floradora Avenue Fresno, California		Suspended indefinitely effective 8/20/2007.	<u>Personal Care Service Provider</u>	<u>Provider Number</u>	
Petrovsky, Mary Catherine aka: Petrovsky, Mary Christine Petrovsky, Mary C. Gotshalk, Mary Christine 5330 Huckleberry Way Santa Rosa, California	33453	Suspended indefinitely effective 7/19/2007.	Bravo, Theresa Marie 12506 Caminito De La Gauneda San Diego, California		Suspended indefinitely effective 06/30/04.
Pruitt, Holly Marie 2422 North Marks Avenue, #337 Fresno, California		Suspended indefinitely effective 9/20/2007.	Chang, Mayblia Moua 1063 Summerview San Diego, California		Suspended indefinitely effective 06/30/04.
Reed, Matthew 3323 East Dakota Avenue Fresno, California		Suspended indefinitely effective 10/18/2007.	Garcia, Angelica Gutierrez 300 West Central Avenue, #2201 Tracy, California		Suspended indefinitely effective 06/30/04.
Reed, Peggy Lee aka: Stoker, Peggy Lee Hearn, Peggy Lee Quick, Peggy Lee 10300 King River Road, #170 Reedley, California		Suspended indefinitely effective 06/20/03.	Garcia, Rosemarie 2828 Broadway San Diego, California		Suspended indefinitely effective 06/30/04.
Rice, William Cedrick 371 East Jensen Fresno, California		Suspended indefinitely effective 7/19/2007.	Heu, Dang 3216 North 42 nd Kansas City, Kansas		Suspended indefinitely effective 06/30/04.
Saguibo, Veronica 94-1377 Hiapo Street Waipahu, Hawaii		Suspended indefinitely effective 12/20/05.	Jackson, Beth Earl 865 Gwen Street San Diego, California		Suspended indefinitely effective 06/30/04.
Shaboyan, Eghis V. aka: Shaboyan, Egisc 1714 W. Dakota Avenue Fresno, California		Suspended indefinitely effective 9/20/2007.	Koca, Toni Lee 288 Broadway, #56 Chula Vista, California		Suspended indefinitely effective 06/30/04.
Shaboyan, Grachya 3087 West Santa Ana Avenue Fresno, California		Suspended indefinitely effective 9/20/2007.	Tang, Kai D. 3233 North Claremont Fresno, California		Suspended indefinitely effective 07/06/04.
Shaboyan, Knarik 1714 West Dakota Avenue Fresno, California		Suspended indefinitely effective 9/20/2007.	Vu, Nyoua 8660 Lepus Road San Diego, California		Suspended indefinitely effective 06/30/04.
Thomas, Erycka Resean 108 North Van Ness Avenue Fresno, California		Suspended indefinitely effective 7/19/2007.	Vu, Phoua Chang 11249 Westonhill Drive San Diego, California		Suspended indefinitely effective 06/30/04.
Vasquez, Francisca Magdalena aka: Vasquez, Magdalena 14 Manchester Court Novato, California		Suspended indefinitely effective 9/20/2006.	Vue, May Choua 7027 Osler Street San Diego, California		Suspended indefinitely effective 06/30/04.
Villa, Rosemary L. aka: Villa, Rose 3508 North Claremont Avenue Fresno, California		Suspended indefinitely effective 4/19/2007.	Vue, Pao Thao 95 West Santa Ana Avenue, #C Clovis, California		Suspended indefinitely effective 06/30/04.
			Williams, Phyllis Denise 4384 41 st Street, #5 San Diego, California		Suspended indefinitely effective 06/24/04.
			Wodke, Joseph 400 Barnes Avenue Medford, Oregon and/or 6 Mace Road Medford, Oregon		Suspended indefinitely effective 10/13/04.



County of San Diego

HEALTH AND HUMAN SERVICES AGENCY
1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417

AGING & INDEPENDENCE SERVICES
P O Box 23217, SAN DIEGO CA 92193-3217
(858) 495-5858 FAX (858) 495-5080

This is to inform you that your name and identification number have been added to the California Department of Health Services Medi-Cal Suspended and Ineligible (S&I) Provider List. You are ineligible to provide services to In-Home Supportive Services (IHSS) recipients for 10 years from the date of suspension. Your services are terminated automatically. IHSS has informed the recipient you are currently assisting that your services are terminated.

Under the California Institution Code (WIC), Sections 14123 and 12305.81, an IHSS Individual Provider is ineligible to provide services to IHSS eligible recipients if he/she is convicted of a crime involving fraud or abuse of the Medi-Cal program, or if he/she is suspended from the federal Medicare program for any reason. The convictions that prohibit serving as an Individual Provider include crimes against the elderly, dependent adults, and children.

Ineligible Providers are not entitled to a hearing under the *California Administrative Procedures Act*. For information regarding the Suspended and Ineligible Provider (S&I) List, you can go to the following websites:

www.medi-cal.ca.gov.

Click on the *S&I Provider List* link under Provider Reference. Then, click on *Medi-Cal Suspended & Ineligible Provider List (susp u)*.

<http://oig.hhs.gov>

The Office of Inspector General Excluded Provider List

You can also call the Telephone Service Center (TSC) at 1-800-541-5555.

Thank you.

Social Worker

Telephone Number

Date

ATTACHMENT C



County of San Diego

HEALTH AND HUMAN SERVICES AGENCY
1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417

AGING & INDEPENDENCE SERVICES
P O Box 23217, SAN DIEGO CA 92193-3217
(858) 495-5858 FAX (858) 495-5080

This is to inform you that your current In-Home Supportive Services (IHSS) Individual Provider (IP), _____ with IP number _____, has been added to the California Department of Health Services (CDHS) Medi-Cal Suspended and Ineligible (S&I) Provider List. He/she is ineligible to provide IHSS services for 10 years from the date of the suspension. When an Individual Provider is added to this list, his/her services are terminated automatically.

Under the California Institution Code (WIC), Sections 14123 and 12305.81, the IHSS Individual Provider is ineligible to provide services to IHSS eligible recipients if he/she is convicted of a crime involving fraud or abuse of the Medi-Cal program, or if he/she is suspended from the federal Medicare program for any reason. The convictions that prohibit serving as an Individual Provider include crimes against the elderly, dependent adults, and children.

Ineligible Providers are not entitled to a hearing under the *California Administrative Procedures Act*. For information regarding the Suspended and Ineligible Provider (S&I) List, you can go to the following websites:

www.medi-cal.ca.gov.

Click on the *S&I Provider List* link under Provider Reference. Then, click on *Medi-Cal Suspended & Ineligible Provider List (susp u)*.

<http://oig.hhs.gov>

The Office of Inspector General Excluded Provider List

You can also call the Telephone Service Center (TSC) at 1-800-541-5555.

If you need assistance in finding a provider, please contact your Social Worker or the IHSS Public Authority Registry at 1-866-351-7722 or (619) 476-6215.

Thank you.

Social Worker

Telephone Number

Date

ATTACHMENT B

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
ADVANCE SPECIAL NOTICE 08-02**

March 14, 2008

SUBJECT: IHSS INDIVIDUAL PROVIDER DIRECT DEPOSIT

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: EBB 08003 – Provider Direct Deposit

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff of the availability of direct deposit services to qualifying Individual Providers, and the implementation of this new service in the Case Management, Information, and Payrolling System (CMIPS).

II. BACKGROUND

Direct deposit through Electronic Fund Transfer (EFT) was a service previously allowed only to IHSS recipients who are eligible to Advance Payments of their IHSS benefits. Direct deposit of Advance Pay benefits was implemented when Assembly Bill 4252 (Chapter 1141, Statutes of 1986) took effect on January 1, 1987. The California Department of Social Services (CDSS) has extended the direct deposit service to all IHSS IP's who meet the criteria to elect for the processing of IHSS payments to a designated account at a financial institution through EFT. An IP who is enrolled to have IHSS payments deposited directly into his/her designated account will receive Direct Deposit Remittance Advice with information about his/her direct deposit, payroll deductions, and a new timesheet for the next pay period instead of receiving IHSS payroll warrants by mail.

III. POLICY

CDSS has the "authority to formulate and adopt policies which are consistent with law and necessary for the administration of public social services" as provided in the Welfare and Institution Code Sections 10553 and 10554. The direct deposit service is implemented in order that "payments for IHSS authorized services rendered shall be sent to the recipient's Individual Provider" with more efficiency and security.

IV. SOCIAL WORKER PROCEDURES

- The Social Worker will direct inquiries about direct deposit to the CDSS Help Desk at 1-866-376-7066, or to the CDSS website to access the Provider Outreach Letter and the Provider Direct Deposit Enrollment Form. The website is www.dss.cahwnet.gov. Click Forms/Brochures.
- The official Provider Outreach Letter and the Provider Direct Deposit Enrollment Form will be sent by CDSS to eligible IHSS Providers.
- The Social Worker will not enter any information associated with the direct deposit on CMIPS but should be aware of the various field codes related to direct deposit.

V. DIRECT DEPOSIT TIMELINES

- On March 17, 2007, the Provider Outreach Letter and the Provider Direct Deposit Enrollment Form will be mailed to qualifying IP's. An IP who has been active in CMIPS for ninety days and has current payments in CMIPS will be sent the outreach letter and the enrollment form. Subsequent mailings will be made monthly to qualifying IP's.
- On March 17, 2007, a toll free telephone number 1-866-376-7066 will be available for direct deposit questions and support. The CDSS Help Desk will only address questions pertaining to direct deposit, and can only support English language speakers.
- On May 1, 2008, the State Controller's Office will start the EFT process for enrolled IP's. Payments entered into CMIPS by April 30, 2008 will be transferred electronically to the account identified by the IP for direct deposit.
- The Provider Outreach Letter and the Provider Direct Deposit Enrollment Form are available in eleven different languages.
- Undeliverable enrollment mail will be forwarded to the county of record.

VI. CHANGES IN CMIPS

- PELG screen
A new field titled *EFT* will be added. This field will display "N" for no direct deposit, or "Y" for active direct deposit. This field will be available on the County Download at the end of March 2008.
- PSUM screen
A new column titled *E* for EFT will be displayed at the end of the Warrant Detail line. When a payment is sent to the State Controller's Office as an EFT, the payment line will have an "F" in this column. A blank value in this field indicates that the payment is a paper warrant.
- The County Payment Voucher Report will display the new message "89- Provider Direct Deposit" for EFT payments.
- EFT transactions cannot be voided if an IP with direct deposit is paid incorrectly. The county will be responsible for initiating the payment recovery process.

VII. REVIEW STATEMENT

This is an Advance Special Notice. Additional information will be sent out as it becomes available. 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.



ELLEN SCHMEDING
Assistant Deputy Director

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

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 08-01**

January 21, 2008

SUBJECT: REIMBURSEMENT PROCEDURE FOR MISSED BUY-OUT

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: ACL 07-46

I. PURPOSE

This Special Notice provides IHSS staff with information about changes to the Case Management, Information, and Payrolling System (CMIPS). These changes allow reimbursement to a recipient for an overpaid Medi-Cal Share of Cost (SOC) when the recipient misses the State's Buy-Out at the beginning of the month through no fault of his/her own. This Special Notice also provides information on the identification and processing of eligible reimbursements and includes examples.

II. BACKGROUND

The implementation of the IHSS Plus Waiver (IPW) Program required that the In-Home Supportive Services (IHSS) Program comply with existing Medi-Cal rules and regulations. Medi-Cal rules require that all Medi-Cal recipients meet their entire Medi-Cal SOC before payments for services are allowed. The Buy-Out is processed towards the end of the month, for the following month, and is based on the information contained in the Medi-Cal Eligibility Data System (MEDS) Monthly Renewal File and the CMIPS Response File. CMIPS verifies via MEDS if a recipient owes a Medi-Cal SOC. Any medical expenses that occur from the 1st-15th of the month are processed and applied to the SOC. Subsequent timesheets are also applied against the SOC. Any outstanding SOC is deducted from the IHSS provider payment and must be paid by the recipient to the IHSS provider. A recipient that is Medi-Cal eligible will have a calculation for the IHSS and the Medi-Cal SOC completed by the Medi-Cal worker. The recipient must pay the lower of the two SOC's, and the State will pay (or "Buy-Out") the difference between the two SOC's with State General Fund (SGF) monies. IHSS couples cases will be evaluated for a missed Buy-Out if one of the recipient's is either in the IPW (2L) or PSCP (2M) Program and the other recipient is in the Residual (2N) Program. CMIPS will process the spend-down on the IPW (2L) or PCSP (2M) case and reduce the Medi-Cal SOC. The Residual (2N) case will have the SOC deducted from the provider's warrants. A recipient must be designated as Medi-Cal eligible on the MEDS Monthly Renewal File to have the State make the Buy-Out payment. Once the Buy-Out is processed, changes to the Buy-Out amount for

IHSS SPECIAL NOTICE 08-01 REIMBURSEMENT FOR MISSED BUY-OUT

that time period will not be processed. A new IHSS recipient will rarely be included in the Buy-Out during their first month of IHSS eligibility. These recipients must pay the entire Medi-Cal SOC and are ineligible for the X-27 reimbursement. Recipients and providers receive written, monthly notification of any remaining SOC that is owed.

III. POLICY

In order to be eligible for an X-27 reimbursement of a failed IHSS Buy-Out for the current and/or previous month the recipient must have:

- Missed the Buy-Out through a system, administrative, or processing error.
- Been Medi-Cal eligible for the reimbursement period.
- Incurred an actual expense in excess of his/her SOC obligation.
- Actually paid for that expense out-of-pocket.

The recipient must have incurred an actual out-of-pocket expense for the excess SOC amount in order to be considered for reimbursement through either:

- An X-27 SPEC transaction;
- A Conlan II claim for any excess SOC situation;

Provided that the recipient has missed the Buy-Out for the current and/or previous month, and through no fault of his/her own, the recipient can be reimbursed through an X-27 SPEC transaction.

Cases with more than two months of exclusion from the Buy-Out must be reviewed to determine the circumstances and resolve the issues surrounding the extended period of exclusion. The recipient must be informed that he/she may submit a Conlan II claim to request reimbursement for excess SOC payments that *are not* payable through an X-27 SPEC transaction. A recipient may file a Conlan II claim to request reimbursement for covered medical services received and paid for 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.

Note: Conlan II referrals can be made by calling 1-877-508-1327.

The X-27 SPEC transaction is:

- Funded solely through State General Fund (SGF) monies.
- Can only be used for reimbursement of a failed Buy-Out.
- Will be subject to Quality Assurance review.

A recipient *can* be paid using an X-27 SPEC transaction. A provider *cannot* be paid using an X-27 SPEC transaction. IHSS Staff must determine the reason for the recipient's exclusion from the Buy-Out process for each applicable month before using the X-27 SPEC transaction. X-27 SPEC transactions cannot be entered for periods prior to June 1, 2006 when the SOC Point of Service (POS) was implemented.

IV. PROCEDURES

IHSS SOCIAL WORKER

The X-27 SPEC transaction may be entered only:

- Against an IHSS *recipient* case.
- For a single, complete eligibility month (no partial months).

The Social Worker will review the recipient's case file to determine the following:

- The recipient's eligibility to an X-27 reimbursement.
- The cause of the missed Buy-Out.
- The amount of the reimbursement.

In order to document the recipient's eligibility to an X-27 SPEC reimbursement, the Social Worker will include the following information before submitting the case file to the IHSS Social Work Supervisor:

- The name of the recipient.
- The case number.
- The recipient's Social Security number.
- The name of the provider for the month of the requested reimbursement.
- The amount of the missed Buy-Out for each month for which reimbursement is requested.
- A MELG record for each eligibility month, for which reimbursement is requested.
- WARD and SOCD screens for each eligibility month, for which reimbursement is requested.
- A narrative entry with an explanation of why the Buy-Out was missed and any actions taken.

IHSS SOCIAL WORK SUPERVISOR

The IHSS Social Work Supervisor will:

- Review all case files associated with an X-27 reimbursement request for eligibility and accuracy.
- Approve reimbursement requests that meet the specified criteria.
- Forward the reimbursement requests to the Program Manager for approval.

After approval by the Program Manager the Social Work Supervisor will request:

- NOA 527 if the reimbursement is approved.
- NOA 526 if the reimbursement is denied.

SPECIAL (SPEC) TRANSACTIONS

Clarifications regarding the usage of the following special SPEC transactions have been included to assist in their correct application.

An X-01 SPEC transaction:

This transaction is used to make payments resulting from a State Hearing but cannot be used for a SOC reimbursement request. Each case will be evaluated individually for an X-27 reimbursement or a Conlan II claim.

The X-15 SPEC transaction:

This transaction cannot be used to reimburse recipients for out-of-pocket SOC expenses in excess of their obligation. This and all other SPEC transactions involve state/county and federal sharing ratios.

The C-02 SPEC transaction:

- Was used for making adjustments when there was a retroactive adjustment to the SOC amount.
- Can no longer be used for IPW (2L) and PCSP (2M) cases.

The C-02 SPEC transaction can still be used for:

- IPW (2L) and PCSP (2M) cases when the adjustment is prior to the implementation of SOC POS on June 1, 2006.
- All IHSS-R cases regardless of time period.

V. REVIEW STATEMENT

This Special Notice was reviewed by the standard review committee.

VI. FILING STATEMENT

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



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Verónica Hernández (858) 495-5131
Attachments

GLOSSARY

Buy-Out - The difference between the higher MEDS Share-of-Cost (SOC), and the lower IHSS SOC. This amount will be paid by the California Department of Social Services (CDSS).

MEDS IHSS Renewal File – Monthly data received from MEDS containing individual eligibility and SOC information. This information is used to process the Buy-Out and assign Secondary Aid Codes.

Share-of-Cost (SOC) Comparison - CMIPS compares the Medi-Cal SOC with the IHSS SOC. The recipients eligible for the SOC comparison are responsible for the lower of the two amounts. To be eligible for the SOC comparison, the recipient must be eligible for Full-Scope Federal Financial Participation (FFP) Medi-Cal and the IHSS Plus Waiver (IPW) Program. California Department of Social Services (CDSS) will pay Medi-Cal Recognized Expenses (MRE's) *equal* to the difference between the two share-of-cost amounts. This amount is the "Buy-Out".

Spenddown - The Spenddown refers to the amount of SOC paid by the recipient to the IHSS provider, or any other Medi-Cal recognized service that can be applied against and reduce the Medi-Cal SOC.

CASE EXAMPLES

ELIGIBLE FOR X-27 SPEC TRANSACTION REIMBURSEMENT

Case Study: Sophia Marks

Case: 9999999999

SSN: 999-99-9999

Sample Assumption: The recipient called regarding a SOC overpayment in the first part of December, and the case is being reviewed immediately.

- Situation: Until November, the recipient was eligible for A&DFPL/Medi-Cal with a "0" IHSS SOC.
- Effective 11/01/06, she had an IHSS SOC of \$45 and a Medi-Cal SOC of \$821.
- On Nov. 22, 2006, Medi-Cal again qualified her for A&DFPL through MEDS.
- Current CMIPS system information still shows a Medi-Cal SOC of \$821 and an IHSS SOC of \$45.

Would the reimbursement for November be completed through Conlan II and the reimbursement for December through the X-27 SPEC transaction?

The facts according to MEDS and CMIPS

Month	Case Name	MEDS SOC (MELG & SOCR)	IHSS SOC (CMIPS)	State's MRE Amount	Actual Amount of State MRE (MEDS SOC – IHSS SOC)	First Pay Period SOC (WARD)	Second Pay Period SOC (WARD)	Payroll SOC Deductions (WARD)	Balances on MEDS (SOCR)
November		1091.00	0.00	1091.00	1091.00	0.00	0.00	0.00	
December		821.00	282.00	539.00	N/A	N/A	N/A	N/A	N/A

*This is only reimbursable if the recipient has made an out-of-pocket payment. The provider has to submit timesheets before it can be determined if there was an out-of-pocket expense.

Pertinent Data: Recon File Process Date 10/26/06.

Since the change to the recipient's SOC happened after the Recon File was processed for November, the recipient was not adversely affected for November. CMIPS processed the State's monthly payment for Medi-Cal Recognized Expenses (MRE) for the entire Medi-Cal SOC for November. A review of the warrant (WARR) screen shows that CMIPS did not deduct any SOC from any provider's pay warrant. There is nothing to refund for November because:

- The State's payment for MRE is not recipient money.
- There were no deductions from the provider's pay warrants.

For December, the MRE payment was processed on information effective 11/22/06. The next change was made on 11/28/06 after the Recon File was processed for the December payment of MRE. CMIPS correctly processed the Buy-Out based on the information in the system at the time. The recipient could be reimbursed up to \$237 (\$282 minus \$45 IHSS SOC the recipient is responsible for), **but only** after the timesheets are processed. Until this point, there is no overpayment. The recipient has not paid any money towards her SOC. The X-27 SPEC transaction is for **reimbursement** of an overpayment of MRE SOC money paid to her IHSS provider. No timesheets have been processed for any of this recipient's providers and the recipient has not paid any money for which she needs reimbursement. The system no longer makes a total SOC adjustment at the beginning of the month. Under Medi-Cal rules, SOC payments are processed in "real time" when the provider accesses the system whether by a POS terminal in the doctor's office or when CMIPS processes a timesheet. The X-27 SPEC transaction is not to be issued at the beginning of the month because an error was made in State's MRE payment. When the X-27 SPEC transaction is used, it must be made clear to the recipient why she receiving the warrant. In addition, the MELG screen still shows a November SOC of \$1,091 and for December a SOC of \$821. The MELG screen is updated when information from MEDS is received via the CMIPS/MEDS interface. As long as this information remains "as current" in MEDS, CMIPS will continue to use it. Only Medi-Cal can make corrections to their information. Since CMIPS interfaces with MEDS before it deducts any SOC from the provider's warrants, if MEDS has been corrected to zero, there is nothing for CMIPS to deduct. For this reason, corrections cannot be processed without researching each case's individual circumstances.

NOT ELIGIBLE FOR X-27 SPEC TRANSACTION REIMBURSEMENT

Case Study: Felicia Hunter

Case: 0000000000

SSN: 999-99-9999

Situation: The Medi-Cal case was closed in error 8/31/06 due to Cal-Win conversion problems. The Medi-Cal case was reopened with a SOC. The client paid the higher Medi-Cal SOC of \$550, rather than the IHSS SOC of \$314, for both September and October 2006. Amount = \$241.02 for PP2 in September and October 2006 (Balance of SOC due was \$5.02 for PP2 if correct SOC of \$314 was used; \$308.98 SOC deducted for PP1 in September and October and \$241.02 deducted from PP2 for those months).

The facts according to MEDS and CMIPS

The information shown in the chart below was taken from the screen(s) shown in () below the column title.

Month	Case Name	MEDS SOC (MELG & SOCR)	IHSS SOC (CMIPS)	Buy-Out Amount	Actual Amount Bought Out (MEDS SOC - IHSS SOC)	First Pay Period SOC (WARD)	Second Pay Period SOC (WARD)	Total Payroll SOC Deductions (WARD)	Balances on MEDS (SOCR)
August		504.00	314.00	190.00	190.00	308.98	0.00	308.98	550.00
September		550.00	314.00	236.00	0.00	308.98	241.02	550.00	0.00
October		550.00	314.00	236.00	0.00	308.98	241.02	550.00	0.00

***August:** According to CMIPS records, the recipient should have paid another \$5.02 to meet her SOC obligation. Based on Medi-Cal records which include a retroactive increase in the Medi-Cal SOC, the recipient should have paid another \$51.02 to meet her SOC obligation.

****September/October:** Only eligible for reimbursement (CONLAN II) if this amount was actually paid to the IHSS provider, in addition to the \$314 SOC the recipient is responsible for paying to meet her Medi-Cal SOC obligation.

Pertinent Data: Medi-Cal eligibility not reported to CMIPS until 9/14/06 for both September and October. According to CMIPS segment 027, this case was in "T" status as of the end of August. "T" status did not change to "E" until October 5, 2006. CMIPS correctly processed this case for all months, based on the information contained in the database. This case does not meet the criteria for an X-27 reimbursement. This is a retroactive Medi-Cal eligibility change. According to the SOCR screen, MEDS changed the Medi-Cal SOC for August to \$550 from the \$504 which was originally transmitted to CMIPS. CMIPS used the March 25, 2006 (segment 025) information for processing the August Buy-Out. No Buy-Outs were processed for September or October since the case was in "T" status. SOC deductions for September and October were based on the information received from MEDS on September 14, 2006, which

IHSS SPECIAL NOTICE 08-01 REIMBURSEMENT FOR MISSED BUY-OUT

Attachment B

indicated a \$550 Medi-Cal SOC. Since no timesheets had been received prior to the receipt of the information from MEDS, CMIPS used the Medi-Cal SOC for processing.

County Action: The recipient must be advised to file a Conlan II claim for reimbursement of overpaid Medi-Cal SOC due to retroactive changes made by Medi-Cal. The recipient must have paid their provider the correct SOC amount and a portion of the Buy-Out amount to be eligible for reimbursement. The recipient is only eligible for reimbursement of that portion of the Buy-Out amount that she actually paid to the provider. This is a Medi-Cal SOC and Medi-Cal considers the IHSS program as another Medi-Cal provider. The recipient cannot be reimbursed unless she has overpaid her SOC.

NOT ELIGIBLE FOR X-27 SPEC TRANSACTION REIMBURSEMENT

Recipient: Fozzie Bear
 Case: 0000000000
 SSN: 999-99-9999
 IHSS Provider: Tavia Miller
 Contact: Shaylah Marks

Complaint: I have an email from Shaylah explaining the situation to one of her co-workers. The constituent says IHSS is inaccurately billing her for her share-of-cost. Her share-of-cost is \$539.97. They are taking out an additional \$45 at the end of the month and moving it to the next month. Thus, she never reaches her required shared costs amount which makes her ineligible for Medi-Cal.

The facts according to MEDS and CMIPS

The information shown in the chart below was taken from the screen(s) shown in () below the column title.

Month	Case Name	MEDS SOC (MELG & SOCR)	IHSS SOC (CMIPS)	Buy-Out Amount	Actual Amount Bought Out (MEDS SOC – IHSS SOC)	First Pay Period SOC (WARD)	Second Pay Period SOC (WARD)	Total Payroll SOC Deductions (WARD)	Balances on MEDS (SOCR)
August		821.00	585.11	236.00	236.00	539.97	45.03	585.00	0.00
September		821.00	585.11	236.00	236.00	539.97	45.03	585.00	0.00
October		821.00	585.11	236.00	236.00	539.97			0.00
November		821.00	585.11	236.00	236.00	539.97			
December		821.00	585.11	236.00	236.00				

Pertinent Data: CMIPS records indicate the recipient’s IHSS SOC has been \$585.11 since at least March 2006. The Medi-Cal SOC has been \$821 during the same period. CMIPS has been correctly calculating the payroll deductions: \$539.97 from the first pay period and \$45.03 from the second pay period, since the first pay period wages were insufficient to cover the entire SOC. Why the recipient thinks her SOC is only the first amount of \$539.97 is unknown. The recipient may be confused due to the new way CMIPS processes the payroll and deducts SOC. Prior to June 2006, CMIPS deducted both the Buy-Out and SOC on the first of the month. Now, CMIPS only deducts the Buy-Out amount at the beginning of the month and deducts any available SOC as timesheets are submitted. If there aren’t enough hours submitted on the first timesheet to cover the entire SOC for the month, CMIPS will deduct it from the next timesheet submitted. In this case, the second timesheet period is the last two (2) weeks of the month and the remaining SOC amount is not deducted until after the first of the following month, when the second pay period timesheet is processed. The recipient is probably used to having her SOC certified at the beginning of the month. Medi-Cal rules state that the recipient has the right to pay her SOC anywhere (i.e. the doctor, dentist, not just her provider). Additionally, under Medi-Cal rules, the

SOC cannot be deducted in advance of the hours worked by the provider. Timesheets cannot be submitted before the hours are actually worked. With the exception of December, the recipient has been Medi-Cal certified every month. While the month of December has not been completed, a review of both the Medi-Cal and CMIPS information shows the SOC information unchanged.

ELIGIBLE FOR X-27 SPEC TRANSACTION REIMBURSEMENT

Case: Shallabah Marks
 SSN: 999-99-9999
 Contact: (999) 999-9999

Situation: The recipient is complaining that too much SOC is being deducted from her provider's warrants.

The facts according to MEDS and CMIPS

The information shown in the chart below was taken from the screen(s) shown in () below the column title.

Month	Case Name	MEDS SOC (MELG & SOCR)	IHSS SOC (CMIPS)	Buy-Out Amount	Actual Amount Bought Out (MEDS SOC – IHSS SOC)	First Pay Period SOC (WARD)	Second Pay Period SOC (WARD)	Total Payroll SOC Deductions (WARD)	Balances on MEDS (SOCR)
January		748.00	553.50	194.50	0.00	643.63	104.37	\$ 748.00	0.00
February		836.00	553.50	282.50	0.00	643.63	192.37	\$ 836.00	0.00
March		836.00	553.50	282.50	283.00	553.00	N/A	\$ 553.00	0.00
									TOTAL

Pertinent Data:

The only information that was entered into CMIPS in time for the Recon File Processing was done in February in time for the State's payment of Medi-Cal Recognized Expenses (MRE) for March 2007. CMIPS correctly paid the State's Medi-Cal Recognized Expense (\$283) portion of the Medi-Cal SOC leaving a balance of \$553 which was deducted from the provider's warrant for the first pay period for March. The provider was issued a warrant for the balance. For the prior months, CMIPS did not receive any information from MEDS in time to do the SOC comparison and pay the State's Medi-Cal Recognized Expense portion of the Medi-Cal SOC. CMIPS can only do the SOC comparison and make the State's payment for MRE if the information is transmitted by MEDS prior to the monthly payment.

County Action:

This case is eligible for an X-27 reimbursement if the delay in posting the information to CMIPS was not the recipient's fault, e.g. the recipient completed and submitted all paperwork timely, cooperated with the county social worker, etc. The X-27 SPEC is only available for reimbursement to the recipient when a payment of MRE by the State is missed through no fault of the recipient. **The recipient must experience an actual out-of-pocket expense to be eligible for reimbursement.**

This example qualifies for an X-27 reimbursement because it involves the State's once-a-month

payment of Medi-Cal Recognized Expenses. The payment/reimbursement involves only State General Fund money. Reimbursements for other overpayments should be referred to the Conlan II Business Services Center. Provided that the recipient has met the eligibility criteria, the county should process an X-27 SPEC transaction to reimburse the recipient for the out-of-pocket payments for January and February. It is the responsibility of the county to ensure that the recipient has actually made an out-of-pocket payment for which she needs reimbursement.