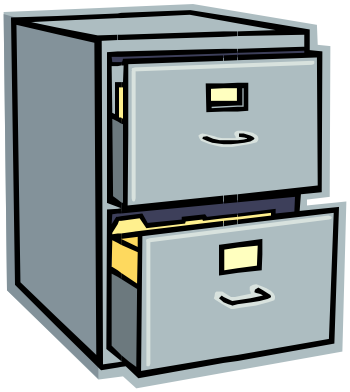
IN-HOME SUPPORTIVE SERVICES SPECIAL NOTICE ARCHIVES 2010



IHSS SPECIAL NOTICES 2010

YEAR	NUMBER	SUBJECT (ABBREVIATED)	REMARKS
2010	10-01	Verification of Social Security Card and ID	Issued 2/19/10
	10-02	Hospital Error Rate Study Instructions	Issued 3/1/10
	07-10 Add A	Conlan II Reimbursement Process	Issued 3/10/10
	10-03	IHSS & PACE	Issued 4/30/10
	10-04	Sharepoint Case Tracking Tool	Issued 5/3/10
	06-07 Add A	Modified Notice of Action (NOA)	Issued 6/16/10
	10-05	Providers in Pending Status	Issued 6/18/10
	10-06	Case Information Request PI Unit	Issued 7/9/10
	09-14 Add A	Revised SOC 295	Issued 7/9/10
	10-07	Q&A Expanded IHSS Provider Enrollment	Issued 8/12/10
	10-08	Revised 426A	Issued 10/5/10
	10-09	IHSS Interpreter Procedures	Issued 10/5/10
	10-10	Provider Enrollment – Inter-County Transfer	Issued 12/9/10
	10-11	3.6 Reduction	Issued 12/17/10
	10-11 Add	3.6 Reduction	Issued 12/29/10

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10-11
ADDENDUM

December 29, 2010

SUBJECT: **IHSS 3.6 Percent Service Reduction**

EFFECTIVE DATE: **December 31, 2010**

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

SOURCE: **ACL 10-61**

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with additional information and instructions on the implementation of the 3.6 reduction of services for IHSS recipients.

II. BACKGROUND

AB1612 requires form NA 690 to be mailed at least 30 days prior to the effective date of the 3.6 percent reduction. The new NOA message 303 (Temp) will show the total authorized hours before the reduction, and the total authorized hours after the reduction. The California Department of Social Services (CDSS) will mail out NOAs to current recipients between December 26, and December 30, 2010. A NOA message insert (303-A) will be included with each NOA sent by CDSS. The NOA message insert will explain the new law to recipients, and will be available in English, Spanish, Armenian, and Chinese (Attachments). The NOA message will also include the appeals information translated into the same languages.

The NOA message inserts 303-A and 303-B directs recipients to contact their local IHSS office. IHSS and other AIS staff can expect phone calls as a result of these instructions.

III. IHSS STAFF RESPONSIBILITIES

Social Worker Responsibilities

The assigned IHSS Social Worker will continue to conduct assessments and reassessments, and submit the information for data entry into the Case Management Information and Payrolling System (CMIPS) following standard procedures. CMIPS will automatically calculate the 3.6 percent reduction and apply the reduction to the total authorized hours.

Note:
Severely Impaired and Non-Severely Impaired categories *will not* change as a result of the reduction.

Request for Reassessment
If a request for a reassessment is received within 90 days of the issuance of the 3.6 reduction NOA the Social Worker will:

- Determine if there is a change in circumstances or assessed need (e.g. hospitalization)
- Request additional information from the recipient to document the change (if any)

If there has been a change in circumstance, the Social Worker will reassess the individual's service needs.

If the request is solely in response to the 3.6 percent reduction the Social Worker will:

- Explain the hearing process to the recipient
- Deny the request for a reassessment

State Hearings
Hearing requests based solely on the 3.6 percent reduction will be dismissed. Recipients will continue to have the right to appeal any other county action made on their IHSS case. If an oral request is received for a state hearing on the 3.6 reduction, IHSS staff will refer the recipient to the State Hearings Division at:

1 (800) 743-8525

If a written request for a state hearing is received for the 3.6 percent reduction the request should be faxed to the State Hearings Division at fax number:

1 (916) 651-5210

CMIPS Data Entry
CMIPS will perform a one-time process that reduces the "Authorized to Purchase" hours on existing recipient cases that are in "E", "I", or "L" status by 3.6 percent. All existing providers in "E", "I", or "L" status with a code of "1" on line E, field 3, (a one-to-one relationship) will also be updated automatically. The SOC 293 and the SOC 311 will be suppressed for the 3.6 reduction. Additional details on CMIPS data entry were included in IHSS Special Notice 10-11 issued December 13, 2010.

IHSS Recipient Responsibilities
The IHSS recipient or his/her authorized representative is responsible for advising the service provider about the reduction in hours, and for choosing how the reduction will be applied to their hours (which services will be reduced or eliminated).

- The Recipient does not need to report the information to the Social Worker
- The Social Worker *will not* distribute or allocate the remaining hours

Clerical Responsibilities
The designated office assistant will ensure that:

- Between December 31, 2010, and January 31, 2011the NOA message insert 303-A along with the appeals information is included with each and every NOA sent from each district office.

- Beginning February 1, 2011 and continuing through June 30, 2012 NOA message insert 303-B along with the appeals information is included with each and every NOA sent from each district office.

CMIPS NOA Messages

303 (temp) - Beginning February 1, 2011 and as a result of a new state law your total monthly authorized hours of ###. ## will be reduced by 3.6 percent to ###. ##. (WIC, section 12301.06) Please see the insert for more information about the new law.

303 - As a result of a new state law your total monthly authorized hours of ###. ## have been reduced by 3.6-percent to ###. ## (WIC, section 12301.06) Please see the insert for more information about the new law.

IV. REVIEW STATEMENT

This notice was not reviewed by an Organizational Review Committee (ORC).

V. FILING STATEMENT

HSS Special Notices, Bulletins, and Memos are being archived at the following link:
S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated

And at the county intra-net at:
http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS
Hard copies of this Special Notice will not be distributed by Program Support.

WIL QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Mary Harrison (858) 505-6952
Dist. Codes 7 & 8

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE -303-A

Beginning February 1, 2011, your total authorized monthly hours will be reduced by 3.6 percent. Here is why:

A new state law (Section 12301.06 of the Welfare and Institutions Code) says the California Department of Social Services must reduce all IHSS recipients' total authorized monthly hours by 3.6 percent.

The new law allows you to choose which of your specific authorized IHSS services, shown on the front of your IHSS Notice of Action, will be reduced. For example, if you lose three hours of service per month, you can choose to reduce three hours from one authorized service or split it up among different services. You are responsible for informing your provider(s) of your reduction in total authorized services and which specific service hours you have chosen to reduce. You do not have to report which hours you choose to reduce; this is between you and your provider.

The 3.6 percent reduction will remain in effect until June 30, 2012. The new law also applies to all reassessments made during this timeframe. On July 1, 2012 your total monthly hours will go back up to your full authorized service level, based on your most recent assessment.

Your hearing rights are included with this message. However, requests for a state hearing only about the new state law requiring the 3.6 percent reduction in service hours will be dismissed.

If you do not understand the changes or have questions about the new law please contact your county IHSS office.

RIGHT TO REQUEST A STATE HEARING

1. You have the right to a conference with representatives of the County Welfare Department to talk about this intended action. At such a conference, you may speak for yourself or be represented by a lawyer, a friend or other spokesperson. If you want a conference, contact your county department.
2. Whether you request a conference or not, you also have the right to request a State Hearing and decision by the director of the California Department of Social Services (see form below). Your request may be written or oral but it must state that you want a hearing and why you are dissatisfied. YOUR REQUEST FOR A HEARING MUST BE MADE WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.
3. IF YOU REQUEST A STATE HEARING AT ANYTIME BEFORE THE EFFECTIVE DATE OF THE COUNTY'S PROPOSED ACTION, YOUR SERVICES MAY CONTINUE UNITL THE HEARING. You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request in made in good faith.
4. You may request a State Hearing on your own, or you may ask your county department for assistance. In either case, however, be sure to inform your county department worker as soon as possible.
5. At a State Hearing you have the right to be represented by an attorney or any other person (a friend, relative, or other spokesperson), of your choice. You may obtain free legal advice and the services of a lawyer. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response. You may also contact the nearest social service rights organization for assistance in presenting your claim.
6. State regulations governing State Hearings for social services are available at the office of County Welfare Department.
7. Information Practices- The information you are requested to provide is mandatory in order to process your request for a State Hearing pursuant to W&IC 10950. A case file will be established by the Office of the Chief Administrative Law Judge. You have the right to examine the materials that constitute the record for decision. Any information you provide may be shared with the County Welfare Department or the United States Department of Health and Human Services.

If you wish to make a written request for a State Hearing, please send this page to the County Welfare Department. The address is found on the front side of your IHSS Notice of Action on the top right hand corner.

To make an oral request for a State Hearing, or obtain further information about your State Hearing rights or files you may contact;

Public Inquiry and Response
California Department of Social Services
744 P Street, Mail Station 8-4-23
Sacramento, CA 95814
(800) 952-5253 (toll-free number)*
TDD (800) 952-8349* For Hearing and Speech Impaired
*You may have to dial a "1" first.

REQUEST FOR A STATE HEARING

Name (Last, First, Middle Initial) | Phone No. | Social Security No.

Address | City | State | Zip Code

I hereby request a State Hearing before the California Department of Social Services on the action taken by the County regarding my social services. The reasons for my request are as follows:

I have trouble understanding English, therefore I request an interpreter for my hearing in the following: | Language | Dialect

Signature | Date Signed

AUTHORIZED REPRESENTATIVE

I have authorized the following person to act on my behalf in my appeal. I authorize the Department to release any or all information about my case to that person

Name of Authorized Representative

Address of Authorized Representative

Signature of State Hearing Applicant | Date Signed

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE-303-B

Your total monthly authorized hours have been reduced by 3.6-percent. Here is why:

A new state law (Section 12301.06 of the Welfare and Institutions Code) says the California Department of Social Services must reduce all IHSS recipients' total authorized monthly hours by 3.6 percent.

The new law allows you to choose which of your specific authorized IHSS services, shown on the front of your IHSS Notice of Action, will be reduced. For example, if you lose three hours of service per month, you can choose to reduce three hours from one authorized service or split it up among different services. You are responsible for informing your provider(s) of your reduction in total authorized services and which specific service hours you have chosen to reduce. You do not have to report which hours you choose to reduce; this is between you and your provider.

The 3.6 percent reduction will remain in effect until June 30, 2012. The new law also applies to all reassessments made during this timeframe. On July 1, 2012 your total monthly hours will go back up to your full authorized service level, based on your most recent assessment.

Your hearing rights are included with this message. However, requests for a state hearing only about the new state law requiring the 3.6 percent reduction in service hours will be dismissed.

If you do not understand the changes or have questions about the new law please contact your county IHSS office.

RIGHT TO REQUEST A STATE HEARING

1. You have the right to a conference with representatives of the County Welfare Department to talk about this intended action. At such a conference, you may speak for yourself or be represented by a lawyer, a friend or other spokesperson. If you want a conference, contact your county department.
2. Whether you request a conference or not, you also have the right to request a State Hearing and decision by the director of the California Department of Social Services (see form below). Your request may be written or oral but it must state that you want a hearing and why you are dissatisfied. YOUR REQUEST FOR A HEARING MUST BE MADE WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.
3. IF YOU REQUEST A STATE HEARING AT ANYTIME BEFORE THE EFFECTIVE DATE OF THE COUNTY'S PROPOSED ACTION, YOUR SERVICES MAY CONTINUE UNITL THE HEARING. You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request in made in good faith.
4. You may request a State Hearing on your own, or you may ask your county department for assistance. In either case, however, be sure to inform your county department worker as soon as possible.
5. At a State Hearing you have the right to be represented by an attorney or any other person (a friend, relative, or other spokesperson), of your choice. You may obtain free legal advice and the services of a lawyer. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response. You may also contact the nearest social service rights organization for assistance in presenting your claim.
6. State regulations governing State Hearings for social services are available at the office of County Welfare Department.
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Address | City | State | Zip Code

I hereby request a State Hearing before the California Department of Social Services on the action taken by the County regarding my social services. The reasons for my request are as follows:

I have trouble understanding English, therefore I request an interpreter for my hearing in the following: | Language | Dialect

Signature | Date Signed

AUTHORIZED REPRESENTATIVE

I have authorized the following person to act on my behalf in my appeal. I authorize the Department to release any or all information about my case to that person

Name of Authorized Representative

Address of Authorized Representative

Signature of State Hearing Applicant | Date Signed

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE -303-A

Comenzando el 1º de febrero del 2011, la cantidad total de sus horas autorizadas mensualmente se reducirá un 3.6 por ciento. La razón es la siguiente:

Una nueva ley estatal (la Sección 12301.06 del Código de Bienestar Público e Instituciones) estipula que el Departamento de Servicios Sociales de California tiene que reducir en un 3.6 por ciento la cantidad total de horas autorizadas mensualmente para los beneficiarios de Servicios de Apoyo en el Hogar (IHSS).

La nueva ley le permite a usted elegir cuáles de sus servicios específicos autorizados de IHSS (estos aparecen en el frente de su notificación de acción de IHSS) se reducirán. Por ejemplo, si pierde tres horas de servicio al mes, usted puede reducir tres horas de un servicio autorizado o puede dividir las horas entre diferente servicios. Usted es responsable de avisarle a sus proveedores acerca de la reducción en el total de servicios autorizados y cuáles horas específicas de servicio usted ha escogido reducir. Usted no tiene que reportar cuáles horas ha escogido reducir, esto es algo entre usted y su proveedor.

La reducción del 3.6 por ciento permanecerá en vigor hasta el 30 de junio del 2012. La nueva ley también aplica a todas la reevaluaciones que se hagan durante este período de tiempo. El 1º de julio del 2012, el total mensual de sus horas cambiará al nivel completo de sus servicios autorizados, basándose en su evaluación más reciente.

Sus derechos a una audiencia se incluyen en este mensaje. Sin embargo, no se aceptarán las peticiones para una audiencia con el Estado solamente para tratar la nueva ley estatal que requiere la reducción del 3.6 por ciento para horas de servicio.

Si usted no entiende los cambios o tiene preguntas acerca de la nueva ley, por favor comuníquese con la oficina de IHSS del condado.

DERECHO A SOLICITAR UNA AUDIENCIA CON EL ESTADO

1. Usted tiene derecho a una conferencia con representantes del departamento de bienestar público del condado para hablar acerca de la acción que se propone llevar a cabo. En dicha conferencia, usted puede hablar por sí mismo o puede ser representado por un abogado, un amigo o una persona que hable de parte de usted. Si usted quiere una conferencia, comuníquese con el departamento del condado.
2. Ya sea que solicite una conferencia o no, usted también tiene derecho a solicitar una audiencia con el Estado y una decisión del director del Departamento de Servicios Sociales de California (vea el formulario en la parte de abajo). Su petición puede ser escrita u oral pero tiene que indicar el motivo por el cual quiere una audiencia y porqué no está satisfecho. SU PETICIÓN PARA UNA AUDIENCIA SE TIENE QUE HACER ANTES DE QUE PASEN 90 DÍAS A PARTIR DE LA FECHA EN QUE SE ENVIÓ ESTA NOTIFICACIÓN.
3. SI USTED SOLICITA UNA AUDIENCIA CON EL ESTADO EN CUALQUIER MOMENTO ANTES DE LA FECHA EN QUE ENTRE EN VIGOR LA ACCIÓN, ES POSIBLE QUE SUS BENEFICIOS CONTINÚEN HASTA QUE SE LLEVE A CABO LA AUDIENCIA. Usted no será responsable de pagar el dinero por los servicios recibidos cuando la audiencia está pendiente, aún si el resultado es una negación, siempre y cuando su petición se haga de buena fe.
4. Usted mismo puede solicitar una audiencia con el Estado, o puede pedirle al departamento del condado que le ayude. En cualquier caso, sin embargo, asegúrese de informar lo más pronto posible al trabajador del departamento del condado encargado de su caso.
5. En una audiencia con el Estado, usted tiene derecho a ser representado por un abogado o cualquier otra persona que usted escoja (un amigo, pariente, u otra persona que hable por usted). Usted puede obtener asesoramiento legal gratuito y los servicios de un abogado. Usted puede obtener ayuda para localizar asistencia legal gratuita llamando el número de teléfono gratuito de la Oficina de Preguntas y Respuestas al Público *(Public Inquiry and Response)*. Usted también puede comunicarse con la organización de derechos para servicios sociales más cercana para ayuda para presentar su reclamo.
6. Los ordenamientos estatales que gobiernan las audiencias con el Estado para servicios sociales están disponibles en la oficina de bienestar público del condado.
7. Procedimientos relacionados a la información. Es obligatorio que proporcione la información que se le pide para poder tramitar su petición para una audiencia con el Estado de acuerdo a lo estipulado en la Sección 10950 del Código de Bienestar Público e Instituciones (W&IC). Se establecerá un expediente del caso en la Oficina del Jefe de Jueces de Leyes Administrativas *(Office of the Chief Administrative Law Judge)*. Usted tiene derecho a examinar los documentos del expediente para la decisión. Cualquier información que usted proporcione se puede compartir con el departamento de bienestar público del condado o el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Si usted desea presentar por escrito una petición para una audiencia con el Estado, por favor envíe esta página al departamento de bienestar público del condado. La dirección se encuentra en la parte de arriba, a mano derecha, de la primera página de su notificación de acción del Programa de Servicios de Apoyo en el Hogar (IHSS)

Para solicitar por teléfono una audiencia con el Estado, o para obtener más información acerca de sus derechos a una audiencia con el Estado o sus expedientes, comuníquese con:

Public Inquiry and Response
California Department of Social Services
744 P Street, Mail Station 8-4-23
Sacramento, CA 95814
1-800-952-5253 (número de teléfono gratuito)*
TDD 1-800- 952-8349* para personas con problemas de audición o del habla
*Es posible que tenga que marcar el "1" primero.

PETICIÓN PARA UNA AUDIENCIA CON EL ESTADO

Nombre (Apellido, primer nombre, inicial del nombre que usa en medio) | Número de teléfono | Número de Seguro Social

Dirección | Ciudad | Estado | Código Postal

Por medio del presente solicito una audiencia con el Estado ante el Departamento de Servicios Sociales de California acerca de la acción que llevó a cabo el condado en relación a mis servicios sociales. La razón de mi petición es la siguiente:

Tengo problemas para entender el inglés, por lo tanto, solicito un intérprete para mi audiencia en el siguiente idioma: | Idioma | Dialecto

Firma | Fecha de la firma

REPRESENTANTE AUTORIZADO

He autorizado a la siguiente persona para actuar en mi nombre en mi apelación. Autorizo al Departamento para que comparta con esta persona cualquier o toda la información acerca de mi caso.

Nombre del representante autorizado

Dirección del representante autorizado

Firma de la persona que solicita la audiencia con el Estado | Fecha de la firma

El total de sus horas autorizadas mensualmente se ha reducido un 3.6 por ciento. La razón es la siguiente:

Una nueva ley estatal (la Sección 12301.06 del Código de Bienestar Público e Instituciones) estipula que el Departamento de Servicios Sociales de California tiene que reducir en un 3.6 por ciento la cantidad total de horas autorizadas mensualmente para los beneficiarios de Servicios de Apoyo en el Hogar (IHSS).

La nueva ley le permite a usted elegir cuáles de sus servicios específicos autorizados de IHSS (estos aparecen en el frente de su notificación de acción de IHSS) se reducirán. Por ejemplo, si pierde tres horas de servicio al mes, usted puede reducir tres horas de un servicio autorizado o puede dividir las horas entre diferente servicios. Usted es responsable de avisarle a sus proveedores acerca de la reducción en el total de servicios autorizados y cuáles horas específicas de servicio usted ha escogido reducir. Usted no tiene que reportar cuáles horas ha escogido reducir, esto es algo entre usted y su proveedor.

La reducción del 3.6 por ciento permanecerá en vigor hasta el 30 de junio del 2012. La nueva ley también aplica a todas la reevaluaciones que se hagan durante este período de tiempo. El 1º de julio del 2012, el total mensual de sus horas cambiará al nivel completo de sus servicios autorizados, basándose en su evaluación más reciente.

Sus derechos a una audiencia se incluyen en este mensaje. Sin embargo, no se aceptarán las peticiones para una audiencia con el Estado solamente para tratar la nueva ley estatal que requiere la reducción del 3.6 por ciento para horas de servicio.

Si usted no entiende los cambios o tiene preguntas acerca de la nueva ley, por favor comuníquese con la oficina de IHSS del condado.

DERECHO A SOLICITAR UNA AUDIENCIA CON EL ESTADO

1. Usted tiene derecho a una conferencia con representantes del departamento de bienestar público del condado para hablar acerca de la acción que se propone llevar a cabo. En dicha conferencia, usted puede hablar por sí mismo o puede ser representado por un abogado, un amigo o una persona que hable de parte de usted. Si usted quiere una conferencia, comuníquese con el departamento del condado.
2. Ya sea que solicite una conferencia o no, usted también tiene derecho a solicitar una audiencia con el Estado y una decisión del director del Departamento de Servicios Sociales de California (vea el formulario en la parte de abajo). Su petición puede ser escrita u oral pero tiene que indicar el motivo por el cual quiere una audiencia y porqué no está satisfecho. SU PETICIÓN PARA UNA AUDIENCIA SE TIENE QUE HACER ANTES DE QUE PASEN 90 DÍAS A PARTIR DE LA FECHA EN QUE SE ENVIÓ ESTA NOTIFICACIÓN.
3. SI USTED SOLICITA UNA AUDIENCIA CON EL ESTADO EN CUALQUIER MOMENTO ANTES DE LA FECHA EN QUE ENTRE EN VIGOR LA ACCIÓN, ES POSIBLE QUE SUS BENEFICIOS CONTINÚEN HASTA QUE SE LLEVE A CABO LA AUDIENCIA. Usted no será responsable de pagar el dinero por los servicios recibidos cuando la audiencia está pendiente, aún si el resultado es una negación, siempre y cuando su petición se haga de buena fe.
4. Usted mismo puede solicitar una audiencia con el Estado, o puede pedirle al departamento del condado que le ayude. En cualquier caso, sin embargo, asegúrese de informar lo más pronto posible al trabajador del departamento del condado encargado de su caso.
5. En una audiencia con el Estado, usted tiene derecho a ser representado por un abogado o cualquier otra persona que usted escoja (un amigo, pariente, u otra persona que hable por usted). Usted puede obtener asesoramiento legal gratuito y los servicios de un abogado. Usted puede obtener ayuda para localizar asistencia legal gratuita llamando el número de teléfono gratuito de la Oficina de Preguntas y Respuestas al Público *(Public Inquiry and Response)*. Usted también puede comunicarse con la organización de derechos para servicios sociales más cercana para ayuda para presentar su reclamo.
6. Los ordenamientos estatales que gobiernan las audiencias con el Estado para servicios sociales están disponibles en la oficina de bienestar público del condado.
7. Procedimientos relacionados a la información. Es obligatorio que proporcione la información que se le pide para poder tramitar su petición para una audiencia con el Estado de acuerdo a lo estipulado en la Sección 10950 del Código de Bienestar Público e Instituciones (W&IC). Se establecerá un expediente del caso en la Oficina del Jefe de Jueces de Leyes Administrativas *(Office of the Chief Administrative Law Judge)*. Usted tiene derecho a examinar los documentos del expediente para la decisión. Cualquier información que usted proporcione se puede compartir con el departamento de bienestar público del condado o el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Si usted desea presentar por escrito una petición para una audiencia con el Estado, por favor envíe esta página al departamento de bienestar público del condado. La dirección se encuentra en la parte de arriba, a mano derecha, de la primera página de su notificación de acción del Programa de Servicios de Apoyo en el Hogar (IHSS)

Para solicitar por teléfono una audiencia con el Estado, o para obtener más información acerca de sus derechos a una audiencia con el Estado o sus expedientes, comuníquese con:

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*Es posible que tenga que marcar el "1" primero.

PETICIÓN PARA UNA AUDIENCIA CON EL ESTADO

Nombre (Apellido, primer nombre, inicial del nombre que usa en medio) | Número de teléfono | Número de Seguro Social

Dirección | Ciudad | Estado | Código Postal

Por medio del presente solicito una audiencia con el Estado ante el Departamento de Servicios Sociales de California acerca de la acción que llevó a cabo el condado en relación a mis servicios sociales. La razón de mi petición es la siguiente:

Tengo problemas para entender el inglés, por lo tanto, solicito un intérprete para mi audiencia en el siguiente idioma: | Idioma | Dialecto

Firma | Fecha de la firma

REPRESENTANTE AUTORIZADO

He autorizado a la siguiente persona para actuar en mi nombre en mi apelación. Autorizo al Departamento para que comparta con esta persona cualquier o toda la información acerca de mi caso.

Nombre del representante autorizado

Dirección del representante autorizado

Firma de la persona que solicita la audiencia con el Estado | Fecha de la firma

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE 303-A

Սկսած 2011թ. փետրվարի 1-ից, Ձեր ընդհանուր ամսական հաստատված ժամաքանակը կնվազեցվի 3.6 տոկոսով: Հետևյալ պատճառով.

Ըստ նոր ընդունված նահանգային օրենքի (Բարեկեցության և հաստատությունների մասին օրենսգիրք, Հոդված 12301.06), Սոցիալական ապահովության ծառայության Կալիֆորնիայի դեպարտամենտը պարտավոր է նվազեցնել բոլոր IHSS (Տնային աջակցության ծառայություններ) ստացող անձանց ընդհանուր հաստատված ամսական ժամաքանակը՝ 3.6 տոկոսով:

Նոր օրենքը Ձեզ թույլ է տալիս ընտրություն կատարել, թե IHSS-ի՝ Ձեզ համար հաստատած հատկապես ո՞ր ծառայությունները կրճատվեն, որոնք նշված են IHSS-ի Գրություն- ծանուցման սկզբնամասում: Օրինակ՝ եթե ամսական Ձեզնից կրճատվում է երեք ժամ, ապա Դուք կարող եք ընտրել, թե այդ ժամերը ո՞ր հաստատված ծառայությունից կրճատվեն կամ կարող եք բաժանել դրանք տարբեր ծառայությունների միջև: Դուք եք կրում պատասխանատվություն՝ տեղեկացնելու Ձեզ ծառայություն տրամադրող (ներ)ին՝ հաստատված ծառայությունների ընդհանուր կրճատված քանակի մասին, և թե հատկապես ո՞ր ծառայության ժամերն եք ընտրել կրճատման համար: Դուք հաշվետու չեք, թե որ ժամերն եք ընտրել կրճատման համար. դա կարգավորվում է միայն Ձեր և Ձեզ ծառայություն տրամադրողի միջև:

3.6 տոկոս կրճատումը ուժի մեջ է մնալու մինչև 2012թ. հունիսի 30-ը: Նոր օրենքը վերաբերում է նաև բոլոր այն վերագնահատումներին, որ կկատարվեն տվյալ ժամանակահատվածի ընթացքում: 2012թ. հուլիսի 1-ին Ձեր ընդհանուր հաստատված ծառայության ամբողջական ամսական ժամաքանակի մակարդակը կվերականգնվի՝ համաձայն Ձեր վերջին գնահատման:

Սույն գրությունը պարունակում է նաև Ձեր դատաքննության իրավունքները: Սակայն նահանգային քննություն կատարելու մասին խնդրանքները, որոնք վերաբերում են միայն նոր նահանգային օրենքին, որով նախատեսվում է 3.6 տոկոսով ծառայության ժամաքանակի կրճատում, կմերժվեն:

Եթե կատարված փոփոխություններն անհասկանալի են Ձեզ կամ հարցեր ունեք նոր օրենքի վերաբերյալ, խնդրում ենք դիմել Ձեր շրջանի IHSS-ի գրասենյակ:

ՆԱՀԱՆԳԱՅԻՆ ՔՆՆՈՒԹՅՈՒՆ ՀԱՅՑԵԼՈՒ ԻՐԱՎՈՒՆՔ

1. Դուք իրավունք ունեք խորհրդակցել Սոցիալական ապահովության շրջանային դեպարտամենտի ներկայացուցիչների հետ՝ Ձեր այս մտադրությունը քննարկելու նպատակով: Այդ խորհրդակցության ժամանակ ինքներդ կարող եք ներկայացնել Ձեր պահանջը կամ Ձեզ կարող է ներկայացնել որևէ իրավաբան, ընկեր կամ այլ ներկայացուցիչ: Եթե խորհրդակցության կարիք ունեք, դիմե՛ք Ձեր շրջանային դեպարտամենտ:

2. Անկախ նրանից՝ կպահանջեք խորհրդակցություն, թե ոչ, Դուք նաև իրավունք ունեք պահանջել գործի Նահանգային քննություն և որոշման ընդունում սոցիալական ծառայությունների նահանգային դեպարտամենտի տնօրենի կողմից (տե՛ս ձևը ստորև): Ձեր պահանջը կարող է լինել գրավոր կամ բանավոր, բայց դրանում պետք է հստակ արտահայտվի քննություն անցկացնելու Ձեր ցանկությունը և Ձեր դժգոհության պատճառը: ՔՆՆՈՒԹՅՈՒՆ ԱՆՑԿԱՑՆԵԼՈՒ ՄԱՍԻՆ ՁԵՐ ՀԱՅՑԸ ՊԵՏՔ Է ՆԵՐԿԱՅԱՑՎԻ ՍՈՒՏՆ ԳՐՈՒԹՅԱՆ ՈՒՂԱՐԿՄԱՆ ԱՄՍԱԹՎԻՑ ՍԿՍԱԾ 90 ՕՐՎԱ ԸՆԹԱՑՔՈՒՄ:

3. ԵԹԵ ԴՈՒՔ ՆԱՀԱՆԳԱՅԻՆ ՔՆՆՈՒԹՅՈՒՆ ՊԱՀԱՆՋԵՔ ՄԻՆՉԵՎ ՇՐՋԱՆԻ ԿՈՂՄԻՑ ՆԱԽԱՏԵՍՎԱԾ ԳՈՐԾՈՂՈՒԹՅԱՆ ՈՒԺԻ ՄԵՋ ՄՏՆԵԼԸ, ԱՊԱ ՁԵՐ ԾԱՌԱՅՈՒԹՅՈՒՆՆԵՐԸ ԿԱՐՈՂ ԵՆ ՇԱՐՈՒՆԱԿՎԵԼ ՄԻՆՉԵՎ ՔՆՆՈՒԹՅՈՒՆԸ: Դուք պատասխանատվություն չեք կրում վճարելու այն ծառայությունների համար կամ փոխհատուցելու այն գումարները, որոնք ստացել եք մինչև քննությունը, եթե նույնիսկ քննության արդյունքում Ձեր հայցը մերժվի, պայմանով, եթե բարեխղճորեն եք ներկայացրել Ձեր պահանջը:

4. Դուք կարող եք ինքնուրույն պահանջել Նահանգային քննություն կամ խնդրել Ձեր շրջանային դեպարտամենտին աջակցել Ձեզ այդ գործում: Բոլոր դեպքերում Ձեր շրջանային դեպարտամենտի աշխատակցին անպայման հայտնե՛ք դրա մասին որքան հնարավոր է շուտ:

5. Նահանգային քննության ժամանակ Դուք իրավունք ունեք, որ Ձեզ ներկայացնի փաստաբան կամ Ձեր ընտրությամբ որևէ այլ անձ (ընկեր, ազգական կամ այլ ներկայացուցիչ): Դուք կարող եք ստանալ անվճար իրավաբանական խորհրդատվություն և իրավաբանի ծառայություններ: Պարզելու համար, թե ինչպես կարող եք անվճար իրավաբանական աջակցություն ստանալ, զանգահարե՛ք Հասարակական հարցումների պատասխանման ծառայության անվճար հեռախոսահամարին: Կարող եք դիմել նաև մոտակա սոցիալական ծառայության իրավունքների կազմակերպություն՝ Ձեր հայցի ներկայացմանն աջակցելու համար:

6. Սոցիալական ծառայություններին առնչվող Նահանգային քննությունները կարգավորող պետական կանոնակարգերը առկա են Սոցիալական ապահովության շրջանային դեպարտամենտի գրասենյակում:

7. Անհրաժեշտ տեղեկատվություն – Ձեզնից պահանջվում է տրամադրել պարտադիր տեղեկատվություն, որպեսզի Ձեր հայցին ընթացք տրվի և այն ներկայացվի Նահանգային քննության՝ համաձայն W& IC 10950-ի (Սոցիալական ապահովության և հաստատությունների մասին օրենսգիրք, Հոդված 10950):Գլխավոր միջնորդ դատավորի գրասենյակի կողմից կկազմվի գործ: Դուք իրավունք ունեք ծանոթանալու որոշման համար պատրաստված գործի նյութերին: Ձեր հայտնած ցանկացած տեղեկություն կարող է տրամադրվել Սոցիալական ապահովության շրջանային դեպարտամենտին կամ Միացյալ Նահանգների առողջապահության և սոցիալական զարգացման ծառայությունների դեպարտամենտին:

Եթե ցանկանում եք գրավոր պահանջ ներկայացնել Նահանգային քննության համար, խնդրում ենք ուղարկել այս էջը Սոցիալական ապահովության շրջանային դեպարտամենտին: Հասցեն նշված է այս ծանուցման առաջին էջում՝ վերևի աջ անկյունում:

Նահանգային քննության համար բանավոր պահանջ ներկայացնելու կամ Նահանգային քննության Ձեր իրավունքների կամ գործի նյութերի վերաբերյալ լրացուցիչ տեղեկություններ ստանալու համար դիմե՛ք.

Հասարակական հարցումների պատասխանման ծառայություն
Սոցիալական ծառայությունների նահանգային դեպարտամենտ
744 P Street, Mail Station 8-4-23
Sacramento, Ca 95814
(800) 952-5253 (անվճար հեռախոսահամար)*
TDD (800) 952-8349* Լսողության և խոսելու խնդիրներ ունեցողների համար

*Հնարավոր է, որ նախապես անհրաժեշտ լինի հավաքել "1":

ՆԱՀԱՆԳԱՅԻՆ ՔՆՆՈՒԹՅԱՆ ՀԱՅՑ

Ազգանուն, անուն, այլ անվան սկզբնատառ | Հեռախոս | Սոցիալական ապահովության համար

Հասցե | Քաղաք | Նահանգ | Փոստային կոդ

Սույնով հայցում եմ Նահանգային քննություն սոցիալական ծառայությունների նահանգային դեպարտամենտի կողմից՝ կապված ինձ հատկացվող սոցիալական ծառայությունների վերաբերյալ Շրջանի ձեռնարկած գործողության հետ: Իմ հայցի պատճառները հետևյալն են.

Ես դժվարությամբ եմ հասկանում անգլերեն, հետևաբար իմ գործի լսման համար խնդրում եմ տրամադրել
թարգմանիչ Լեզու Բարբառ իմ քննության համար հետևյալ.

Ստորագրություն | Ստորագրման ամսաթիվ

ԼԻԱԶՈՐՎԱԾ ՆԵՐԿԱՅԱՑՈՒՑԻՉ

Ես լիազորում եմ սույն անձին՝ հանդես գալ իմ անունից իմ բողոքարկման գործում: Ես լիազորում եմ Դեպարտամենտին՝ հայտնելու իմ գործի վերաբերյալ ցանկացած տեղեկատվություն այդ անձին:

Լիազորված ներկայացուցչի անուն, ազգանուն

Լիազորված ներկայացուցչի հասցե

Նահանգային քննության բողոքարկուի ստորագրություն | Ստորագրման ամսաթիվ

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE 303-B

Ձեր ընդհանուր ամսական հաստատված ժամաքանակը կնվազեցվի 3.6 տոկոսով: Հետևյալ պատճառով.

Ըստ նոր ընդունված նահանգային օրենքի (Բարեկեցության և հաստատությունների մասին օրենսգիրք, Հոդված 12301.06), Սոցիալական ապահովության ծառայության Կալիֆորնիայի դեպարտամենտը պարտավոր է նվազեցնել բոլոր IHSS (Տնային աջակցության ծառայություններ) ստացող անձանց ընդհանուր հաստատված ամսական ժամաքանակը՝ 3.6 տոկոսով:

Նոր օրենքը Ձեզ թույլ է տալիս ընտրություն կատարել, թե IHSS-ի Ձեզ համար հաստատած հատկապես ո՞ր ծառայությունները կրճատվեն, որոնք նշված են IHSS-ի Գրություն- ծանուցման սկզբնամասում: Օրինակ՝ եթե ամսական Ձեզնից կրճատվում է երեք ժամ, ապա Դուք կարող եք ընտրել, թե այդ ժամերը ո՞ր հաստատված ծառայությունից կրճատվեն կամ կարող եք բաժանել դրանք տարբեր ծառայությունների միջև: Դուք եք կրում պատասխանատվություն՝ տեղեկացնելու Ձեզ ծառայություն տրամադրող (ներ)ին՝ հաստատված ծառայությունների ընդհանուր կրճատված քանակի մասին, և թե հատկապես ո՞ր ծառայության ժամերն եք ընտրել կրճատման համար: Դուք հաշվետու չեք, թե որ ժամերն եք ընտրել կրճատման համար. դա կարգավորվում է միայն Ձեր և Ձեզ ծառայություն տրամադրողի միջև:

3.6 տոկոս կրճատումը ուժի մեջ է մնալու մինչև 2012թ. հունիսի 30-ը: Նոր օրենքը վերաբերում է նաև բոլոր այն վերագնահատումներին, որ կկատարվեն տվյալ ժամանակահատվածի ընթացքում: 2012թ. հուլիսի 1-ին Ձեր ընդհանուր հաստատված ծառայության ամբողջական ամսական ժամաքանակի մակարդակը կվերականգնվի՝ համաձայն Ձեր վերջին գնահատման:

Սույն գրությունը պարունակում է նաև Ձեր դատաքննության իրավունքները: Սակայն նահանգային քննություն կատարելու մասին խնդրանքները, որոնք վերաբերում են միայն նոր նահանգային օրենքին, որով նախատեսվում է 3.6 տոկոսով ծառայության ժամաքանակի կրճատում, կմերժվեն:

Եթե կատարված փոփոխություններն անհասկանալի են Ձեզ կամ հարցեր ունեք նոր օրենքի վերաբերյալ, խնդրում ենք դիմել Ձեր շրջանի IHSS-ի գրասենյակ:

ՆԱՀԱՆԳԱՅԻՆ ՔՆՆՈՒԹՅՈՒՆ ՀԱՅՑԵԼՈՒ ԻՐԱՎՈՒՆՔ

1. Դուք իրավունք ունեք խորհրդակցել Սոցիալական ապահովության շրջանային դեպարտամենտի ներկայացուցիչների հետ՝ Ձեր այս մտադրությունը քննարկելու նպատակով: Այդ խորհրդակցության ժամանակ ինքներդ կարող եք ներկայացնել Ձեր պահանջը կամ Ձեզ կարող է ներկայացնել որևէ իրավաբան, ընկեր կամ այլ ներկայացուցիչ: Եթե խորհրդակցության կարիք ունեք, դիմե՛ք Ձեր շրջանային դեպարտամենտ:

2. Անկախ նրանից՝ կպահանջեք խորհրդակցություն, թե ոչ, Դուք նաև իրավունք ունեք պահանջել գործի Նահանգային քննություն և որոշման ընդունում սոցիալական ծառայությունների նահանգային դեպարտամենտի տնօրենի կողմից (տե՛ս ձևը ստորև): Ձեր պահանջը կարող է լինել գրավոր կամ բանավոր, բայց դրանում պետք է հստակ արտահայտվի քննություն անցկացնելու Ձեր ցանկությունը և Ձեր դժգոհության պատճառը: ՔՆՆՈՒԹՅՈՒՆ ԱՆՑԿԱՑՆԵԼՈՒ ՄԱՄՆ ՁԵՐ ՀԱՅՑԸ ՊԵՏՔ է ՆԵՐԿԱՅԱՑՎԻ ՍՈՒՅՆ ԳՐՈՒԹՅԱՆ ՈՒՂԱՐԿՄԱՆ ԱՄՍԱԹՎԻՑ ՄԿՍԱԾ 90 ՕՐՎԱ ԸՆԹԱՑՔՈՒՄ:

3. ԵԹԵ ԴՈՒՔ ՆԱՀԱՆԳԱՅԻՆ ՔՆՆՈՒԹՅՈՒՆ ՊԱՀԱՆՋԵՔ ՄԻՆՉԵՎ ՇՐՋԱՆԻ ԿՈՂՄԻՑ ՆԱԽԱՏԵՍՎԱԾ ԳՈՐԾՈՂՈՒԹՅԱՆ ՈՒԺԻ ՄԵՋ ՄՏՆԵԼԸ, ԱՊԱ ՁԵՐ ԾԱՌԱՅՈՒԹՅՈՒՆՆԵՐԸ ԿԱՐՈՂ ԵՆ ՇԱՐՈՒՆԱԿՎԵԼ ՄԻՆՉԵՎ ՔՆՆՈՒԹՅՈՒՆԸ: Դուք պատասխանատվություն չեք կրում վճարելու այն ծառայությունների համար կամ փոխհատուցելու այն գումարները, որոնք ստացել եք մինչև քննությունը, եթե նույնիսկ քննության արդյունքում Ձեր հայցը մերժվի, պայմանով, եթե բարեխղճորեն եք ներկայացրել Ձեր պահանջը:

4. Դուք կարող եք ինքնուրույն պահանջել Նահանգային քննություն կամ խնդրել Ձեր շրջանային դեպարտամենտին աջակցել Ձեզ այդ գործում: Բոլոր դեպքերում Ձեր շրջանային դեպարտամենտի աշխատակցին անպայման հայտնե՛ք դրա մասին որքան հնարավոր է շուտ:

5. Նահանգային քննության ժամանակ Դուք իրավունք ունեք, որ Ձեզ ներկայացնի փաստաբան կամ Ձեր ընտրությամբ որևէ այլ անձ (ընկեր, ազգական կամ այլ ներկայացուցիչ): Դուք կարող եք ստանալ անվճար իրավաբանական խորհրդատվություն և իրավաբանի ծառայություններ: Պարզելու համար, թե ինչպես կարող եք անվճար իրավաբանական աջակցություն ստանալ, զանգահարե՛ք Հասարակական հարցումների պատասխանման ծառայության անվճար հեռախոսահամարին: Կարող եք դիմել նաև մոտակա սոցիալական ծառայության իրավունքների կազմակերպություն՝ Ձեր հայցի ներկայացմանն աջակցելու համար:

6. Սոցիալական ծառայություններին առնչվող Նահանգային քննությունները կարգավորող պետական կանոնակարգերը առկա են Սոցիալական ապահովության շրջանային դեպարտամենտի գրասենյակում:

7. Անհրաժեշտ տեղեկատվություն – Ձեզնից պահանջվում է տրամադրել պարտադիր տեղեկատվություն, որպեսզի Ձեր հայցին ընթացք տրվի և այն ներկայացվի Նահանգային քննության՝ համաձայն W& IC 10950-ի (Սոցիալական ապահովության և հաստատությունների մասին օրենսգիրք, Հոդված 10950):Գլխավոր միջնորդ դատավորի գրասենյակի կողմից կկազմվի գործ: Դուք իրավունք ունեք ծանոթանալու որոշման համար պատրաստված գործի նյութերին: Ձեր հայտնած ցանկացած տեղեկություն կարող է տրամադրվել Սոցիալական ապահովության շրջանային դեպարտամենտին կամ Միացյալ Նահանգների առողջապահության և սոցիալական զարգացման ծառայությունների դեպարտամենտին:

Եթե ցանկանում եք գրավոր պահանջ ներկայացնել Նահանգային քննության համար, խնդրում ենք ուղարկել այս էջը Սոցիալական ապահովության շրջանային դեպարտամենտին: Հասցեն նշված է այս ծանուցման առաջին էջում՝ վերևի աջ անկյունում:

Նահանգային քննության համար բանավոր պահանջ ներկայացնելու կամ Նահանգային քննության Ձեր իրավունքների կամ գործի նյութերի վերաբերյալ լրացուցիչ տեղեկություններ ստանալու համար դիմե՛ք.

Հասարակական հարցումների պատասխանման ծառայություն
Սոցիալական ծառայությունների նահանգային դեպարտամենտ
744 P Street, Mail Station 8-4-23
Sacramento, Ca 95814
(800) 952-5253 (անվճար հեռախոսահամար)*
TDD (800) 952-8349* Լսողության և խոսելու խնդիրներ ունեցողների համար

*Հնարավոր է, որ նախապես անհրաժեշտ լինի հավաքել "1":

ՆԱՀԱՆԳԱՅԻՆ ՔՆՆՈՒԹՅԱՆ ՀԱՅՑ

Ազգանուն, անուն, այլ անվան սկզբնատառ | Հեռախոս | Սոցիալական ապահովության համար

Հասցե | Քաղաք | Նահանգ | Փոստային կոդ

Սույնով հայցում եմ Նահանգային քննություն սոցիալական ծառայությունների նահանգային դեպարտամենտի կողմից՝ կապված ինձ հատկացվող սոցիալական ծառայությունների վերաբերյալ Շրջանի ձեռնարկած գործողության հետ: Իմ հայցի պատճառները հետևյալն են.

Ես դժվարությամբ եմ հասկանում անգլերեն, հետևաբար իմ գործի լսման համար խնդրում եմ տրամադրել թարգմանիչ Լեզու Բարբառ իմ քննության համար հետևյալ.

Ստորագրություն | Ստորագրման ամսաթիվ

ԼԻԱԶՈՐՎԱԾ ՆԵՐԿԱՅԱՑՈՒՑԻՉ

Ես լիազորում եմ սույն անձին՝ հանդես գալ իմ անունից իմ բողոքարկման գործում: Ես լիազորում եմ Դեպարտամենտին՝ հայտնելու իմ գործի վերաբերյալ ցանկացած տեղեկատվություն այդ անձին:

Լիազորված ներկայացուցչի անուն, ազգանուն

Լիազորված ներկայացուցչի հասցե

Նահանգային քննության բողոքարկումի ստորագրություն | Ստորագրման ամսաթիվ

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE 303-A

從2011年2月1日開始，你每月的總共授權時數將減少百分之3.6。原因是：

一個新的州法例（福利和慈善法規第12301.06欄）表示加州社會服務處必須減少所有IHSS領取者百分之3.6每月的總授權時數。

新的法例允許你選擇那一個授權你的IHSS服務（顯示在你的IHSS的行動通知的首頁）將被減少時數。例如，如果你每月被減少了三個小時的服務，你可以選擇從一個授權的服務減少三個小時，或者平分減少在不同的服務裏。你有責任通知你的提供者你總共減少的授權服務，以及你選擇減少那一個服務時間。你不必報告你選擇減少了那些時數; 這是你和你的提供者之間的事宜。

減少百分之3.6將會一直有效到2012年6月30日。新法例也將適用於在這次期限所作出所有的重新評估。根據你最近的評估，在2012年7月1日，你的每月總時數將回復到你全部授權的服務水平。

此訊息包括你的聽證權利。但是，僅只是要求有關新州法例減少百分之3.6服務時間的州聽證會將不會受理。

如果你不明白新的改變或有關新規例的疑問，請聯絡你郡 IHSS 的辦公室。

要求州聽證會的權利

1. 你有權利與郡福利部代表在會議談論這個行動。在這會議裏，你可為自己或由律師，朋友或其他發言人代表發言。如果你想要一個會議，請聯絡你的郡政府部門。
2. 無論你是否要求一個會議，你也有權利要求州聽證和一個由社會服務部主任所作的決定（見下面的表格）你的請求可以書面或口頭申請，但必須指出你請求聽證會和你有何不滿意。**你的聽證會請求必須在本通知的郵寄日期90天之內申請。**
3. **如果你要求州聽證會日期隨時在郡提出的行動有效日期之前舉行，你的服務可能會一直繼續到聽證會。**你將不會承擔償還在聽證會之前收到的款項，即使結果是被拒絕，只要你的請求是真誠提出。
4. 你可以自己要求一個州聽證會，或者你可以要求你郡部門的援助。無論如何，請盡快通知你的郡部門工作人員。
5. 你有權選擇委託律師或任何其他人（朋友，親戚或其他發言人）代表你出席州聽證會。你可以得到免費的法律諮詢和律師的服務。你可從公眾詢問處的免費電話獲得免費法律援助地址。你也可以聯絡就近的社會服務權利組織提出委託你申請的要求。
6. 州政府規定社會服務處聽證會可在郡福利辦公室提供。
7. 資料處理 - 根據州聽證法例 W&IC10950，要求你提供的資料是硬性規定的，以便處理你所要求的州聽證會。案件文件將由仲裁長辦公室確定。你有權審查構成決定紀錄的資料。你提供的資料可以與郡福利部或美國衛生與人文服務部分享。

如果你想書面請求州聽證，請將此頁寄回郡福利部。地址是在此通知頭版的右上角。

有關口頭請求州聽證會，或取得更多有關你的州聽證權利或檔案文件的資料，你可以聯絡：

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 8-4-23
Sacramento, CA 95814
(800) 952-5253 (toll-free number)*
TDD (800) 952-8349* 聽覺和言語障礙
*你可能必須要先撥打“1” 字

要求州聽證會

姓名（姓，名，中間名縮寫）　電話號碼　社會保險號碼

地址　城市　州　郵政編碼

我在此向社會服務處有關對我的社會服務行動要求州聽證會。我要求的原因如下：

我不太懂英語，所以我要求我的聽證會翻譯員翻譯的語言是：　語言　地方話

簽名　簽名日期

授權代表

我已授權下面所述人士在聽證會代表本人。本人授權部門透露任何或所有有關我案件的資料給該人。

授權代表姓名

授權代表地址

州聽證會申請人簽名　簽名日期

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE 303-B

你每月的總共授權時數被減少百分之3.6。原因是：

一個新的州法例（福利和慈善法規第12301.06欄）表示加州社會服務處必須減少所有IHSS領取者百分之3.6每月的總授權時數。

新的法例允許你選擇那一個授權你的IHSS服務（顯示在你的IHSS的行動通知的首頁）將被減少時數。例如，如果你每月被減少了三個小時的服務，你可以選擇從一個授權的服務減少三個小時，或者平分減少在不同的服務裏。你有責任通知你的提供者你總共減少的授權服務，以及你選擇減少那一個服務時間。你不必報告你選擇減少了那些時數; 這是你和你的提供者之間的事宜。

減少百分之3.6將會一直有效到2012年6月30日。新法例也將適用於在這次期限所作出所有的重新評估。根據你最近的評估，在2012年7月1日，你的每月總時數將回復到你全部授權的服務水平。

此訊息包括你的聽證權利。但是，僅只是要求有關新州法例減少百分之3.6服務時間的州聽證會將不會受理。

如果你不明白新的改變或有關新規例的疑問，請聯絡你郡 IHSS 的辦公室。

要求州聽證會的權利

1. 你有權利與郡福利部代表在會議談論這個行動。在這會議裏，你可為自己或由律師，朋友或其他發言人代表發言。如果你想要一個會議，請聯絡你的郡政府部門。
2. 無論你是否要求一個會議，你也有權利要求州聽證和一個由社會服務部主任所作的決定（見下面的表格）你的請求可以書面或口頭申請，但必須指出你請求聽證會和你有何不滿意。**你的聽證會請求必須在本通知的郵寄日期90天之內申請。**
3. **如果你要求州聽證會日期隨時在郡提出的行動有效日期之前舉行，你的服務可能會一直繼續到聽證會。**你將不會承擔償還在聽證會之前收到的款項，即使結果是被拒絕，只要你的請求是真誠提出。
4. 你可以自己要求一個州聽證會，或者你可以要求你郡部門的援助。無論如何，請盡快通知你的郡部門工作人員。
5. 你有權選擇委託律師或任何其他人（朋友，親戚或其他發言人）代表你出席州聽證會。你可以得到免費的法律諮詢和律師的服務。你可從公眾詢問處的免費電話獲得免費法律援助地址。你也可以聯絡就近的社會服務權利組織提出委託你申請的要求。
6. 州政府規定社會服務處聽證會可在郡福利辦公室提供。
7. 資料處理 - 根據州聽證法例 W&IC10950，要求你提供的資料是硬性規定的，以便處理你所要求的州聽證會。案件文件將由仲裁長辦公室確定。你有權審查構成決定紀錄的資料。你提供的資料可以與郡福利部或美國衛生與人文服務部分享。

如果你想書面請求州聽證，請將此頁寄回郡福利部。地址是在此通知頭版的右上角。

有關口頭請求州聽證會，或取得更多有關你的州聽證權利或檔案文件的資料，你可以聯絡：

Public Inquiry and Response
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(800) 952-5253 (toll-free number)*
TDD (800) 952-8349* 聽覺和言語障礙
*你可能必須要先撥打 "1" 字

要求州聽證會

姓名（姓，名，中間名縮寫）　電話號碼　社會保險號碼

地址　城市　州　郵政編碼

我在此向社會服務處有關對我的社會服務行動要求州聽證會。我要求的原因如下：

我不太懂英語，所以我要求我的聽證會翻譯員翻譯的語言是：　語言　地方話

簽名　簽名日期

授權代表

我已授權下面所述人士在聽證會代表本人。本人授權部門透露任何或所有有關我案件的資料給該人。

授權代表姓名

授權代表地址

州聽證會申請人簽名　簽名日期

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10–11

December 13, 2010

SUBJECT: 3.6 PERCENT SERVICE REDUCTION

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

SOURCE: EBB 10025 December 8, 2010

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with instructions on completing the manual updates to CMIPS for the 3.6 reduction of services for IHSS Recipients. Cases with a beginning date on line M, Field 2 that is ***after*** February 2, 2011 ***must be manually updated by the Social Worker by close of business on December 17, 2011.***

II. BACKGROUND

Assembly Bill (AB) 1612 added section 12301.06 to the Welfare and Institution Code (WIC) which requires the California Department of Social Services (CDSS) to reduce every IHSS recipient's total authorized hours by 3.6 percent effective February 1, 2011. AB 1612 requires Notices of Action (NOA) to be mailed at least 30 days prior to the effective date of the reduction.

III. CMIPS UPDATES

On December 17, 2010, all cases in active status (E or L) will be updated automatically in CMIPS with the 3.6 percent service reduction. NOAs will be mailed from December 22, 2010 to December 31, 2010.

- Cases with ***ending dates prior to January 31, 2011*** (Line M, field 3 and line ZZ, field 4) will be updated to have a beginning date of February 1, 2011 (line M, field 2).
- The above update will create an N line eligibility segment that could span more than a year. The N line eligibility Ending Date will be January 31, 2011.
- The RELC screen will display two new fields: the "NET" field and the "AB1612" field.
- The "NET" field will display the authorized hours *prior* to the reduction, while the "AB1612" field will show the number of reduced hours/minutes.
- The "Purchase" field (line aa, field 6) will display the authorized purchase hours after the reduction.

- The "RELB" screen (line M, field 5) will display the reduced, authorized to purchase hours.
- CMIPS will be enhanced with a new hard edit "Elig Cannot Span 3.6 Reduc Dt". This edit will prohibit an M line segment from containing the month of February 2011 within the date range of 12/1/2010 through 3/31/2011.

All active providers (E or L status on line B, Field 4) with a code of 1 on line E, field 3, will be updated automatically when the recipient's assessment is updated. A one-time update will be applied to all other active status providers, reducing the hours on line F, field 4 by 3.6 percent.

The 30-day NOA will print on a special NOA form and will contain the assessment grid hours. The NOA will also include the 303 message containing the original authorized hours, and the reduced authorized hours. The current "Secondary Aid Code" display on the top right side of the standard NOA will be replaced with the recipient language code. The language code will assist with attaching the correct language insert.

IV. MANUAL UPDATES

Cases with a beginning date after February 1, 2011 must be manually updated by the Social Worker ***before*** the December 17, 2010 system run in order for CMIPS to apply the service reduction and issue the 30-day NOA. The SOC 293 M line must have a Beginning Date that is ***less than or equal*** to February 1, 2011.

Social Worker Responsibilities
For every case in the attached ad hoc list, the assigned Social Worker must manually update the beginning date to February 1, 2011 or to an earlier date.

For cases that are updated in CMIPS after the December 17, 2010 run date (e.g. cases that have been recertified or reassessed but case information has not been entered until after the CMIPS run date), the Social Worker will need to perform a two-day update when adding or updating the eligibility dates.
For eligibility dates that are prior to, and continuing after February 1, 2011, the Social Worker will:

- Enter the effective beginning date (line ZZ, field 3). The ending date will be January 31, 2011 (line ZZ, field 4).
- When the turn-around document is received the following day, update the fields to include the ongoing February assessment and the correct ending date.

Note: *The beginning date and the end date must be updated on the RELC screen in order to generate the automatic NOA in CMIPS.*

Clerical Staff Responsibilities
Data entry of the 3.6 service reduction documents will be given priority for data entry. Turn-around documents must be printed immediately and distributed as soon as possible for the second phase of the update. Social Workers will complete the secondary update and submit for data entry on receipt of the document.

V. REVIEW STATEMENT

This Special Notice was not reviewed by an Organizational Review Committee (ORC).

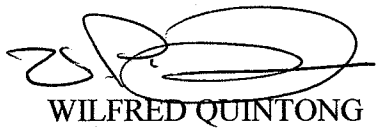
VI. FILING STATEMENT

IHSS Special Notices, Bulletins, and Memos are being archived at the following link:
S:\AIS\Operations\IHSS\automated Forms\IHSS Policy and Procedure – Automated

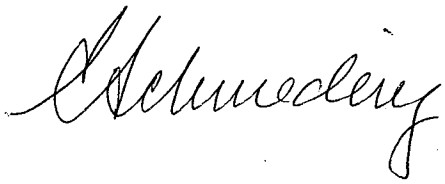
And at the county intra-net at:

http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide+AISIHSS

Hard copies of this Special Notice will not be distributed by Program Support.



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido @ 858/505-6366

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES

SPECIAL NOTICE 10-10

December 9, 2010

SUBJECT: **Provider Enrollment – Inter-County Transfers**

EFFECTIVE DATE: **Immediately**

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

SOURCES: **Amended Welfare and Institution Code (WIC) Section 12301.6**
EBB 10023 – Enrollment Screen Update

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with updated procedures for an incoming Inter-County Transfer (ICT), when the current Individual Provider (IP) is transferring with the recipient.

II. BACKGROUND

Senate Bill 1612 (Chapter 19, Statutes of 2010) amended WIC Section 1201.6, allowing the Public Authority (PA) to accept a Department of Justice (DOJ) criminal background clearance for an IP that is transferring from another county. This amendment supersedes the prior mandate that requires a transferring IP to undergo and pass another DOJ background check in the receiving county.

III. POLICY

An active IP need only submit to a DOJ criminal background check in one county. The receiving county is authorized to secure a criminal background clearance from the transferring county, by verifying the incoming IP's eligibility as an IHSS provider through the Case Management, Information, and Payrolling System (CMIPS).

IV. SOCIAL WORKER PROCEDURES

To facilitate in verifying the provider's DOJ clearance, the assigned Social Worker will:

- Contact the recipient or his/her authorized representative
- Ask if his/her IP is transferring with the recipient

If the IP is not transferring, no additional information is required. If the IP is transferring, the SW will:

- Obtain the *IP's Name, Social Security Number (SSN), Telephone Number, and Address.* Note: Ensure that, at minimum, the IP's name and telephone number are obtained
- Inform the recipient that his/her IP will be contacted by the Public Authority regarding the enrollment requirements
- Send an e-mail to the Provider Enrollment Manager with the following information:
    - "IP ICT" on the subject line
    - A note that the IP is transferring with the recipient
    - IP's name, SSN, telephone number, and address
    - Recipient's name and case number

When the SOC 311 turn-around document is received from the Public Authority with "IP eligible, ICT" indicated on the E line, complete the SOC 311 and activate the IP in San Diego County.

V. PROVIDER ENROLLMENT RESPONSIBILITY

The Provider Enrollment designated staff will contact the transferring IP after receiving the e-mail from the Social Worker. If the transferring IP has already completed DOJ clearance in another county, he/she will be requested to attend the IP enrollment session and submit the required paperwork, identification card (ID), and SSN. If the transferring IP has not completed DOJ clearance in another county, he/she will be requested to attend the IP enrollment session, submit the required paperwork, ID, and SSN, and get fingerprinted.

VI. ENROLLMENT SCREEN UPDATE

A new field titled "DOJ COUNTY" is added to the CMIPS Enrollment screen on December 1, 2010. This field displays the county number that is associated to the user who last updated the fingerprint flag from "N" to "Y". The DOJ COUNTY field values are defaulted and cannot be updated by the county. CMIPS has performed a one-time update for all enrollment screens that already have a "Y" in the FINGERPRINT field.

VII. REVIEW STATEMENT

This Special Notice has been reviewed by an Organizational Review Committee (ORC).

VIII. FILING STATEMENT

IHSS Special Notices, Bulletins, and Memos are being archived at the following link:
S:\AIS\Operations\IHSS\automated Forms\IHSS Policy and Procedure – Automated

And at the county intra-net at:
http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide+AISIHSS

Hard copies of this Special Notice will not be distributed by Program Support.

WILFRED QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido @ 858/505-6366

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10-09

October 5, 2010

SUBJECT: **IHSS Interpreter Procedures**

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 Support Services (IHSS) staff of the procedures for requesting interpreter services.

II. BACKGROUND

The Health and Human Services Agency (HHSA) interpreter procedures were tailored to the IHSS program.

III. POLICY

Interpreter services must be provided free of charge to any non-English speaking client who requires language translation. Whenever possible, these services are to be provided by staff who speak the client's primary language. If there are no bilingual staff available, staff must provide interpreter services by using one of the following methods:

1. The Social Worker must notify their supervisor that a client needs interpreter services. The Social Work Supervisor must get pre-approval from the IHSS manager before requesting interpreter services.

    a. The Social Work Supervisor must first search the list of *"Employees Receiving Bilingual Pay"* to find a volunteer interpreter. The list is updated quarterly and provided to supervisors and managers. If an updated list is needed the Social Work Supervisor may contact the AIS Interpreter Services Coordinator, Ben Sevilla at 858-495-5885.

    b. The Social Work Supervisor must contact the identified interpreter's supervisor to request services.

c. The Social Worker is responsible for arranging the date, time, and location where the client and interpreter will meet.

2. If the Social Work Supervisor is unable to locate a volunteer interpreter, a *"Request for Interpreter"* (Attachment A) must be completed by the Social Work Supervisor to procure a vendor for interpreter services.

   a. The *"Request for Interpreter"* must be forwarded by the Social Work Supervisor to the AIS Interpreter Services Coordinator, Ben Sevilla, by email or county mail to request a vendor.

   b. The vendor will contact the Social Worker and make arrangements for interpreter services to be provided.

3. If the Social Worker needs an interpreter to speak to a client over the phone, and has exhausted the search for a volunteer interpreter, he/she may use the *"Language Line Services."* AIS has a subscription that provides assistance in 140 languages, 365 days a year, 24 hours a day.

   The Social Worker will need the following codes to use the Language Line Services.

Language Line	1-800-752-6096
Personal Code	Last name, first name, (required)
Client ID	501211
Organization	Aging & Independence Services

Billing is charged to the AIS organizational ID number by using the staff's first and last name rather than their telephone number. Any telephone can be used. The cost is per minute and depends on the language and time of day. Use the Telephone Translation Service only when necessary.

4. If the client insists that they want to use their own interpreter, the client must be informed that the Social Worker will not be responsible for any inaccurate or misinterpreted information provided by their interpreter.

   a. The interpreter must be at least 18 years old.

   b. The client and the interpreter both must sign the HHSA 20-49 Civil Rights/Interpreter form (Attachment B)

   c. The Social Worker will document in the case narrative how communication with the client was achieved.

   d. The interpreter should not be the provider of services.

IV. REVIEW STATEMENT

This notice was not reviewed by an Organizational Review Committee (ORC).

V. FILING STATEMENT

HSS Special Notices, Bulletins, and Memos are being archived at the following link:
S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated

And at the county intra-net at:
http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS
Hard copies of this Special Notice will not be distributed by Program Support.

WIL QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Gina Brown (858) 495-5554
Dist. Codes 7 & 8

REQUEST FOR INTERPRETER
From: Health and Human Services Agency
County of San Diego

Date of request:

LANGUAGE:

Worker requesting interpreter:

Worker phone number:

Office:

Manager:

Mail Stop:

Client name:

Client case number:

Client phone number (if appointment set-up call is needed):

Address where interpretation will occur:

Date of interpretation (actual/tentative date?):

Time of interpretation:

Approximate length of time needed:

FOLLOW-UP NOTES

Refer to HHSA Bilingual Lists:

_____

Alliance for African Assistance:

_____

Private Interpreting Company:

_____

Other:

_____

SAN DIEGO COUNTY
HEALTH AND HUMAN SERVICES AGENCY

CIVIL RIGHTS/INTERPRETERS

Policy on Confidentiality:

The purpose of this policy is to protect the rights of applicants for, or recipients of, social services or financial assistance against identification, exploitation, and embarrassment.

As a condition of being an interpreter for persons who are receiving services or other assistance from San Diego County Health and Human Services Agency, I agree not to divulge any information obtained in the course of such work to unauthorized persons. I further agree not to publish or otherwise make public any information regarding persons who have received services.

I recognize that unauthorized release of confidential information may make me subject to a criminal action under the provisions of the Welfare and Institutions Code, Section 10850, which states in part:

> *"Except as otherwise provided in this section, no person shall publish or disclose or permit or cause to be published or disclosed any list of persons receiving public social services. Except for purposes directly connected with the administration of public social services, no person shall publish, disclose, or use or permit or cause to be published, disclosed, or used, any confidential information pertaining to an applicant or recipient.* ***Any violation of this paragraph is a misdemeanor.****"*

I, _____, understand San Diego County Health and Human Services Agency's policy on confidentiality and my responsibility to follow this policy in my role as an interpreter/translator.

_____	_____	_____
Interpreter/Translator's Name (Print)	Interpreter/Translator's Signature	Date

I agree to have _____ act as an interpreter/translator.

_____	_____	_____
Client's Name (Print)	Client's Signature	Date

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

October 5, 2010

SUBJECT: **Revised SOC 426A**

EFFECTIVE DATE: **Immediately**

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

REFERENCE: **All County Letter (ACL) I-65-10**

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff that the SOC 426A *IHSS Program Recipient Designation of Provider* form has been updated.

II. BACKGROUND

All IHSS recipients must complete, sign, and submit the SOC 426A form before their provider can receive a payment for services through the IHSS program. The SOC 426A must be completed for each and every provider before hours can be authorized.

III. POLICY

Effective immediately IHSS staff will begin using the updated SOC 426A *IHSS Program Recipient Designation of Provider* form. Prior versions of this form can no longer be used. It is the responsibility of all IHSS staff to ensure that any form being used is the most current.

The SOC 426A *IHSS Program Recipient Designation of Provider* form can be accessed at the follow link:

http://www.dss.cahwnet.gov/cdssweb/PG168.htm#soc

And can be accessed on the S: drive at the following path:

S:\AIS\Operations\IHSS\Automated Forms\SW Forms\State of California (SOC) Forms

The SOC 426A is currently being translated into Armenian, Chinese, and Spanish and will be available in the future.

IV. REVIEW STATEMENT

This notice was not reviewed by an Organizational Review Committee (ORC).

V. FILING STATEMENT

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

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

And at the county intra-net at:

http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS

Hard copies of this Special Notice will not be distributed by Program Support.

WIL QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Gina Brown (858) 495-5554
Dist. Codes 7 & 8

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
RECIPIENT DESIGNATION OF PROVIDER

INSTRUCTIONS:

- Use black or blue ink. Print information clearly.
- You (or your legally authorized representative) must fill out this form to let the county know who you have chosen to provide your services.
- You (or your legally authorized representative) must sign the declaration at the bottom to show that you understand and agree to all of the terms and conditions listed.
- If you have multiple providers, you must fill out a separate form for each person who will be providing services.
- Please return this form to the county. The county will keep the original form and give you a copy.
- You must let the county know if you change your provider(s). You must tell the county within 10 calendar days of the change.

1. Recipient's Name:	
2. County IHSS Case #:	
3. Provider's Name:	
4. Provider's Address:	
City, State, ZIP Code:	
5. Provider's Telephone Number:	
6. Provider's Date of Birth:	
7. Provider's Gender (check box):	☐ Male ☐ Female
8. Provider's Relationship to Recipient (if any):	☐ Parent ☐ Child ☐ Spouse ☐ Other: _____
9. Provider's Start Date:	

RECIPIENT DECLARATION

- I DECLARE that the person named above is my choice to provide IHSS for me as authorized by the county.
- I UNDERSTAND that the above-named provider cannot be paid federal and/or state IHSS funds for any services provided to me until he/she has completed the entire provider enrollment process, which includes completing, signing and returning (in person) the Provider Enrollment Form (SOC 426), submitting fingerprints and being cleared of disqualifying crimes through a criminal background check, completing a provider orientation, and signing and returning the Provider Enrollment Agreement (SOC 846).
- I UNDERSTAND that I will be informed by the county if the person I have chosen to be my provider does not complete the provider enrollment process, or if he/she is determined ineligible to be a provider.
- **I UNDERSTAND that if I choose to receive services from this person before he/she is enrolled as a provider, and he/she is ultimately found ineligible, or after I have been informed that he/she is ineligible, I will be responsible for paying him/her with my own money.**
- I UNDERSTAND AND AGREE that the county can provide information about my authorized services and service hours to the provider named above.

RECIPIENT'S OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE:	DATE:
PRINTED NAME:	

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

August 12, 2010

SUBJECT: **Questions and Answers (Q&A) Expanded In-Home Supportive Services (IHSS) Provider Enrollment Requirements**

EFFECTIVE DATE: Immediately

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

REFERENCE: **All County Letter (ACL) 10-35**

I. PURPOSE

The purpose of this Special Notice is to clarify and update several issues related to the expanded In-Home Supportive Services (IHSS) provider enrollment requirements. The following "Questions and Answers" were provided through All County Letter 10-35.

II. BACKGROUND

Expanded provider enrollment requirements for IHSS went into effect November 1, 2009. Providers enrolled in the Case Management Information and Payrolling System (CMIPS) prior to the effective date (current providers) had until June 30, 2010 to complete the requirements.

III. POLICY

Effective November 1, 2009, requirements for providers were expanded to include:

- Sign the SOC 426 *Provider Enrollment Form* and return it in person to an enrollment location specified by the IHSS Public Authority
- Submit fingerprints and undergo a criminal background check
- Receive provider orientation information that informs them about the rules and requirements of being an IHSS provider
- Sign a provider agreement stating that they understand and agree to the rules and requirements for being a provider under the IHSS program

CRIMINAL BACKGROUND CHECKS

1. **Does Welfare and Institutions Code (W&IC) section 12305.81, which "prohibits any individual who in the last 10 years has been convicted of, or incarcerated following a conviction for, a crime involving fraud against a government health care or supportive services program, or a violation of subdivision (a) of Section 273a of the Penal Code (PC) (abuse of a child under circumstances/conditions likely to produce great bodily harm or death), or Section 368 of the PC (abuse of an elder or dependent adult), or similar violations in another jurisdiction," apply <u>only</u> to felony offenses?**

   No. W&IC section 12305.81 applies to both felony and misdemeanor offenses. Hence, an individual who in the last 10 years has been convicted for or incarcerated following a conviction for a crime specified in W&IC section 12305.81 – regardless

of whether the crime was a felony or a misdemeanor – would not be eligible to be enrolled as a provider or to receive payment for providing supportive services in the IHSS program.

2. **Who pays for background checks?**

W&IC section 12305.86(b) states that criminal background checks are to be conducted at the provider/applicant's expense. This statute, which was added by ABX4 19, supersedes earlier statute (W&IC section 15660(d)(2)) in regard to the fees charged for the criminal background checks. The statute does not address whether another entity (e.g., community based organization) would be prohibited from paying for the background check; however, the intent of the law is that state funds would not be used. Counties are advised to carefully research the statutes governing other programs to determine whether the funding could be used for these purposes.

The fee waiver for an indigent individual to obtain a copy of his/her criminal history record referred to in W&IC section 12305.86(c)(3) applies only to those individuals found ineligible to be providers based on the results of information found through an initial criminal background check. An individual cannot use the fee waiver process to avoid the costs of the initial criminal background check. The response to Question #8 in ACL 10-05 provides information about the fee waiver.

3. **Does the fingerprinting/criminal background review process place the county, Public Authority (PA) or Non-Profit Consortium (NPC) in the position of the employer of record?**

No. W&IC section 12305.86 requires that the counties perform background checks of current and potential providers. If a county/PA/NPC chooses not to perform background checks, they do so in violation of statute.

There is no statute that expressly or implicitly states that the county/PA/NPC becomes the "employer of record" either because they perform a provider background check or for any other reason. There are many instances in which a public agency performs a background check and this does not create an employment relationship between the subject and the agency (e.g. community care licensing, nursing/physician, state bar license).

The IHSS recipient is the employer for all purposes except where, by statute, another entity is specifically deemed the "employer." Notably, W&IC section 15660 (which grants DOJ the authority to perform the background checks at issue) specifically references the recipient as the employer. ("For purposes of this paragraph, 'employer' includes, but is not limited to, an in-home supportive services

recipient.") W&IC section 12302.2, which obligates the state to make deductions from provider pay for income tax, disability benefits, and unemployment compensation, specifically refers to the recipient as the employer.

4. **Would a conviction for, or incarceration following a conviction, under W&IC section 10980, within the past 10 years, disqualify an individual from being a provider?**

   County District Attorneys (DAs) have discretion under which code section(s) to prosecute crimes involving fraud against government programs. Whether an individual would be disqualified for a conviction under W&IC section 10980 depends upon which government program was involved. If the Criminal Offender Record Information (CORI) showing a conviction under W&IC section 10980 does not specify which program the individual committed fraud against, it will be necessary for the county/PA to obtain additional information from either the court or law enforcement to determine whether the fraud involved a health care or supportive services program. The California Department of Social Services (CDSS) is consulting with county DAs to obtain additional information about the prosecution of crimes involving fraud against government programs so that guidance can be provided to counties/PAs at a later date.

   Fraud against a public social services program, such as California Work Opportunity and Responsibility to Kids (CalWORKs), would not disqualify an individual from being an IHSS provider. This is because CalWORKs is not considered "a government health care or supportive services program" per W&IC section 12305.81 and, it is funded under Title IV, rather than Titles V, XX or XXI, of the Social Security Act. Other non-disqualifying programs would include the Foster Care Program, the Food Stamps Program, the Supplemental Nutrition Program for Women, Infants and Children (WIC), etc.

5. **W&IC section 12305.81 states that, "a person shall not be eligible to provide or receive payment for providing supportive services for 10 years following a conviction for, or incarceration following a conviction for, fraud against a government health care or supportive services program, including Medicare, Medicaid, or services provided under Title V, Title XX, or Title XXI of the federal Social Security Act..." Which specific health or supportive services programs would be included in this description?**

   Prior fraud against the IHSS program would disqualify an individual from being an IHSS provider. In addition, fraud against one of the programs listed below which are fully or partially funded under Titles V, XX and XXI of the Social Security Act, would make an individual ineligible. (Note: This list of programs is <u>not</u> exhaustive.)

- Title V. (Maternal and Child Health Services Block Grant): Sudden Infant Death Syndrome Program, Oral Health Program, Breastfeeding Program, California Birth Defects Monitoring Program, California Diabetes and Pregnancy Program, Childhood Injury Prevention Program, Fetal and Infant Mortality Review Program, Local Health Department Maternal, Child and Adolescent Health Program, Maternal, Child and Adolescent Health in Schools Program, and Regional Perinatal Programs of California.

- Title XX. (Block Grants to States for Social Services): There are currently no identified government health care or supportive services programs funded under Title XX in California.

- Title XXI. (State Children's Health Insurance Program): Healthy Families Program, and the Access for Infants and Mothers (AIM) Program.

PROVIDER ENROLLMENT REQUIREMENTS

6. What are the rules for "existing" vs. "new" providers?

A new provider is any provider who was not enrolled prior to November 1, 2009 and who did not exist in Legacy CMIPS prior to that date. New providers must complete the new provider enrollment process and be determined eligible before their timesheets can be processed and a warrant issued.

An existing provider is any provider who exists in the legacy Case Management, Information, and Payrolling System (CMIPS), in any status, from January 1, 2001, to October 31, 2009. These "existing providers" may continue to work and be paid for authorized hours they work for a recipient if they were enrolled as an active provider for that recipient prior to July 1, 2010 and he/she completed at least one of the provider enrollment requirements by June 30, 2010. Providers who meet the above condition will have until December 31, 2010 to complete any remaining provider enrollment requirements. Additionally, after June 30, 2010, an existing provider cannot receive payment for providing services to another (new) recipient, until he/she completes all of the enrollment requirements and is determined eligible.

If an existing provider did not complete at least one of the enrollment requirements prior to July 1, 2010, he/she has been terminated. In order to be re-employed as an IHSS provider and be paid by the IHSS program, he/she must complete all the enrollment requirements and be determined eligible.

Please refer to ACL 10-33 dated June 15, 2010, for additional information regarding the above provider requirements.

7. **Are recipients required to submit the Recipient Designation of Provider form (SOC 426A) even if there has been no change in the provider?**

   Yes. All recipients, regardless of whether their providers are new or existing, eventually will be required to have on file a completed SOC 426A for each provider. However, if there has been no change in a recipient's provider and there is currently on file a copy of the 9/02 version of the Provider Enrollment Form (SOC 426) with the client certification (Part II) completed, a recipient need not complete the SOC 426A at the present time. Because all providers will be required to complete the revised SOC 426 (currently under development), and because the revised SOC 426 will not include a client certification, all recipients will need to complete the SOC 426A when their provider completes the revised SOC 426. Once the revised SOC 426 is released, counties will be required to obtain the revised SOC 426 from providers and the SOC 426A from recipients. This may be done at the time of a recipient's reassessment, or at some other time at the discretion of the county. For recipients who select a new provider or who make a change in their existing provider, the SOC 426A must be completed at the time the recipient makes his/her selection/change.

8. **Are new providers eligible to receive retroactive pay for services they provide for recipients once they have completed all of the provider enrollment requirements?**

   Yes. If an individual seeking to be a provider begins providing services for an eligible recipient prior to completing all of the provider enrollment requirements, and he/she is ultimately determined to be eligible to be a provider, he/she would be eligible to receive retroactive payment to the start date of employment for the services he/she provided.

   However, if the individual is ultimately found ineligible to be a provider for any reason, he/she cannot receive payment from the IHSS program. The recipient will have to pay for services provided from his/her own pocket. For this reason, CDSS strongly encourages counties/PAs/NPC to ensure that recipients fully understand the potential financial responsibility they accept by allowing individuals to provide services prior to completing all of the provider enrollment requirements. CDSS suggests that counties provide this clarification at the same time that they provide direction to recipients on their responsibilities as employers, i.e., when recipients complete the Application for Social Services (SOC 295) and the Recipient/Employer Responsibility Checklist (SOC 332).

9. **Why is there no start date field on the SOC 426A?**

   CDSS is revising the SOC 426A to include a start date field and will release the revised form shortly. Both the SOC 426 and SOC 426A are mandated forms. Counties are not permitted to substitute county-developed forms or to revise these forms in any way.

10. **Are the counties required to retain copies of the Provider Enrollment Agreement (SOC 846) indefinitely?**

    Yes. W&IC section 12301.24(d) states that counties shall indefinitely retain the SOC 846 in the provider's file. Retaining the provider enrollment agreement form can serve as verification of a provider's eligibility and his/her understanding of the IHSS program rules and procedures which benefits both the provider and recipient. Counties may consider archiving these documents electronically or by other means. Government Code section 12168.7 requires that storing such documents be done in a manner that would not substantially alter their original form.

11. **What identification must an individual present when submitting the SOC 426?**

    A provider/applicant must present one piece of current and valid U.S. government-issued (federal or state) picture ID along with an original Social Security card or original official correspondence from the Social Security Administration (SSA) verifying his/her Social Security number (SSN). Refer to ACL 09-52 for acceptable forms of identification. If the spelling, order, or other details of the provider's/applicant's name as it appears on the SOC 426 and other ID does not match the Social Security card, the SSA may not verify the SSN. See Question #25 for information on the SSN verification process.

12. **Can the Medi-Cal Eligibility Data System (MEDS) be used to obtain an individual's SSN if they do not have an original Social Security card or original official correspondence from the SSA?**

    No. Providers/applicants must present documentation in the form of an original Social Security card or original official correspondence from the SSA.

13. **Would an individual be required to present a Social Security card when he/she presents a United States (U.S.) passport as the primary identification?**

    Yes. A U.S. passport is acceptable as identification; however, it does not allow for the verification of the SSN. Therefore, the county must also view an original Social Security card or original official documentation from the SSA so that the SSN provided on the SOC 426 can be confirmed.

TRANSLATED MATERIALS

14. When will the translated provider enrollment forms and orientation materials be made available?

The languages that currently meet the five percent statewide IHSS recipient population threshold are: Armenian, Chinese and Spanish. Pending further court action in the Beckwith, et al. v. Wagner litigation, revisions may be necessary to the SOC 426. When the revision of the SOC 426 is completed, the form will be translated into all three threshold languages and camera-ready copies will be posted on the below-referenced web page.

A camera-ready copy of the version of SOC 426 currently in use (dated 9/02) is available in Spanish on the CDSS Translated Forms and Publications web page at: http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

Translations of the Provider Orientation Guide and handouts in the threshold languages are now available on the new IHSS Provider Orientation page of the CDSS Adult Programs web site at: http://www.cdss.ca.gov/agedblinddisabled/PG2082.htm.

Pursuant to the Dymally-Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and state regulation (Manual of Policies and Procedures Division 21, Civil Rights Nondiscrimination, section 115), counties are responsible for providing translation/interpretation services for non-English speaking or limited English proficient populations.

Questions relating to these translated materials should be directed to the CDSS Language Services Unit, at (916) 651-8876 or LTS@dss.ca.gov.

PROVIDER ORIENTATION

15. When will written provider orientation materials be available?

All provider orientation materials have been made available. The CD-ROM and the required handouts were distributed to counties on October 20, 2009. The written Provider Guide and required handouts were mailed on November 23, 2009.

Translations of the orientation materials in Spanish, Armenian and Chinese have been completed. See Question #14 above for information on where the translated documents can be accessed online. These materials were mailed to counties in mid-December 2009. Translation of the Provider Orientation CD-ROM was completed and the translations were mailed to counties in mid-January 2010.

16. Are existing providers required to attend an on-site orientation session?

No. Existing providers are not required to attend an on-site orientation session. They also have the option of reviewing the Provider Orientation Guide or CD-ROM, whichever they prefer and find most accessible.

Existing providers are required, however, to submit the SOC 426 in person and present their original government-issued ID and Social Security card. Existing providers must also return a signed SOC 846. It is not necessary for the either form to be signed in the presence of county/PA staff.

17. When will the orientation materials include the final list of crimes that would disqualify a provider?

Pending further court action, at this time the ruling of the Alameda County Superior Court in the Beckwith, et al. v. Wagner court case provides the crimes that would make an individual ineligible to be a provider in the IHSS program. These are limited to a conviction (or incarceration following a conviction) within the last 10 years for those crimes specified in W&IC section 12305.81:

1) Fraud against a governmental health care or supportive services program;
2) Violation of subdivision (a) of Section 273a of the PC (abuse of a child under circumstances/conditions likely to produce great bodily harm or death); or
3) Violation of Section 368 of the PC (abuse of an elder or dependent adult).

This change will be incorporated into the provider orientation training curriculum at the next revision of the materials.

18. Will the provider orientation be made available in DVD format?

The provider orientation training covers detailed information and instructions. It was determined that it was best suited to a power-point presentation format and, as a result, the format dictated use of the CD-ROM. However, the training materials will be revised in the next fiscal year and other formats will be considered at that time.

19. Can counties present other information that new providers would need to know about the IHSS program during the orientation?

Yes. As stated in ACL 09-54, counties are required to use the materials developed by CDSS, but they may supplement the orientation with county-specific information and/or directions.

PROVIDER APPEALS

20. Is there a new form counties will be required to use for appeals?

CDSS developed a Fact Sheet Supporting Denial form that Provider Enrollment Appeals Unit (PEAU) staff forward to counties or PAs each time an appeal has been filed. The form requests the criminal conviction code(s) and conviction date(s) used by counties/PAs as the basis for declining to enroll a prospective provider or to find a provider ineligible. Counties should also provide any additional documentation not obtained from the Department of Justice (DOJ) that was used as part of the eligibility determination as an attachment to this form. If a county/PA has concerns or questions regarding transferring/sharing relevant conviction data obtained from the DOJ with CDSS via the form, they are urged to contact the Record Access & Security Program, DOJ, at (916) 227-3460 or RecordSecurity@doj.ca.gov for guidance. Although the form is intended to simplify the transmission of this information from the county to the state, counties are not mandated to use this form; a locally-developed form may be used as long as it contains all of the required information.

CMIPS ISSUES

21. Does the input of a termination reason code on the CMIPS Provider Enrollment screen pose any county liability in terms of violation of confidentiality of CORI received from DOJ?

No. The reason codes in CMIPS were updated to identify ineligibility reasons in a general way. According to DOJ, the county can input the reason for ineligibility/termination into CMIPS and it would not violate the confidentiality of the CORI. Further, DOJ indicated that it is acceptable for CMIPS to be updated with information that indicates that an individual is not eligible as a result of information from the criminal background check.

22. CMIPS is a point-in-time system. It does not track provider enrollment process. Will the new provider enrollment screens only be completed when the provider has completed the enrollment process and is either eligible or ineligible for payment?

No. The ENRL screen can be accessed at any time using the provider's SSN. Since it is unlikely that most providers will complete the entire enrollment process at one time, the screen was designed to allow counties to check off the necessary items as they are completed. Providers who have not completed the entire process are in pending "P" status. Once all of the steps have been completed, county staff must change the provider to "E" (eligible) status on the PELG screen. However, be aware that the system will not allow a change in the provider's status to "E" on the PELG screen until the enrollment process has been completed.

Additionally, the system requires both the ENRL enrollment process to be completed AND the SSNV field on the PELG screen to be verified in "V" before the PELG status can be changed to "E."

23. Will the Informing Notices to providers link to the new provider enrollment screen so that notices/letters to providers can be generated automatically as they are currently when counties make changes to client eligibility and NOAs are generated?

No. As stated in ACL 09-66, page three, counties will be responsible for generating and mailing provider enrollment eligibility notification letters.

24. How will county staff record provider ineligibility based on a conviction received as a result of the background check?

The county staff will enter the ENRL screen in either "A" (add) or "C" (change) mode. In the Fingerprint/BI field on the ENRL screen they will enter a "Y" to show the background check has been completed. In the Enrollment Status field they will enter "I" (ineligible) and enter Termination Reason Code 11.

25. What is the SSN verification process and how often are the results posted on provider records?

The SSN verification process is a batch process that is performed twice a week by the CMIPS vendor. The new provider records are sent to the SSA for verification. The results of each batch will be posted to each provider record within 3 business days of when the batch was run. The batch is customarily run on Tuesdays and Fridays, but holidays may change this schedule. If the SSN is correct and has been verified it will be followed by a "V" on the H3 line of the PELG screen. If the SSN does not match the SSA records the provider will be included on the CMIPS Online SSN Verification Report to be resolved by county staff. A new provider is not eligible to be paid until their SSN is in "V" status.

26. Why are the forced manual edit and extra steps necessary when entering a P.O. Box on the provider screen?

At this time, system functionality necessitates that the forced edit be used to meet the new residential address and mailing requirements. This programming ensures that a county worker examines this requirement while still allowing counties the option of overriding the restriction on mailing checks to P.O. Boxes, if the county has approved an exemption. Information and instructions regarding the use of a P.O. Box as a mailing address will be transmitted in an upcoming ACL.

SOC 295

27. Why has CDSS included additional language on the revised SOC 295 that seems to go beyond what is required by ABX4 4?

In addition to revisions to meet the requirements of ABX4 4, the revised SOC 295 includes language that informs IHSS applicants of some key program aspects and recipient responsibilities, including:

- The basic responsibilities of IHSS recipients as the employer of their provider of IHSS service;
- The new requirements individuals must meet to be paid as IHSS providers; and
- New program integrity and fraud detection and prevention activities.

28. ACL 09-63 indicates that the application form SOC 295 will be further updated and an ACL "issued with new requirements as they are implemented." Does this mean that these instructions are not final?

ACL 09-63 was released with the new form and instructions to use the revised SOC 295. The new form is posted on CDSS' Forms and Publications website (http://www.dss.cahwnet.gov/cdssweb/FormsandPu 271.htm). The statement regarding the application being further updated was included simply to inform counties that this form will be revised again as other requirements, such as recipient fingerprinting and timecard fingerprinting, are implemented at a later date.

29. The application states, "To promote program integrity, I may be subject to unannounced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns" from DHCS, CDSS, and/or the county. This statement does not specify why such visits might occur. Aren't these visits and letters to be in a more targeted fashion and per protocols that are still to be developed per ABX4 19?

This reference conveys that recipients/providers may be subject to an unannounced home visit. The protocols are being developed with input from stakeholders. County staff may provide clarification to recipients and providers as needed. The SOC 295 will be further updated as new program requirements become effective.

PROVIDER I-9 POLICIES

30. Are counties/PAs/NPC required to obtain and retain a copy of Form I-9? If so, how should the signed form be maintained?

No. Counties/PAs/NPCs are not required to obtain and retain a copy of Form I-9. Completing the Form I-9 is a requirement of the U. S. Citizenship and Immigration Services (USCIS). The Form I-9 instructions state that the form is not filed with the

USCIS; it must be retained by the employer, which in the case of IHSS would be the recipient.

As stated in ACL 09-69, some counties/PAs/NPCs have made it a practice to retain these forms to assist their recipients. Counties/PAs/NPC may continue to do so provided that these forms are filed in a secure and confidential manner, such as in the IHSS provider's file or in a specific Form I-9 file. Additionally, counties/PAs/NPC may consider archiving the documents electronically or by other means. State law specifies that storing such documents shall be accomplished in a manner that would not substantially alter its original form (Government Code section 12168.7) and federal regulations permit that Form I-9 may be signed and retained electronically (8 Code of Federal Regulations, section 274a.2).

31. How should the county/PA/NPC proceed with provider enrollment when an individual presents a Social Security card imprinted with "Valid for Work Only with DHS Authorization"?

For the purpose of verifying an individual's SSN in order to complete the provider enrollment process, the county/PA/NPC may accept a Social Security card imprinted with "Valid for Work Only with DHS Authorization."

However, when an individual who possesses a Social Security card with this notation is hired by a recipient as a provider and he/she completes the Form I-9, additional steps would need to be taken to verify whether the individual is authorized to work in the U.S. For more information on the steps needed to verify this employment eligibility, refer to the USCIS's website (http://www.uscis.gov/portal/site/uscis) and click on the link to the E-Verify Homepage.

INTER-COUNTY TRANSFERS

32. When a recipient moves from one county to another and begins receiving services from a new provider, how long does the transferring county continue to pay the case?

Consistent with regulations for the inter-county transfer process, upon acknowledgement from the receiving county that the new provider is an eligible provider, the transferring county has the responsibility for authorizing services and continuing payment to the new provider until the transfer period ends, at which time the receiving county becomes responsible. The receiving county has the responsibility for assisting the recipient in obtaining an existing enrolled provider or ensuring the recipient's new provider has completed the provider enrollment requirements.

33. **When a recipient moves from one county to another along with his/her existing provider, must the provider undergo a criminal background check in the new county?**

Yes. The provider must submit fingerprints and undergo a criminal background check in the new county even if the individual has completed one in the originating county. However, an existing provider who has completed at least one of the provider enrollment requirements by June 30, 2010, has until December 31, 2010 to complete the remaining provider enrollment requirements, including the criminal background check.

IV. REVIEW STATEMENT

This notice was not reviewed by an Organizational Review Committee (ORC).

V. FILING STATEMENT

HSS Special Notices, Bulletins, and Memos are being archived at the following link:
S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated

And at the county intra-net at:
http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS
Hard copies of this Special Notice will not be distributed by Program Support.

WIL QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Gina Brown (858) 495-5554
Dist. Codes 7 & 8

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 09-14
Addendum A
July 9, 2010

SUBJECT: Revised SOC 295 In-Home Supportive Services Recipient Application Form

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All-County Letter 09-63

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff that the *SOC 295 In-Home Supportive Services (IHSS) Recipient Application Form* has been revised.

II. BACKGROUND

AB X4 4 and AB X419 created new requirements for an individual to be paid as an IHSS provider, and established fraud detection and prevention activities. The *SOC 295 In-Home Supportive Services Recipient Application Form* has been revised to inform recipients of these program requirements and of their responsibilities as an IHSS applicant/recipient.

III. POLICY

Effective November 1, 2009 IHSS social workers must use the revised version of the SOC 295.

IV. SOCIAL WORKER PROCEDURES

The revised *SOC 295 In-Home Supportive Services Recipient Application Form* **must be completed and explained at both intake and renewal, until all recipients have received the information provided in this form.**

- Form SOC 295 is available on the S drive in the "Automated Forms" folder. The link is: S:\AIS\Operations\IHSS\Automated Forms\SW Forms\State of California (SOC) Forms

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

- Print two copies to be finalized and signed during the home visit. The form is completed and signed by the participant or his/her authorized representative at the home visit. One copy is to be left with the recipient. The other copy is to be retained in the case file under the miscellaneous tab.

V. REVIEW STATEMENT

This Special Notice has not been reviewed by the standard review committee.

VI. FILING STATEMENT

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

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

And at the county intra-net at:

http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS

Hard copies of this Special Notice will not be distributed by Program Support.

WILFRED QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Gina Brown (858) 495-5554
Distribution Codes 7 & 8

APPLICATION FOR SOCIAL SERVICES

TO THE APPLICANT: *This form is subject to verification.*
NOTE: *Retain your copy of this application.*

* **SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

CASE NUMBER:	DATE OF APPLICATION:

1. NAME			*SOCIAL SECURITY NUMBER
ADDRESS			SEX ☐ Male ☐ Female
CITY	ZIP CODE	TELEPHONE ( )	BIRTHDATE

2. Are you a veteran? ☐ Yes ☐ No	ARE YOU A SPOUSE/CHILD OF A VETERAN? ☐ Yes ☐ No	IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER:

3. Do you receive SSI/SSP benefits? ☐ Yes ☐ No	IF "YES", CHECK YOUR TYPE OF LIVING ARRANGEMENT: ☐ Independent Living ☐ Board and Care ☐ Home of Another
SERVICES BEING REQUESTED:	

4. Have you received In-Home Supportive Services (IHSS) in the past? ☐ Yes ☐ No
If "YES", complete the following:

DATE AND COUNTY WHERE SERVICE WAS LAST RECEIVED	TOTAL MONTHLY HOURS	NAME USED (IF DIFFERENT FROM ABOVE)

5. LIST FAMILY MEMBERS IN HOUSEHOLD	BIRTHDATE	*SOCIAL SECURITY NUMBER
NAME OF SPOUSE ☐ NAME OF PARENT ☐		
CHILD/OTHER RELATIVE		
CHILD/OTHER RELATIVE		

6. The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.

A. My ethnic origin is (*see reverse side for correct code*):	B. I speak and understand English: ☐ Yes ☐ No My primary language is (*see reverse side for correct code:*)

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1) Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2) Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3) Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4) Notifying the County IHSS office when I hire or fire a provider.

In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1) In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2) If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3) The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4) I will be responsible for paying for any services I receive that are not included in my IHSS authorization.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity, I may be subject to unannounced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

SIGNATURE OF APPLICANT:	DATE:
SIGNATURE OF APPLICANT'S REPRESENTATIVE: *(ONLY IF APPLICABLE)*	DATE: *(ONLY IF APPLICABLE)*
REPRESENTATIVE'S RELATIONSHIP TO APPLICANT: *(ONLY IF APPLICABLE)*	REPRESENTATIVE'S TELEPHONE NUMBER: *(ONLY IF APPLICABLE)* ( )
REPRESENTATIVE'S ADDRESS: *(ONLY IF APPLICABLE)*	

To report suspected fraud or abuse in the provision or receipt of IHSS services please call the fraud hotline 800-822-6222 or go to www.stopmedicalfraud@dhcs.ca.gov.

FOR AGENCY USE ONLY

INCOME ELIGIBLE:	STATUS ELIGIBLE:	VERIFICATION:	SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTATIVE:	TELEPHONE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO			( )
RECIPIENT STATUS: ☐ Refugee ☐ Cuban/Haitian Entrant			SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS (*EXPLAIN*)	

A. Ethnic Codes:

1. White
2. Hispanic
3. Black
4. Other Asian or Pacific Islander
5. American Indian or Alaskan Native
7. Filipino
C. Chinese
H. Cambodian
J. Japanese
K. Korean
M. Samoan
N. Asian Indian
P. Hawaiian
R. Guamanian
T. Laotian
V. Vietnamese

B. Language Codes:

O. American Sign Language (AMISLAN or ASL)
1. Spanish - NOA will be issued in Spanish
2. Cantonese
3. Japanese
4. Korean
5. Tagalog
6. Other non-English
7. English
9. Spanish - NOA will be issued in English
A. Other Sign Language
B. Mandarin
C. Other Chinese Languages
D. Cambodian
E. Armenian
F. Ilacano
G. Mien
H. Hmong
I. Lao
J. Turkish
K. Hebrew
L. French
M. Polish
N. Russian
P. Portuguese
Q. Italian
R. Arabic
S. Samoan
T. Thai
U. Farsi
V. Vietnamese

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10-06

July 9, 2010

SUBJECT: **PROGRAM INTEGRITY UNIT - INFORMATION REQUESTS**

EFFECTIVE DATE: **IMMEDIATELY**

EXPIRATION DATE: **WHEN INCORPORATED INTO THE IHSS PROGRAM GUIDE**

REFERENCE:

I. PURPOSE

The purpose of this Special Notice is to provide instructions to In-Home Supportive Services (IHSS) staff on the forwarding of case information to the IHSS Program Integrity Unit.

II. BACKGROUND

The IHSS Program Integrity Unit was created to provide additional review and oversight of services that have been authorized for IHSS recipients.

III. POLICY

Ensure the safety of IHSS recipients and the integrity of the IHSS program through random, unannounced home visits and the monitoring of services and providers.

IV. REQUEST FOR DOCUMENTS

Cases for review will be randomly selected by the Program Integrity Unit Supervisor. Information from the identified case files will be requested monthly by email to the IHSS Social Work Supervisor(s). The case list will be sorted by unit and include the assigned worker number. The following documents will be forwarded to the IHSS Program Integrity unit by the designated Office Assistant, or by the IHSS Social Worker:

- 12-42 IHSS Worksheet
- SOC 293A Face Sheet
- 12-43 or 12-43A Service Activities Narrative for current eligibility period

Documents should be forwarded as soon as reasonably possible, but no later than ten working days from the date of the request. Whenever possible the documents will be sent electronically by email to:

AppealsClerk.HHSA@sdcounty.ca.gov

The subject line will include Attn: IHSS Program Integrity Unit. Until scanners are available in all district IHSS offices, hard copies may be sent via county mail to the IHSS Program Integrity Unit at MS W402.

Do not send documentation on cases where:

- A reassessment/renewal was completed within the last 30 days
- A reassessment/renewal is due or scheduled within the next 30 days
- There is an active, unresolved fraud referral

The Social Worker or Social Work Supervisor will email to the Program Integrity Unit Supervisor a list of any requested cases that are not currently available for random home visits, and indicate the reason they are not available. If necessary, clarification on case information may be requested and provided worker to worker or supervisor to supervisor.

Attached is a draft form created by the Program Integrity Unit to communicate the results of the home visit and any action taken by the Social Worker as a result. Input on the attached form will be requested at the next supervisors meeting.

Time for the above activities may be claimed as:

- KRONOS Code: HHS-1001994-7411 IHSS PCSP-SS GENERAL FUND//////
- Time Study Code: 7411 IHSS – PCSP-Plus Option Anti-Fraud

Note: The Kronos profile must be added by Payroll before it can be searched, added or used.

V. REVIEW STATEMENT

Because of its information nature, this notice was not reviewed by an Organizational Review Committee (ORC).

VI. FILING STATEMENT

HSS Special Notices, Bulletins, and Memos are being archived at the following link:
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And at the county intra-net at:
http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS
Hard copies of this Special Notice will not be distributed by Program Support.

Wil Quintong/es

WIL QUINTONG
Assistant Deputy Director

Ellen Schmeding

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Mary Harrison (858) 505-6952
Dist. Codes 7 & 8

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
STRATEGIC PLANING AND OPERATIONAL SUPPORT
IHSS PROGRAM INTEGRITY UNIT

IHSS PROGRAM INTEGRITY UNANNOUNCED HOME VISIT RESULTS

District: _____ Social Worker: _____ SWS:_____

Response due by e-mail to assigned IHSS PI SW, SPOS Fraud & Integrity
By:

Assigned IHSS PI SW: **Phone:**

CLIENT NAME (last, first):
CASE NUMBER: 37-
PROVIDER NAME (last, first):

☐ **Immediate Action needed (within 10 calendar days)**

IHSS PI SW FINDINGS:

IHSS PI SW COMMENTS/SUGGESTIONS:

Please review, discuss or confirm the above information/circumstances with the client (authorized rep.) and determine whether changes and/or update information to the case are warranted.

If you have any questions or concerns, please contact IHSS PI SW. If no action will be taken by IHSS SW please indicate that below in the "comments/action taken".

DISTRICT WORKER COMMENTS/ACTION TAKEN:

Hours Increased: ☐ ____ **Hours Decreased:** ☐ ____**Case Closed:** ☐ **O/P:** ☐ **No Action:** ☐ **Other:** ☐

Completion Date: _____

Please complete this form and send it back electronically to the sending IHSS Program Integrity Social Worker.

DRAFT

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10-05

June 30, 2010

SUBJECT: **PROVIDERS IN PENDING STATUS JUNE 30, 2010**

EFFECTIVE DATE: **JUNE 30, 2010**

EXPIRATION DATE: **DECEMBER 31, 2010**

REFERENCE: **ALL COUNTY LETTER (ACL) 10-33**

I. PURPOSE

The purpose of this Special Notice is to explain to In-Home Supportive Services (IHSS) staff under what circumstances a provider may continue to provide and be paid for services through the IHSS program beyond June 30, 2010.

II. BACKGROUND

Expanded provider enrollment requirements for IHSS went into effect November 1, 2009. Providers enrolled in the Case Management Information and Payrolling System (CMIPS) prior to the effective date (current providers) had until June 30, 2010 to complete the requirements.

III. POLICY

Effective November 1, 2009, all providers must complete the following requirements to be enrolled as an IHSS care provider:

- Sign the SOC 426 *Provider Enrollment Form* and return it in person to an enrollment location specified by the IHSS Public Authority
- Submit fingerprints and undergo a criminal background check
- Receive provider orientation information that informs them about the rules and requirements of being an IHSS provider
- Sign a provider agreement stating that they understand and agree to the rules and requirements for being a provider under the IHSS program

In order to continue to receive payment for providing services to IHSS recipients, providers who were enrolled in the Case Management Information and Payrolling System (CMIPS) prior to November 1, 2009 *must complete at least one of the four enrollment requirements by June 30, 2010.* Providers who meet this requirement can continue to work and be paid by the IHSS program and will have until December 31, 2010 to complete the remaining requirements. *Providers who do not meet this requirement will be terminated and will not be paid for any hours worked after June 30, 2010.* These providers will need to complete all four steps before

they can be paid by the IHSS program. **All current providers in San Diego County have received orientation material by mail and have met one requirement.**

IV. SUMMARY

Current Provider – A provider enrolled in the CMIPS system after January 1, 2001 and prior to November 1, 2009.

- If one of the four provider requirements has been completed, a Current Provider will be eligible for continued payment after June 30, 2010 only for recipients for which they are currently active and providing services.

- Current Providers hired by a new/different recipient after June 30, 2010 will have to complete all four requirements and be determined eligible to be an IHSS provider before being enrolled and receiving payment for services to that recipient.

- Providers who begin working prior to completing the requirements may be enrolled and paid retroactively *only if they are determined to be an eligible IHSS provider*.

- Current Providers who continue working for the recipient after June 30, 2010 may be paid retroactively to July 1, 2010 if:
    - all requirements are completed
    - they are determined an eligible IHSS provider

  If the provider is found to be ineligible, the recipient will be responsible for payment of any services provided.

V. TERMINATION PROCESS

Providers (and their recipients) who had not completed at least one of the four requirements were issued reminder notices during the first week of June 2010 by the California Department of Social Services (CDSS). A final notification will inform the recipient(s) of the provider(s) that will be terminated as of June 30, 2010.

Termination of providers will be determined by the information that has been entered in CMIPS on the Provider Enrollment screens. Public Authority staff will ensure that all provider enrollment information accurately reflects completion of one requirement by June 30, 2010.

A report will be issued by CDSS to each county (with the monthly download) indicating providers and recipients who were affected by the termination process. A process for correcting an erroneous termination will be issued by a Program Manager Letter.

VI. STAFF IMPACT

Public Authority staff will work diligently to ensure that all current San Diego providers are transitioned. If, for some reason a provider is missed, the Public Authority will correct this erroneous termination.

VII. REVIEW STATEMENT

This notice was not reviewed by an Organizational Review Committee (ORC).

VIII. FILING STATEMENT

HSS Special Notices, Bulletins, and Memos are being archived at the following link:
S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated

And at the county intra-net at:
http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS
Hard copies of this Special Notice will not be distributed by Program Support.

WIL QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Mary Harrison (858) 505-6952
Dist. Codes 7 & 8

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

June 16, 2010

SUBJECT: **MODIFIED NOTICE OF ACTION (NOA) #350 MESSAGE**

EFFECTIVE DATE: **Immediately**

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

REFERENCE: **ALL-COUNTY INFORMATION NOTICE: l-44-10**

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff of the modifications to the Notice of Action (NOA) #350 message stuffer.

II. BACKGROUND

The Share-of-Cost (SOC) Buyout program was eliminated on October 1, 2009 and the IHSS Plus Waiver (IPW) program was replaced with IHSS Plus Option (IPO) effective October 1, 2009. NOA #350 message was modified to reflect these statutory changes.

III. POLICY

Effective immediately, the modified NOA message will need to be included as an attachment when any Share-of-Cost NOA is generated.

IV. PROCEDURES

IHSS SOCIAL WORKERS

Depending upon which program the recipient is assigned, IHSS Social Workers will need to mark the appropriate box [“A” for IHSS Plus Option (IPO) Program, “B” for Personal Care Services Program (PCSP), or “C” for Residual (IHSS - R) Program] on the NOA #350 message.

V. REVIEW STATEMENT

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

VI. FILING STATEMENT

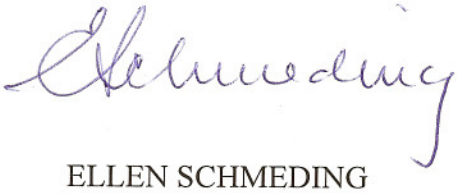
IHSS Special Notices are archived at:

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

And at the county intranet at:

http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS

WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido at (858)505-6366

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

(A) ☐ IHSS PLUS OPTION (IPO) PROGRAM

(B) ☐ PERSONAL CARE SERVICES PROGRAM (PCSP)

You get IHSS as a service of your Medi-Cal through either the IHSS Plus Option (IPO) or the Personal Care Services Program (PCSP). A box is checked above next to (A) or (B) to tell you which program you get services from. See your Medi-Cal notice for information about your Medi-Cal eligibility and any Medi-Cal share of cost you may have to pay.

If you have a Medi-Cal share of cost, a letter will be sent to you each time one of your provider's payments is processed telling you how much you need to pay your provider. You will only pay the IHSS share of cost indicated at the top of your attached In-Home Supportive Services (IHSS) Notice of Action (NA 690) if you are discontinued from Medi-Cal.

OR

(C) ☐ IHSS-RESIDUAL (IHSS-R) PROGRAM

You get IHSS from the IHSS-Residual program. Your IHSS share of cost is displayed at the top of your attached In-Home Supportive Services (IHSS) Notice of Action (NOA 690). If you have an IHSS share of cost, that amount will be deducted each month from your provider's paycheck and you will be sent a letter telling you to pay that amount to your provider. If you are Medi-Cal eligible and have a Medi-Cal share of cost, you may provide proof of the amount you paid your provider to your Medi-Cal eligibility worker and that amount will be used toward meeting your Medi-Cal share of cost.

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING. PLEASE SEND YOUR WRITTEN REQUEST TO THE COUNTY ADDRESS ON THE TOP RIGHT HAND CORNER OF THE ATTACHED IN-HOME SUPPORTIVE SERVICES NOTICE OF ACTION (NOA 690) FORM.

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10-04

May 3, 2010

SUBJECT: **SHAREPOINT CASE TRACKING TOOL**

EFFECTIVE: **May 3, 2010**

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 using SharePoint to track cases to and from Records Library (RL) and to various district offices.

II. BACKGROUND

When the use of the Case Data System (CDS) was discontinued, a new method of tracking IHSS cases was required. A system has been developed in SharePoint to track IHSS cases to and from RL, IHSS district offices and other locations.

III. POLICY

All cases will be tracked using the SharePoint Tracking Tool effective May 3, 2010.

Access is limited to staff who are authorized to use the tool. Users are divided into three categories:

- Members - Principal users of the tracking tool. They are composed of IHSS and RL clerical staff that have the ability to edit information on case activity and location as well as produce relevant reports.
- Visitors - IHSS supervisors and administrators will have the ability to search for a case in the system and will have "read only" access to case information.
- Owners - IHSS and RL staff with full administrative control of the site. They can add and/or delete members and visitors, authorize access level and edit information.

Site maintenance and case back up will be performed by Northrop Grumman (NG) staff. The tracking tool can be accessed from the County intranet using the following link:

http://cwss/sites/hhsa/ais/ihss/default.aspx

IV. PROCEDURES

Before adding, sending, requesting, or receiving a case using the SharePoint case tracking tool, a *case search* must be done first to see if the case is in the database.

Case Search

STEP	PROCEDURE – CASE SEARCH
1.	Open *Internet Explorer* on your desktop and type http://cwss/sites/hhsa/ais/ihss/default.aspx in the web browser to access *IHSS Case Tracking*. The screen that appears is the IHSS *Case Tracking Home Page*.
2.	Locate "This Site" that is found on the upper right hand corner of the Home Page screen.
3.	Type the Case Name or Case Number on the box opposite "This Site." Click on the magnifying glass icon. • When using case name, type *Last Name, First Name.* • When using case number, type only the 6 digit numeric or alpha numeric combination. E.g. 458963 or A45686
4.	The case result screen appears after clicking the magnifying glass icon. This screen shows if the case being searched is in the tracking database.
5.	If the screen does not show a match on the case search, the case must be added to the database before continuing. Refer to procedures for *Adding Case to the IHSS Case Tracking Database*.
6.	If the screen shows a match on the case search, click the topmost item showing the case number to go to the *Library* screen.
7.	Use the *Library* screen to request, receive, or send a case.

Adding a Case to the IHSS Tracking Database

STEP	PROCEDURE – ADDING A CASE
1.	Search for the case in the database on the *IHSS Case Tracking Home Page*. Refer to procedures for *Case Search.*
2.	If the search result screen does not show a match on the case, go back to the *IHSS Case Tracking Home Page* and click on *Case Records* on the left section of the screen.
3.	Click on *New* to go to the *Library: New Item* screen.
4.	Complete the following information on the *Library: New Item* screen: • Case Number – Only the 6 digit numeric or alpha numeric combination must be entered. E.g. 256980, B12546 • Case Name – Follow the format *Last Name, First Name.* • Description – Use the drop down menu to indicate if the case is *Active, Closed – Denied,* or *Closed Terminated.* • Category – Choose *IHSS* from the drop down menu. • Comments – Any important information related to the case. E.g. Case is

	being requested by Appeals. • Status – Choose *Sent* from the drop down menu. • Status Date – The date the case will be sent out. Use the format: MM/DD/YYYY (04/21/2010) or click the calendar icon to enter the date.
5.	Leave the *Requesting Worker ID and Mail Stop* blank.
6.	Click *OK* when data entry is completed.

Sending a Case

STEP	PROCEDURE – SENDING A CASE

1.	Search for the case in the database on the *IHSS Case Tracking Home Page*. Refer to procedures for *Case Search*.
	• If there is no match for the case being searched, add the case to the database. Refer to procedures for *Adding Case to the IHSS Case Tracking Database.*
	  ○ After adding the case to the database, go back to the *IHSS Case Tracking Home Page.*
	  ○ Click on the case number under *All Case Records* to go to the *Library* screen.
	• If there is a match for the case being searched, click on the topmost item showing the case number to go to the *Library* screen.

2.	On the *Library* screen, click *Edit Item* to make necessary changes on the case information.
3.	Make the following changes on the case information as necessary: • Description – Choose *Active, Closed – Denied*, or *Closed – Terminated* as appropriate. • Category – Choose the location that is sending the case from the drop down menu. • Comments – Any important information related to the case. E.g. Sent to El Cajon. Forward the case to LSXX. • Status – Choose *Sent* from the drop down menu to confirm that the case is sent out. • Status Date – The date the case is sent out. Use the format: MM/DD/YYYY (04/21/2010) or click the calendar icon to enter the date. • Leave the *Requesting Worker ID* and *Mail Stop* blank.

Requesting a Case from the Records Library

Use *e-mail* when requesting a case from IHSS district office, Appeals, Quality Control unit, or Fraud and Integrity unit. Do not use the case tracking tool.

STEP	PROCEDURE – REQUESTING A CASE
1.	Search for the case on the *IHSS Case Tracking Home Page*. Refer to procedures for *Case Search.*
2.	On the *Library* screen, look for *Status* of the case. If Status shows *Received* and

	Category shows *Record Room,* the case is in the Records Library.
3.	Click on *Check Out* to request the case.

4.	When the *Transactions: New Item* screen appears, complete the following information:
	• Check Out To – Type the requestor's name. Use Last Name, First Name or click on the open book icon to browse the requestor's correct name in the directory.
	  o If the browser icon is used, type the requestor's last name, first name.
	  o Click on the magnifying glass icon.
	  o Click on the name highlighted in orange. Click *OK.*
	• Requesting Worker ID – Type the requestor's worker number, if it is available.
	Note: If the requestor does not have Requesting Worker ID, write in the case destination. E.g. Escondido, Appeals, etc.
	• Mail Stop – Type the requestor's mail stop.
	• Click *OK* to submit the request to the Records Library.
	• After clicking OK, the *IHSS Case Tracking Home Page* reappears. The requested case must show under *Pending Requests* for the Records Library to process.
	Note: Only cases that are requested from RL will show under *Pending Requests* on the *IHSS Case Tracking Home Page.*

Receiving a Case from the Records Library

STEP	PROCEDURE – RECEIVING A CASE
1.	Click the *Case Librarian Page* on the *IHSS Case Tracking Home Page.*
2.	Under *Requests Completed,* locate and click on the case that is requested.
3.	When the *Library* screen appears, click on *Edit Item* for necessary changes on the case information.
4.	Make the following changes: • Description – Choose *Active, Closed – Active, or Closed – Terminated* as appropriate. • Category – Choose the location that is receiving the case from the drop down menu. • Comments – Any important information related to the case. E.g. Case is assigned to SS14. • Status – Choose *Received* from the drop down menu to confirm that the case is received. • Status Date – The date the case is received. Use the format: MM/DD/YYYY (04/21/2010) or click the calendar icon to enter the date.
5.	Click *OK* when the data entry is completed.

Receiving a Case from Other Locations

STEP	PROCEDURE – RECEIVING A CASE OTHER LOCATIONS
1.	On the *IHSS Case Tracking Home Page*, type the Case Name (Last Name, First Name) or the 6 digit numeric or alpha numeric combination on the box opposite "This Site." Then, click on the magnifying glass icon.
2.	When the case search screen appears, click on the first item showing the case number to go to the *Library* screen.
3.	When the *Library* screen appears, click on *Edit Item* for necessary changes on the case information.
4.	Make the following changes: • Description – Choose *Active, Closed – Denied*, or *Closed – Terminated* as appropriate. • Category – Choose the location that is receiving the case from the drop down menu. • Comments – Any important information related to the case. E.g. Case is forwarded to SS14. • Status – Choose *Received* to confirm that the case is received from the drop down menu. • Status Date – The date the case is received. Use the format: MM/DD/YYYY (04/21/2010) or click the calendar icon to enter the date.
5.	Click *OK* when the data entry is completed.

V. REVIEW STATEMENT

This Special Notice was reviewed by an organizational review committee.

VI. FILING STATEMENT

IHSS Special Notices are being archived at the following link:

S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated
And at the county intranet at:

http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS

Hard copies of this Special Notice will not be distributed by Program Support.

WILFRED QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido at (858) 505-6366

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10-03

April 30, 2010

SUBJECT:	**IHSS & the Program of All-inclusive Care for the Elderly (PACE)**
EFFECTIVE DATE:	**Immediately**
EXPERATION 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 coordinating services for recipients who may be eligible to assistance from either PACE or IHSS.

II. BACKGROUND

The California Department of Social Services (CDSS) receives a report each month identifying PACE recipients who are also receiving IHSS services. PACE and IHSS are both funded through the Personal Care Services Program (PCSP), recipients cannot receive services from both programs at the same time.

III. POLICY

The PACE program will screen each applicant and determine if he/she is currently receiving IHSS services. Any IHSS recipients must be informed that when he/she is enrolled into PACE, their IHSS services will be terminated.

IV. PROCEDURES

PACE will:

- Provide IHSS with a list of active IHSS recipients who are enrolled into the PACE program each month. A *10 Day Waiver Agreement* (Attachment) requesting termination of IHSS services will also be included.
- Scan and email the *10 Day Waiver Agreement* for each new PACE recipient every month to the IHSS Senior Office Assistants.
- Include the IHSS Program Manager, and the IHSS Operations Manager in the "cc" field of the email.

IHSS will:

- Designate staff that will clear and distribute the information to the assigned Social Worker and Social Work Supervisor.
- Coordinate the closing date of the IHSS case with the start date of PACE services to prevent duplication of, or a break in services.
- Issue a Notice of Action (NOA) to the IHSS recipient confirming the termination of IHSS services.

If a recipient chooses to receive services from PACE, the IHSS case must be terminated. If a *10 Day Waiver Agreement* has not been signed and received for the case file, timely notice must be given before the case can be closed.

V. REVIEW STATEMENT

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

VI. FILING STATEMENT

IHSS Special Notices are being archived at the following link:

S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated
And at the county intra-net at:

http://hhsa-pg.sdcounty.ca.gov/AisIhss/default.asp?Guide=AISIHSS

Hard copies of this Special Notice will not be distributed by Program Support.

WILFRED QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Gina Brown (858) 495-5554
Distribution Codes 7 & 8

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

AGING & INDEPENDENCE SERVICES
P.O. BOX 23217, SAN DIEGO, CALIFORNIA 92193-3217
(858) 495-5885 FAX (858) 495-5080

10 DAY WAIVER AGREEMENT
TERMINATION OF IN-HOME SUPPORTIVE SERVICES

IHSS Recipient Name: _____

IHSS Case No: _____

Social Security No: _____

DOB: _____

I understand and agree that in order to receive services from PACE, I must allow my In-Home Supportive Services (IHSS) case to close effective _____ (last day of the month). PACE and IHSS will coordinate the beginning and end date of services, so that I am not at risk of being without services or assistance.

Recipient's Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Referred By: _____ Date: _____

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

AGING & INDEPENDENCE SERVICES
P.O. BOX 23217, SAN DIEGO, CALIFORNIA 92193-3217
(858) 495-5885 FAX (858) 495-5080

ACUERDO DE RENUNCIA AL PERIODO DE NOTIFICACIÓN DE DIEZ DÍAS TERMINACIÓN DE SERVICIOS DE AYUDA EN EL HOGAR

Nombre del beneficiario de IHSS: _____

Número de caso de IHSS: _____

Número de Seguro Social: _____

Fecha de nacimiento: _____

Entiendo y estoy de acuerdo en que a fin de recibir servicios del Programa de Cuidado Completo para los Ancianos (PACE, por sus siglas en inglés), debo permitir que mi caso de Servicios de Ayuda en el Hogar (IHSS, por sus siglas en inglés) sea cerrado a partir de _____ (último día del mes). PACE y IHSS coordinarán la fecha de inicio y terminación de servicios de modo que yo no esté a riesgo de estar sin servicios o asistencia.

Firma del beneficiario: _____ Fecha: _____

Dirección (Número/Calle): _____

Ciudad: _____ Estado: _____ Código Postal: _____

Referido por: _____ Fecha: _____

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

March 10, 2010

SUBJECT: CONLAN II REIMBURSEMENT PROCESS

EFFECTIVE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: ALL COUNTY INFORMATION NOTICE: 1-03-10

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with additional clarification of the Conlan II reimbursement process and issue a revised 12-52 HHSA "Share-of-Cost Specialist Information Letter."

II. BACKGROUND

The California Court of Appeals directed the Department of Health Care Services (DHCS) to ensure that Medi-Cal recipients entitled to reimbursement for covered expenses under Conlan II receive notification and are promptly reimbursed.

Medi-Cal recipients (including IHSS recipients) who received and paid for medically necessary services are eligible for reimbursement for the following time periods.

- Retroactive Period: The three months prior to the time of Medi-Cal application
- Evaluation Period: The time between the dates that an application for IHSS was submitted and the date it was approved.
- Post Approval Period: The time after the recipient was approved for Medi-Cal and addresses the excess share of cost expenses.

III. POLICY

Medi-Cal recipients must be notified of potential eligibility to Conlan II reimbursement.

IV. REIMBURSEMENT PROCESS

In order to be considered for reimbursement of retroactive benefits, the recipient must:

- Have experienced an *actual out-of-pocket expense.*
- Submit a completed claim to the Department of Health Care Services.
- Submit proof of payment with the claim.

The CDSS Conlan II Unit will send a written notification to the recipient with a notice of the recipient's rights and instructions for a State Hearing if the claim is denied.

Only *IHSS recipients* are entitled to reimbursement under the Conlan II court order. The Conlan II packet for IHSS can be requested from the DHCS Beneficiary Services Center (BSC) at 916/403-2007.

IHSS staff may refer to Special Notice 07-04 Conlan II and Special Notice 07-10 Conlan II – Additional Claims for details on claiming.

V. INSTRUCTIONS FOR THE REVISED 12-52 HHSA

- The SOC Specialist will include in the revised initial contact letter information on filing a claim for Conlan II reimbursement. (Attachment A)
- Clerical staff must start using the revised 12-52 HHSA immediately, and recycle old copies as necessary.
- The revised 12-52 HHSA can be found on the S drive under "Automated Forms." The link is: *S:\AIS\Operations\IHSS\Automated Forms*.

VI. REVIEW STATEMENT

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

VII. FILING

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

WILL QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido @ 858/505-6366

IHSS SPECIAL NOTICE 07-10 ADDENDUM A
CONLAN II REIMBURSEMENT PROCESS

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, CALIFORNIA 92193-3217

Dear : _____
_____
_____

This letter is to inform you that your application for In-Home Supportive Services (IHSS) has been received. I am the Social Worker assigned to be your contact person for questions related to your IHSS application.

If you receive a Medi-Cal application packet in the mail, complete the Medi-Cal application immediately, and return it with the photocopies of any requested verifications in the return envelope provided. **Your application for Medi-Cal must be approved before your IHSS application can be processed.** If you are unable to complete the application, arrange to have a relative or a friend assist you.

If you are *currently*, or *within the last three months* have paid out-of-pocket for medically necessary services:

- Keep your receipts and payment records.
- Request *retroactive* Medi-cal when you complete the Medi-Cal application.

If you are approved for IHSS services, you may file a claim for reimbursement with the California Department of Social Services.

To file a claim:

- Contact the Department of Health Care Services (DHCS) Beneficiary Services Center (BSC) at (916) 403-2007 to request a Conlan II claim packet for IHSS.
- Complete the claim packet and return it directly to the BSC at the address provided on the claim packet,

To request the status of your claim, call the toll free number at (877)508-1327.

If you have specific questions regarding your Medi-Cal application, please call ACCESS Center at 1-866-262-9881.

You may call me directly if you have any questions related to your IHSS application, or if you receive information on the status of your application for Medi-Cal or Social Security.

Thank you.

_____	_____	_____	_____
IHSS Share of –Cost Specialist	Worker #	Telephone	Date

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10-02

March 1, 2010

SUBJECT: **HOSPITAL ERROR RATE STUDY INSTRUCTIONS**

EFFECTIVE DATE: **IMMEDIATELY**

EXPIRATION DATE: **WHEN ERROR RATE STUDY IS COMPLETED**

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with instructions for reviewing, documenting, and responding to the hospital error rate study received from the California Department of Social Services (CDSS).

II. BACKGROUND

Welfare and Institutions Code (WIC) section 12305.7 requires the California Department of Social Services (CDSS) to conduct an annual error rate study. The objective of the study is to estimate the extent of payment and service authorization errors, as well as potential fraud, in the provision of IHSS.

III. POLICY

Response to the error rate study must be completed in a timely manner and the results documented in the recipient case file.

IV. PROCEDURE

The Excel document containing the error report (Attachment A) has been sorted and organized by district office (unit) and Social Worker. The report contains:

- Recipient's case number
- Dates of hospitalization
- Name of hospital
- A breakdown of the provider's paid hours for the study period

Also included are two columns with the ***minimum*** and ***maximum*** number of paid hours. This represents the range that the final amount of the overpayment may fall within.

The Social Work Supervisor is responsible for entering the information into the Excel spreadsheet for their unit only, and forwarding the document to Program Support when the reviews have been completed. The information will be compiled into one document and returned to the state.

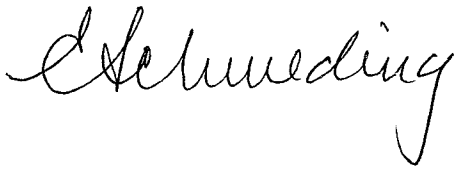
V. REVIEW STATEMENT

This notice was not reviewed by an Organizational Review Committee (ORC).

VI. FILING STATEMENT

HSS Special Notices, Bulletins, and Memos are being archived at the following link:
S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated

And at the county intra-net at:
http://hhsa-pg.sdcounty.ca.gov/Aislhss/default.asp?Guide=AISIHSS
Hard copies of this Special Notice will not be distributed by Program Support.



WIL QUINTONG
Assistant Deputy Director

ELLEN SCHMEDING
Assistant Deputy Director

Contact: Mary Harrison (858) 505-6952
Dist. Codes 7 & 8 Attachments

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 10-01

February 19, 2010

SUBJECT: **Verification of Social Security Card and Government Approved Identification**

EFFECTIVE DATE: **Immediately**

EXPERATION 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 procedures for verifying the identity of a recipient and/or provider when conducting a home visit to determine initial or continuing eligibility of services.

II. POLICY

The identity of the recipient and the provider (when the provider is present at the home visit) must be established prior to conducting a needs assessment or discussing confidential information **at every home visit**.

III. BACKGROUND

Eligibility for IHSS services cannot be established or determined if the identity of the applicant/recipient has not been confirmed. Verification of identity ensures program confidentiality and integrity, and acts as a deterrent for fraud and identity theft.

IV. SOCIAL WORKER PROCEDURES

New Applications
New applications cannot be granted unless the identity of the applicant has been established. The Social Worker must give the applicant the opportunity to provide the required documents before denying the application.

Ongoing Eligibility
The Social Worker must give the recipient an opportunity to provide identification in order to receive services.

The *Med-Cal Identity Verification Chart* (Attachment A), from the Medi-Cal Program Guide, provides a list of documents that may be used to establish identity and verify Social Security numbers.

The HHSA 12-53C *Request for Information*, form (Attachment B) has been created so that information is requested in writing.

If available at the time of the home visit, the Social Worker will confirm identity by:

- Viewing an acceptable, and current government issued photo identification.
- Viewing an original, unaltered Social Security Card.

The Social Worker will document in the case narrative that:

- The identity of the specified individual was confirmed.
- The specific document(s) used to confirm identification.

Applicants, recipients, or providers who refuse or fail to provide verification of identity must be informed verbally and in writing that their eligibility will be affected. The Social Worker will provide them with a written *Request for Information* (Attachment B), and allow 7-10 days for the information to be provided. If the information is not provided within the specified time frame, eligibility for services and/or payment for services may be denied, terminated or delayed.

V. REVIEW STATEMENT

This Special Notice has not been reviewed by the standard review committee.

VI. FILING STATEMENT

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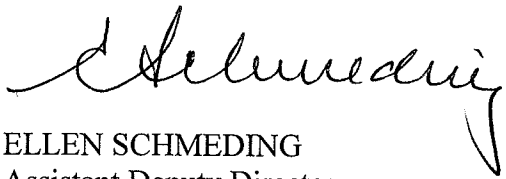
Hard copies of this Special Notice will not be distributed by Program Support.

WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Gina Brown (858) 495-5554
Distribution Codes 7 & 8

MEDI-CAL IDENTITY VERIFICATION CHART

PRIORITY (highest to lowest)	**EXAMPLES** (in order of preference)
A. PICTURE I.D.	1. California driver's license
	2. Out-of-state driver's license
	3. Military I.D.
	4. California I.D. card issued by the DMV
	5. Passport
	6. Citizenship or alien status documentation
	7. School I.D.
	8. Current work badge/Building pass
B. OFFICIAL GOVERNMENT DOCUMENTATION	1. Birth certificate
	2. Marriage certificate/Adoption record
	3. Divorce decree
	4. Social Security card
	5. Name change court order
	6. Alien status document (i.e., I94)
C. OTHER LESS PREFERRED I.D. (ATTEMPT TO OBTAIN TWO FORMS IF THIS CATEGORY IS USED)	1. Document containing a social security number
	2. Church membership or baptism record
D. ACCEPT THIS I.D. VERIFICATION ONLY AFTER ALL OTHER SOURCES HAVE BEEN EXHAUSTED	1. Affidavit signed and dated under penalty of perjury

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

AGING & INDEPENDENCE SERVICES
P.O. BOX 23217, SAN DIEGO, CALIFORNIA 92193-3217
(858) 495-5885 FAX (858) 495-5080

Dear _____
_____
_____

☐ Please provide the following by_____:

_____

_____

_____

☐ Other:_____

If the above information is not received, eligibility for In-Home Supportive Services and /or payment for services will be denied, delayed, or terminated. If you are unable to provide the information requested you must contact me by the above deadline.

Thank you,

_____
Social Worker
In-Home Supportive Services

Phone No.:_____ Date:_____