

**IN-HOME SUPPORTIVE
SERVICES
SPECIAL NOTICE
ARCHIVES
2012**



IHSS SPECIAL NOTICES 2012

YEAR	NUMBER	SUBJECT (ABBREVIATED)	REMARKS
2012	11-06 ADD A	Update to Health Certification Form	Issued 1/10/2012
	12-01	IHSS Fraud Referral Tracking System (FRTS)	Issued 2/16/2012
	12-02	SSI/SSP and CAPI Payment Standards-New Benefit Level for SOC Cases	Issued 2/16/2012
	12-03	Revised Forms for Direct Deposit	Issued 2/23/2012
	12-04	New Notice for IHSS Providers	Issued 2/27/2012
	12-05	Voter Registration Act	Issued 3/22/2012
	12-06	3.6 Percent Service Reduction	Issued 7/13/2012
	12-07	IHSS Recipients Notice of New Timesheets	Issued 08/22/2012
	12-08	Post Conversion Activity – Review and Correction of Case Issues	Issued 09/10/2012
	12-09	Workaround for the IHSS Fraud Referral Tracking System (FRTS)	Issued 10/08/2012
	12-10	CMIPS II Workarounds	Issued 10/17/2012
	12-11	Recipient Education Materials	Issued 11/01/2012
	12-12	CMIPS II Forms and NOAs	Issued 12/14/2012
	12-12 ADD A	Revisions to CMIPS II NOAs	Issued 1/3/2013
	12-12 13	IHSS Consumer Satisfaction Survey	Issued 12/19/2012

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-13**

December 19, 2012

SUBJECT: Instructions for the IHSS Process and Consumer Satisfaction Survey

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

I. PURPOSE

The purpose of this special notice is to provide In-Home Supportive Services (IHSS) staff with instructions on submitting the 12-84A HHS *IHSS Process and Consumer Satisfaction Survey* to AIS Program Support once the form is returned by the recipient to the IHSS district office.

II. BACKGROUND

As part of IHSS quality assurance and quality improvement, IHSS clerical staff will send IHSS recipients the 12-84A *IHSS Process and Consumer Satisfaction Survey* (Attachment A) and the 12-93 HHS *Survey Cover Letter* (Attachment B) with the Notice-of-Action (NOA) for grantings and at annual reassessment. Each clerk will include a corresponding business reply envelope with the survey.

III. STAFF PROCEDURES

Social Worker Responsibilities

Social Workers will promptly forward any 12-84A *IHSS Process and Consumer Satisfaction Surveys* received to the Senior Office Assistant for forwarding to AIS Program Support.

Clerical Responsibilities

Clerical staff will recycle the survey cover letter if returned with the survey. When other miscellaneous items are received or important information has been written on the cover letter, clerical will send the additional information along with the survey to AIS Program Support. Surveys must be compiled and sent monthly to AIS Program Support, at Mail Stop W433.

Any written requests for a fair hearing must be forwarded immediately to the Appeals department at fax number (619) 237-8465.

Surveys will be tracked by the month received and by the IHSS district office location. The month received is defined as the days between the first and the last day of the month in which the survey is date-stamped by clerical staff.

Tracking Responses by Question

The Senior Office Assistant (SOA), or the individual designated by the SOA, will be responsible for tabulating the total responses to each of the 11 questions on the survey using the attached *IHSS Process and Consumer Satisfaction Survey Results* form (Attachment C).

Outdated versions of the 12-84A *IHSS Process and Consumer Satisfaction Survey* will not be used for tracking the survey results by question. Such documents will be sent, in a separate stack, along with the rest of the surveys to Program Support.

The following information must be included on the *IHSS Process and Consumer Satisfaction Survey Results* form:

- IHSS office location
- Survey month/year
- Total number of surveys received
- Name and telephone number of the person completing the form

Attachments A and B in English and Spanish and Attachment C are available electronically at the following location:

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

Sending Surveys to AIS Program Support:

The total surveys for each month must be sent to AIS Program Support by the first Friday of the month following the Survey Month. Individual surveys forwarded after the total surveys for the month have been sent to Program Support cannot be included in the count for that month.

Reporting the results of the Survey

The data received from the SOA or designated clerical staff of each IHSS office will be combined by AIS Program Support monthly for reporting to AIS management and other stakeholders.

IV. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by an Organizational Review Committee (ORC).

V. 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=AIHSS>

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Perla Delgado (858) 495-5554

Attachments

Distribution Codes 7 & 8

In-Home Supportive Services (IHSS) Process and Consumer Satisfaction Survey

Please help us improve our services to the individuals that we serve. Indicate whether you agree or disagree with the statements below.

1. I am satisfied with the service I am receiving from my IHSS Social Worker.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My IHSS Social Worker tried to understand my needs.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The IHSS Social Worker was courteous.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The IHSS Social Worker was sensitive to my disability/illness.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. When I call my IHSS Social Worker, the people I speak with are courteous and helpful.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If I have to leave a message for my IHSS Social Worker, my call is returned within 24 hours.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. When the IHSS Social Worker visited, he or she did a good job explaining how my needs would be assessed.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. The IHSS Social Worker helped me feel comfortable discussing my personal needs (bowel and bladder, bathing, etc.).	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Applicable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. The IHSS Social Worker informed me of my right to an appeal if I disagree with a change to my services.	Strongly Agree <input type="checkbox"/>	Agree <input type="checkbox"/>	Neither Agree Nor Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Strongly Disagree <input type="checkbox"/>	Not Applicable <input type="checkbox"/>
10. The IHSS Social Worker reviewed my rights and responsibilities and the consequences of committing fraud.	Strongly Agree <input type="checkbox"/>	Agree <input type="checkbox"/>	Neither Agree Nor Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Strongly Disagree <input type="checkbox"/>	Not Applicable <input type="checkbox"/>
11. I am satisfied with the services I am receiving from my individual provider.	Strongly Agree <input type="checkbox"/>	Agree <input type="checkbox"/>	Neither Agree Nor Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Strongly Disagree <input type="checkbox"/>	Not Applicable <input type="checkbox"/>

Please add any additional comments you may have about your care provider or Social Worker.

Please share/state what you like about the IHSS Program.

What could IHSS do to improve the program (Please be specific)?



County of San Diego

NICK MACCHIONE, FACHE
DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY

PAMELA B. SMITH
AIS DIRECTOR

AGING & INDEPENDENCE SERVICES
P.O. BOX 23217, SAN DIEGO, CALIFORNIA 92193-3217
(858) 495-5885 FAX (858) 495-5080
www.sandiego.networkofcare.org/aging

Dear IHSS Recipient:

Please take a moment to fill out the enclosed "Customer Satisfaction Survey" for In-Home Supportive Services (IHSS). Our goal is to continue to improve our services to the community, and your opinion is very important to that process. Completing the survey is completely anonymous and will have no impact on your hours or services.

Please use the enclosed envelope to return the survey.

Thank you for taking the time to let us hear from you.

Sincerely,

PAMELA B. SMITH, Director
Aging & Independence Services

PBS/gb
Enclosures

IHSS Process and Consumer Satisfaction Survey Results

IHSS Office Location
Month/Year
Total Surveys Received: _____

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	N/A	Un-answered	Total Surveys
Question 1								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 2								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 3								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 4								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 5								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 6								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 7								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 8								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 9								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 10								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Question 11								0
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Average	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Completed by
Telephone number

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

January 3, 2013

SUBJECT: REVISIONS TO THE NOTICE OF ACTION TEMPLATES FOR USE WITH THE CASE MANAGEMENT, INFORMATION & PAYROLLING SYSTEM II (CMIPS II)

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Procedure Manual

**REFERENCES: All-County Letter No. 12-55, dated November 1, 2012
All-County Letter No. 12-55E, dated December 27, 2012**

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with information on the amended language of two Notice of Action (NOA) templates for use with the Case Management, Information & Payrolling System II (CMIPS II).

II. REVISED NOA TEMPLATES

Notice of Action In-Home Supportive Services (IHSS) Approval (NA 1250) and Notice of Action In-Home Supportive Services (IHSS) Change (NA 1253) have both been amended to remove the phrase "Reading Services", as this is not an approved activity for IHSS providers.

Attached to this Special Notice are the revised NOA 1250 (Attachment A) and NOA 1253 (Attachment B) forms that reflect this change.

III. REVIEW STATEMENT

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

IV. FILING STATEMENT

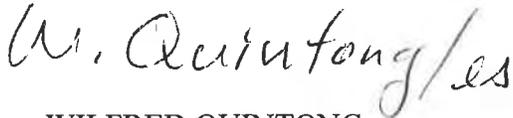
IHSS Special Notices are being archived at the following link:

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

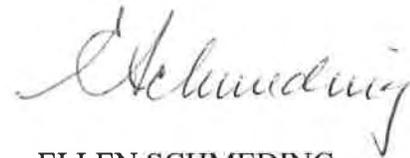
And at the County intranet at:

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

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Sary Villarreal (858) 694-3255

Attachments: NOA 1250 and NOA 1253

Distribution Codes 7 & 8

**NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)
APPROVAL**

COUNTY OF _____

Notice Date : _____
Case Name : _____
Case Number : _____
Social Worker Name : _____
Social Worker Number : _____
Social Worker Telephone : _____
Social Worker Address : _____

NOTE: This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

(ADDRESSEE)

Total Hours:Minutes of IHSS you can get each month: _____.

Based on an assessment done on _____, you can get the services shown below for the amount of time shown in the column "Authorized Amount of Service You Can Get."

- 1) If there is a zero in the "Authorized Amount of Service You Can Get" column or the amount is less than the "Total Amount of Service Needed" column, the reason is explained on the next page(s).
- 2) "Not Needed" means that your social worker found that you do not require assistance with this task. (MPP 30-756.11)
- 3) "Pending" means the county is waiting for more information to see if you need that service. See the next page(s) for more information.

SERVICES Note: See the back of the next page for a short description of each service.	TOTAL AMOUNT OF SERVICE NEEDED	ADJUSTMENT FOR OTHERS WHO SHARE THE HOME	AMOUNT OF SERVICE YOU NEED	SERVICES YOU REFUSED OR YOU GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HOURS: MINUTES	(PRORATION)	HOURS: MINUTES		HOURS: MINUTES
DOMESTIC SERVICES (per MONTH):					
RELATED SERVICES (per WEEK):					
Prepare Meals					
Meal Clean-up					
Routine Laundry					
Shopping for Food					
Other Shopping/Errands					
NON-MEDICAL PERSONAL SERVICES (per WEEK):					
Respiration Assistance (Help with Breathing)					
Bowel, Bladder Care					
Feeding					
Routine Bed Bath					
Dressing					
Menstrual Care					
Ambulation (Help with Walking, including Getting In/Out of Vehicles)					
Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)					
Bathing, Oral Hygiene, Grooming					
Rubbing Skin, Repositioning					
Help with Prosthesis (Artificial Limb, Visual/Hearing Aid) and/or Setting up Medications					
ACCOMPANIMENT (per WEEK):					
To/From Medical Appointments					
To/From Places You Get Services in Place of IHSS					
PROTECTIVE SUPERVISION (per WEEK):					
PARAMEDICAL SERVICES (per WEEK):					
TOTAL WEEKLY HOURS:MINUTES OF SERVICE YOU CAN GET:					
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS:MINUTES: x 4.33 =					
SUBTOTAL MONTHLY HOURS:MINUTES OF SERVICE YOU CAN GET:					
ADD MONTHLY DOMESTIC HOURS:MINUTES OF SERVICE YOU CAN GET (from above):					
TOTAL HOURS:MINUTES OF SERVICE YOU CAN GET PER MONTH:					
TIME LIMITED SERVICES (per MONTH):					
Heavy Cleaning:					
Yard Hazard Abatement					
Remove Ice, Snow					
Teaching and Demonstration					
TOTAL HOURS:MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:					

Questions?: Please contact your IHSS social worker. See top of page for phone number.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

**NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)
CHANGE**

COUNTY OF _____

Notice Date : _____
Case Name : _____
Case Number : _____
Social Worker Name : _____
Social Worker Number : _____
Social Worker Telephone : _____
Social Worker Address : _____

NOTE: This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

(ADDRESSEE)

As of _____ the services you can get and/or the amount of time you can get for services has changed.
Here's why: MMDYYYYY
Total Hours:Minutes of IHSS you can get each month is now: _____. This is a/an Increase/decrease of _____.
You will now get the services shown below for amount of time shown in the column "Authorized Amount of Service You can Get." That column shows the hours/minutes you got before, the hours/minutes you will get from now on, and the difference. If you are getting less time for a service, the reason(s) is shown on the next page.
1) If there is a zero in the "Authorized Amount of Service You Can Get" column or the amount is less than the "Total Amount of Service Needed" column, the reason is explained on the next page(s).
2) "Not Needed" means that your social worker found that you do not require assistance with this task. (MPP 30-756.11)
3) "Pending" means the county is waiting for more information to see if you need that service. See the next page(s) for more information.

SERVICES	TOTAL AMOUNT OF SERVICE NEEDED	ADJUSTMENT FOR OTHERS WHO SHARE THE HOME	AMOUNT OF SERVICE YOU NEED	SERVICES YOU REFUSED OR YOU GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET		
	HOURS: MINUTES	(PRORATION)	HOURS: MINUTES		HOURS	MINUTES	+/-
Note: See the back of the next page for a short description of each service.							
DOMESTIC SERVICES (per MONTH):							
RELATED SERVICES (per WEEK):							
Prepare Meals							
Meal Clean-up							
Routine Laundry							
Shopping for Food							
Other Shopping/Errands							
NON-MEDICAL PERSONAL SERVICES (per WEEK):							
Respiration Assistance (Help with Breathing)							
Bowel, Bladder Care							
Feeding							
Routine Bed Bath							
Dressing							
Menstrual Care							
Ambulation (Help with Walking, including Getting In/Out of Vehicles)							
Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)							
Bathing, Oral Hygiene, Grooming							
Rubbing Skin, Repositioning							
Help with Prosthesis (Artificial Limb, Visual/Hearing Aid) and/or Setting up Medications							
ACCOMPANIMENT (per WEEK):							
To/From Medical Appointments							
To/From Places You Get Services in Place of IHSS							
PROTECTIVE SUPERVISION (per WEEK):							
PARAMEDICAL SERVICES (per WEEK):							
TOTAL WEEKLY HOURS:MINUTES OF SERVICE YOU CAN GET:							
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS:MINUTES:					x	4.33	=
SUBTOTAL MONTHLY HOURS:MINUTES OF SERVICE YOU CAN GET:							
ADD MONTHLY DOMESTIC HOURS:MINUTES OF SERVICE YOU CAN GET (from above):							
TOTAL HOURS:MINUTES OF SERVICE YOU CAN GET PER MONTH:							
TIME LIMITED SERVICES (per MONTH):							
Heavy Cleaning:							
Yard Hazard Abatement							
Remove Ice, Snow							
Teaching and Demonstration							
TOTAL HOURS:MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:							

Questions?: Please contact your IHSS social worker. See top of page for phone number.
State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

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

December 14, 2012

SUBJECT: NEW AND REVISED RECIPIENT AND PROVIDER FORMS, NOTICE OF ACTION TEMPLATES, AND NOTICE OF ACTION MESSAGES FOR USE WITH CASE MANAGEMENT, INFORMATION & PAYROLLING SYSTEM II (CMIPS II)

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Procedure Manual

REFERENCES: All-County Letter No. 12-55

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with information and instructions for new and revised State of California (SOC) forms, and new Notice of Action (NOA) templates and messages for use with the Case Management, Information & Payrolling System II (CMIPS II).

II. IHSS PROCEDURES

NEW AND REVISED RECIPIENT AND PROVIDER FORMS

The following new and revised SOC forms (see Attachment A) must be utilized at intake and recertification for processing case actions in CMIPS II.

SOC 838-IHSS Recipient Request for Assignment of Authorized Hours to Providers

Social Worker Responsibilities

This form is mandatory for cases with multiple providers. For each individual provider assigned to the recipient, the recipient (or his/her authorized representative) must specify the number of hours that each provider is permitted to work, by completing and returning this form to the IHSS Social Worker.

Once the form is received, the Social Worker will place a copy of the form in the recipient case file and provide a copy to the recipient. If the recipient requests a change in the assigned hours for a provider, a new SOC 838 form is required. A verbal request from the recipient or his/her authorized representative is acceptable for terminating a provider.

Clerical Responsibilities

The SOC 838 “*IHSS Recipient Request for Assignment of Authorized Hours to Providers*” form must be included in all application and redetermination packets. Clerical staff is responsible for ensuring that this form is in stock and available for staff use. The SOC 838 is available electronically at the following locations.

In the “Clerical” and “Social Worker” folders at:

S:\AIS\Operations\IHSS\Automated Forms

At the California Department of Social Services (CDSS) website at:

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

SOC 839-IHSS Recipient Time Sheet Signature Authorization

Social Worker Responsibilities

This form gives a designated individual the authority to sign timesheets on behalf of a recipient for any provider who is working for that recipient. The authority of the designated individual is restricted to that of timesheet signatory.

A provider cannot sign his/her own timesheet on behalf of the recipient, unless the provider is the legal guardian or conservator of the recipient. A provider parent may also sign on behalf of a recipient who is a minor child. Copies of the letters of guardian or of conservatorship must be in the case file, and the signature is recorded on this form prior to signing any timesheets. This form may be revoked at any time at the request of the recipient. Once the form is received, the Social Worker will retain a copy of the form in the recipient case file and complete the following:

- Send a copy of the form to the IHSS Public Authority Payroll using Mail Stop W256

Or

- Email a scanned image of the form to the Provider Services Manager, Claudia Cleeton at: Claudia.Cleeton@sdcounty.ca.gov

- Document the process and the completion of the process in a *Case Note* in CMIPS II

Note: The SOC 839 is effective immediately and replaces the
12-44 HHSA “*Timesheets Signature Authorization Form*” (see Attachment D)

Recycle all electronic and hard copies of the old form.

SOC 840-IHSS Provider or Recipient Change of Address and/or Telephone

Social Worker Responsibilities

This form allows the provider or recipient to inform the County of any change of address and/or telephone number. The form is optional for recipients, ***if*** the address and/or telephone number change has been documented by the Social Worker during a reassessment or if the change is reported by the recipient by phone. When the recipient completes the form, the Social Worker must retain a copy in the recipient case file and document in a *Case Note* in CMIPS II that the SOC 840 form was received.

The SOC 840 form must be completed by providers in order to update the provider's information in CMIPS II. When a provider calls the Social Worker to report a change of address and/or telephone number, the Social Worker will transfer the call to the IHSS Public Authority at 1-866-351-7722.

The IHSS Public Authority will send the SOC 840 form to providers upon request. If requested, the IHSS Social Worker can also provide the SOC 840 to the provider. If the SOC 840 is returned to the Social Worker, he/she will:

- Email a scanned image of the form to the Provider Services Manager, Claudia Cleeton at: Claudia.Cleeton@sdcounty.ca.gov.
- Forward the original form to the IHSS Public Authority Payroll to Mail Stop W256
- Complete a *Person Note* in CMIPS II documenting that the SOC 840 form was mailed to the provider and/or received and sent the IHSS Public Authority Payroll.

NEW NOA TEMPLATES AND NOA MESSAGES

The new NOA templates and messages (found in Attachments B and C) have been developed and designed to replace the existing NA 690 (IHSS Notice of Action). These notices cover the four major actions (approval, denial, change, termination) for which the recipient would receive a NOA, as well as covering share-of-cost (SOC) and other miscellaneous actions. All notices provide the applicant or recipient with information on how to file an appeal.

III. REVIEW STATEMENT

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

IV. FILING STATEMENT

IHSS Special Notices are being archived at the following link:

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

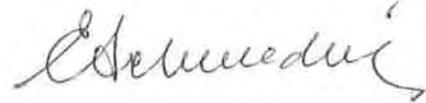
And at the County intranet at:

<http://hhsa-pg.sdcountry.ca.gov/AisIhss/default.asp?Guide=AIHSS>

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Sary Villarreal (858) 694-3255

Attachments: SOC forms and CMIPS II NOA Templates and Messages

Distribution Codes 7 & 8

ATTACHMENT A— NEW CMIPS II FORMS

SOC 838—IHSS Recipient Request for Assignment of Authorized Hours to Providers

SOC 839—IHSS Recipient Time Sheet Signature Authorization

SOC 840—IHSS Provider or Recipient Change of Address and/or Telephone

IN-HOME SUPPORTIVE SERVICES (IHSS) RECIPIENT REQUEST FOR ASSIGNMENT OF AUTHORIZED HOURS TO PROVIDERS

IHSS RECIPIENT CASE NUMBER

RECIPIENT NAME	(FIRST	MIDDLE	LAST)
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PROVIDER NAME	(FIRST	MIDDLE	LAST)	PROVIDER IDENTIFICATION NUMBER	HOURS ASSIGNED PER MONTH
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I understand that by completing and submitting this form to the county In-Home Supportive Services (IHSS) program, I am requesting the IHSS program to assign the indicated number of my authorized hours to the named provider. I further understand that by making this request, my provider's timesheets will NOT be processed for more than the hours I have requested be assigned to him/her on this form. This request will remain in effect until I submit a new request form to the county IHSS program.

RECIPIENT SIGNATURE	DATE
---------------------	------

AUTHORIZED REPRESENTATIVE (IF RECIPIENT CANNOT SIGN ON THEIR OWN BEHALF)	RELATIONSHIP TO RECIPIENT	TELEPHONE NUMBER
--	---------------------------	------------------

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE
--	------

PROVIDER SIGNATURE	DATE
--------------------	------

COUNTY USE ONLY

COMMENTS

SOCIAL WORKER NAME	(FIRST	MIDDLE	LAST)	SOCIAL WORKER IDENTIFICATION NUMBER
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IN-HOME SUPPORTIVE SERVICES (IHSS) RECIPIENT TIME SHEET SIGNATURE AUTHORIZATION

RECIPIENT NAME (FIRST MIDDLE LAST)	RECIPIENT CASE NUMBER
------------------------------------	-----------------------

This form gives the designated individual the authority to sign timesheets on behalf of the recipient for any provider who is working for the named recipient. The authority of the designated individual is limited to that of timesheet signatory and his/her authority can be terminated at any time at the request of the recipient.

INDIVIDUAL AUTHORIZED TO SIGN TIMESHEET (FIRST MIDDLE LAST)	RELATIONSHIP TO RECIPIENT	TELEPHONE NUMBER
---	---------------------------	------------------

AUTHORIZED SIGNATURE	DATE
----------------------	------

RECIPIENT SIGNATURE	DATE
---------------------	------

AUTHORIZED REPRESENTATIVE (IF RECIPIENT CANNOT SIGN ON THEIR OWN BEHALF)	RELATIONSHIP TO RECIPIENT	TELEPHONE NUMBER
--	---------------------------	------------------

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE
--	------

COUNTY USE ONLY

COMMENTS

SOCIAL WORKER NAME (FIRST MIDDLE LAST)	SOCIAL WORKER IDENTIFICATION NUMBER
SOCIAL WORKER SUPERVISOR SIGNATURE	SUPERVISOR APPROVAL DATE

ATTACHMENT B— NEW NOTICE OF ACTION (NOA) TEMPLATES FOR CMIPS II

NA 1250—Notice of Action—IHSS Approval

NA 1251—Notice of Action—IHSS Approval (Continued)

NA 1252—Notice of Action—IHSS Denial

NA 1253—Notice of Action—IHSS Change

NA 1254—Notice of Action—IHSS Change (Continued)

NA 1255—Notice of Action—IHSS Termination

NA 1256—Notice of Action—IHSS Share of Cost

NA 1257—Notice of Action—IHSS Multipurpose

**NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)
APPROVAL**

COUNTY OF _____

Notice Date : _____
Case Name : _____
Case Number : _____
Social Worker Name : _____
Social Worker Number : _____
Social Worker Telephone : _____
Social Worker Address : _____

NOTE: This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

(ADDRESSEE)

[_____]
[_____]

Total Hours:Minutes of IHSS you can get each month: _____.

Based on an assessment done on _____, you can get the services shown below for the amount of time shown in the column "Authorized Amount of Service You Can Get."
MMDDYYYY

- 1) If there is a zero in the "Authorized Amount of Service You Can Get" column or the amount is less than the "Total Amount of Service Needed" column, the reason is explained on the next page(s).
- 2) "Not Needed" means that your social worker found that you do not require assistance with this task. (MPP 30-756.11)
- 3) "Pending" means the county is waiting for more information to see if you need that service. See the next page(s) for more information.

SERVICES Note: See the back of the next page for a short description of each service.	TOTAL AMOUNT OF SERVICE NEEDED	ADJUSTMENT FOR OTHERS WHO SHARE THE HOME	AMOUNT OF SERVICE YOU NEED	SERVICES YOU REFUSED OR YOU GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HOURS: MINUTES	(PRORATION)	HOURS: MINUTES		HOURS: MINUTES
DOMESTIC SERVICES (per MONTH):					
RELATED SERVICES (per WEEK):					
Prepare Meals					
Meal Clean-up					
Routine Laundry					
Shopping for Food					
Other Shopping/Errands/Reading Services					
NON-MEDICAL PERSONAL SERVICES (per WEEK):					
Respiration Assistance (Help with Breathing)					
Bowel, Bladder Care					
Feeding					
Routine Bed Bath					
Dressing					
Menstrual Care					
Ambulation (Help with Walking, including Getting In/Out of Vehicles)					
Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)					
Bathing, Oral Hygiene, Grooming					
Rubbing Skin, Repositioning					
Help with Prosthesis (Artificial Limb, Visual/Hearing Aid) and/or Setting up Medications					
ACCOMPANIMENT (per WEEK):					
To/From Medical Appointments					
To/From Places You Get Services in Place of IHSS					
PROTECTIVE SUPERVISION (per WEEK):					
PARAMEDICAL SERVICES (per WEEK):					
TOTAL WEEKLY HOURS:MINUTES OF SERVICE YOU CAN GET:					
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS:MINUTES:					x 4.33 =
SUBTOTAL MONTHLY HOURS:MINUTES OF SERVICE YOU CAN GET:					
ADD MONTHLY DOMESTIC HOURS:MINUTES OF SERVICE YOU CAN GET (from above):					
TOTAL HOURS:MINUTES OF SERVICE YOU CAN GET PER MONTH:					

TIME LIMITED SERVICES (per MONTH):					
Heavy Cleaning:					
Yard Hazard Abatement					
Remove Ice, Snow					
Teaching and Demonstration					
TOTAL HOURS:MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:					

[_____]

Questions?: Please contact your IHSS social worker. See top of page for phone number.
State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)
APPROVAL (CONTINUED)

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date: _____
Case Name: _____
Case Number: _____

You must immediately tell the county about any changes that might affect your eligibility or need for IHSS, including changes in income, property, living arrangements, medical conditions or the ability to work. If you have any questions or think more facts should be considered, call your social worker.

Rules: The applicable Manual of Policies and Procedure (MPP) sections are shown above and on the previous page in parentheses. You may review the MPP at your local IHSS office.

Questions?: Please contact your IHSS social worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of the first page of this notice tells how.

**NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)
CHANGE**

COUNTY OF _____

Notice Date : _____
Case Name : _____
Case Number : _____
Social Worker Name : _____
Social Worker Number : _____
Social Worker Telephone : _____
Social Worker Address : _____

NOTE: This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

(ADDRESSEE)

As of _____ the services you can get and/or the amount of time you can get for services has changed.
Here's why: MMDDYYYY

Total Hours:Minutes of IHSS you can get each month is now: _____. This is a/an increase/decrease of _____.

You will now get the services shown below for amount of time shown in the column "Authorized Amount of Service You can Get." That column shows the hours/minutes you got before, the hours/minutes you will get from now on, and the difference. If you are getting less time for a service, the reason(s) is shown on the next page.

- 1) If there is a zero in the "Authorized Amount of Service You Can Get" column or the amount is less than the "Total Amount of Service Needed" column, the reason is explained on the next page(s).
- 2) "Not Needed" means that your social worker found that you do not require assistance with this task. (MPP 30-756.11)
- 3) "Pending" means the county is waiting for more information to see if you need that service. See the next page(s) for more information.

SERVICES	TOTAL AMOUNT OF SERVICE NEEDED	ADJUSTMENT FOR OTHERS WHO SHARE THE HOME (PRORATION)	AMOUNT OF SERVICE YOU NEED	SERVICES YOU REFUSED OR YOU GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET		
	HOURS: MINUTES		HOURS: MINUTES		HOURS: MINUTES NOW	WAS	+/-
Note: See the back of the next page for a short description of each service.							
DOMESTIC SERVICES (per MONTH):							
RELATED SERVICES (per WEEK):							
Prepare Meals							
Meal Clean-up							
Routine Laundry							
Shopping for Food							
Other Shopping/Errands/Reading Services							
NON-MEDICAL PERSONAL SERVICES (per WEEK):							
Respiration Assistance (Help with Breathing)							
Bowel, Bladder Care							
Feeding							
Routine Bed Bath							
Dressing							
Menstrual Care							
Ambulation (Help with Walking, including Getting In/Out of Vehicles)							
Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)							
Bathing, Oral Hygiene, Grooming							
Rubbing Skin, Repositioning							
Help with Prosthesis (Artificial Limb, Visual/Hearing Aid) and/or Setting up Medications							
ACCOMPANIMENT (per WEEK):							
To/From Medical Appointments							
To/From Places You Get Services in Place of IHSS							
PROTECTIVE SUPERVISION (per WEEK):							
PARAMEDICAL SERVICES (per WEEK):							
TOTAL WEEKLY HOURS:MINUTES OF SERVICE YOU CAN GET:							
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS:MINUTES:					x	4.33	=
SUBTOTAL MONTHLY HOURS:MINUTES OF SERVICE YOU CAN GET:							
ADD MONTHLY DOMESTIC HOURS:MINUTES OF SERVICE YOU CAN GET (from above):							
TOTAL HOURS:MINUTES OF SERVICE YOU CAN GET PER MONTH:							
TIME LIMITED SERVICES (per MONTH):							
Heavy Cleaning:							
Yard Hazard Abatement							
Remove Ice, Snow							
Teaching and Demonstration							
TOTAL HOURS:MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:							

Questions?: Please contact your IHSS social worker. See top of page for phone number.
State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)
CHANGE (CONTINUED)

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date: _____
Case Name: _____
Case Number: _____

You must immediately tell the county about any changes that might affect your eligibility or need for IHSS, including changes in income, property, living arrangements, medical conditions or the ability to work. If you have any questions or think more facts should be considered, call your social worker.

Rules: The applicable Manual of Policies and Procedures (MPP) sections are shown above and on the previous page in parentheses. You may review the MPP at your local IHSS office.

Questions?: Please contact your IHSS social worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of the first page of this notice tells how.

NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)
SHARE OF COST

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date: _____
Case Name: _____
Case Number: _____

Here's how your share of cost for IHSS was determined:

	<u>WAS</u>	<u>NOW</u>
Your countable income	\$ _____	\$ _____
Minus SSI/SSP benefit	\$ _____	\$ _____
IHSS Share of Cost	\$ _____	\$ _____

Rules: The rules noted above in parentheses apply; you may review the Manual of Policy and Procedures (MPP) at your local IHSS office.

Questions?: Please contact your IHSS social worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTE: This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

Notice Date : _____
Case Name : _____
Case Number : _____
Social Worker Name : _____
Social Worker Number : _____
Social Worker Telephone : _____
Social Worker Address : _____

(ADDRESSEE)

┌ _____ ┐
└ _____ ┘

┌ _____ ┐
└ _____ ┘

You must immediately tell the county about any changes that might affect your eligibility or need for IHSS, including any changes in income, property, living arrangements, medical conditions or the ability to work. If you have any questions or think more facts should be considered, call your social worker.

Rules: The rules noted above in parentheses apply; you may review the Manual of Policy and Procedures (MPP) at your local IHSS office.

Questions?: Please contact your IHSS social worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

ATTACHMENT C—NEW NOTICE OF ACTION (NOA) MESSAGES FOR CMIPS II

Title	Message Text	Form & Comments
<p>Provisional - Pending Disability/ Blindness/ Medi-Cal Eligibility Determination</p>	<p>As of MMDDYYYY, you can get In-Home Supportive Services temporarily while it is being determined if you are disabled and /or blind (MPP 30-759.3) and/or eligible for Medi-Cal (W&IC 14132.951(d)(1) & (2)).</p> <p>If you are determined to be disabled or blind and that you need ongoing services, you will continue to get IHSS as long as you are otherwise eligible.</p> <p>If it is determined you are not disabled or blind your services will stop and you may have to pay back any money we paid for services you received.</p> <p>If you are determined eligible for Medi-Cal, you will receive a notice from Medi-cal and you will get IHSS under the PCSP or IPO program.</p> <p>If you are not eligible for Medi-Cal, you may be able get IHSS under the IHSS Residual program.</p> <p>You will get another Notice of Action telling you about your final IHSS eligibility.</p>	<p>NA 1250 (APPROVAL) If necessary, spillover to NA 1251 (APPROVAL CONTINUATION) NA 1254 (CHANGE CONTINUATION)</p>
<p>Final Approval of Prior Provisional Approval</p>	<p>You have been getting In-Home Supportive Services (IHSS) on a temporary basis. You have now been determined disabled or blind. If you meet all of the other eligibility criteria, you will continue to get IHSS through the following program:</p> <p>system select one of the following Funding Program:</p> <ul style="list-style-type: none"> IHSS Plus Option (IPO) Program (W&IC 14132.952) Personal Care Services Program (PCSP) (MPP 30-780) In-Home Supportive Services-Residual (IHSS-R) Program (MPP 30-755.1) 	<p>NA 1250 (APPROVAL) If necessary, spillover to NA 1251 (APPROVAL CONTINUATION)</p>
<p>Application Previously Denied in Error</p>	<p>On MMDDYYYY, we sent you a Notice of Action telling you that you could not get In-Home Supportive Services (IHSS). That Notice was sent in error.</p> <p>Your application date of MMDDYYYY, will be restored and you will be contacted by a County Social Worker.</p>	<p>NA 1257 (MULTIPURPOSE)</p>

Title	Message Text	Form & Comments
Advance Payment	<p>As requested you will receive payment in advance for you IHSS Service as of MMDDYYYY. (MPP 30-769.731)</p> <p>After receiving IHSS services for a year, you may request your advance payment be made by direct deposit to your bank account. To request direct deposit contact the IHSS direct deposit help desk at <i>[HP Help Desk Phone Number]</i>.</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Advance Payment Qualified	<p>Because you meet the program rules that define severely impaired as a combined total of 20 hours per week of Personal Care, Paramedical and Meal Preparation and Clean-up services, you may request advance payment for your IHSS Services by contacting your social worker. (MPP 30-769.731)</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Advance Payment – Termination –No longer qualify	<p>As of MMDDYYYY you can no longer get advance payment for the value of your IHSS services. Here's why: You are no longer severely impaired based on program rules of a combined total of 20 per week of Personal Care, Paramedical and Meal Preparation and Clean-up. (MPP 30-769.731) Your provider will not get paid by the IHSS Program unless they submit timesheets twice per month reporting their time worked. If your advance payment was being deposited directly into your bank account, the direct deposit has been cancelled.</p>	<p>NA 1254 (CHANGE CONTINUATION)</p>
Advance Payment Termination – Recipient Request	<p>As of MMDDYYYY you will no longer get an advance payment for the value of your IHSS services. Here's why: You asked to have the payment cancelled. Your provider will need to turn in timesheets approved by you twice a month in order to get paid for the work they do for you. If your advance payment was being deposited directly into your bank account, the direct deposit has been cancelled. (MPP 30-769.731)</p>	<p>NA 1254 (CHANGE CONTINUATION)</p>

Title	Message Text	Form & Comments
Advance Payment – Termination- Reconciling timesheets not submitted in 90 days	<p>As of MMDDYYYY your advance payment status will be cancelled. Here's why:</p> <p>Timesheets totaling the amount of hours used to calculate your advance payment have not been received in the 90 days since the advance payment was issued to you. (MPP 30-767.133(b))</p> <p>Now your provider will be paid in arrears. They must submit timesheets that have been approved by you, at the end of each pay period in order to get paid.</p> <p>If your advance payment was being deposited directly into your bank account, the direct deposit has been cancelled.</p>	NA 1254 (CHANGE CONTINUATION)
Advance Payment – Termination- Did not pay provider timely	<p>As of MMDDYYYY you will no longer get an advance payment for the value of your IHSS services. Here's why:</p> <p>You did not pay your provider on time. When you receive advance payment you must pay your provider(s) in a timely manner. (MPP 30-767.133 (c))</p> <p>If your advance payment was being deposited directly into your bank account, the direct deposit has been cancelled.</p>	NA 1254 (CHANGE CONTINUATION)
Advance Payment – Termination- Incorrect use of payment	<p>As of MMDDYYYY you will no longer get an advance payment for the value of your IHSS services. Here's why:</p> <p>You used your payment for something other than authorized services. When you receive advance payment, you cannot use your payment for anything other than authorized services. (MPP 30-767.133 (a))</p> <p>If your advance payment was being deposited directly into your bank account, the direct deposit has been cancelled.</p>	NA 1254 (CHANGE CONTINUATION)
Auth to Purchase – Alternative Resource decreased hours	<p>As of MMDDYYYY, the hours of IHSS you get are increased. Here's why:</p> <p>You told us that some or all of the following services are no longer being provided to you through an Alternative Resource: (MPP 30-763.6)</p> <p>List all services that apply.</p>	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Alternative Resource – First Authorization that recipient receiving services from Alternative Resource	The hours of IHSS you get are decreased. Here's why: You told us that some of all of each of the following services are being provided to you by an alternative resource at no cost to you: List all services which apply: If you stop receiving these services through this alternative resource please contact your social worker. (MPP 30-763.6)	NA 1250 (APPROVAL) If necessary, spillover to NA 1250 APPROVAL CONTINUATION) NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
Auth to Purchase – Alternative Resource increased hours	As of MMDDYYYY, the hours of IHSS you get are decreased. Here's why: You told us that additional amounts of each of the following services are now being provided to you through an Alternative Resource: (MPP 30-763.6) List all services which apply:	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
Request for additional assistance	You requested additional assistance. In an assessment done on MMDDYYYY, your social worker found that your current ## hours and ## minutes meet your needs with no substantial risk to your safety. (MPP 30-761.2)	NA 1250 (APPROVAL) *May need to inform the recipient of the authorized services/hours again even if there is no change so as to document that a determination has been made. NA 1254 (CHANGE CONTINUATION)
Denial – SSI Board & Care Rate	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You live in a relative's home and you get the board and care rate in your payment from Social Security. (MPP 30-701(o)(2), MPP 30-755.1, MPP 46-140.11(b)]	NA 1252 (DENIAL)
Denial – Citizenship	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You are an alien not lawfully admitted for permanent residence in the U.S. (MPP 30-770.4)	NA 1252 (DENIAL) Subject to MEDS Interface changes

Title	Message Text	Form & Comments
Denial – Non-California Residency	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You do not have State of California residency. (MPP 30-774.4)	NA 1252 (DENIAL)
Denial – Not in own home	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You do not live in your own home. (MPP 30-701(o)(2), MPP 30-755.1)	NA 1252 (DENIAL)
Denial – Whereabouts unknown	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You have not told the county where you are currently living. (MPP 30-701(o)(2), MPP 30-755.21, MPP 30-760.1)	NA 1252 (DENIAL)
	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You are in a hospital and have no plan for returning home. (MPP 30-701(o)(2), MPP 30-755.1)	NA 1252 (DENIAL)
	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You are in an intermediate care facility and have no plan for returning home. (MPP 30-701(o)(2), MPP 30-755.1)	NA 1252 (DENIAL)
	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You are in a skilled nursing facility and have no plan for returning home. (MPP 30-701(o)(2), MPP 30-755.1)	NA 1252 (DENIAL)
	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You are in a community care facility and have no plan for returning home. (MPP 30-701(o), MPP 30-755.1)	NA 1252 (DENIAL)
Denial – Not 65, Blind or Disabled	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You are not 65 or older, blind, or disabled. (MPP 30-771.25)	NA 1252 (DENIAL)
Refuse to Pay Share of Cost	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: Your application was assessed under the IHSS Residual program and you told us that you would not pay your IHSS Share of Cost. (MPP 30-755.233(d))	NA 1252 (DENIAL)

Title	Message Text	Form & Comments
Denial – No Assessed Need	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You do not need any services to safely stay in your home. (MPP 30-761)	NA 1252 (DENIAL)
Denial – Share of Cost Exceeds Need – IHSS-R	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: Your application was assessed under the IHSS Residual program, and Your IHSS Share of Cost is more than the cost of your IHSS services. The Share of Cost is the amount you must pay from your own pocket toward your services. Your Share of Cost is \$####.##. Your IHSS service cost is \$####.## (W&IC 12304.5) See the attached "share of cost" page for information on how your share of cost was calculated. (W&IC 12304.5)	NA 1252 (DENIAL)
Denial – Need met through Alternate Resources/ Voluntary Services / Refused Services	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: All of your Individual Assessed Needs are being met through Alternative Resources, Voluntary Services or you have Refused Services. (MPP 30-763.6, MPP 30-009.213) (System display list of services)	NA 1252 (DENIAL)
Denial – Death	To the estate of RECIPIENT FULL NAME. The County has been notified of MMDDYYYY as the date of death of RECIPIENT FULL NAME; therefore the application for IHSS services has been denied.	NA 1252 (DENIAL)
Denial – Did not provide adequate information	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You did not tell us enough information to determine if you can get services. (MPP 30-760.1)	NA 1252 (DENIAL)
Denial - Non-Compliance with Medi-Cal Eligibility	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: The IHSS program has been informed that you did not provide Medi-Cal with the required information to complete a Medi-Cal eligibility determination which is a requirement for IHSS eligibility. See your Medi-Cal notice for further information.	NA 1252 (DENIAL)
Application Withdrawn – Recipient Request	On MMDDYYYY, you asked to withdraw your application for In-Home Supportive Services (IHSS). If you change your mind you can submit a new application. (MPP 30-009.213)	NA 1257 (MULTIPURPOSE)

Title	Message Text	Form & Comments
Denial– IHSS- R Excess Resource	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You cannot get IHSS because you have more personal/real property than allowed under SSI/SSP rules. (MPP 30-773)	NA 1252 (DENIAL)
Application Denied – Invalid SSN	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: The Social Security Number you provided was invalid.	NA 1252 (DENIAL)
Application Denied – Duplicate SSN	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: The Social Security Number you provided has been determined to belong to someone else.	NA 1252 (DENIAL)
Denial – Medical Certification	You did not provide the county with a medical certification as required to authorize services. (WIC 12309.1)	NA 1252 (DENIAL)
Free-Form Text NOA	The NOA Text will be printed exactly as keyed by the user. There are no spell-check capabilities and the field is limited to 200 characters as indicated in the DSD	NA 1251 (APPROVAL CONTINUATION) NA 1254 (CHANGE CONTINUATION) NA 1257 (MULTIPURPOSE) NA 1252 (DENIAL) NA 1255 (TERMINATION)
Fingerprint Exemption "Refused" on Initial Assessment	The County has denied your application for In-Home Supportive Services (IHSS). Here's why: You refused to provide your fingerprint for purposes of verifying your identity which is a requirement of the IHSS program (W&IC 12305.73 (a)).	NA 1252 (DENIAL)
Fingerprint Exemption "Refused" on Assessment other than Initial Assessment	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You refused to provide your fingerprint for purposes of verifying your identity which is a requirement of the IHSS program (W&IC 12305.73 (a)).	NA 1255 (TERMINATION)

Title	Message Text	Form & Comments
Funding Source Approval	<p>As of MMDDYYYY, you are approved for In-Home Supportive Services through the following program: system select one of the following Funding Programs:</p> <ul style="list-style-type: none"> <input type="checkbox"/> IHSS Plus Option (IPO) Program (W&IC 14132.952) <input type="checkbox"/> Personal Care Services Program (PCSP) (MPP 30-780) <input type="checkbox"/> In-Home Supportive Services-Residual (IHSS-Residual) Program (MPP 30-755.1) 	NA 1250 (APPROVAL)
Transfer to new Program	<p>As of MMDDYYYY, you will no longer get In-Home Supportive Services through the system select one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> IHSS Plus Option (IPO) Program (W&IC 14132.952) <input type="checkbox"/> Personal Care Services Program (PCSP) (MPP 30-780) <input type="checkbox"/> In-Home Supportive Services-Residual (IHSS-Residual) Program (MPP 30-755.1) <p>You will now get IHSS through the system select one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> IHSS Plus Option (IPO) Program (W&IC 14132.952) <input type="checkbox"/> Personal Care Services Program (PCSP) (MPP 30-780) <input type="checkbox"/> In-Home Supportive Services-Residual (IHSS-Residual) Program (MPP 30-755.1) 	NA 1253 (CHANGE)
Reason for Transfer from PCSP to IPO	<p>You will get services from the IPO Program because you: system select all of the following that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Get advance payments <input type="checkbox"/> Get Restaurant meal allowance <input type="checkbox"/> Get services from your spouse <input type="checkbox"/> You are a child under the age of 18 and get services from your parent. <p>(MPP 30-785)</p>	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Reason for Transfer from IPO to PCSP	<p>You will get services from the PCSP Program because you: system select all of the following that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> No longer get advance payments <input type="checkbox"/> No longer get Restaurant meal allowance <input type="checkbox"/> No longer get services from your spouse <input type="checkbox"/> No longer are a child under the age of 18 and you getting services from your parent. <p>(MPP 30-780, MPP 30-785)</p>	<p>NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)</p>
Reason for Transfer from PCSP/IPO to IHSS-R	<p>You will get services from the IHSS-R Program because you: No longer receive Medi-Cal with federal financial Participation (FFP) (W&IC 14132.951)</p>	<p>NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)</p>
Reason for Transfer from IHSS-R to PCSP	<p>You will get services from the PCSP Program because you: Now receive Medi-Cal with Federal Financial Participation (FFP) (W&IC 14132.951)</p>	<p>NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)</p>
Reason for Transfer from IHSS-R to IPO	<p>You will get services from the IPO Program because you: Now receive Medi-Cal with federal financial Participation (FFP) and system select all of the following that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Get advance payments <input type="checkbox"/> Get Restaurant meal allowance <input type="checkbox"/> Get services from your spouse <input type="checkbox"/> You are a child under the age of 18 and get services from your parent. <p>(MPP 30-785)</p>	<p>NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)</p>
Service Hours increase due to funding source change	<p>Your hours of service are increased. Here's why: You now receive your services from the PCSP program. If you go back to IPO or IHSS-R program your services may be decreased.(W&IC 14132.95(g))</p>	<p>NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)</p>
Service Hours decrease due to funding source = IHSS-R	<p>Your hours of service are decreased. Here's why: You are no longer eligible for the PCSP program. The IHSS-R program maximum hours for non-severely impaired is 195 hours a month. (MPP 30-765; W&IC 12303.4(a)(1) & (2), 12303.4(b)(1) &(2))</p>	<p>NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)</p>

Title	Message Text	Form & Comments
Service Hours decrease due to funding source = IPO	Your hours of service are decreased. Here's why: You are no longer eligible for the PCSP program. The IPO program maximum hours for non-severely impaired is 195 hours a month. (W&IC 14132.952)	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
Service Hours unchanged funding source = IPO to PCSP	As of MMDDYYYY, your eligibility will change from the IPO program to the PCSP program. The PCSP maximum hours allowed are 283. (W&IC 14132.95)	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
Service Hours unchanged funding source = IHSS-R to PCSP	As of MMDDYYYY, your eligibility will change from the IHSS-R program to the PCSP program. The PCSP maximum hours allowed are 283. (W&IC 14132.95)	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
Auth to Purchase No Change	On MMDDYYYY a reassessment of your needs was done. There has been no change to your previous authorization of hours. (MPP 30-761.2)	NA 1253 (CHANGE) *May need to inform the recipient of the authorized services/hours again even if there is no change so as to document that a determination has been made.
Auth to Purchase No Change – Change to some Service Types	On MMDDYYYY a reassessment of your needs was done. There has been a change to authorized hours for some service types which is detailed in other messages. There has been no change to your previous total monthly authorization of hours. (MPP 30-761.2)	NA 1253 (CHANGE)
Assessed Hours increase	As of MMDDYYYY, the hours of IHSS you get are increased. Here's why: The reassessment of your needs done on MMDDYYYY found that your condition has changed and/or that you now need additional assistance in the these areas: (MPP 30-756, MPP 30-757, MPP 30-761, MPP 30-763) List all services which apply:	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Assessed Hours decrease	<p>As of MMDDYYYY, the hours of IHSS you get are decreased. Here's why: The reassessment of your needs done on MMDDYYYY found that your condition has changed and/or that you now need less assistance in the these areas: (MPP 30-756, MPP 30-757, MPP 30-761, MPP 30-763) List all services which apply:</p>	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
Legislative Mandate	<p>As a result of a new state law your total monthly authorized hours of HHH:MM have been reduced by 3.6 percent% to HHH:MM (W&IC 12301.06)</p> <p>Your total authorized hours will be reduced by 3.6 percent.%. Here's why:</p> <p>A new state law, Section 12301.06 of the Welfare and Institution Code, requires the California Department of Social Services to reduce every IHSS recipients total authorized hours by 3.6 percent% effective February 1, 2011. For those recipients who have a documented unmet need, excluding protective supervision, the 3.6 percent% reduction will be taken first from the documented unmet need.</p> <p>The new law allows you to choose how this reduction to your total authorized hours is applied toward each of your personal care services authorized on the front of the Notice of Action.</p> <p>The 3.6 percent% reduction will remain in effect and be applied to each of your reassessments until June 30, 2012. On July 1, 2012 your authorized service hours will be restored to your full authorized level, based on your most recent assessment.</p> <p>Your hearing rights are included on the back of your notice of action. However there is no right to a state appeal when the only issue is a state law requiring an adjustment in service hours.</p> <p>If you do not understand or have questions regarding this notice please contact your county IHSS office.</p>	NA 1250 (APPROVAL) If necessary, spillover to NA 1251 (APPROVAL CONTINUATION) NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Not Currently Residing in Own Home – Temporarily Hospitalized	As of MMDDYYYY, you are temporarily ineligible to receive In-Home Supportive Services (IHSS). Here's why: You are hospitalized. (MPP 30-701(o)(2), MPP 30-755.1) You must be residing in your own home to be eligible for IHSS. You may be eligible to have services restored when you are once again residing in your own home. Please contact your social worker when you are getting ready to return home.	NA 1257 (MULTIPURPOSE)
Not Currently Residing in Own Home – Temporarily in SNF	As of MMDDYYYY, you are temporarily ineligible to receive In-Home Supportive Services (IHSS). Here's why: You are staying in a skilled nursing facility. (MPP 30-701(o)(2), MPP 30-755.1) You must be residing in your own home to be eligible for IHSS. You may be eligible to have services restored when you are once again residing in your own home. Please contact your social worker when you are getting ready to return home.	NA 1257 (MULTIPURPOSE)
Not Currently Residing in Own Home – Temporarily in ICF	As of MMDDYYYY, you are temporarily ineligible to receive In-Home Supportive Services (IHSS). Here's why: You are staying in an intermediate care facility. (MPP 30-701(o)(2), MPP 30-755.1) You must be residing in your own home to be eligible for IHSS. You may be eligible to have services restored when you are once again residing in your own home. Please contact your social worker when you are getting ready to return home.	NA 1257 (MULTIPURPOSE)
Not Currently Residing in Own Home – Temporarily in CCF	As of MMDDYYYY, you are temporarily ineligible to receive In-Home Supportive Services (IHSS). Here's why: You are staying in a community care facility. (MPP 30-701(o)(2), MPP 30-755.1) You must be residing in your own home to be eligible for IHSS. You may be eligible to have services restored when you are once again residing in your own home. Please contact your social worker when you are getting ready to return home.	NA 1257 (MULTIPURPOSE)
Resources Disposed of for Less Than Fair Market Value	As of MMDDYYYY, you are temporarily ineligible to receive In-Home Supportive Services (IHSS). Here's why: You sold, donated, transferred or otherwise disposed of your property and/or other resources for less than it was worth (fair market value). You cannot get IHSS for the period MMDDYYYY through MMDDYYYY. (MPP 30-773)	NA 1257 (MULTIPURPOSE)

Title	Message Text	Form & Comments
Out of State for More Than 6 Months	As of MMDDYYYY, your IHSS eligibility will be suspended and you can no longer get In-Home Supportive Services (IHSS) because you will have been out of state for longer than six months. You cannot get IHSS until you return to California and a reassessment of your needs has been completed. (MPP 30-770.45)	NA 1257 (MULTIPURPOSE)
Mode of Service –County Contract	You will be receiving all or some of your IHSS services through the county contract service agency. You will be contacted by the service agency to schedule the days that services will be provided. (MPP 30-767)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Mode of Service-County Homemaker	All or some of your IHSS services will be provided by a county homemaker. You will be contacted by the county homemaker to schedule the days that services will be provided. (MPP 30-767)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Mode of Service-Individual Provider	All or some of your IHSS services will be provided by a person selected by you. Please contact the county IHSS office when you select a provider(s). (MPP 30-767)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Heavy Cleaning (1 month)	Beginning MMDDYYYY you get ### hours and ## minutes of heavy cleaning services for one month because a recent assessment showed that your home needs thorough cleaning to remove excessive debris or dirt which is a hazard to your safety, or because you are at risk of eviction for failing to prepare your home for necessary pest control treatment. These hours are allowed for one month only. (MPP 30-757.12)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Yard Hazard Abatement (1 month)	Beginning MMDDYYYY you get ### hours and ## minutes for yard hazard abatement for one month because these substances pose a fire/safety hazard. These hours are allowed for one month only. (MPP 30-757.161)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Ice and Snow Removal	As of MMDDYYYY, you can get ### hours, ## minutes for removal of ice and snow from entrances and walkways around your home where they pose a hazard to your safety. Ice and snow removal are available only for a limited time and only during icy and snowy weather. (MPP 30-757.162)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Teaching & Demonstration (3 month)	As of MMDDYYYY you get ### hours and ## minutes of teaching and demonstration services for _ months. The following month, your hours will be decreased to ### hours and ## minutes.	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Denial – Paramedical Services	You cannot get paramedical services. (MPP 30-757.19)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Paramedical	We are unable to make a determination on your request for paramedical services at this time because we have not received enough information to complete the assessment of your need to paramedical services. (MPP 30-757.196 & .197)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Paramedical – Additional Hours	We are unable to make a determination on your request for additional paramedical services at this time because we have not received enough information to complete the assessment of your need for paramedical services. (MPP 30-757.196 & .197)	NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Services Proration	<p>Because you share living arrangements with another person(s), your authorized hours for the following Services have been prorated by the amount shown in the Adjustment column on the front page of this NOA:</p> <p>System list prorated services:</p> <p>This means that these tasks are being performed for other persons in the household so the time it takes to perform these tasks has been divided among each person, and you receive only your share of this time. If your provider is performing a task for you alone, there has been no proration of time. (MPP 30-763)</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Mid-Month Begin date	<p>For the period MMDDYYYY through MMDDYYYY, your authorized service hours have been prorated. Your total authorized hours for this period are ### hours, ## minutes. Here's why: Your services begin date is after the 1st of the month.</p> <p>Beginning next month you will receive your full authorization of ### hours, ## minutes. The attached form shows the monthly number of hours you have been approved to receive for each service.</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Mid-Month End date	<p>For the period MMDDYYYY through MMDDYYYY, your authorized service hours have been prorated. Your total authorized hours for this period are ### hours, ## minutes. Here's why: Your services end date is before the end of the month.</p>	<p>NA 1255 (TERMINATION) Or NA 1257 (MULTIPURPOSE)</p>
Death	<p>For the period MMDDYYYY through MMDDYYYY, the authorized service hours for RECIPIENT FULL NAME have been prorated due to their death. The total authorized hours for this period are ### hours, ## minutes.</p>	<p>NA 1255 (TERMINATION)</p>
Denial -Protective Supervision – 24 Hours Not Required	<p>You cannot get Protective Supervision Service. Here's why: An assessment of your needs done on MMDDYYYY, found that you do not need 24-hour supervision to ensure your safety. (MPP 30-757.17)</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>

Title	Message Text	Form & Comments
Denial - Protective Supervision – Other Reason	<p>You cannot get Protective Supervision Service. Here's why:</p> <p>Protective Supervision Service cannot be authorized for friendly visiting or other social activities. MPP 30-757.172</p> <p>Protective Supervision Service cannot be authorized when the need is caused by a medical condition and the form of the supervision needed is medical. MPP 30-757.172</p> <p>Protective Supervision Service cannot be authorized in anticipation of a medical emergency. MPP 30-757.172</p> <p>Protective Supervision Service cannot be authorized to prevent or control a recipient's anti-social or aggressive behavior. MPP 30-757.172</p> <p>Protective Supervision Service cannot be authorized to guard against deliberate self-destructive behavior, such as suicide, or when an individual knowingly intends to harm himself/herself. MPP 30-757.172</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Protective Supervision	<p>We are unable to make a determination on your request for protective supervision services at this time because we have not received enough information to complete the assessment of your need to protective supervision. (MPP 30-757.173)</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Approval – Protective Supervision	<p>As of MMDDYYYY, you can get ### hours, ## minutes per week of protective supervision services because a recent assessment showed that you are non-self-directing, confused, mentally impaired or mentally ill and need 24-hour supervision to safeguard you from injury, hazard or accident. During times outside of IHSS authorized protective supervision, supervision must be provided through another agency or person. MPP 30-757.171</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Maximum hours of Protective Supervision	<p>The maximum number of Protective Supervision hours you may receive per month is 195 because you receive your IHSS services through the PCSP program and are determined to be non-severely impaired by the PCSP program rules. (MPP 30-765; MPP 30-780, W&IC 12303.4(a)(1) & (2), 12303.4(b)(1) &(2))</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>

Title	Message Text	Form & Comments
<p>Reduction – No Unmet Need (On-going)</p>	<p>Because of a new state law, your total monthly authorized hours have been reduced by XX percent, from ###:## to ###:##. (W&IC Section 12301.07)</p> <p>Beginning MM/DD/YYYY, the total authorized monthly service hours you get will be reduced by XX percent. Here's why:</p> <p>There is a new state law (Welfare and Institutions Code section 12301.07) that requires the California Department of Social Services to make a XX percent reduction in each IHSS recipient's total authorized monthly service hours.</p> <p>You can decide which of your authorized services will be reduced. You can choose to reduce all of the hours from one authorized service or you can split it up among several different authorized services. Your provider(s) will be informed of the total reduction in your authorized hours by a note on his/her timesheet(s). However, you are responsible for telling your provider(s) which specific service hours you have chosen to reduce. You do not have to tell the county how you have chosen to apply the reduction; this is between you and your provider.</p> <p>If you believe that the XX percent reduction in your authorized service hours puts you at risk of placement in out-of-home care, you can request an IHSS Care Supplement. You must complete the enclosed IHSS Application for Care Supplement (SOC 877) and return it to the county within 15 days of receiving this notice. The county will review your application and determine whether you are at risk of out-of-home placement.</p> <p>If you request an IHSS Care Supplement within 15 days of receiving this notice, the reduction in your service hours will not go into effect and you will continue to get the same number of authorized service hours you have been getting until the county determines if you are at risk for out-of-home placement. If the county determines that you are at risk for placement in out-of-home care, your service hours may not be reduced at all or they may be reduced less than XX percent.</p> <p>If you do not request an IHSS Care Supplement within 15 days of receiving notice, the reduction in your service hours will go into effect but you can still request the IHSS Care Supplement. If the county determines that you are at risk for placement in out-of-home care, your service hours may be partially or fully restored.</p> <p>The county will send you a notice telling you if your IHSS Care Supplement request has been approved or denied. If you disagree with the county's decision, you can request a state hearing on that</p>	<p>Initial Assessment – NA 1251 (APPROVAL CONTINUATION) OR</p> <p>Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)</p>

Title	Message Text	Form & Comments
	<p>decision. Information about your hearing rights is included with this notice. However, requests for a state hearing only to dispute the new state law requiring the XX percent reduction in authorized service hours will be dismissed.</p> <p>If you do not understand the information in this notice or you have any questions, contact your county IHSS office.</p>	
Reduction – Unmet Need (Ongoing)	<p>Because of a new state law, your total monthly authorized hours of have been reduced by XX percent, from ###:## to ###:##. (W&IC Section 12301.07) You have an unmet need because your most recent assessment showed that you need more hours than the maximum amount allowed by law. Your unmet need hours were considered first when the reduction in authorized hours was calculated.</p> <p>Beginning MM/DD/YYYY, the total authorized monthly service hours you get will be reduced by XX percent. Here's why:</p> <p>There is a new state law (Welfare and Institutions Code section 12301.07) that requires the California Department of Social Services to make a XX percent reduction in each IHSS recipient's total authorized monthly service hours.</p> <p>You can decide which of your authorized services will be reduced. You can choose to reduce all of the hours from one authorized service or you can split it up among several different authorized services. Your provider(s) will be informed of the total reduction in your authorized hours by a note on his/her timesheet(s). However, you are responsible for telling your provider(s) which specific service hours you have chosen to reduce. You do not have to tell the county how you have chosen to apply the reduction; this is between you and your provider.</p> <p>If you believe that the XX percent reduction in your authorized service hours puts you at risk of placement in out-of-home care, you can request an IHSS Care Supplement. You must complete the enclosed IHSS Application for Care Supplement (SOC 877) and return it to the county within 15 days of receiving this notice. The county will review your application and determine whether you are at risk of out-of-home placement.</p> <p>If you request an IHSS Care Supplement within 15 days of receiving this notice, the reduction in your service hours will not go into effect and you will continue to get the same number of authorized service hours you have been getting until the county determines if you are at risk for out-of-home placement. If the county determines that you are at risk for placement in out-of-home care, your service hours may not</p>	<p>Initial Assessment – NA 1251 (APPROVAL CONTINUATION) OR Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)</p>

Title	Message Text	Form & Comments
	<p>be reduced at all or they may be reduced less than XX percent.</p> <p>If you do not request an IHSS Care Supplement within 15 days of receiving notice, the reduction in your service hours will go into effect but you can still request the IHSS Care Supplement. If the county determines that you are at risk for placement in out-of-home care, your service hours may be partially or fully restored.</p> <p>The county will send you a notice telling you if your IHSS Care Supplement request has been approved or denied. If you disagree with the county's decision, you can request a state hearing on that decision. Information about your hearing rights is included with this notice. However, requests for a state hearing only to dispute the new state law requiring the XX percent reduction in authorized service hours will be dismissed.</p> <p>If you do not understand the information in this notice or you have any questions, contact your county IHSS office.</p>	
IHSS Care Supplement received timely	Because your request for an IHSS Care Supplement was submitted timely, the proposed reduction in your authorized monthly hours will not take effect. You will continue to get ###:## authorized hours until the county determines if the proposed reduction in hours puts you at risk of placement in out-of-home care.	Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)
IHSS Care Supplement received untimely	Because your request for an IHSS Care Supplement was not submitted timely, the proposed reduction in your authorized monthly hours has taken effect. Your authorized monthly hours have been reduced to ###:##. If the county determines that the reduction in hours puts you at risk of placement in out-of-home care, your authorized hours may be partially or fully restored.	Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)
Timely Care Supplement Approved – No Hours Reduced	The county has approved your request for an IHSS Care Supplement because the proposed reduction in your authorized monthly hours puts you at risk of placement in out-of-home care. Your authorized monthly hours will not be reduced. You will continue to get ###:## authorized monthly hours.	Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Timely Care Supplement Approved – Partial Hours Reduced	The county has approved your request for an IHSS Care Supplement because the proposed reduction in your authorized monthly hours puts you at risk of placement in out-of-home care. Your total monthly authorized hours of have been reduced less than the amount proposed, from ###:## to ###:##.	Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)
Timely Care Supplement Denied	The county has denied your request for an IHSS Care Supplement because the proposed reduction in your authorized monthly hours does not put you at risk of placement in out-of-home care. The reduction in your authorized monthly hours will take effect. Your authorized monthly hours will be reduced from ###:## to ###:##.	Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)
Untimely Care Supplement Request Approved – Hours Fully Restored	The county has approved your request for an IHSS Care Supplement because the reduction in your authorized monthly hours puts you at risk of placement in out-of-home care. The authorized monthly hours that were reduced have been fully restored. You will now get ###:## authorized monthly hours.	Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)
Untimely Care Supplement Request Approved – Hours Partially Restored	The county has approved your request for an IHSS Care Supplement because the reduction in your authorized monthly hours puts you at risk of placement in out-of-home care. The authorized monthly hours that were reduced have been partially restored. You will now get ###:## authorized monthly hours.	Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)
Untimely Care Supplement Request Denied	The county has denied your request for an IHSS Care Supplement because the reduction in your authorized monthly hours does not put you at risk of placement in out-of-home care. The reduction in your authorized monthly hours will continue. You will get ###:## authorized monthly hours.	Change, Reassessment, Inter-County Transfer, State Hearing Assessment – NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Restaurant Meals Allowance – Approval	Your request for a Restaurant Meal Allowance in place of meal preparation, meal clean-up, and shopping for food services is approved. As of MMDDYYYY, you will receive a Restaurant Meal Allowance of \$62.00. If you change your mind, you can ask the county to change back to meal preparation, meal clean-up, and shopping for food services. (MPP 30-757.133)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Restaurant Meals Allowance Termination – Recipient Request	As of MMDDYYYY, you will no longer receive a Restaurant Meal Allowance. Here's why: You asked to have your Restaurant Meal Allowance stopped. You will now get any individual assessed need (hours and minutes) for meal prep, meal clean-up, shopping for food from your previous assessment. If you change your mind, you can ask to have your Restaurant Meal Allowance restored. (MPP 30-757.131 & .132 & .133)	NA 1254 (CHANGE CONTINUATION)
Restaurant Meals Allowance Termination – No Assessed Need Meal Prep	As of MMDDYYYY, you will no longer receive a Restaurant Meal Allowance. Here's why: An assessment showed that you do not have need for meal preparation. You must have a need for meal preparation to be eligible for a Restaurant Meal Allowance. (MPP 30-757.131 & .132 & .133)	NA 1254 (CHANGE CONTINUATION)
Restaurant Meals Allowance Increase Payment Amount	As of MMDDYYYY, your Restaurant Meal Allowance will increase due to an increase to the State Maximum payment. (MPP 30-757.133)	NA 1257 (MULTIPURPOSE)
Restaurant Meals Allowance – Not qualified	Your request for a Restaurant Meal Allowance in place of meal preparation, meal clean-up, and shopping for food services is denied. You are not eligible to receive a Restaurant Meal Allowance because you must have a need for meal preparation. (MPP 30-757.131 & .132 & .133)	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Deny – Restaurant Meal Allowance	Your request for Restaurant Meal Allowance is denied. Here's why: You are not eligible to receive Restaurant Meal Allowance because you do not have adequate cooking facilities at home. Ask your social worker for a referral to Social Security for evaluation of your eligibility for a Restaurant Meal Allowance through Supplemental Security Payment. (MPP 30-757.133 (a)(3))	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Termination – Restaurant Meals Allowance – Receiving SSP payment	As of MMDDYYYY, you will no longer receive a Restaurant Meal Allowance. Here's why: You are getting a meal allowance as part of your Supplemental Security Payment. (MPP 30-757.133 (a)(2))	NA 1254 (CHANGE CONTINUATION)
Auth to Purchase – Refused Service decreased hours	As of MMDDYYYY, the hours of IHSS you get are increased. Here's why: You told us that you no longer refuse some or all of the following services: (MPP 30-009.213) List all services which apply:	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
Refused Services – First Authorization that Recipient Refused Services	The hours of IHSS you get are decreased. Here's why: You refused some or all of each of the following services: (MPP 30-009.213) List all services which apply: If you change your mind, contact your social worker.	NA 1250 (APPROVAL) NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
Auth to Purchase – Refused Service increased hours	As of MMDDYYYY, the hours of IHSS you get are decreased. Here's why: You told us that you refuse additional amounts of each of the following services: (MPP 30-009.213) List all services which apply:	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)
IHSS SOC	You get IHSS from the IHSS-Residual program. Your IHSS share of cost is displayed on a separate page of this notice. 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.	NA 1256B (IHSS SHARE OF COST)
IHSS SOC – increase - more countable income	As of MMDDYYYY, your IHSS share of cost is \$_____. Your IHSS share of cost was \$_____. It increased because you have more countable income. See the attached "share-of-cost" page for how it was calculated.	NA 1256B (IHSS SHARE OF COST)

Title	Message Text	Form & Comments
IHSS SOC – increase-decrease SSI/SSP benefit levels	As of MMDDYYYY, your IHSS share of cost is \$_____. Your IHSS share of cost was \$_____. It increased because a state law decreased the SSI/SSP benefit levels. See the attached “share-of-cost” page for how it was calculated.	NA 1256B (IHSS SHARE OF COST)
IHSS SOC – increase – COLA	As of MMDDYYYY, your IHSS share of cost is \$___1 st ___. Your IHSS share of cost was \$___2 nd ___. It increased because a cost of living adjustment was made to the social security payments available to you which are \$___3 rd ___, \$___3 rd ___, \$___3 rd ___. If the social security amount you receive is different than listed here, contact your IHSS worker within 10 calendar days. MPP 30-755.233	NA 1256B (IHSS SHARE OF COST)
IHSS SOC – decrease -less countable income	As of MMDDYYYY, your IHSS share of cost is \$_____. Your IHSS share of cost was \$_____. It decreased because you have less countable income. See the attached “share-of-cost” page for how it was calculated.	NA 1256B (IHSS SHARE OF COST)
IHSS SOC –decrease – increase SSI/SSP benefit levels	As of MMDDYYYY, your IHSS share of cost is \$_____. Your IHSS share of cost was \$_____. It decreased because a state law increased the SSI/SSP benefit levels. See the attached “share-of-cost” page for how it was calculated.	NA 1256B (IHSS SHARE OF COST)
IHSS Service of Medi-Cal	You get IHSS as a service of your Medi-Cal. 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 share-of-cost, a letter will be sent to you each time one of your providers’ timesheets is processed telling you how much you need to pay your provider.	Initial Assessment - NA 1251 (APPROVAL CONTINUATION) OR Change, Reassessment, Inter-County Transfer Assessment – NA 1254 (CHANGE CONTINUATION)
State Hearing – Outcome Compliance	This NOA reflects the outcome of your state hearing dated.	NA 1254 (CHANGE CONTINUATION)
State Hearing – Conditional Withdrawal	This NOA reflects the results of the assessment done in agreement with the terms of your conditional withdrawal of your request for a State Hearing.	NA 1254 (CHANGE CONTINUATION)
State Hearing – Payment	To comply with the recent State Hearing order, you will receive a one-time payment.	NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
No Hours Authorized	<p>You do not receive any authorized hours for the services listed below because your spouse is able and available to provide these services to you at no cost. (MPP 30-763.41)</p> <p>List all services which apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Domestic Services <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Meal Clean-up <input type="checkbox"/> Laundry <input type="checkbox"/> Shopping for food <input type="checkbox"/> Other shopping and errands <input type="checkbox"/> Heavy Cleaning <input type="checkbox"/> Yard Hazard Abatement <input type="checkbox"/> Teaching and Demonstration Services 	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Limited Hours Authorized	<p>You receive only a limited number of authorized hours for meal preparation because your spouse is able and available part of the time to provide these services to you at no cost (MPP 30-763.41)</p>	<p>NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)</p>
Termination – No longer in own home	<p>As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You cannot continue to get IHSS because you no longer reside in your own home. (MPP 30-701 (o)(2), MPP 30-755.1)</p>	<p>NA 1255 (TERMINATION)</p>
Termination – Recipient Request	<p>As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You asked to stop all of your service hours. (MPP 30-009.213)</p>	<p>NA 1255 (TERMINATION)</p>
Termination – Did not pay Share of Cost	<p>As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You did not pay your IHSS Share of Cost. The IHSS Share of Cost is the amount you must pay from your own pocket toward your IHSS services. (MPP 30-755.233(c))</p>	<p>NA 1255 (TERMINATION)</p>

Title	Message Text	Form & Comments
Termination – Out of State more than 60 days	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You have been out of the State of California for more than 60 days in a row and it appears that you do not plan to come back. (MPP 30-770.44)	NA 1255 (TERMINATION)
Termination – Out of country	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop Here's why: You have been out of the country for a full calendar month or for 30 days in a row. (MPP 30-770.46)	NA 1255 (TERMINATION)
Termination – Moved out of State	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You told us that you are going to reside outside the State of California. (MPP 30-770.4)	NA 1255 (TERMINATION)
Termination – Failure to cooperate	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You did not cooperate with the County in providing needed information to show that you need services to remain safely in your home. (MPP 30-760.1)	NA 1255 (TERMINATION)
Termination – IHSS-R SOC exceeds need	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: Your application was assessed under the IHSS Residual program and your Share of Cost is more than the cost of your assessed IHSS services. The Share of Cost is the amount you must pay from your own pocket toward your services. Your Share of Cost is \$####.##. Your IHSS services cost is \$####.##. See the attached "share of cost" page for information on how your share of cost was calculated. (W&IC 12304.5)	NA 1255 (TERMINATION)
Termination – No Assessed Need	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You do not need any services to safely stay in your own home. (MPP 30-761.25)	NA 1255 (TERMINATION)

Title	Message Text	Form & Comments
Termination – Need met through Alternate Resources	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: All of your Individual Assessed Needs are being met through Alternative Resources, Voluntary Services or you have Refused Services. (MPP 30-763.6, MPP 30-009.213) (System display list of services)	NA 1255 (TERMINATION)
Termination -Non-Compliance with Medi-Cal Eligibility	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You did not provide Medi-Cal with the required information to continue your Medi-Cal eligibility which is a requirement for IHSS eligibility. See your Medi-Cal notice for further information.	NA 1255 (TERMINATION)
Termination – Residence-Hospital	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You are in a hospital and have no plan for returning home. (MPP 30-701(o)(2), MPP 30-755.1)	NA 1255 (TERMINATION)
Termination – Residence-Intermediate Care Facility	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You are in an intermediate care facility and have no plan for returning home. (MPP 30-701(o)(2), MPP 30-755.1)	NA 1255 (TERMINATION)
Termination – Residence-Skilled Nursing Facility	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You are in a skilled nursing facility and have no plan for returning home. (MPP 30-701(o)(2), MPP 30-755.1)	NA 1255 (TERMINATION)
Termination – Residence - Community Care Facility	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You are in a Community care facility and have no plan for returning home. (MPP 30-701(o)(2), MPP 30-755.1)	NA 1255 (TERMINATION)
Termination – Whereabouts unknown	As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why: You did not tell us where you are currently living. (MPP 30-701(o)(2), MPP 30-755.21, 30-760.1)	NA 1255 (TERMINATION)
Termination – Recipient Death	To the estate of RECIPIENT FULL NAME. The County has been notified of MMDDYYYY as the date of death of RECIPIENT FULL NAME; therefore IHSS services have been terminated.	NA 1255 (TERMINATION)

Title	Message Text	Form & Comments
Termination - Erroneous	<p>On MMDDYYYY, we sent you a Notice of Action telling you that the IHSS services you had been getting would stop. That Notice was sent in error.</p> <p>As of MMDDYYYY, you can get IHSS through the following program: system select one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> IHSS Plus Option (IPO) Program (W&IC 14132.952) <input type="checkbox"/> Personal Care Services Program (PCSP) (MPP 30-780) <input type="checkbox"/> In-Home Supportive Services-Residual (IHSS-Residual) Program (MPP 30-755.1) 	NA 1257 (MULTIPURPOSE)
Termination –IHSS-R Excess Resource	<p>As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why:</p> <p>You cannot get IHSS because you have more personal/real property than allowed under SSI/SSP rules. (MPP 30-773)</p>	NA 1255 (TERMINATION)
Terminations – Invalid SSN	<p>As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why:</p> <p>The Social Security Number you provided is not valid.</p>	NA 1255 (TERMINATION)
Terminations – Duplicate SSN	<p>As of MMDDYYYY, the In-Home Supportive Services (IHSS) you have been getting will stop. Here's why:</p> <p>The Social Security Number you provided has been determined to belong to someone else.</p>	NA 1255 (TERMINATION)
Termination – Medical Certification	<p>You did not provide the county with a medical certification as required to authorize services. (WIC 12309.1)</p>	NA 1255 (TERMINATION)
Unmet Need – PCSP (NSI)	<p>You are receiving your IHSS services through the PCSP program and under the program rules are determined as non-severely impaired. The maximum number of hours you may get is 283 per month. Therefore, you have an unmet need of service. (W&IC 12303.4)</p> <p>You have a total of ## hours and ## minutes of unmet need.</p>	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Unmet Need – PCSP (SI)	<p>You are receiving your IHSS services through the PCSP program and under the program rules are determined as severely impaired. The maximum number of hours you may get is 283 per month. Therefore, you have an unmet need of service. (W&IC 12303.4)</p> <p>You have a total of ## hours and ## minutes of unmet need.</p>	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
Unmet Need –IPO (NSI)	You are receiving your IHSS services through the IPO program and under that program rules are determined as non-severely impaired. The maximum number of hours you may get is 195 per month. Therefore, you have an unmet need of service. (W&IC 12303.4) You have a total of ## hours and ## minutes of unmet need.	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Unmet Need –IPO (SI)	You are receiving your IHSS services through the IPO program and under that program rules are determined as severely impaired. The maximum number of hours you may get is 283 per month. Therefore, you have an unmet need of service. (W&IC 12303.4) You have a total of ## hours and ## minutes of unmet need.	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Unmet Need – IHSS-R (NSI)	You are receiving your IHSS services through the IHSS-R program and under that program rules are determined as non-severely impaired. The maximum number of hours you may get is 195 per month. Therefore, you have an unmet need of service. (W&IC 12303.4) You have a total of ## hours and ## minutes of unmet need.	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Unmet Need –IHSS-R (SI)	You are receiving your IHSS services through the IHSS-R program and under that program rules are determined as severely impaired. The maximum number of hours you may get is 283 per month. Therefore, you have an unmet need of service. (W&IC 12303.4) You have a total of ## hours and ## minutes of unmet need.	NA 1251 (APPROVAL CONTINUATION) OR NA 1254 (CHANGE CONTINUATION)
Auth to Purchase – Voluntary Service decreased hours	As of MMDDYYYY, the hours of IHSS you get are increased. Here's why: You told us that some or all of the following services are no longer being provided to you voluntarily: (MPP 30-763.6) List all services which apply:	NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)

Title	Message Text	Form & Comments
<p>Voluntary Services – First Authorization that Recipient receiving Voluntary Services</p>	<p>The hours of IHSS you get are decreased. Here's why: You told us some or all of each of the following services are being provided to you voluntarily and the individual providing them does not wish to be paid: List all services which apply:</p> <p>If the individual decides they would like to be paid for providing services, contact your social worker. (MPP 30-763.6)</p>	<p>NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)</p>
<p>Auth to Purchase – Voluntary Service increased hours</p>	<p>As of MMDDYYYY, the hours of IHSS you get are decreased. Here's why: You told us that additional amounts of each of the following services are now being provided to you voluntarily: (MPP 30-763.6) List all services which apply:</p>	<p>NA 1253 (CHANGE) If necessary, spillover to NA 1254 (CHANGE CONTINUATION)</p>



County of San Diego

AGING & INDEPENDENCE SERVICES
P O Box 23217, SAN DIEGO CA 92193-3217

Recipient: _____

Case Number: _____

Social Worker: _____

Telephone No.: _____

TIMESHEET SIGNATURE AUTHORIZATION FORM

I _____, hereby authorize _____
Recipient's Name Authorized Individual

to sign my Individual Provider Timesheets to allow the County of San Diego, through the Case Management Information and Payrolling System (CMIPS), to issue payment for time worked and service provided.

I am unable to sign my timesheets because: _____

Authorized Signature: _____ Date _____

Relationship to Recipient: _____

TIMESHEET SIGNATURE VERIFICATION FORM

I _____, swear that the following mark is my true and legal signature.
Recipient's Name

Recipient's Mark

Subscribed and sworn to me this _____ day of _____ 20____.

By: _____
Social Worker Signature

Witness: _____

Date: _____

Witness: _____

Date: _____

Note: This form is required when the recipient cannot sign, or signs with a mark.

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-11**

November 1, 2012

SUBJECT: IHSS Recipient Education Materials

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All County Letter (ACL) No.12-24

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) Staff about the release of IHSS recipient education materials that are available for training IHSS recipients on how to manage their IHSS care providers.

II. BACKGROUND

The state of California has implemented the Community First Choice Option (CFCO) in order to provide home and community-based attendant services and supports. The California Department of Social Services (CDSS) and the California Department of Health Care Services submitted a State Plan Amendment to the federal Centers for Medicare and Medicaid Services (CMS) on December 1, 2011 to implement CFCO.

One of the services the State is required to provide under CFCO is voluntary training for IHSS recipients. The attached fact sheets containing information on the selection, management, and dismissal of IHSS care providers were created to assist in providing training to IHSS recipients.

III. IHSS PROCEDURES

IHSS Social Workers are required to provide information to IHSS recipients regarding the selection, management, and dismissal of IHSS care providers, when requested by the recipient, or when a need has been identified by the Social Worker. The following fact sheets are available for use by staff:

IHSS Program Information

- Overview of the IHSS Services (Attachment A) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- IHSS Authorized Tasks (Attachment B) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Paramedical Services (Attachment C) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)

- Share-of-Cost (Attachment D) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Teaching and Demonstration (Attachment E) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Timesheets (Attachment F) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)

Finding, Hiring and Working with a Provider

- Interviewing, Hiring and Firing a Provider (Attachment G) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Getting Started with Your New Provider (Attachment H) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- IHSS Consumer and Provider Job Agreement (Attachment I) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Communication with Your Provider (Attachment J) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Setting and Maintaining Boundaries (Attachment K)- [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Supervising Your Provider (Attachment L) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Deciding When to Fire a Provider (Attachment M) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)

Other Helpful Information

- Suggestions on How to Handle Money (Attachment N) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)
- Recognizing Abusive Behavior (Attachment O) - [Full Color \(pdf\)](#), [Black and White \(pdf\)](#)

The IHSS recipient fact sheets along with translated versions are available on the CDSS website: <http://www.cdss.ca.gov/agedblinddisabled/PG1829.htm>

Translated versions of the fact sheets are available in Armenian, Spanish and Chinese.

IV. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by an Organizational Review Committee (ORC).

V. 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 automatically distributed by Program Support.



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Wendy Contreras (858) 505- 6366

Distribution Codes 7 & 8

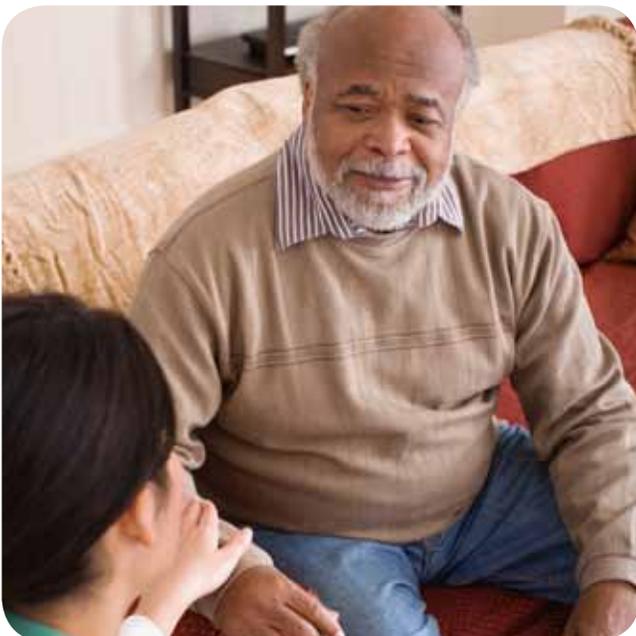
Overview of the IHSS Program

The IHSS program provides services to eligible people over the age of 65, the blind and/or disabled.

The goal of the IHSS program is to allow you to live safely in your own home and avoid the need for out of home care.

Services almost always need to be provided in your own home. This could be a house, apartment, hotel, or the home of a relative.

If you receive Supplemental Security Income (SSI) or meet all Medi-Cal income eligibility requirements, you may be able to receive IHSS services. IHSS is a Medi-Cal program and is funded by federal, state, and county dollars.



Services

These are the types of services IHSS can provide:

- Personal care services like dressing, bathing, feeding, toileting
- Paramedical services like helping with injections, wound care, colostomy and catheter care under the direction of a licensed medical professional
- House cleaning
- Cooking
- Shopping
- Laundry
- Accompaniment to and from medical appointments

Some of the things IHSS cannot pay for include:

- Moving furniture
- Paying bills
- Reading mail to you
- Caring for pets, including service animals
- Gardening
- Repair services
- Sitting with you to visit or watch TV
- Taking you on social outings
- Waiting for you in the doctor's office

Application Process

1. How to Apply

Contact the In-Home Supportive Services program in your county. A county representative will ask you questions to gather information about the nature of your disability, things that you need help with, your income, and assets. This may take up to 20 minutes.

2. Home Visit

A social worker will come to your home to determine the types of authorized services that you need and the number of hours for each service. Some of the things the county will consider are your medical condition, living arrangement, and any resources that may already be available.

3. Health Care Certification Form

You will receive a form for your doctor to complete, certifying your need for IHSS. This form must be completed before services can be authorized.

4. Authorization

The county will send you a Notice of Action (NOA) telling you if you have been approved for IHSS. The NOA will specify what services have been approved, how much time is authorized for each service, and how many total monthly hours have been approved.

Hiring Provider(s)

Once eligibility is established, you can hire one or more people to provide your care. A friend or relative may serve as your care provider, or a referral may be obtained through the IHSS Public Authority Caregiver Registry. Your care provider must complete all the necessary provider enrollment steps prior to starting work. You or your provider can contact your social worker or Public Authority for more information about provider enrollment requirements.



IHSS Authorized Tasks

Mark the tasks you need your provider to do and show how often the task needs to be done. Talk about anything special you want him/her to know as you go through the list. Write notes to help your provider remember your requests.

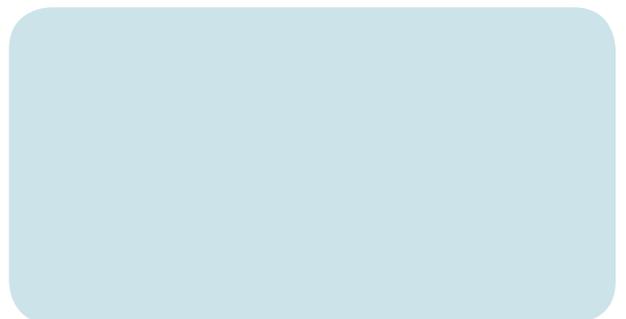
REMEMBER: IHSS will only pay for services that have been authorized by your social worker. When authorizing hours for someone to help you, your social worker considered the things you were able to do safely without help. It is important for you to remain as independent as possible, so you should not ask your provider to do things you can do for yourself safely.

Use the chart below to show whether the tasks need to be done daily (D), weekly (W), monthly (M), or on another schedule (O) such as two times per week.

D=Daily	W=Weekly	M=Monthly	O=Other
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Authorized Task	How often	Notes
Housework		
<input type="checkbox"/> Mop kitchen and bathroom floors		
<input type="checkbox"/> Clean bathroom		
<input type="checkbox"/> Make bed		
<input type="checkbox"/> Change bed linen		
<input type="checkbox"/> Clean sinks		
<input type="checkbox"/> Clean stovetop		
<input type="checkbox"/> Clean oven		
<input type="checkbox"/> Clean refrigerator		
<input type="checkbox"/> Vacuum/sweep		
<input type="checkbox"/> Wipe counter		
<input type="checkbox"/> Dust		
<input type="checkbox"/> Empty trash		

Authorized Task	How often	Notes
Meals		
<input type="checkbox"/> Prepare meals		
<input type="checkbox"/> Meal cleanup		
Laundry		
<input type="checkbox"/> Wash, dry, fold, and put away laundry		
Shopping		
<input type="checkbox"/> Grocery shopping		
<input type="checkbox"/> Other shopping and errands		
Personal Care Services		
<input type="checkbox"/> Dressing		
<input type="checkbox"/> Grooming and oral hygiene		
<input type="checkbox"/> Bathing		
<input type="checkbox"/> Bed bath		
<input type="checkbox"/> Bowel and bladder care		
<input type="checkbox"/> Menstrual care		
<input type="checkbox"/> Help with walking		
<input type="checkbox"/> Move in and out of bed		
<input type="checkbox"/> Help on/off seat or in/out of vehicle		
<input type="checkbox"/> Repositioning		
<input type="checkbox"/> Rub skin		
<input type="checkbox"/> Assistance with prosthesis/meds		
Paramedical Services		
<input type="checkbox"/> Blood sugar checks		
<input type="checkbox"/> Injections		
<input type="checkbox"/> Other paramedical services		
Accompaniment Services		
<input type="checkbox"/> To medical appointments		
<input type="checkbox"/> To alternative resources		



Paramedical Services

What is a Paramedical Service?

In IHSS, paramedical services are services that require authorization and training by a medical professional before they can be provided.

Some examples of paramedical services are:

- Administering medication or giving injections
- Blood/urine testing
- Wound care
- Catheter care and ostomy irrigation
- Any treatments requiring sterile procedures
- Enemas, digital stimulation, or the insertion of suppositories
- Tube feeding
- Suctioning

Let your new provider know what will be expected.

During the job interview, you should discuss all of the IHSS services, including paramedical, for which you have been approved IHSS hours. Some providers may not be comfortable providing some types of personal care and/or paramedical services and may not want the responsibility that comes with this type of care.

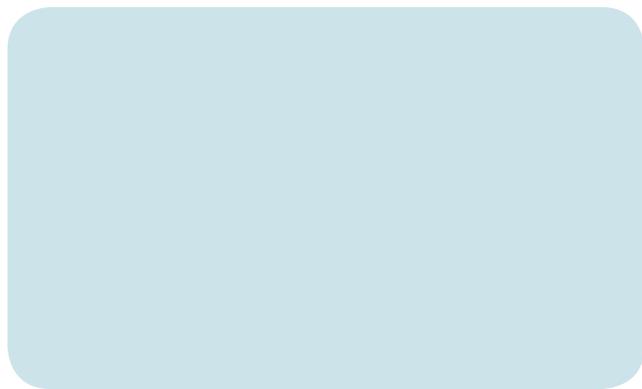
Your provider must be trained to perform paramedical services.

IHSS regulations require that a licensed healthcare professional, such as a doctor, order and direct the paramedical services. Your doctor will need to complete a paramedical form, and you will also need to sign this form. The completed form must be received by the county before your provider can be paid to provide these services.

- You need to make arrangements for your new provider to be trained by your doctor on how to provide any paramedical services you need and the risks involved. If you are not sure about how the services should be done, you should also ask your doctor about this.



- You and your provider should also know what to do if there is an emergency while your provider is performing paramedical services.
- It is very important that your provider NOT perform any paramedical service for you until he/she has received proper training by a licensed healthcare professional.



Things to keep in mind:



Always be sure that your provider washes his/her hands and wears gloves before performing any paramedical task. This will help to protect the health of both you and your provider.



Paramedical services needs may change more frequently than other services. If your needs change, you should contact your social worker so he/she can request a new paramedical order from your doctor.



Your provider may also need to receive additional training on any new paramedical services your doctor may order.

Share-of-Cost

What is a Share-of-Cost?

Most people receive IHSS as a part of their Medi-Cal benefits. Depending on the amount of income received, some people must agree to pay a certain amount each month toward their Medi-Cal expenses, before Medi-Cal will pay.

The money that must be paid before Medi-Cal will pay is called a Share-of-Cost (SOC). The SOC allows a person with income above the allowed amount to receive IHSS if he/she agrees to pay the SOC.

Your SOC may be paid to your IHSS provider, a pharmacy, doctor's office, or when purchasing other medical services or goods.

How Does Share-of-Cost Work?

You will pay your share to the provider when you receive an "Explanation of Share-of-Cost" letter that identifies the amount of the SOC to be paid that pay period. The SOC amount will also appear on your provider's timesheet under "Share-of-Cost Liability."



The amount you need to pay your provider may change each pay period, depending on whether you have paid your SOC for other medical expenses before the timesheet is processed each pay period.

If you have more than one IHSS provider, you will not be able to choose which provider your SOC is paid to. Any SOC that you have not paid will be subtracted from the first IHSS provider's timesheet that is processed by the county. If you or your provider have questions about the SOC, contact your county IHSS or Public Authority office.

Here are some examples of how Share-of-Cost works:

Example 1:

Mrs. Smith has a SOC of \$200 for the month of June.	\$200
She sees her doctor on the 5 th and pays \$50 at the doctor's office.	-\$50
She fills a prescription on the 6 th and pays \$60 at the pharmacy.	-\$60
The total amount Mrs. Smith has paid toward her SOC is \$110 (\$50 + \$60).	\$110
When Mrs. Smith's provider submits his timesheet on the 16 th , Mrs. Smith has a remaining SOC balance of \$90 (\$200 – \$110).	\$90
The State will deduct \$90 from her provider's paycheck.	
Mrs. Smith will need to pay her IHSS provider/employee \$90.	\$90

Example 2:

Mr. Lee has a SOC of \$100 for the month of June.	\$100
He sees his doctor on the 5 th and pays \$75 at the doctor's office.	-\$75
He fills a prescription on the 6 th and pays \$25 at the pharmacy.	-\$25
The total amount of Mr. Lee's expenses is \$100 (\$75 + \$25).	\$100
Mr. Lee has met his SOC for the month.	\$0
Mr. Lee's provider submits her timesheet on the 16 th .	
The State will pay for all of the authorized hours worked in June, and Mr. Lee will not have to pay any money to his IHSS provider.	\$0

Teaching and Demonstration

Teaching and Demonstration services may be authorized to allow your provider to teach you how to perform some of the IHSS services that you currently receive.

Eligible Services

Your provider may be paid to show you how to perform the following services:

- Housework such as sweeping, vacuuming, washing and waxing your floors, washing your kitchen counters and sinks, and cleaning the bathroom.
- Preparing and cleaning up after meals.
- Washing and drying your laundry.
- Personal care services such as feeding, bathing, and dressing.
- Yard work for removal of high grass or weeds when they could cause a fire.

Important Information

If you would like to find out if you are eligible to have your provider teach you how to do some of the services you now receive, here are some things you need to know:

- Your provider must have the skills to be able to teach you how to perform the services.
- Teaching and Demonstration services can only be authorized for three months.



- The goal of Teaching and Demonstration is to allow you to become more independent. This means that because you will need less help after your provider has finished teaching you how to do the services for which Teaching and Demonstration is approved, your IHSS hours may be reduced.

Contact your county IHSS office for more information on this service. Your social worker will determine whether this service can be approved for you.

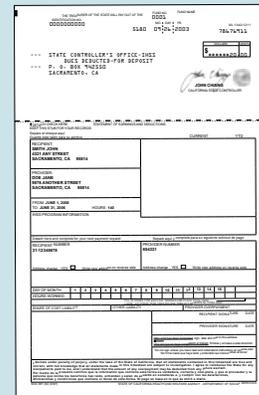
Timesheets

As the employer, you are responsible for keeping track of the number of hours a provider works each day and checking to make sure that the correct number of hours are entered on timesheets.

If you have multiple providers, you must also make sure that each provider does not work more than the number of hours they have been assigned.

Keeping track of service hours.

- Timesheets are sent to each provider two times each month and are attached to the check and/or pay stub that the provider receives.
- If you have more than one provider, you will need to decide how many hours each provider should work each month. If you need help with this, contact your county IHSS office.
- The authorized hours should be spread throughout the month to ensure that your care needs are met. In most cases, the hours worked the first half of the month should be about half of your total hours.



Providers are only eligible to be paid for the authorized hours they worked.

- It is YOUR responsibility to let each provider know how many hours are assigned to him/her. Make sure you and your provider(s) agree on the number of hours of work for each week.
- Use a calendar or other tool to keep track of the amount of time worked by your provider(s). Fill in the number of hours worked every time he/she works and ask him/her to write their initials next to the number.
- Before signing the timesheet, compare the hours the provider has put in with your records to make sure he/she included only hours actually worked.

Here are some additional tips to help you and your provider avoid timesheet problems:

1. Use black or blue ink only to write the hours worked. Numbers must be readable. Timesheets completed in pencil will not be accepted.
2. A zero (0) should be entered for any days that the provider does not work.
3. Make sure you and your provider agree on how many hours he/she worked before you sign the timesheet. If you have disagreements with your provider about the number of hours worked and cannot reach agreement, call your county IHSS office for help.
4. Check to make sure the hours on the timesheet for the pay period are not more than the hours that are authorized. Your provider will not be paid for any additional hours.
5. Do not send any other documents with the timesheet.
6. Do not use correction fluid or tape to fix an entry. To correct a mistake, cross out what's wrong and enter the correct information. Both you and your provider should initial any change.
7. Do not cross out or change the names or pay periods in the boxes at the top of the timesheet. Timesheets are only good for the person and pay period listed.
8. Sign and date the timesheet in ink at the end of the pay period, **and not before**. Both you and the provider must sign the timesheet **after** the hours have been worked.
9. Timesheets are due as soon as possible after the 15th and the last day of each month. The correct mailing address is provided by your county.
10. If the provider moves, he/she must notify the local IHSS office or Public Authority to request an address change form. This should be done within 10 days of moving.

Common Timesheet Mistakes

- Information is left out.
- The timesheet is not signed by both the provider and the consumer.
- A pencil is used to fill out or sign the timesheet.
- The numbers cannot be read.
- A mistake is covered with correction fluid or tape.
- The number of hours worked in the pay period is not entered correctly.
- Some of the information on the timesheet is torn off when the pay stub (the upper part of the form) was detached.
- The timesheet is mailed before the last day worked in the pay period.
- More hours are claimed than were authorized for payment.

Making any of these mistakes will cause a delay in processing because the timesheet will be returned for correction.

Finding, Interviewing and Hiring a Provider

Finding a Provider

Hiring a provider is an important task, and you should take the time to find the right person.

As the employer, you can hire anyone who meets IHSS provider enrollment requirements and can meet your needs. This may be a family member, friend, or someone referred from the Public Authority Registry. Other ways to find a provider may be through your church, posting a flyer, placing an ad in your local newspaper, or simply by word of mouth.

Remember to be careful about what personal information you give out about yourself in this process. Never put your home address on a flyer. If you cannot find a provider, contact your county IHSS office or Public Authority for assistance.

Interviewing Providers

Before you interview a provider, you should take the time to review the services that have been authorized for you and how much time has been authorized for each service. If you feel that one provider cannot provide all of the services you need or work all of the authorized hours, you may wish to hire more than one provider. If you have specific needs, such as a special diet or finding someone who is capable of lifting, be sure to mention this during the interview.

You may find the following steps helpful:

1. Screen applicants through a telephone interview.
2. Meet in person with the strongest candidates.
3. Check references.



Telephone Screening Interview

During this phone call, you should get a good idea of the person's availability, experience, and ability to perform the needed tasks. This is also a good time to let them know that IHSS providers must attend a provider orientation, be fingerprinted, and pass a background check. If you are satisfied with the person, the next step would be to set up a time to meet with him/her to discuss your needs and authorized services and find out more about him/her.

Face-to-Face Interview

This interview can take place in your home or in a public place nearby. Consider asking a friend or family member to join you so that they can help with the interview and help decide who to hire. If possible, it is a good idea to interview more than one person. Make notes during the interview that you can refer to later when checking references or choosing who to hire. Here is some additional information to talk about during the interview:

- Ask to see identification. This may be a valid California driver's license or identification card with a photo.
- Explain your expectations for work behavior including the use of your belongings, arrival and departure times, and other information that will be important for the person you hire to know.
- Go over the services and hours authorized for you.
- Ask if they have been an IHSS provider before, and if they have gone through the provider enrollment process, including being fingerprinted.
- Give them a chance to ask you questions about the job and the services that you need.

Checking Provider References

Checking references will provide you with valuable information about the person you are thinking about hiring. When calling references, ask questions that will give you an idea of the kind of work they did, how long they were employed, their reliability, and their strengths and weaknesses. Keep notes about what the references tell you as this may help you decide who to hire.

Making the Decision

Look at your notes and compare the strengths, qualifications, and references of each person you interviewed and decide which one best meets your needs. Once you have made your decision, let the person know and then contact your county IHSS office so that your provider can begin the enrollment process if they have not already done this.



Getting Started With Your New Provider



Starting off on the right foot

During your first meeting with a new provider, it is important to tell them what you expect. It is best to talk about any difficult issues and agree on things before he/she starts work.

Some of the things you may want to talk to your provider about are listed below.

- **Authorized tasks review**

Explain what tasks the provider will be doing for you and how much time he/she can spend on each task. The county will send you a list of authorized tasks and the amount of time authorized when they approve or change your hours. Be sure to tell your provider how you would like to have the tasks done.

- **Health issues**

Tell your provider about any allergies, special diet needs, and other issues that require special care.

- **Infectious diseases**

It is best for you and your provider to tell each other if either of you have any infectious diseases, including HIV, Hepatitis, Tuberculosis (TB), and others.

- **Supplies**

Show the provider where supplies are kept and how to correctly use any special equipment.

- **Medications**

Explain what help you need, if any, and go over your daily medication schedule.



- **Emergency information**

Share all of the information your provider needs to know if an emergency happens. Include who to call in case of an emergency and how to get out of the house. Post emergency information in an easy to see place at all times.

- **Work schedule**

Be clear on what days your provider will be coming and how many hours he/she will work each day. Agree on a way to keep track of hours so you can make sure the timesheet is filled out correctly. Consider using a calendar or note pad as a way to keep track of tasks and hours worked each day.

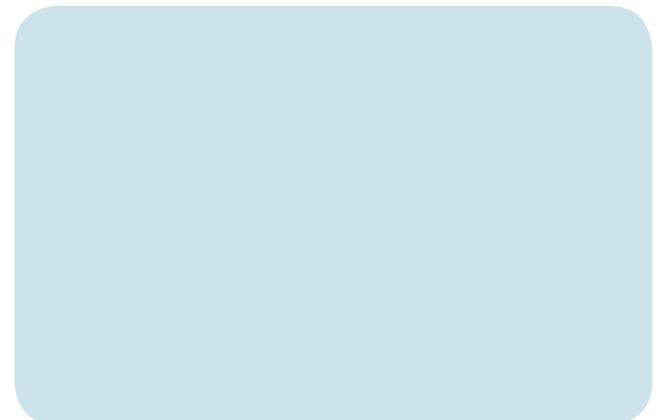
- **Contact information**

Give each other all the telephone numbers where you can be reached and the best times for you to contact each other.



- **Transportation for medical appointments and errands**

IHSS does not pay for the cost of gas, car insurance, or public transportation. Make sure you are clear on who will pay these costs, and that your provider has car insurance and a valid driver's license.



IHSS Consumer and Provider Job Agreement

This job agreement will help explain job duties and work schedule. You can use this form to guide your discussion with your new provider.

Complete and sign this job agreement. Use it as a record of agreed upon responsibilities.



1. This job agreement is between:

_____ & _____
Consumer/Employer
Print Name

Provider/Employee
Print Name

2. The consumer and provider agree to the following general rules.

The consumer agrees to:

- Assign and direct the work of the provider.
- Let the provider know ahead of time, whenever possible, when hours or duties change.
- Not ask the provider to do work for anyone other than him/her or do things that have not been authorized by IHSS.
- Sign the provider's timesheet on time if it correctly shows the hours that were worked.

The provider agrees to:

- Perform the agreed upon tasks and duties.
- Call the consumer as soon as possible if they are late, sick, or unable to work.
- Come to work on time (see hours of work on the back of this page).
- Keep personal calls at a minimum and not make long distance telephone calls using the consumer's telephone.
- Not ask to borrow money or ask for a cash advance.
- Give the consumer a two-week notice, whenever possible, before taking a vacation or leaving the job.

3. The provider will be paid at the rate set by the county for IHSS providers.

4. The hours of work for this job are shown below.

Changes in the scheduled days and hours are to be agreed upon by both parties, with advance notice. Some providers may need to work split shifts each day in order to meet the consumer's needs.

	MON	TUES	WED	THURS	FRI	SAT	SUN
Hours							
Hours							

5. IHSS does not pay provider gas or transportation expenses.

The consumer and provider, by signing this document, agree to the terms outlined above. If the agreement changes, both parties will initial and date the changes.

Consumer/Employer Signature

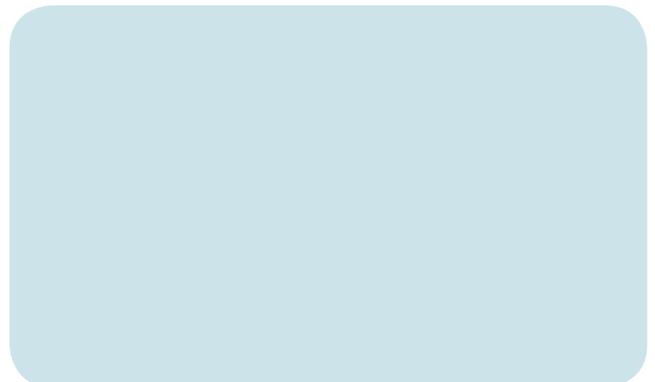
Date

Phone Number

Provider/Employee Signature

Date

Phone Number



Communicating With Your Provider



How you communicate with your provider can affect the quality of care you receive.

Having good communication is the first step to a positive working relationship.

In order to communicate well, always state your needs clearly. Listen to how your provider responds and ask questions about anything you do not understand.

Take time to learn about your provider.

- Ask your provider what name he/she would like to be called and use that name.
- Ask about any habits your provider may have that could affect you such as smoking, and talk about habits you have that your provider should be aware of.

Make sure what you are saying is being understood by your provider.

- Don't talk too fast or too slow.
- If you are talking to your provider and he/she looks confused, ask them if they understand what you are saying. By asking your provider, you will know for sure if he/she understood you or if you need to provide more details.

Helpful hints for good communication.

- Keep the lines of communication open to avoid misunderstandings.
- It may help to use humor and patience when dealing with difficult situations. The tone of your voice can also improve the outcome.
- Take responsibility for your own feelings and respect your provider's concerns by using "I" statements.



For example:

"I see/hear/feel (state the issue).

It makes me feel (state your feelings).

I need (state a possible solution)."



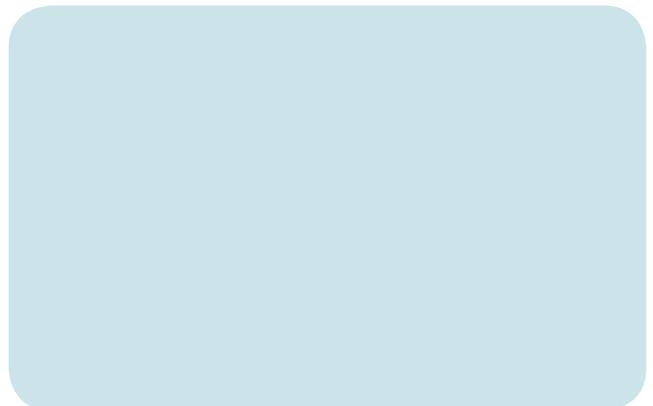
This might sound like:

"I understand this task is hard to learn, but it makes me feel uncomfortable when you grumble under your breath. I would like you to ask me for more direction and let me know what you are feeling so we can work out the problem."

"This is the third time this week you have been 20 minutes late. I'm feeling frustrated because my schedule is off when you are late. I need you here on time."

Keep the lines of communication open and focused on your care.

- Be friendly, but keep your relationship as professional as possible. Remember he/she is there to provide IHSS services for you.
- Your provider may not want to share details about his/her personal life. Respect their privacy.
- Cultural differences may sometimes affect how you get along and may create misunderstandings. Talk about these things immediately and work on a solution that will satisfy both of you.



Setting and Maintaining Boundaries

Part of your job as the employer is to set expectations for your provider.

Restrictions on tasks and hours.

- Do not ask your provider to do things or work hours that have not been authorized. IHSS will not pay for unauthorized tasks or extra hours.

Professional behavior when the workplace is a home.

- Your provider should not bring children or others to your home. Your home is a workplace, and his/her job is to provide IHSS services for you.
- Your provider should not be spending his/her time visiting with you instead of working. Your provider may need to be politely reminded to stay on task.
- He/she should bring his/her own lunch or dinner if working at meal time.
- He/she should not use your property or belongings for his/her own needs.

Protecting your privacy.

- Your provider should not share your name, address, telephone number, health, family situation, or behaviors with any unauthorized people.



- It is important for your provider to know about your health conditions and family contacts in case of an emergency. However, keep other personal information private.
- Your provider should not have access to your checkbook, bank accounts, credit cards, financial information, or to money that is kept in your home.
- You should secure any valuables in a safe place and not tell your provider where they are kept.

Things to Avoid

- **Do not let your provider sign your name at any time.**
- **Do not sign a timesheet that is incorrect.**
- **Do not sign a blank timesheet.**
- **Do not share your bank information with your provider and do not add their name to your savings, checking, or credit card accounts.**
- **Do not share your Social Security number.**
- **Ask for a receipt if you give money to your provider to purchase something for you.**
- **Do not leave valuables or important documents in a visible location.**
- **Keep an eye on things such as telephone usage, medications, etc.**
- **Do not let him/her borrow money, vehicles, or personal belongings.**
- **Do not get involved in your provider's personal life.**

Supervising Your Provider

As an employer, you will need to supervise your provider. This may feel uncomfortable if you have never done this before. However, the following information may help.

1. Let your provider know what tasks must be completed each time he/she works.

If it seems like there is not enough time to do all the authorized services, you and your provider should talk about how to make the best use of the IHSS time authorized. If your condition changes and you need more or less hours, contact your county IHSS office.



2. Communicate your needs.

Your provider needs to know how you like things done so he/she can complete tasks in a way that works for you.

- **Be clear.** Explain in as much detail as possible how you would like your provider to complete each authorized task. Keep in mind the amount of time your provider has to do the task. You may be more comfortable starting with things like housework or laundry before talking about any personal care needs.
- **Be patient.** You may need to remind your provider how you would like him/her to do things more than once.
- **Be specific.** If you would like your authorized tasks done in a specific way, let your provider know.

3. Be reasonable in what you expect.

- A new provider may need to work for you a few times before learning your expectations and needs.

4. Let your provider know how things are going.

- **Say something positive** when he/she does things the way you like them done.
- **Say something to correct** your provider when tasks are not completed the way you want them. Politely let him/her know how you specifically want things done. Some helpful tips include:
 - Use a friendly tone of voice.
 - Don't blame or humiliate your provider.
 - Treat your provider with respect.

5. It is important NOT to ask your provider to do unauthorized tasks or services not covered.

When the social worker assesses your needs, he/she will decide which IHSS services to authorize for you. You should not ask your provider to do services not authorized or not covered by IHSS. If you need help with tasks not covered by the IHSS program such as taking care of pets, assistance with mail or finances, or accompaniment to social activities, you should ask family members, friends, church volunteers, or others to help you.

6. Make good use of time.

As your provider's employer and supervisor, it is your job to make sure he/she is completing the IHSS services within the authorized time. Your provider should not be doing anything except providing IHSS services to you while they are being paid as an IHSS care provider.

Your provider should NOT be:

- Making personal telephone calls
- Watching TV
- Spending too much time visiting with you
- Bringing children or others to work
- Doing his/her personal business or activities



Deciding When to Fire a Provider

As an employer, you have the right to fire your provider for any reason, but you should think about this decision carefully before you take action.



Can the problems be solved?

It can be hard to tell someone that you no longer need their services. Try to work on any minor problems with your provider before you decide to fire him/her.

Talk to your provider about your concerns.

Try to tell your provider as soon as you see a problem. It is best not to let problems build up, but if they do, make a list of the things you are unhappy about and decide what must change in order for you to keep your provider. Have an open talk with your provider and reach agreements about any improvements you need to see in his/her job performance. Tell him/her when the improvements will need to be made.

Remember that communication is a two-way street. Allow your provider to ask questions and be open to any thoughts and concerns he/she may have.

If you are not comfortable about having this talk alone, ask a friend or family member to be there to support you.

If your provider is not willing to improve.

If your provider does not improve his/her performance, it may be time to end his/her employment. If it is possible, it is best to give your provider two weeks' notice. This will give him/her time to look for a new job and you time to get a new provider.



Terminate an unsafe provider right away!

If your provider is treating you in an abusive or threatening manner, you should call 911 and fire him/her immediately. Your personal safety is most important. If you need help doing this, call your IHSS county office, friends, or family members to help you.

Some reasons for firing your provider might be:

- Not meeting your care needs
- Stealing your money or personal property
- Coming in late often or not coming to work at all
- Using your personal property without permission



If You Need A New Provider Quickly

If you have to fire your provider without notice, you have several options to find a new person quickly:

- Contact your Public Authority for a list of available providers.
- Ask a family member or friend for short-term help (remember all providers must be fingerprinted and pass a criminal background check to be paid by IHSS).

Always contact your IHSS county office if you change providers.

Suggestions on How to Handle Money



If your provider is authorized to shop and run errands, you will need to give him/her the money to pay for the items you need. It is important that you take steps to protect both of you when you give your provider money.

1. If you need to have your provider get money out of your purse or wallet, always watch him/her. If the wallet or purse is in another room, ask him/her to bring it to you so you can get the cash out.
2. When the provider returns, count the change, look at the receipt to make sure that only those items requested were purchased, and ask your provider to initial the log.
3. Keep receipts in a large envelope or folding file so you can easily answer any questions that come up.
4. Do not share any of your bank information with your provider.

Be very organized about the use of money to help avoid misunderstandings.

Keeping a Log

You should write down the amount of money you gave to your provider, the amount spent, and the amount of change returned. You can use a notebook for this or copy the log provided on the back of this page. Below is a sample of how to complete the log.

Date	Money given to provider			Amount Spent (from receipts)	Change returned to consumer		
	Amount \$	Consumer Initials	Provider Initials		Amount \$	Consumer Initials	Provider Initials
10/15/12	\$20.00	FM	SS	\$16.85	\$3.15	FM	SS
10/22/12	\$5.00	FM	SS	\$4.25	\$0.75	FM	SS

IHSS Expenditure Log

Consumer Name: _____

Provider Name: _____



Date	Money given to provider			Amount Spent (from receipts)	Change returned to consumer		
	Amount \$	Consumer Initials	Provider Initials		Amount \$	Consumer Initials	Provider Initials

Recognizing Abusive Behaviors

Sometimes a provider, family member (including a child), or friend steps over the line and becomes abusive.

In California, abusing a child, a person over 65, or anyone between the ages of 18 and 64 who has physical or mental limitations, is a crime punishable by law.

Abuse can occur in many ways including physical or sexual abuse, financial abuse, neglect, and psychological abuse or intimidation. Here are some examples of abuse:

- Being slapped, hit, choked, pinched, kicked, shoved, raped, or molested.
- Being constantly yelled at, threatened with bodily harm, or threatened to be left alone.
- Being left alone by a care provider when you cannot get necessary food, water, clothing, shelter, or health care.



- Being kept from getting mail, telephone calls, or visitors; or prevented from leaving your home without good reason.
- Having money, property, or items of value being taken by force or without your approval.
- Being neglected by someone who should be providing care, food, or water.

Report Abuse!

If you are being abused, even by a family member, you should get help right away by contacting:

- **911**
- **Adult Protective Services (APS)**

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**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-10**

October 17, 2012

**SUBJECT: Workarounds for Case Management, Information and Payrolling System II
(CMIPS II)**

EFFECTIVE DATE: Immediately

EXPIRATION DATE: Once a software release provides a data fix to CMIPS II

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with temporary instructions on workarounds that have been developed to assist CMIPS II users in processing case actions in CMIPS II. Once the system has been corrected, these workarounds will no longer be necessary.

II. IHSS PROCEDURES

The following workarounds are to be used by IHSS staff when processing case actions in CMIPS II.

Notice of Action (NOA) Forms

NOA for State Hearing Decisions (SH01 and HR04)

Both SH01 and HR04 NOAs (requiring 10-day notice) are automatically generated when complying with a state hearing decision upholding a negative action. Ten day notice is not required by regulation, since the recipient has already been notified of the negative action.

Workaround: The effective date will be set to accommodate the business rules requiring 10-day notice.

NOA Reason for Transfer from IPO to PCSP (FS04)

When a change from IPO to PCSP occurs, the wording "system select all of the following that apply:" was inadvertently left in the message.

Workaround: Remove "system select all of the following that apply." Social Workers should be aware of the potential for recipient questions.

NOA Denial – No Assessed Need (DN12)

Currently, when an assessed need is indicated as a refused service or is being met by alternate resource, DN12 *No Assessed Need* is being triggered along with DN14 *Need Met by Alternate Resource or Refused Service*.

Workaround: The user will cross out the DN12 wording "no assessed need" on the NOA.

NOA Alternative Resource (AR02)

A spelling error in NOA message AR02 exists. NOA message AR02 reads “The hours of IHSS you get are decreased. Here’s why: You told us that some **of** all of each of the following services are being provided to you by an alternative resource at no cost to you.” The correct NOA should read “The hours of IHSS you get are decreased. Here’s why: You told us that some **or** all of each of the following services are being provided to you by an alternative resource at no cost to you.” The versions of this NOA in languages other than English did not have the error.

Workaround: No action required. Staff should be aware of the potential for recipient questions.

Forms

Forms Pre-Population v. Length of Field Corrections

Several forms do not have the middle initial and suffix populated when either or both of these name components are present in the CMIPS II Application. Additionally, the NOA forms NA 1251 and 1254 (Continuation) need the Case Name data field right-justified.

Workaround: As long as names in CMIPS II conform to the character limitations in Legacy CMIPS, they will print legibly in CMIPS II. Continue current process of entering the suffix as part of last name.

Form Pre-Population

The SOC 295 Application for Social Services, SOC 310 Statement of Facts, SOC 321 Paramedical Services and the SOC 3067 SCIF Claim Reporting Form need additional information pre-populated.

Workaround:

- SOC 295 Application for Social Services: The date that is printed on the form is incorrect and should be updated to reflect the actual application date. The applicant information should be added if available.
- SOC 310 Statement of Facts: Reduce the font size on this form to 10 so that the city name will fit within the form field.
- SOC 321 Paramedical Services: Print the district office address in the “Return To:” field, print the social worker name in the “Signed” field, and print the social worker phone number in the “Phone Number” field.
- SOC 3067 SCIF Claim Reporting Form: Add the county name as the division (following the firm name) and add the provider home address (mailing address) in the employee section.

SOC 332 In-Home Supportive Services Recipient/Employer Responsibility Checklist

The form SOC 332 In-Home Supportive Services Recipient/Employer Responsibility Checklist (5/06) in CMIPS II is outdated. The form needs to be updated in CMIPS II to version 9/09.

Workaround: Staff will access and print the correct version from the CDSS website.

SOC 426B – FAQs About the Provider Enrollment Form

Form SOC 426B FAQs About the IHSS Provider Enrollment Form is no longer relevant to the In-Home Supportive Services (IHSS) Program.

Workaround: Users will not select the Provider Enrollment Packet nor select the form SOC 426B from the forms list.

2009-Provider Enrollment Forms

The following forms located in CMIPS II are outdated and will not be used:

- SOC 426A Program Recipient Designation of Provider
- SOC 426B FAQs About the IHSS Provider Enrollment Form
- SOC 847 Important Information for Prospective Providers About the IHSS Program Provider Enrollment Process
- All attachments

Workaround: Staff will access and print the correct version from the CDSS website.

Error Messages

Error Message - Cannot Rescind Converted Terminated or Denied Case

When the user attempts to rescind a converted *Denied* or *Terminated* case, CMIPS II will display the error message, "Rescind Case action not allowed against a case which was Denied or Terminated prior to Conversion. Please take Reactivate Case action."

Workaround: The user will select *Reactivate* instead of *Rescind*.

Recipient Fingerprinting and P. O. Box Requirements

Recipient fingerprinting is not required as a condition of eligibility for IHSS. IHSS care providers are not prohibited by state regulations from using a P.O. Box address without an exemption (Note: As a deterrent to Fraud, San Diego procedures still require a form and supervisory approval to use a P.O. box).

Workaround: When creating an application, the user will select "Fingerprint Equipment Unavailable" from the drop-down list for the Fingerprint exemption field. When using a P. O. Box for Providers, the user should check the P. O. Box Exemption Checkbox.

Error Messages for Leave and Terminate

CMIPS II allows users to select an *Authorization End Date* prior to the *Initial Assessment Authorization Start Date*. A case can also be placed on leave status with a date prior to the *Authorization Start Date*.

Example: A case with an application date of 7/22/2011 and a subsequent initial assessment with an authorization period of 9/1/2011 – 12/31/2011 can be placed on leave with an 8/1/2011 date.

Workaround: Before the user runs *Check Eligibility*, the user will review the authorization segments to verify that a case is not terminated or on leave prior to the authorized start date, and that the authorized start date is correct.

Processing Assessment with On-Going Eligibility – Authorization Start Date

A user attempting to process *Check Eligibility and Submit for Approval* on a case that has ongoing eligibility and *Pending Evidence* is not required to enter an Authorization Start Date. The error message, “No Medi-Cal Eligibility Record” will display. CMIPS II verifies there is a Medi-Cal eligibility record that matches the *Authorization Start Date* month, or if the *Authorization Start Date* is a future date, the system verifies there is a Medi-Cal Eligibility Data System (MEDS) record for the current month. In this case, there is no *Authorization Start Date*, therefore the system looks for a MEDS eligibility record that matches the application date. Because this is a converted case and the CMIPS Legacy system does not retain all previous Medi-Cal eligibility records, the MEDS record associated with the application date could not be found causing the error.

Workaround: The user must remember to enter an *Authorization Start Date* prior to *Check Eligibility and Submit for Approval*.

Modify Error Message – Authorization Start Date

Users are receiving the message, “Authorization Start Date must be prior to or one day after the previous Authorization End Date. Verify previous Authorization End Date when a case status changes from *Leave* to *Eligible*. The error message will not be triggered.

Workaround: The user will enter an end date one day prior to the effective date of the change to a status of eligible.

Fields

Modify Living Arrangement Code Tables

The *Living Arrangement Code Table* currently indicates two separate entries: Tenant and Landlord. A Change Request (CR) will be created combining these two entries to “Tenant/Landlord” and the remaining value will be removed. The *Landlord* option will be removed; the *Tenant* option will be Tenant/Landlord.

Workaround: The user will choose "Tenant" when appropriate for the recipient/applicant living arrangement. The "landlord" option from the drop down will not be used.

Erroneously Entered State Hearings Record

Currently, a user has no recourse when an error is made, and a State Hearings record is erroneously entered for a case. The State has a business need to be able to identify the entry as erroneous and to preclude it from being reported on the reports associated with State Hearings.

Workaround: User will set the Outcome to “Dismissal” and add a Case Note for a State Hearing which was added by mistake.

Person Record – Active Address, Telephone Number, Alternate ID v. Inactive

All records associated with the *Person Record* such as address, telephone number and alternative ID records display a status of “active”.

Workaround: The user will search for this data by the latest effective date to get the current address, telephone number or alternate ID.

Remove ICT Telephone Number Match Edit

The system has an edit requiring the telephone number from the Inter-County Transfer (ICT) assessment to match the telephone number provided when the ICT was initiated. This edit prevented the evidence from being accepted when the two numbers did not match.

Workaround: If an error is encountered, the user will update the telephone number to match the telephone number at ICT initiation. Once the assessment has been completed, the telephone number can then be changed to a more current telephone number if necessary.

Unlinking of Service Tasks from Functional Ranks (Repositioning and Rubbing Skin)

Legacy CMIPS required hours to be assessed for *Repositioning and Rubbing Skin* service when the *Functional Rank* was greater than 2 for *Functional Area Transfer*. There is no functional area associated with the *Repositioning and Rubbing Skin* service. Error messages were also associated with a *Functional Rank* of 6. Also, Legacy CMIPS required assignment of hours based on service type and *Functional Rank* as the user processes through *Service Evidence* rather than during *Check Eligibility* or *Submit for Approval* actions.

Workarounds:

When there is no assessed need for *Transfer* but an assessed need exists for *Rubbing Skin & Repositioning*, the user will:

1. FI Rank- Transfer = Select assessed rank 2
2. Service Task-Transfer = 00:00 (leave blank)
3. Service Task-Rubbing Skin & Repositioning = Enter assessed HH:MM
Note: May require comments if need is outside the HTG
4. Then, process *Check Eligibility* and activate the evidence. The error message, “Assessed Need required when FI rank is greater than 2”, should not display.

When an assessed need for *Transfer* exists but no assessed need exists for *Rubbing Skin & Repositioning*, the user will:

1. FI Rank- Transfer = Select the assessed rank of 2 or greater
2. Service Task-Transfer = Enter assessed HH:MM
Note: May require comments if need is outside the HTG for the FI Rank
3. Service Task-Rubbing Skin & Repositioning = 00:00 (leave blank)
4. Then, process *Check Eligibility* and activate the evidence. The error message, “Assessed Need required when FI rank is greater than 2”, will not display.

When an assessed need for *Transfer, Rubbing Skin & Repositioning* exists, the user will:

1. FI Rank- Transfer = Select assessed rank of 2 or greater

2. Service Task-Transfer = Enter assessed HH:MM
Note: May require comments if need is outside the HTG for the FI Rank
3. Service Task-Rubbing Skin & Repositioning = Enter assessed HH:MM
Note: May require comments if need is outside the HTG for the FI Rank
4. Then, process *Check Eligibility* and activate the evidence. The error message, “Assessed Need required when FI rank is greater than 2”, should not display.

Unlinking of service tasks from functional ranks (Bowel & Bladder and Menstrual Care)

Bowel & Bladder and *Menstrual Care* share a functional rank. However, time is not always necessary for bowel & bladder although it may be necessary for menstrual. CMIPS II is producing the error message “Functional Rank of 3 or higher must have associated Assessed Need for Bowel & Bladder Care” when a female recipient is ranked 3 in bowel/bladder/menstrual and only has time assessed in the menstrual care service type.

The error message is only triggered in the following condition:

Gender: Female
 FI RANK= 3 or greater
 Service type, BOWEL & BLADDER = 00:00 (no hours)
 Service type, MENSTRUAL CARE = HH:MM

Workaround:

The user will update the fields as follows:

1. GENDER = Female
2. Functional Index RANK= 2
3. BOWEL & BLADDER= 00:00 (leave blank)
4. MENSTRUAL CARE= Enter assessed HH:MM
5. Process Check Eligibility and activate evidence= No error message should be triggered.

OR

1. GENDER = Female
2. Functional Index RANK = 3
3. BOWEL & BLADDER = 00:01
4. MENSTRUAL CARE = Enter assessed HH:MM
5. Process Check Eligibility and activate evidence = No error message should be triggered.

Med Cert Date & Reason Required for Denial on Assessment Type "Initial"

When attempting to deny a case at initial intake, CMIPS II gives an error stating that “Med Cert Date and Med Cert Reason are required for assessment type “Initial”.

Workaround: All case denials require that the Med Cert fields be updated. From the *Program Evidence* screen, the user will determine the following:

1. If Med Cert was sent but NOT received, then enter:
 Med Cert Date = Enter MM/DD/YYYY (no earlier than App Date)

Med Cert Reason= Exception

2. If Med Cert was NOT sent, then enter:
Med Cert Date = Enter MM/DD/YYYY (today's date)
Med Cert Reason= Exception
3. If Med Cert was sent and received, then complete the fields as appropriate.
Med Cert Date = Enter MM/DD/YYYY
Med Cert Reason= Select as appropriate

Other

Person Search Results

Description: When conducting a Person Search, CMIPS II does not allow a user to see all of the actual records that meet the *Person Search* criteria.

Workaround: Once the user has received the message “Your search has exceeded the maximum limit for the number of records that can be returned. Please narrow your search criteria”, the user may enter additional search criteria to narrow their *Person Search* resulting in fewer records for display.

Initial SCI Lookup

When an application is created in CMIPS II, an initial Statewide Client Index (SCI) look-up is not required. If an SCI lookup does not occur, the user is not able to select a Client Index Number (CIN). Cases that are created without selecting a CIN will result in a Statewide Automated Welfare System (SAWS) referral.

Workaround: When creating an application in CMIPS II, staff must ensure that they conduct an SCI look-up before creating the application.

Multiple Tasks Generated for "Medical Certification Due"

Daily tasks are generated for "Medical Certification Due" until trigger is resolved.

Workaround:

1. Eligible for Extension
Update pending evidence as follows:
 - Med Cert Date = enter new MM/DD/YYYY
 - Med Cert Reason= pending
2. Not Eligible for Extension
Terminate the case for “Medical Certification”.
3. Manually close each task with a comment.

ICT Case Cannot be Assigned to a Case Owner Requiring Supervisory Approval.

When a case is in Inter-County Transfer Status, the receiving county ICT Coordinator assigns a case owner to complete the ICT Assessment. If the case owner requires supervisory approval, on "submit for approval" the user/case owner receives the following error "You do not have the required privileges to maintain this data", and the ICT Assessment cannot be submitted. This only occurs when the user/case owner requires supervisory approval.

Workaround: ICT cases will be assigned to case owners who do not require supervisory approval. The case can be reassigned to a case owner who requires supervisory approval once the transfer is complete, and the case is no longer in ICT status.

III. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by an Organizational Review Committee (ORC).

IV. 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=AIHSS>

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


WILFRED QUINTONG
Assistant Deputy Director


ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Wendy Contreras (858) 505- 6366
Distribution Codes 7 & 8

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-09**

October 8, 2012

SUBJECT: Workaround for the IHSS Fraud Referral Tracking System (FRTS)

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When FRTS functionality is working as designed

REFERENCE: IHSS Special Notice 12-01 IHSS Fraud Referral Tracking System (FRTS)

I. PURPOSE

The purpose of this Special Notice is to provide instructions on a workaround that allows In-Home Supportive Services (IHSS) staff to continue to respond to the IHSS Program Integrity (PI) unit's findings using the Fraud Referral Tracking System (FRTS).

II. BACKGROUND

In 2009, the California Department of Social Services (CDSS) approved the implementation of the IHSS Program Integrity unit in San Diego County. The Fraud Referral Tracking System (FRTS) was created to generate referrals to the IHSS Program Integrity unit and the Public Assistance Fraud Division (PAFD). FRTS would also track the referrals and findings, narrate actions taken by IHSS, and generate statistical reports.

Some functions of FRTS are currently not working as designed. This workaround has been established until the issues with FRTS have been resolved.

III. IHSS PROCEDURES

The *Outstanding Findings* spreadsheet, which identifies the FRTS referrals that have been completed, can be accessed by the IHSS Social Work Supervisors at the following path:

S:\ENTERPRISE\IHSS_PI

The IHSS Social Work Supervisor (SWS) will access the spreadsheet, click on the tab for his/her respective District Office, and provide a copy of the spreadsheet to his/her staff for completion of their individual referral responses.

Social Worker Responsibilities

The Social Worker will take the following actions:

1. Access FRTS at: <https://frtsprod.cosd.co.san-diego.ca.us/>
2. On the FRTS Menu Screen, select “*IHSS Referral*” from the drop-down menu.
3. Enter the referral number, acquired off the *Outstanding Findings* spreadsheet, in the “*Referral Tracking Number*” field and click “*Submit*”.
Note: It is not necessary to enter the IHSS CMIPS number. Furthermore, attempting to locate the FRTS referral by using the CMIPS case number will generate a new referral.
4. Once in the “*IHSS Referral*” screen, the Social Worker can view the details of the unannounced visit that was completed by the IHSS PI social worker in the *Narrative* section.
5. Read the narrative.
 - a) If action is needed: establish contact with the client, guardian, or conservator to discuss the findings and determine the action that must be taken.
 - b) Proceed to step 6; be sure to copy and/or write down the appropriate FRTS referral number.
 - c) If no action is needed, the process ends.
6. In the “*IHSS Referral*” screen select the “*Menu*” button, and then select “*IHSS SW Response*” from the drop-down menu. If logged out of FRTS, log into FRTS and select “*IHSS SW Response*” from the drop-down menu. You will have to enter the appropriate FRTS referral number to access this screen.
7. In the “*IHSS SW Response*” screen:
 - a) If a response has already been completed, proceed to step 9.
 - b) If the “*IHSS SW Response*” screen has not been completed, enter a narrative on the *Describe Action Taken* section. The following information is required in the narrative:
 1. The date that the IHSS SW established contact with the client, guardian, or conservator.
 2. Indication that all the findings were reviewed.
 3. Indication of the action taken. If the service hours will be increased or decreased, include the amount of the increase/decrease.
 4. Click “*Process*”.
 5. No further action is needed.
 - c) If unable to enter information into the “*IHSS SW Response*” screen, proceed to step 8.
8. Generate a response via email. Send the email directly to the assigned IHSS PI Social Worker, and include the IHSS Supervisor and IHSS PI Supervisor in the email.
Note: The assigned PI Social Worker can be identified on the “*IHSS Referral*” screen and/or the *Outstanding Findings* spreadsheet.

The response must include the following information:

- a) The FRTS referral number.
 - b) The case name.
 - c) Indication of the inability to complete the response via FRTS.
 - d) Details of the action taken, including the steps taken in 7(b)(1) – 7(b)(3) above.
 - e) No further action needed. Process ends.
9. Send an email to the assigned IHSS PI Social Worker; include the IHSS Supervisor and the IHSS PI Supervisor in the email. The email must include the following information:
- a) The FRTS referral number.
 - b) The case name.
 - c) Indication that the Social Worker was successfully able to complete the response for the FRTS referral.
 - d) No further action needed. Process ends.

IV. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by an Organizational Review Committee (ORC).

V. 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=ASIHSS>

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Perla Delgado (858) 495-5554

Distribution Codes 7 & 8

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

September 10, 2012

SUBJECT: Post Conversion Activity – Review and Correction of Case Issues

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When corrections have been completed

I. PURPOSE

The “Post-Conversion Activity Reporting Tool” (PCAR) is used to help manage post go-live activities. The purpose of this document is to provide instructions for the correction of issues identified through the PCAR.

II. SOCIAL WORKER/STAFF PROCEDURES

Updates to Make When First Accessing a Recipient Case

Make the following updates the first time the recipient case is accessed for editing.

On the Person Home screen:

1. Edit addresses and phone numbers.
2. Modify ethnicity and language fields to an appropriate value. During the conversion process, default or derived values were populated into some of these fields.
3. Modify Contact information (such as contact language, phone numbers and types) and add emergency and other contacts as needed.

Updates to Make at the First Change or Reassessment

Make the following updates when linking companion cases and/or the first time a change or reassessment is conducted. Refer to the “Assessments” procedure for more information.

Household Information

Within household evidence, update data fields as required.

1. Add household members as needed.
2. Search for and link companion cases.
3. Update the number of shared versus recipient-only rooms.
4. Update the living arrangement.

Note: Adding household members, linking companion cases, and/or adjusting living arrangement and/or share rooms may result in an increase or decrease in total authorized hours.

Services and Tasks

Within service evidence:

1. Within service evidence, edit/clean up task frequencies, prorate tasks as required, split out voluntary services and alternative resources, and add comments for HTGs as required.
2. Add/update disaster preparedness data.
3. Create and paste in an assessment narrative.

Note: Editing services and tasks (prorating, editing adjustments, etc.) may result in an increase or decrease in total authorized hours even if service hours were not changed.

Running Check Eligibility

When a user runs “Check Eligibility,” the business rules in CMIPS II process all the data entered. Depending on changes made in the evidence (e.g., adding household members, prorating services, increasing hours, etc.), the resulting authorized hours may change. Corresponding NOA messages will also present. Check that the hours are as expected and that the NOA messages are appropriate.

Check Eligibility and Converted Cases

On a converted case where a change assessment or reassessment was executed and no change to any of the service evidence hours was made, when the worker runs “Check Eligibility,” there may still be a change in total authorized hours. This is a result of the following factors:

- The conversion of decimals to minutes may require “rounding”
- The application of the business rules in CMIPS II to the data that was entered

Should this occur, the following error message may be received:

“Total Auth to Purchase is decreased by [XX:XX] due to conversion of Legacy hours to CMIPS II hours and minutes. Please increase a Monthly Service Type by [XX:XX] or a Weekly Service by [XX:XX] as indicated by the CMIPS II Conversion to Hours and Minutes handout”

If this error message displays, refer to the “CMIPS Conversion to Hours and Minutes Handout”.

Updates to Make when First Accessing a Provider Record

The following updates should be made the first time the provider record is accessed for editing.

On the Person Home screen:

1. Edit addresses (add a residence address) and phone numbers
2. Modify ethnicity, language, and fingerprint fields to an appropriate value. During the conversion process, default or derived values have been populated into some of these fields.

On the Provider Details Screen:

1. Validate enrollment and eligibility information and update as required
2. Assign hours if hours were formerly assigned (during conversion the default is to assign all available hours to each provider)

III. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by an Organizational Review Committee (ORC).

IV. 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=AIHSS>

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

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

CMIPS II will use the numbers in the table below to convert decimal to minutes.

Decimal	Minutes	Rounded Minutes	Decimal	Minutes	Rounded Minutes	Decimal	Minutes	Rounded Minutes
0.00	0.00	0	0.41	24.60	25	0.81	48.60	49
0.01	0.60	1	0.42	25.20	25	0.82	49.20	49
0.02	1.20	1	0.43	25.80	26	0.83	49.80	50
0.03	1.80	2	0.44	26.40	26	0.84	50.40	50
0.04	2.40	2	0.45	27.00	27	0.85	51.00	51
0.05	3.00	3	0.46	27.60	28	0.86	51.60	52
0.06	3.60	4	0.47	28.20	28	0.87	52.20	52
0.07	4.20	4	0.48	28.80	29	0.88	52.80	53
0.08	4.80	5	0.49	29.40	29	0.89	53.40	53
0.09	5.40	5	0.50	30.00	30	0.90	54.00	54
0.10	6.00	6	0.51	30.60	31	0.91	54.60	55
0.11	6.60	7	0.52	31.20	31	0.92	55.20	55
0.12	7.20	7	0.53	31.80	32	0.93	55.80	56
0.13	7.80	8	0.54	32.40	32	0.94	56.40	56
0.14	8.40	8	0.55	33.00	33	0.95	57.00	57
0.15	9.00	9	0.56	33.60	34	0.96	57.60	58
0.16	9.60	10	0.57	34.20	34	0.97	58.20	58
0.17	10.20	10	0.58	34.80	35	0.98	58.80	59
0.18	10.80	11	0.59	35.40	35	0.99	59.40	59
0.19	11.40	11	0.60	36.00	36			
0.20	12.00	12	0.61	36.60	37			
0.21	12.60	13	0.62	37.20	37			
0.22	13.20	13	0.63	37.80	38			
0.23	13.80	14	0.64	38.40	38			
0.24	14.40	14	0.65	39.00	39			
0.25	15.00	15	0.66	39.60	40			
0.26	15.60	16	0.67	40.20	40			
0.27	16.20	16	0.68	40.80	41			
0.28	16.80	17	0.69	41.40	41			
0.29	17.40	17	0.70	42.00	42			
0.30	18.00	18	0.71	42.60	43			
0.31	18.60	19	0.72	43.20	43			
0.32	19.20	19	0.73	43.80	44			
0.33	19.80	20	0.74	44.40	44			
0.34	20.40	20	0.75	45.00	45			
0.35	21.00	21	0.76	45.60	46			
0.36	21.60	22	0.77	46.20	46			
0.37	22.20	22	0.78	46.80	47			
0.38	22.80	23	0.79	47.40	47			
0.39	23.40	23	0.80	48.00	48			
0.40	24.00	24						

No.	Priority	Description	General Direction	Actions
55035	20 High Correct Immediately	Derived Value Assigned for Provider There is no source field in legacy CMIPS. <u>Check the box for all providers whose assigned hours are less than the authorized hours for the recipient, and assign the provider's hours as they were previously assigned in legacy CMIPS.</u>	Per CDSS: If there are assigned hours for the providers, enter on Assign Case provider screen. If hours are not assigned no action is required.	This is primarily multiple providers, but could also be errors remaining from the 3.6 reduction. This information will be exported and distributed after sorting for easy access and correction. If not corrected overpayments could result.
50068	10 Correct Immediately	CIN Occurs with more than one SSN This CIN has more than one SSN associated with it. Contact the other case owner to reconcile the conflict.	This should have been cleared during data readiness. If not then determine correct CIN/SSN combination and have county MEDS clerk make the correction in MEDS.	Quality Control & Assurance workers will evaluate these errors and provide follow-up or instructions.
50073	35 Correct Immediately	Potential companion cases	The case shares a residence address with other IHSS cases. Determine if this is a companion case and update CMIPS II accordingly.	This information will be distributed in an Excel spreadsheet.
5066	35 Correct at Reassessment or the next time the case is touched. Whichever is the earliest	Case has additional household members	Review the case for additional household members to be added to CMIPS II.	Check line G Field 2 in Legacy CMIPS

No.	Priority	Description	General Direction	Actions
55001	40 Correct at reassessment or the next time the case is touched. Whichever is the earliest	Contact Language	Default value assigned for contact language	Review and correct as needed
55002	40 Correct at Reassessment or the next time the case is touched. Whichever is the earliest	Contact phone number and type	Default value assigned for contact phone number and type.	Review and correct as needed
55003	38 Correct at Reassessment or the next time the case is touched. Whichever is the earliest	Recipient Ethnicity	Default value assigned for ethnicity	Review and correct as needed
55009	38 Correct at Reassessment or the next time the case is touched. Whichever is the earliest	Recipient Spoken Language	Default value assigned for spoken language.	Review and correct as needed

No.	Priority	Description	General Direction	Actions
55031	35 Correct at Reassessment or the next time the case is touched. Whichever is the earliest	Number of shared rooms	This information is not in Legacy CMIPS. Add this information at recertification.	Review and correct as needed

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

August 21, 2012

SUBJECT: IHSS Recipients Notice of New Timesheets

EFFECTIVE DATE: Immediately

EXPIRATION DATE: September 30, 2012

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) Staff that effective immediately the “*IHSS Recipients Notice of New Timesheets*” must be provided to all IHSS applicants at the face-to-face home visit, along with all other mandated information.

II. BACKGROUND

The California Department of Social Services (CDSS) issued notices to IHSS recipients informing them of the new timesheet that will be used when the Case Management, Information, and Payrolling System II (CMIPS II) is implemented on September 4, 2012 (Attachments A, B, and C).

III. SOCIAL WORKER/STAFF PROCEDURES

Social Worker Responsibilities

IHSS social workers must issue the state developed notice to new IHSS applicants at the intake interview. The notice informs applicants about changes in the timesheet format and mailing location. It also provides important instructions for completing the new timesheet correctly.

Form GEN 1365 *Notice of Language Services* (Attachment D) notifies applicants of their right to translation services and must be issued to those applicants who receive the notice in a language that is not their primary language.

This requirement will remain in effect until September 30, 2012.

Electronic versions of these forms are available at the following location:

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

**IHSS SPECIAL NOTICE 12-07
IHSS Recipients Notice of New Timesheets**

IV. REVIEW STATEMENT

Due to its informational content, an Organizational Review Committee (ORC) has not reviewed this Special Notice.

V. FILING STATEMENT

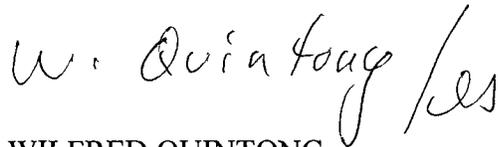
IHSS Special Notices are at the following locations:

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

At the county intranet at:

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

Program Support will not distribute hard copies of this Special Notice.



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Perla Delgado (858) 495-5554

Attachment

Distribution Codes 7 & 8

IHSS Recipients

Notice of New Timesheets

Please Keep for Future Use

As of MM/YY the IHSS program in your county will be getting a new payroll system that will use a New IHSS Timesheet. Your provider will be receiving the New IHSS Timesheet with their paycheck (a sample of the New Timesheet is enclosed). This notice gives you information about the New Timesheet. It is important that the timesheet be completed correctly so that your provider is paid correctly and on time. Please read and follow the instructions in this notice.

Where New Timesheets are Processed for Payment: New Timesheets will be processed at a Timesheet Processing Facility (TPF) in Chico, California. **They will NOT be processed at the county IHSS office. Your provider MUST mail all New Timesheets to the Chico facility.**

The envelope your provider receives with the New Timesheet will have the TPF address printed on it. The TPF address is also on the back of the New Timesheet if the envelope is lost. Your provider **MUST NOT** mail or drop the New Timesheet at any county IHSS office. This will cause a **DELAY** in receiving their paycheck. Old-style timesheets should still be sent to the county IHSS payroll office.

What to Send to the Timesheet Processing Facility (TPF): Send **ONLY** the timesheet to the TPF. **Do not send any other documents to the TPF.** The TPF will **NOT** process any other information. If you or your provider sends other information it will **DELAY** your county receiving this information. If you have other information to report to the IHSS program, send it to your county IHSS office – **Do not mail it to the TPF.**

When to Send Timesheets: Timesheets should be sent to the TPF promptly at the end of each pay period. There are two pay periods each month.

- The first pay period ends on the 15th of the month and the second pay period ends on the last day of the month. If your provider sends their timesheet in early it will either be rejected for payment or held until the end of the pay period.
- If time is claimed after the date the timesheet is received, it will be rejected for payment. For example, if the timesheet is received at the TPF on the 10th of the month and hours are entered on the timesheet for the 14th of the month, it will be rejected for payment. Your provider will have to get another timesheet from the county IHSS payroll office, fill it out and have it signed and then send it to the TPF.
- If time is not claimed after the date the timesheet is received it will be held until the end of the pay period to be processed. For example, if the timesheet is received at the TPF on the 10th of the month but no hours are entered on the timesheet after the 10th of the month, the timesheet will be held until the end of the pay period to be processed.
- If your provider stops working for you, the county IHSS office **MUST immediately** be notified of the provider's work end date. Their timesheet may then be submitted on the last day they work and it will be processed as soon as it is received.

How Your Provider(s) Claims Time Worked: On the New Timesheet, your provider writes the time they worked in **hours and minutes** each day. Your provider no longer needs to change minutes to decimals. For example, if they work 4 hours and 45 minutes they would enter 4 in the “Hours” boxes and 45 in the “Minutes” boxes (see example on enclosed sample Pay Stub).

What Time Your Provider(s) can Claim: You are authorized hours for specific domestic and related and personal care services. The IHSS program only pays for authorized hours and services. Your provider(s) can only be paid for time spent performing authorized services. You or your representative is responsible for scheduling these services to ensure your needs are met throughout the month. The total hours claimed each month for all your providers cannot be more than your total monthly authorized hours. If you have multiple providers you will have to set a schedule for each so that the total of all their hours does not exceed your monthly authorized hours.

If too many of your authorized hours are used during the first pay period, your needs may not be met during the rest of the month. Provider timesheets claiming too many of your hours in the first pay period will be reviewed and you or your provider may be contacted to discuss the hours being claimed. This may **DELAY** your provider’s paycheck.

Completing the New Timesheet: Your provider **MUST** use blue or black ink to complete the timesheet; **MUST NOT** use pencil; **MUST NOT** fold the timesheet; and **MUST NOT** write anything on the timesheet except time worked (hours and minutes), signature and date.

Signing and Dating New Timesheet: You or your representative are responsible for reviewing your provider’s timesheet before you sign it to ensure it is claiming the correct hours. **DO NOT** sign an incorrect or blank timesheet. The new timesheets must be signed and dated on the back side by both you and your provider. Timesheets submitted without both signatures will be rejected for payment. Another timesheet will have to be completed. This will create a **DELAY** for your provider receiving their paycheck.

How to Report a Provider’s Change of Address: If your provider moves, they **MUST immediately** complete a change of address form that they can get from and return to the county IHSS payroll office. IHSS paychecks will **not** be forwarded by the post office. If the payroll system does not have the provider’s correct address, their paycheck will be returned to the State Controller’s Office as undeliverable.

Keep this notice for use in completing the New Timesheet.

Contact the county IHSS Payroll Office if you have questions or need assistance completing the New Timesheet.

Recipientes de IHSS

Aviso de Nuevas Tarjetas de Tiempo

Conservarla Para Uso En El Futuro

A partir de MM/YY el programa de IHSS en su condado conseguirá un sistema nuevo de pago que utilizara una Nueva Tarjeta de Tiempo de IHSS. Su proveedor recibirá la Nueva Tarjeta de Tiempo de IHSS con su cheque de pago (una muestra de la Nueva Tarjeta de Tiempo esta incluida). Este aviso le da información sobre la Nueva Tarjeta de Tiempo es importante que la tarjeta de tiempo sea completada correctamente para que su proveedor sea pagado correctamente y a la hora. Lea por favor y siga las instrucciones en este aviso.

Donde las Nuevas Tarjetas de Tiempo Son Procesadas Para el Pago: Nuevas Tarjetas de Tiempo serán procesadas en una Facilidad del Procesamiento de Tarjeta de Tiempo (TPF) en Chico, California. **No serán procesadas en la oficina de condado IHSS. Su proveedor debe enviar todas las Nuevas tarjetas de Tiempo a la facilidad de Chico.**

El sobre que su proveedor recibirá con la Nueva Tarjeta de Tiempo tendrá la dirección de TPF impresa en el. La dirección de TPF esta también detrás de la Tarjeta de Tiempo si el sobre es perdido. Su proveedor **NO DEBE** enviar ni dejar la Nueva Tarjeta de Tiempo en cualquier oficina de condado de IHSS. Esto causara una **DEMORA** a recibir su cheque de pago. Las Tarjetas de Tiempo viejas todavía deben ser enviadas a la oficina de la nomina del condado IHSS.

Que Enviar a la Facilidad del Procesamiento de la Tarjeta de Tiempo (TPF): Envíe **SOLO** la tarjeta de tiempo al TPF. **No envíe cualquier otro documentos al TPF.** El TPF **NO** procesara cualquier otra información. Si usted o su proveedor envía otra información **DEMORARA** que su condado reciba esta información. Si tiene otra información para reportar al programa IHSS, lo envía a su oficina del condado IHSS-**No lo envíe al TPF.**

Cuando Enviar las Tarjetas de Tiempo: Las Tarjetas de Tiempo deben ser enviadas al TPF puntualmente a fines de cada periodo de paga. Hay dos periodos de paga cada mes.

- El primer periodo de paga termina el 15 del mes y el segundó periodo de paga termina en el ultimo día del mes. Si su proveedor manda la tarjeta de tiempo temprano será rechazada para el pago o retenida hasta el fin del periodo de paga.
- Si tiempo es reclamado después de que la tarjeta de tiempo es recibida, será rechazada para pago. Por ejemplo, si la tarjeta de tiempo es recibida en el TPF el día 10 del mes y las horas son entradas en la tarjeta de tiempo para el 14 del mes, será rechazada para el pago. Su proveedor tendrá que conseguir otra hoja de tiempo de la oficina de pago del condado IHSS, llenarla y firmarla y entonces la envía al TPF.
- Si tiempo no es reclamado después de la fecha que la tarjeta de tiempo es recibida será retenida hasta el fin del periodo de paga para ser procesada. Por ejemplo, si la tarjeta de tiempo es recibida en el TPF el día 10 del mes pero ningunas horas fueron entradas en la tarjeta de tiempo después del día 10 del mes, la tarjeta de tiempo será retenida hasta que el fin del periodo de paga sea procesado.

- Si su proveedor deja de trabajar para usted, la oficina del condado IHSS **DEBE ser** notificada inmediatamente del último día de trabajo del proveedor. Su tarjeta de tiempo entonces puede ser sometida en el último día que trabajo y será procesada en cuanto sea recibida.

Como Sus Proveedor(es) Reclaman Tiempo Trabajando: En la Nueva Tarjeta de Tiempo, su proveedor escribe el tiempo que trabajaron en **horas y minutos** cada día. Su proveedor ya no tiene que cambiar los minutos a decimales. Por ejemplo, si trabajan 4 horas y 45 minutos entrarían 4 en las cajas de “Horas” y 45 en las cajas de “Minutos “(vea ejemplo de talón de cheque incluido).

Que Horas Pueden Reclamar Sus Proveedores: Esta autorizado horas específicas para el servicio doméstico y servicios relacionados y personal. El programa de IHSS solo paga por horas y servicios autorizados. Sus proveedores solo pueden ser pagados por el tiempo que hacen los servicios autorizados. Usted o su representante es responsable de planificar estos servicios para satisfacer sus necesidades durante el mes. Las horas reclamadas cada mes para todos sus proveedores no pueden ser más de las horas autorizadas. Si tiene múltiple proveedores tendrá que poner un horario para cada uno para que el total de sus horas no se pase de las horas autorizadas del mes.

Si muchas de las horas autorizadas son usadas durante el primer periodo de paga, sus necesidades talvez no sean cumplidas durante el resto del mes. Las tarjetas de tiempo del proveedor reclamando demasiado de sus horas en el primer periodo de paga serán revisadas y usted o su proveedor puede que sean contactados para discutir las horas reclamadas. Esto **PUEDE DEMORAR** el pago de su proveedor.

Completando La Nueva Tarjeta de Tiempo: Su proveedor **DEBE** usar tinta azul o negra para completar la tarjeta de tiempo; **NO DEBE** usar lápiz; **NO DEBE** doblar la tarjeta de tiempo; y **NO DEBE** escribir nada en la tarjeta de tiempo solo el tiempo trabajado (horas y minutos), firma y fecha.

Firmando y poniendo la fecha en la nueva Tarjeta de Tiempo: Usted o su representante son responsables de revisar la tarjeta de tiempo de su proveedor antes de firmarla para asegurar que las horas reclamadas están correctas. **NO** firme una tarjeta de tiempo incorrecta o en blanco. Las nuevas tarjetas de tiempo deben ser firmadas y fechadas por usted y su proveedor. Las nuevas Tarjetas de Tiempo entregadas sin las dos firmas serán rechazadas para el pago. Otra tarjeta de tiempo tendrá que ser completada y esto creará una **DEMORA** de pago para su proveedor.

Como reportar el cambio de domicilio de un Proveedor: Si su proveedor se mueve, debe de completar **inmediatamente** una forma de cambio de domicilio que pueden conseguir y regresar al condado de paga de IHSS. Los cheques de paga de IHSS no serán mandados a la oficina de correo. Si el sistema de paga no tiene la dirección correcta, su cheque será regresado a la Oficina del Estado Controlador.

Quédese con este aviso para como completar la Nueva Tarjeta de Tiempo.

Comuníquese con la Oficina de Paga del condado IHSS si tiene preguntas o necesita ayuda completando la Nueva Tarjeta de Tiempo

IHSS Получатели
Уведомление О Новых Табелях
Пожалуйста Сохраните На Будущее

С ММ / УУ программа IHSS в вашем округе получит новую систему начисления заработной платы, которая также будет использовать новые IHSS табеля. Ваш помощник получит новые IHSS табеля с их зарплатой (образец нового табеля приложен). Это уведомление содержит информацию о новых табелях. Очень важно, чтобы табеля были правильно заполнены так, что бы труд вашего помощника был оплачен правильно и своевременно. Пожалуйста, прочитайте и следуйте инструкциям в этом уведомлении.

Где Новые Табеля Обрабатываются Для Оплаты: Новые Табеля будут обрабатываться в Timesheet Processing Facility (TPF) в Чико, Калифорния. Они **НЕ** будут обрабатываться в окружном офисе IHSS. Ваш помощник должен будет отправлять все новые табеля по почте в учреждение в Чико.

Ваш помощник получит конверт с новым табелем на котором будет напечатан адрес TPF. Если конверт потеряется, адрес TPF также напечатан на обратной стороне новых табелей. Ваш помощник **НЕ ДОЛЖЕН** отправлять по почте, либо оставлять новые табеля в любом из офисах IHSS. Это приведет к **ЗАДЕРЖКАМ** в получении их зарплаты. Табеля старого стиля все еще должны быть направлены в бухгалтерию окружного офиса IHSS.

Что Отправлять в Timesheet Processing Facility (TPF): Отправляйте **ТОЛЬКО** табеля в TPF. Не отправлять больше никаких других документов в TPF. TPF **НЕ** обрабатывает ни какой другой информации. Если вы или ваш помощник отправите другую информацию, это только **ЗАДЕРЖИТ** получение этой информации в округе. Если у вас есть какая либо информация для программы IHSS, отправьте её в окружной офис IHSS - **Не отправляйте её в TPF.**

Когда Отправлять Табеля: Табеля должны быть отправлены в TPF в конце каждого платежного периода. Есть два платежных периода каждый месяц.

- Первый платежный период заканчивается 15-го числа текущего месяца и второй платежный период заканчивается в последний день месяца. Если ваш помощник пришлет свои табеля раньше, они будут либо отклонены для оплаты либо задержаны до конца платежного периода.
- Если часы на табеле заявлены после даты когда он был получен, то табель будет отклонен для оплаты. Например, если табель поступает в TPF 10-го числа и часы введены на табеле 14-ым числом того месяца, то табель будет отклонен для оплаты. Ваш помощник будет вынужден получить другой табель из бухгалтерии окружного офиса IHSS, заполнить и подписать его, и затем отправить его в TPF.
- Если часы не заявлены полностью после даты получения табеля, то он будет задержан до конца платежного периода для обработки. Например, если табель поступает в TPF 10-го числа и часы не введены после 10-го числа, то табель будет держаться до конца платежного периода для обработки.
- Если ваш помощник перестает работать для вас, вы **ДОЛЖНЫ немедленно** сообщить в окружной офис IHSS о дате окончания работы помощника. Их табель тогда может быть отправлен в последний день их работы, и он будет обработан как только будет получен.

Как Ваш Помощник Заявляет Отработанные Часы: На Новых Табелях, ваш помощник пишет часы и минуты отработанные каждый день. Ваш помощник теперь не должен изменять минут в десятичные дроби. Например, если они отработали 4 часа и 45 минут, они будут вписывать 4 в графу "Часы" и 45 в графу "Минуты" (см. пример на приложенном образце).

Какие Часы Ваш Помощник Может Заявлять: Вы имеете право на определенное время для конкретных бытовых услуг и персонального ухода. Программа IHSS оплачивает только авторизованное время и услуги. Труд вашего помощника может быть оплачен только за время проведенное при выполнении авторизованных услуг. Вы или ваш представитель несёте ответственность за планирование этих услуг для обеспечения и удовлетворения ваших потребностей в течение месяца. Общее количество часов заявленных всеми вашими помощниками каждый месяц не может быть больше чем ваши ежемесячные авторизованные часы. Если у вас несколько помощников, то вы должны установить расписание для каждого так, чтобы общая сумма всех их часов не превышала ваши ежемесячные авторизованные часы.

Если вы используете слишком много ваших авторизованных часов во время первого периода оплаты, то ваши потребности могут быть не удовлетворены в течение остальной части месяца. Табеля вашего помощника, которые заявляют слишком много часов в течение первого периода оплаты, будут рассмотрены и с вами могут связаться для уточнения заявленных часов. Это может вызвать **ЗАДЕРЖКУ** зарплаты вашего помощника.

Заполнение Нового Табеля: Табеля **ДОЛЖНЫ** быть заполнены только синей или черной ручкой; **НЕДОПУСТИМО** использование карандаша; **НЕДОПУСТИМО** складывать/сгибать табеля, и **НЕДОПУСТИМО** вносить никакой другой информации в табель, только часы и минуты, подпись и дату.

Подпись и Дата Нового Табеля: Вы или Ваш представитель несет ответственность за информацию в табеле вашего помощника. Прежде чем подписать его, убедитесь что в табеле вписано правильное количество часов. **НЕ** подписывайте неправильный или пустой табель. Новые табеля должны быть подписаны и датированы на задней стороне табеля вами и вашим помощником. Табеля представленные без подписей будут отклонены для оплаты. В этом случае должен быть заполнен другой табель. Это может **ЗАДЕРЖАТЬ** получение зарплаты.

Как Сообщить Об Изменении Адреса Вашего Помощника: Если ваш помощник переехал, он/она **ДОЛЖНЫ** немедленно доложить об изменении своего адреса на бланке, который он/она могут получить в бухгалтерии окружного офиса IHSS. Почтовый офис не перенаправляет чеки из IHSS на новый адрес. Если система начисления заработной платы не имеет правильного адреса вашего помощника, то их зарплата будет возвращена в Офис Государственного Контролера, как не подлежащий доставке.

Сохраните это уведомление для использования при заполнении Нового Табеля.

Свяжитесь с бухгалтерией окружного офиса IHSS если у вас возникнут вопросы или вам нужна помощь в заполнении Нового Табеля.

Notice of Language Services

If you do not understand this information or notification, call your county worker. You have the right to interpreter services provided by the county at no cost to you.

(English)

Si no entiende la información o notificación, póngase en contacto con el trabajador social de su condado. El condado debe proporcionarle el servicio de interpretación en forma gratuita.

(Spanish)

إذا لم تفهم هذه المعلومات أو هذا الإشعار فعليك الاتصال بموظف الإقليم. ويحق لك الحصول على خدمات مترجم يقدمها لك الإقليم بالمجان

(Arabic)

Եթե այս ինֆորմացյան չեք հասկանում հաճեցեք կապվել ձեր գավառի պաշտոնյային. իրավունք ունեք առանց վճարման թարգմանիչի ծառայությանը, որ ձեզ կտրվի գավառի կողմից

(Armenian)

ប្រសិនបើអ្នកមិនយល់ព័ត៌មាន ឬការជូនព័ត៌មាននេះទេ សូមទូរស័ព្ទទៅកាន់បុគ្គលិកធ្វើការក្នុងខោនធីរបស់អ្នក ។ អ្នកមានសិទ្ធិ ក្នុងការទទួលសេវាបកប្រែដែលផ្តល់ដោយខោនធីដោយ មិនគិតថ្លៃពីអ្នកឡើយ ។

(Cambodian)

如果您對此份資訊或通知的內容不瞭解，請與貴縣的工作人員聯繫。您有權利要求貴縣所提供的免費口譯人員服務。

(Chinese)

اگر این اطلاعات یا اطلاعیه را نمیفهمید، با کارمند بخش خود تماس بگیرید. شما قانوناً حق دارید از خدمات ترجمه که بطور مجانی توسط بخش فراهم میشود بهره مند شوید.

(Farsi)

Yog koj tsis to taub cov ntaub ntawv lossis daim ntawv no, hu rau koj tus kws khiav ntaub ntawv nyob koj cheeb tsam. Koj muaj cai siv kev pab txhais lus pub dawb uas los ntawm cheeb tsam koj nyob ko.

(Hmong)

この情報やお知らせが理解できない時には、カウンティワーカーにご連絡下さい。あなたにはカウンティから通訳サービスを提供してもらう権利があり、料金は無料です。

(Japanese)

여기 실린 정보 또는 통지서의 내용을 잘 이해 못하시면, 카운티 담당 직원에게 연락하시기 바랍니다. 당신은 카운티로부터 통역 서비스를 무료로 받을 권리를 갖고 있습니다.

(Korean)

ທາກວ່າທ່ານບໍ່ເຂົ້າໃຈຂໍ້ມູນຫລືໃບແຈ້ງຄວາມນີ້ ໃຫ້ໂທໄປຫາພະນັກງານຄາວຕີ້ (county) ຂອງທ່ານ. ທ່ານມີສິດທິຈະຮັບບໍລິການນາຍພາສາທີ່ຈັດໃຫ້ໂດຍຝ່າຍຄາວຕີ້ (county) ໂດຍທ່ານບໍ່ເສັງຄ່າ.

(Lao)

Se gorngv meih maiv bieqc hnyouv naaiv deix mbuox mengh fiex fai mbuox hiuv fiex nor, heuc lorz meih nyei Nquenc zaangc nyei goux sou-gorn mienh. Meih maaih leiz duqv Nquenc zaangc baeqc bun tih waac mienh tengx meih nyei oc

(Mien)

ਜੇਕਰ ਤੁਸੀਂ ਇਸ ਜਾਣਕਾਰੀ ਜਾਂ ਸੂਚਨਾਂ ਨੂੰ ਨਹੀਂ ਸਮਝਦੇ, ਤਾਂ ਆਪਣੇ ਕਾਉਂਟੀ ਵਰਕਰ ਨੂੰ ਕਾਲ ਕਰੋ। ਤੁਹਾਨੂੰ ਕਾਉਂਟੀ ਦੁਆਰਾ ਪ੍ਰਦਾਨ ਕੀਤੀ ਜਾ ਰਹੀ ਦੁਭਾਸ਼ੀ ਦੀ ਸੇਵਾਵਾਂ ਲੈਣ ਦਾ ਹੱਕ ਹੈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ।

(Punjabi)

Если вы не понимаете эту информацию или уведомление, позвоните своему окружному работнику. Вы имеете право на услуги переводчика, которые округ окажет вам бесплатно.

(Russian)

Kung hindi ninyo na-iintidihan ang information (kabatiran) o notification (patalastas), tawagan ang county worker (manggawa) ninyo. May karapatan kayo sa serbisyo ng translator (tagasalin) na ilalaan ng county na wala kayong babayaran.

(Tagalog)

Якщо ви не розумієте цю інформацію або повідомлення, зателефонуйте свому окружному працівнику. Ви маєте право на послуги перекладача, які округ надасть вам безкоштовно.

(Ukrainian)

Nếu quý vị không hiểu thông tin hoặc thông báo này, xin vui lòng gọi cho nhân viên quận. Quý vị có quyền sử dụng các dịch vụ thông dịch miễn phí của quận

(Vietnamese)

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-06**

July 13, 2012

SUBJECT: 3.6% Service Reduction to In-Home Supportive Services (IHSS)

EFFECTIVE DATE: July 6, 2012

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All-County Letter No. 12-33 issued July 6, 2012, EBB 12-16

I. PURPOSE

To provide IHSS staff with instructions and information on the implementation of the 3.6 percent IHSS service reduction.

II. BACKGROUND

In accordance with Assembly Bill 1612, the 3.6 percent IHSS service reduction is restored effective July 1, 2012; however, Senate Bill (SB) 1041 has extended the 3.6 percent reduction until June 30, 2013. The previous 3.6 percent service reduction was restored effective July 1, 2012, and the new 3.6 reduction will begin effective August 1, 2012. Starting on July 16, 2012, the California Department of Social Services (CDSS) will mail a one-time Notice of Action (NOA 304A) informing all recipients of the 3.6 percent reduction.

III. IMPORTANT ITEMS TO NOTE

- NOA 304A (Attachment A and B) directs recipients to contact their local IHSS office. IHSS and other AIS staff can expect phone calls because of these instructions.
- A new NOA insert (304B Attachments E through G) will replace the one currently in use (303B) for the previous reduction.
- Recipients with documented unmet need (other than protective supervision) will receive an additional NOA message (Attachment C and D) that specifies reductions of such unmet need hours.
- Severely Impaired and Non-Severely Impaired categories *will not* change because of the reduction.

- Manual updates will be required on cases with multiple providers, or for providers where the one-to-one relationship (the code of “1” on line E, field 3) has defaulted to zero.
 - All hours for the above providers have been defaulted to the *total hours authorized* for each case.
- An exception list of cases that did not automatically update will be included with the IHSS monthly download and distributed by Program Support.

IV. PROCEDURES

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.

Request for Reassessment

If the Social Worker receives a request for a reassessment 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 (for example, an increase in need as a result of a recent hospitalization)
- Request additional information from the recipient to document the change

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 the Social Worker receives an oral request for a state hearing on the 3.6 reduction, IHSS staff will refer the recipient to the State Hearings Division phone number below.

1 (800) 743-8525

When a written request for a state hearing is received for the 3.6 percent reduction, fax the request to the State Hearings Division at fax number:

1 (916) 651-2789

CMIPS Data Entry

For existing recipient cases that are in “E”, “I” or “L” status, CMIPS will perform a one-time process reducing “Authorized to Purchase” hours by 3.6 percent. All existing providers with a code of “1” on line E, field 3, (a one-to-one relationship) in “E”, “I” or “L” status will update automatically. The printing of the SOC 293 and the SOC 311 will be suppressed. The effective date of this change will be August 1, 2012. System edits will not allow the creation of eligibility segments that span the August 1, 2012 date. The system will automatically create an ending segment (N line) for existing files that contain open segments and create a new segment (M line) starting August 1, 2012.

CMIPS will apply the 3.6 percent reduction to new recipient cases and to any reactivated recipient cases. “Date span editing” will apply to these cases using an August 1, 2012 effective date. Cases entered after July 1, 2012 will require two segments:

- A segment must be created for any days of service provided in July 2012
- A second segment must be created with a beginning date of August 1, 2012

A case authorized retroactively to a period prior to July 1, 2012 will require three segments:

- A segment for any days of service prior to July 1, 2012
- A segment for the July 1 through July 31, 2012 period
- A third segment for the period beginning August 1, 2012

There must be a one-day turnaround between the building of each segment to ensure that all appropriate NOAs are generated and that the recipient is properly notified of the service hours for each period.

Clerical Responsibilities

The designated office assistant will ensure that the appropriate NOA message insert (304B) and appeals information in the appropriate language is included with every NOA sent. Print the appeals information on the reverse side of the NOA message insert. The NOA message insert, with the appeals information, comes in the four State threshold languages (English, Spanish, Armenian, and Chinese).

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

V. REVIEW STATEMENT

Due to the informational nature of this Special Notice, an Organizational Review Committee (ORC) has not reviewed this Special Notice.

VI. FILING STATEMENT

IHSS Special Notices are at the following link:

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

At the County intranet at:

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

Program Support will not distribute hard copies of this Special Notice.



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Perla Delgado (858) 495-5554
Attachment
Distribution Codes 7 & 8

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE – 304A

This notice is being sent to inform you of state law changes that affect your service hours.

As a result of a state law your hours of service previously reduced by 3.6% were temporarily restored for the month of July 2012. As of July 1, 2012 your service hours went back to your full authorized service level of ###.##. These hours are based on your most recent assessment.

Beginning August 1, 2012 a new state law (Section 12301.06 of the Welfare and Institutions Code, as amended) says the California Department of Social Services must again reduce all IHSS recipients' total authorized monthly hours by 3.6 percent. Beginning August 1, 2012, your new service hours will be ###.##.

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 choose to split up those hours 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 tell the county which hours you choose to reduce; this is between you and your provider.

The new law also applies to all reassessments.

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 this new requirement or have questions about the new law please contact your county IHSS office.

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE – 304A

Se le envía esta notificación para informarle que cambios en la ley estatal afectan sus horas de servicios.

Como resultado de una ley estatal, anteriormente sus horas de servicios fueron reducidas en un 3.6% y temporalmente restauradas para el mes de julio 2012. A partir del 1º de julio, 2012, sus horas de servicios volvieron a su nivel completo de servicios autorizados de ###.##. Estas horas están basadas en su evaluación más reciente.

A partir del 1º de agosto, 2012, una nueva ley estatal (Sección 12301.06 del Código de Bienestar Público e Instituciones, en su forma enmendada) estipula que otra vez el Departamento de Servicios Sociales de California tiene que reducir en un 3.6% el número total mensual de horas autorizadas de servicios de todos los beneficiarios. A partir del 1º de agosto, 2012, sus nuevas horas de servicios serán ###.##.

La nueva ley permite que usted escoja cuáles de sus servicios específicos del Programa de Servicios de Apoyo en el Hogar (IHSS) autorizados, (los cuales aparecen en la primera página de la notificación de acción de IHSS) se van a reducir. Por ejemplo, si pierde tres horas de servicios al mes, usted puede reducir tres horas de un servicio autorizado o escoger que esas horas se dividan entre diferentes servicios. Usted es responsable de informar a su proveedor (o proveedores) de la reducción del total de servicios autorizados y cuáles horas específicas usted ha escogido reducir. No tiene que decirle al Condado cuáles horas escoge reducir; esto es entre usted y su proveedor.

La nueva ley también aplica a todas las revaluaciones.

Sus derechos a una audiencia se incluyen con este mensaje. Sin embargo, se rechazarán las solicitudes para una audiencia si solamente son por la nueva ley estatal que requiere una reducción del 3.6% en horas de servicios.

Si no entiende este nuevo requisito o tiene preguntas acerca de la nueva ley, por favor comuníquese con la Oficina de IHSS del Condado.

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE – 304U

This notice is being sent to inform you of state law changes that affect your service hours.

As a result of a state law your hours of service previously reduced by 3.6% were temporarily restored for the month of July 2012. As of July 1, 2012 your service hours went back to your full authorized service level of ###.##. These hours are based on your most recent assessment.

Beginning August 1, 2012 a new state law (Section 12301.06 of the Welfare and Institutions Code, as amended) says the California Department of Social Services must again reduce all IHSS recipients' total authorized monthly hours by 3.6 percent. Beginning August 1, 2012, your new service hours will be ###.##.

State law requires this 3.6 percent reduction to be taken first from your documented unmet need (other than for protective supervision). After the 3.6 percent reduction has been taken, you have a remaining unmet need of ### ## service hours (WIC 12301.06).

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 choose to split up those hours 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 tell the county which hours you choose to reduce; this is between you and your provider.

The new law also applies to all reassessments.

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 this new requirement or have questions about the new law please contact your county IHSS office.

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE – 304U

Se le envía esta notificación para informarle que cambios en la ley estatal afectan sus horas de servicios.

Como resultado de una ley estatal, anteriormente sus horas de servicios fueron reducidas en un 3.6% y temporalmente restauradas para el mes de julio 2012. A partir del 1° de julio, 2012, sus horas de servicios volvieron a su nivel completo de servicios autorizados de ###.##. Estas horas están basadas en su evaluación más reciente.

A partir del 1° de agosto, 2012, una nueva ley estatal (Sección 12301.06 del Código de Bienestar Público e Instituciones [W&IC por sus siglas en inglés], en su forma enmendada) estipula que otra vez el Departamento de Servicios Sociales de California tiene que reducir en un 3.6% el número total mensual de horas autorizadas de servicios de todos los beneficiarios. A partir del 1° de agosto, 2012, sus nuevas horas de servicios serán ###.##.

La ley estatal requiere que esta reducción del 3.6% se haga primero de sus necesidades no satisfechas que están documentadas (que no sean para supervisión protectora). Después que se haya hecho la reducción del 3.6%, a usted le quedan ###.## horas de servicios por necesidades no satisfechas (W&IC 12301.06).

La nueva ley permite que usted escoja cuáles de sus servicios específicos del Programa de Servicios de Apoyo en el Hogar (IHSS) autorizados, (los cuales aparecen en la primera página de la notificación de acción de IHSS), se van a reducir. Por ejemplo, si pierde tres horas de servicios al mes, usted puede reducir tres horas de un servicio autorizado o escoger que esas horas se dividan entre diferentes servicios. Usted es responsable de informar a su proveedor (o proveedores) de la reducción del total de servicios autorizados y cuáles horas específicas usted ha escogido reducir. No tiene que decirle al Condado cuáles horas escoge reducir; esto es entre usted y su proveedor.

La nueva ley también aplica a todas las revaluaciones.

Sus derechos a una audiencia se incluyen con este mensaje. Sin embargo, se rechazarán las solicitudes para una audiencia si solamente son por la nueva ley estatal que requiere una reducción del 3.6% en horas de servicios.

Si no entiende este nuevo requisito o tiene preguntas acerca de la nueva ley, por favor comuníquese con la Oficina de IHSS.

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION MESSAGE – 304B

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, as amended) 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 service hours, as 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 choose to split up those hours among different services. You are responsible for informing your provider(s) of your reduction in total authorized services and the specific service hours you have chosen to reduce. You do not have to tell the county which hours you choose to reduce; this is between you and your provider.

The new law also applies to all reassessments.

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 this new requirement 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 UNTIL 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 is 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 – 304B

El total mensual de sus horas autorizadas se ha reducido en un 3.6%. La razón es la siguiente:

Una nueva ley estatal (Sección 12301.06 del Código de Bienestar Público e Instituciones, en su forma enmendada) estipula que el Departamento de Servicios Sociales de California tiene que reducir en un 3.6% el número total mensual de horas autorizadas de todos los beneficiarios.

La nueva ley permite que usted escoja cuáles de sus servicios específicos del Programa de Servicios de Apoyo en el Hogar (IHSS) autorizados (los cuales aparecen en la primera página de la notificación de acción de IHSS) se van a reducir. Por ejemplo, si pierde tres horas de servicios al mes, usted puede reducir tres horas de un servicio autorizado o escoger que esas horas se dividan entre diferentes servicios. Usted es responsable de informar a su proveedor (o proveedores) de la reducción del total de servicios autorizados y cuáles horas específicas usted ha escogido reducir. No tiene que decirle al Condado cuáles horas escoge reducir; esto es entre usted y su proveedor.

La nueva ley también aplica a todas las revaluaciones.

Sus derechos a una audiencia se incluyen con este mensaje. Sin embargo, se rechazarán las solicitudes para una audiencia si solamente son por la nueva ley estatal que requiere una reducción del 3.6% en horas de servicios.

Si no entiende este nuevo requisito 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 los representantes del Departamento de Bienestar Público del Condado para hablar acerca de esta acción que se propone llevar a cabo. En dicha conferencia, usted puede hablar por sí mismo o puede ser representado por un abogado, amigo u otra persona que hable por usted. Si quiere una conferencia, comuníquese con el departamento de su 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 que aparece a continuación). Su solicitud puede ser verbal o por escrito, pero tiene que indicar que quiere una audiencia y porque no está satisfecho. **SU SOLICITUD PARA UNA AUDIENCIA SE TIENE QUE HACER ANTES DE QUE PASEN 90 DÍAS CONTADOS A PARTIR DE LA FECHA EN QUE SE LE ENVIÓ ESTA NOTIFICACIÓN.**
3. **SI SOLICITA UNA AUDIENCIA CON EL ESTADO ANTES DE LA FECHA EN QUE ENTRE EN VIGOR LA PROPUESTA ACCIÓN DEL CONDADO, SUS SERVICIOS PUEDEN CONTINUAR HASTA LA FECHA DE LA AUDIENCIA.** Usted no será responsable de reembolsar el dinero de los servicios que recibió mientras esperaba la audiencia, aun si el resultado es una negación, siempre y cuando su solicitud se haya hecho de buena fe.
4. Usted mismo puede solicitar una audiencia o puede pedirle al departamento del condado que le ayude. En cualquiera de los casos, asegúrese de informar al trabajador del departamento del condado lo más pronto posible.
5. En una audiencia con el Estado, usted tiene el derecho a ser representado por un abogado o por otra persona (un amigo, pariente, u otra persona que hable a nombre de usted) que usted escoja. Puede obtener asesoramiento legal gratuito y los servicios de un abogado. Puede recibir ayuda para localizar asistencia legal gratuita llamando al número gratuito de la Oficina

- de Preguntas y Respuestas al Público (*Public inquiry and Response*). Para recibir ayuda para presentar su reclamo, también se puede comunicar con la oficina más cercana de la organización de los derechos sobre servicios sociales.
6. Los ordenamientos del Estado que gobiernan las audiencias con el Estado para los servicios sociales están disponibles en la Oficina de Bienestar Público del Condado.
 7. Prácticas en lo relacionado a la información - La información que usted proporciona es obligatoria para procesar su solicitud 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 abrirá un expediente del caso en la Oficina del Jefe de Jueces de Leyes Administrativas. Usted tiene derecho a examinar los materiales que constituyen el registro para una decisión. Es posible que cualquier información que proporcione se comparta con el Departamento de Bienestar Público del Condado o con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Si usted desea hacer una solicitud por escrito para una audiencia con el Estado, por favor envíe esta página al Departamento de Bienestar Público del Condado. La dirección aparece en la parte superior derecha de la primera página de la notificación de acción del Programa de Servicios de Apoyo en el Hogar (IHSS).

Para hacer una solicitud verbal para una audiencia con el Estado, o para obtener más información acerca de sus derechos para una audiencia con el Estado o su expediente, se puede comunicar con:

Public Inquiry and Response
 California Department of Social Services
 744 P Street, Mail Station 8-4-23
 Sacramento, CA 95814
 (800) 952-5253 (Número gratuito)*
 TDD (800) 952-8349* Para personas con problemas auditivos o del habla.

*Puede que primero tenga que marcar el número "1".

SOLICITUD PARA UNA AUDIENCIA CON EL ESTADO

Nombre (apellido, nombre, inicial del nombre que usa en medio)		Número de teléfono	Número de Seguro Social
Dirección		Ciudad	Estado
			Código postal
Por medio de la presente solicito una audiencia con el Estado ante el Departamento de Servicios Sociales de California en relación a la acción que tomé el Condado acerca de mis servicios sociales. La razón es la siguiente:			
<hr/> <hr/> <hr/>			
Tengo dificultad para entender el inglés; por eso solicito un intérprete para mi audiencia. Mi idioma o dialecto es:		Idioma	Dialecto
Firma		Fecha en que se firmó	
REPRESENTANTE AUTORIZADO			
He autorizado a la siguiente persona para que actúe a nombre mío en mi apelación. Autorizo al Departamento para que divulgue cualquier o toda la información relacionada a mi caso a esta persona.			
Nombre del representante autorizado			
Dirección del representante autorizado			
Firma del solicitante de la audiencia con el Estado		Fecha en que se firmó	

Ձեր ընդհանուր ամսական լիազորված ժամաքանակը նվազեցվել է 3.6 տոկոսով: Չեղարկվող պատճառով:

Համաձայն նահանգային նոր օրենքի (Բարեկեցության եւ հաստատությունների մասին օրենսգրքի վերափոխված տարբերակ, Չոփված 12301.06), Սոցիալական ապահովության ծառայության Կալիֆորնիայի դեպարտամենտը պարտավոր է նվազեցնել բոլոր IHSS (Տնային աջակցության ծառայություններ) ստացող անձանց ընդհանուր լիազորված ամսական ժամաքանակը 3.6 տոկոսով:

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

Նոր օրենքը վերաբերում է նաեւ բոլոր վերագնահատումներին:

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

Եթե Ձեզ համար հասկանալի չէ այս նոր պահանջը կամ հարցեր ունեք նոր օրենքի վերաբերյալ, խնդրում ենք դիմել Ձեր վարչաշրջանի IHSS-ի գրասենյակ:

ՆԱԳԱՆՈՒՅԻՆ ԸՆՆՈՒԹՅՈՒՆ ԶԱՅՑԵԼՈՒ ԻՐԱՎՈՒՆՔ

1. Դուք իրավունք ունեք խորհրդակցել Սոցիալական ապահովության շրջանային ղեկարտամենտի ներկայացուցիչների հետ՝ Ձեր պլանավորած գործողությունները քննարկելու նպատակով: Այդ խորհրդակցության ժամանակ ինքներդ կարող եք ներկայացնել Ձեր պահանջը կամ Ձեզ կարող է ներկայացնել իրավաբան, ընկեր կամ այլ ներկայացուցիչ: Եթե խորհրդակցության կարիք ունեք, դիմեք Ձեր շրջանային ղեկարտամենտ:
2. Անկախ նրանից՝ կպահանջեք խորհրդակցություն, թե ոչ, Դուք նաեւ իրավունք ունեք պահանջել գործի նահանգային քննության եւ որոշման ընդունում Կալիֆորնիայի սոցիալական ծառայությունների ղեկարտամենտի տնօրենի կողմից (տես ձեզ ստորև): Ձեր պահանջը կարող է լինել գրավոր կամ բանավոր, բայց դրանում պետք է արտահայտվի քննություն անցկացնելու Ձեր ցանկությունը եվ Ձեր դժգոհության պատճառը: **ԸՆՆՈՒԹՅՈՒՆ ԱՆՑԿԱՑՆԵԼՈՒ ՄԱՍԻՆ ՁԵՐ ԶԱՅՑ ԴԵՏՔ Ե ՆԵՐԿԱՅԱՑՎԻ ՍՈՒՅՆ ԳՐՈՒԹՅԱՆ ՈՐԱՐԿՄԱՆ ԱՄՍԱԹՎԻՑ ՍԿԱԾ 90 ՕՐԿԱ ԸՆԹԱՑՔՈՒՄ:**
3. Եթե ԴՈՒՔ ՆԱԳԱՆՈՒՅԻՆ ԸՆՆՈՒԹՅՈՒՆ ՊԵՐՄԱՅԵՔ ՄԻՆՉԵՎ ԸՐՁԱՆԻ ԿՈՐՄԻՏԵ ՆԱԽԱՏԵՍՎԱԾ ԳՐՈՒԾՈՒԹՅԱՆ ՈՒԺԻ ՄԵՉ ՄՏՆԵԼԸ, ԱՊԱ ՁԵՐ ԾԱՌԱՅՈՒԹՅՈՒՆՆԵՐԸ ԿԱՐՈՂ ԵՆ ԾԱՐՈՒՆԱԿՎԵԼ ՄԻՆՉԵՎ ԸՆՆՈՒԹՅՈՒՆԸ: Դուք պատասխանատվություն չեք կրում վճարելու գումարներ այն ծառայությունների համար, որոնք ստացել եք մինչև քննությունը, եթե նույնիսկ քննության արդյունքում Ձեր հայցը մերժվի՝ այն պայմանով, որ բարեխղճորեն եք ներկայացրել Ձեր պահանջը:
4. Դուք կարող եք ինքնուրույն պահանջել նահանգային քննություն կամ խնդրել Ձեր շրջանային ղեկարտամենտին աջակցել Ձեզ այդ գործում: Ցանկացած ղեպքում Ձեր շրջանային ղեկարտամենտի աշխատակցին անպայման հայտնեք 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, զանգահարեք 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 ղեկարտամենտի 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: Վարչական իրավունքի գլխավոր դատավորի գրասենյակի կողմից կկազմվի գործ: Դուք իրավունք ունեք ծանոթանալու որոշման համար պատրաստված գործի նյութերին: Ձեր հայտնած ցանկացած տեղեկություն կարող է տրամադրվել Սոցիալական ապահովության շրջանային ղեկարտամենտին կամ Միացյալ Նահանգների առողջապահության եւ սոցիալական զարգացման ծառայությունների ղեկարտամենտին: Եթե ցանկանում եք գրավոր պահանջ ներկայացնել նահանգային քննության համար, խնդրում ենք ուղարկել այս էջը Սոցիալական ապահովության շրջանային ղեկարտամենտին: Հասցեն նշված է IHSS գրություն-ծանուցման առաջին էջում՝ վերելի աջ անկյունում: Նահանգային քննության համար բանավոր պահանջ ներկայացնելու կամ նահանգային քննության Ձեր իրավունքների կամ գործի նյութերի վերաբերյալ լրացուցիչ տեղեկություններ ստանալու համար, դիմեք.
Հասարակական հարցումների պատասխանման ծառայություն Կալիֆորնիայի սոցիալական ծառայությունների ղեկարտամենտ 744 P Street, Mail Station 8-4-23 Sacramento, CA 95814 (800) 952-5253 (անվճար հեռախոսահամար)* TDD (800) 952-8349* Ստղության եւ խոսելու խնդիրներ ունեցողների համար *Հնարավոր է, որ նախապես անհրաժեշտ լինի հավաքել «1»:

ՆԱԳԱՆՈՒՅԻՆ ԸՆՆՈՒԹՅԱՆ ԶԱՅՑ

Ազգանուն, անուն, այլ անվան սկզբնատառ	Հեռախոս	Սոցիալական ապահովության համար	
Հասցե	Բաղաք	Նահանգ	Փոստային կոդ
Սույնով հայցում եմ նահանգային քննության Կալիֆորնիայի սոցիալական ծառայությունների ղեկարտամենտի կողմից՝ կապված իմ սոցիալական ծառայությունների վերաբերյալ վարչաթղթանի ձեռնարկած գործողության հետ: Իմ հայցի դրդապատճառները հետևյալն են.			
Ես դժվարությամբ եմ հասկանում անգլերեն, հետեւաբար իմ գործի լսման համար, խնդրում եմ տրամադրել թարգմանիչ՝ հետևյալ լեզվով.	Լեզու	Բարբառ	
Ստորագրություն	Ստորագրման ամսաթիվ		
ԼԻՎՉՈՐԿԱԾ ՆԵՐԿԱՅԱՑՈՒԹՅՈՒՆ			
Ես լիազորում եմ սույն անձին՝ հանդես գալու իմ անունից իմ բողոքարկման գործում: Ես լիազորում եմ Դեկարտամենտին՝ հայտնելու իմ գործի վերաբերյալ ցանկացած տեղեկատվություն նշված անձին:			
Լիազորված ներկայացուցիչ անուն, ազգանուն			
Լիազորված ներկայացուցիչի հասցե			
Նահանգային քննության բողոքարկուցի ստորագրություն		Ստորագրման ամսաթիվ	

(Armenian)

家中協助性服務 行動通知訊息 – 304B

你每月總共的授權時數被削減了3.6%，理由在於：

一個新的州政府法例（經修定的福利和慈善法規，第12301.06欄）表示加州社會服務處必須減少IHSS領取者每月總共的授權時數3.6%。

正如出示在你行動通知的首頁，新的法例允許你選擇那一個被削減IHSS的指定授權服務。例如，如果你每月損失三小時服務時間，你可選擇從一個授權服務減少三小時，或者選擇從幾個不同的服務裏平分減少這些時數。你有責任通知你的提供者有關你總共的授權服務和你選擇指定削減的服務時數。你不必通知郡政府那個服務時數你選擇去削減；這是你和你提供者之間的事宜。

新的法例亦適用於所有新的評估。

此通知連同你的聽證權利資料。然而，州聽證請求只有關削減3.6%服務時數新的州法例將不受理。

如果你不明白這新規定或有關這新的法例，請聯絡你的郡IHSS辦公室。

(Chinese)

請求州聽證會的權利

1. 你有權利與郡福利所代表商談有關這行動的目的。在這個會談，你可能會為自己發言，或由律師、朋友或其他發言人代表。如果你希望有一個會議，請聯絡你的郡政府部門。
2. 不論你是否請求一個會議與否，你也有請求州聽證會的權利，並由加州社會服務處(見表格底部)處長作出決定。你的請求可以書面或口頭的，但必須指出你請求聽證會和為何你不滿意。你請求州聽證會必須在本通知的郵寄日期後的九十天之內。
3. 如果你在郡行動的生效日期前請求州聽證會，你的服務可能會繼續直到聽證會。你不會承擔在你聽證會待決期間收取的服務款項，即使結果被否決，當然你的請求必需是真誠提出的。
4. 你可以自己請求聽證會，或者你可要求你的郡政府部門協助。然而，在任何情況下，請務必盡早告知你的郡工作人員。
5. 你有權選擇由律師或任何其他人(朋友，親屬，或其他發言人)在聽證會代表你。你可獲得免費的法律諮詢和律師服務。請打免費電話號碼到公眾詢問處，你可獲得免費的法律援助。你也可以聯絡就近的社會服務權利組織尋求協助呈遞你的請求。
6. 有關州政府規管社會服務處州聽證會的規定可在郡福利部的辦公室獲取。
7. 資料處理法案 - 根據W&IC 10950, 為了處理你的州聽證會, 你被要求提供的資料是強制性的。首席行政法官辦公室會成立一個案件檔案。你有權審查對構成決定的資料紀錄。你提供的資料可以與郡福利所或美國健康和人文服務部共享。

如果你想作出一個州聽證會的書面請求，請將此頁寄回到郡福利所。地址是在你的IHSS行動通知正面的右上角。

如若作出一個州聽證會的口頭請求，或取得更多你州聽證會權利資料或文件，你可以聯絡：

Public Inquiry and Response
California Department of Social Services
744 P Street, Mail Station 8-4-23
Sacramento, CA 95814
(800) 952-5253 (免費電話號碼)*
TDD (800) 952-8349* 聽覺和語言障礙
*你可能必需首先撥打號碼 "1"

州聽證會請求

姓名(姓, 首名字, 中間名) _____ 電話號碼 _____ 社會保險號碼 _____

地址 _____ 市 _____ 州 _____ 郵遞區號 _____

本人在此, 向加州社會服務處有關郡政府所採取的行動, 請求州聽證會。我請求的理由如下:

我對理解英語有困難, 因此我請求一個傳譯員在我下述的聽證會: _____ 語言 _____ 方言 _____

簽名 _____ 簽署日期 _____

授權代表

我已授權下述的人士在我的上訴作為我的代表。我也授權加州社會服務處發佈任何或所有有關我案件資料給該人士。

授權代表姓名 _____

授權代表地址 _____

州聽證會申請人簽名 _____ 簽署日期 _____

(Chinese)

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-05**

March 22, 2012

SUBJECT: CHANGES TO THE NATIONAL VOTER REGISTRATION ACT

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All County Information Notice I-01-12

I. PURPOSE

The purpose of this Special Notice is to remind staff of the requirement to comply with the National Voter Registration Act (NVRA) and to provide updates and clarification on procedures.

II. BACKGROUND

Under federal law, the NVRA requires states to provide voter registration opportunities at initial application, redetermination, and changes of address regardless of the type of client transaction (in-person, by mail, through the internet, or over the phone).

III. POLICY

All applicants and continuing recipients must be given a “*Voter Registration Card*” (VRC) (Attachment A) and a 12-02 HHS “*Voter Registration/Declination form*” at initial application, redetermination, and changes of address (Attachment B), regardless of whether they indicate they want to register to vote or not.

IV. PROCEDURES

Clerical Responsibilities

A 12-02 HHS “*Voter Registration Interest/Declination*” form and “*Voter Registration Card*” must be included in all application and redetermination packets.

The clerical supervisor will be responsible for ensuring that the above forms are in stock and available for staff use. To request VRCs, contact the Registrar Of Voters’ (ROV), “Voter Outreach Office Specialist”. The current contact is:

Barbara Carr
(858) 571-4235

**SPECIAL NOTICE 12-05
CHANGES TO THE NATIONAL VOTER REGISTRATION ACT**

When you are requesting materials, please identify yourself as an AIS/IHSS liaison for voter registration. All VRCs requested by the department will be tracked by serial number. Cards that are returned will be noted as originating from AIS/IHSS.

The 12-02 HHS “*Voter Registration/Declination form*” is available in English, Spanish, Tagalog, Chinese, Vietnamese, Japanese, and Korean. The forms are available at the following location in the “Clerical” and “Social Worker” folders:

S:\AIS\Operations\IHSS\Automated Forms

Social Worker Responsibilities

The IHSS Social Worker is responsible for providing the 12-02 HHS and the Voter Registration Card at each assessment and reassessment home visit. If the individual declines to register or prefers to register on his/her own, the Social Worker will:

- Complete, and request that the client sign the 12-02 HHS form.
- Provide the Voter Registration Card to the client to complete and send directly to the County Registrar Of Voters.
- Narrate the declination and the action taken in the case record.

If the client refuses to sign the 12-02, complete the form and indicate “refused” on the signature line.

If the client would like to register to vote, the Social Worker will:

- Have the client complete the 12-02 HHS form and the VRC.
- Provide assistance in completing the form if needed.
- Accept and mail the VRC to the County ROV **within 10 days**.
- Narrate the action taken in the case record.

NOTE: If the Voter Registration Form is received within five days before the last day to register to vote in an election, the form must be forwarded to ROV **within five days**.

- Provide the same level of assistance to the applicant/recipient in completing NVRA forms as is normally provided for every other service or application for benefits.
- Inform applicants/recipients that the receipt of benefits is not linked in any way to the individual’s decision to register or not register to vote.

The 12-02 “*Voter Registration Interest/Declination*” form must be retained for a minimum of 24 months regardless of whether the client completes the form or not.

V. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by an Organizational Review Committee (ORC).

VI. FILING STATEMENT

IHSS Special Notices are being archived at the following link:

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

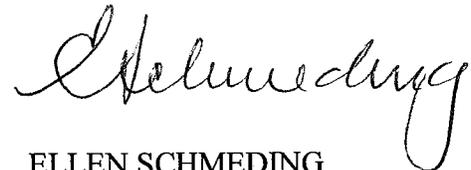
And at the County intranet at:

<http://hhsa-pg.sdcountry.ca.gov/AisIhss/default.asp?Guide=AIHSS>

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

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

Attachment

Distribution Codes 7 & 8

CALIFORNIA VOTER REGISTRATION FORM/FORMULARIO DE INSCRIPCIÓN DE VOTANTES DE CALIFORNIA

SAN DIEGO COUNTY

Fill out this form if you are a new voter, have moved or changed your name, or want to change your political party choice. You must be a U.S. citizen and at least 18 years old by the next election to use this form. Use blue or black ink. Print clearly. - *Complete este formulario si es un votante nuevo, se mudó o cambió su nombre, o si quiere cambiar su afiliación partidaria. Para utilizar este formulario, debe ser ciudadano de los Estados Unidos y tener al menos 18 años de edad en la próxima elección. Use tinta azul o negra. Escriba en letra de imprenta y de manera clara.*

Your legal name: First name - *Nombre legal:* Primer nombre Middle name - *Segundo nombre*

1 Last name - *Apellido*

Optional - *Opcional*
 Mr. - *Sr.* Mrs. - *Sra.*
 Ms. - *Sra.* Miss - *Srta.*

2 Home address - *not a P.O. Box or business address - (Number, Street, Ave., Drive, etc. Include N, S, E, W) -*
Domicilio particular - no casilla postal ni domicilio comercial - (Número, calle, avenida, camino, etc. Incluir N, S, E, O)

Apt or unit # -
 Departamento o unidad N.º

4 City - *Ciudad* State - *Estado* Zip - *Código postal* California county - *Condado de California*

CA

5 If you do not have a street address, describe where you live (*Cross streets, Route, N, S, E, W*) -
Si no posee un domicilio específico, describa dónde vive (entre qué calles, ruta, N, S, E, O)

6 Mailing address - *if different from above, or P.O. Box - Domicilio - en caso de que sea diferente del que figura anteriormente o casilla postal*

7 City - *Ciudad* State - *Estado* Zip - *Código postal* Foreign country - *País extranjero*

8 Date of birth - *Fecha de nacimiento* U.S. state or foreign country of birth - *Lugar de nacimiento en los Estados Unidos o país extranjero*

9 CA driver's license or CA ID card # - *N.º de licencia de conducir de California o tarjeta de identificación de California* SSN (Last 4 numbers) - *SSN (últimos 4 dígitos)*

If you do not have a CA driver's license or ID card, list the last 4 numbers of your Social Security Number, if you have one. - Si no tiene licencia de conducir de California o tarjeta de identificación de California, escriba los últimos 4 dígitos de su número de Seguro Social (SSN), si tiene.

11 Email (optional) - *Dirección de correo electrónica (opcional)* Phone number (optional) - *Número de teléfono (opcional)*

12 Do you want to register with a political party? - *¿Quiere afiliarse a un partido político?*
 Yes, I want to register with a political party (check one) - *Si, quiero afiliarme a un partido político (marque uno):*
 American Independent Party - *Partido Independiente Americana* Green Party - *Partido Verde* Peace and Freedom Party - *Partido Paz y Libertad* Republican Party - *Partido Republicana*
 Democratic Party - *Partido Demócrata* Libertarian Party - *Partido Libertario* Other party (specify): _____
 No, I don't want to register with a political party. (If you check this box, you may not be able to vote for some parties' candidates in primary elections.) - *No, no me quiero afiliar a un partido político. (Si marca este casillero, quizá no pueda votar a los candidatos de algunos partidos en las elecciones primarias.)*

13 To receive a vote-by-mail ballot in all elections, initial here: _____ *Para recibir una boleta de voto por correo en todas las elecciones, coloque sus iniciales aquí: _____*

14 If you were registered to vote before, fill out below: - *Si se inscribió para votar antes, complete a continuación:*

First name - *Primer nombre* Middle initial - *Initial del segundo nombre* Last name - *Apellido*
 Previous address where you were registered - *Dirección en la que estaba inscrito anteriormente* City - *Ciudad*

State - *Estado* Zip - *Código postal* Previous county - *Condado anterior* Political party (if any) - *Partido político (si corresponde)*

15 Are you a U.S. citizen? - *¿Es usted ciudadano de los Estados Unidos?* Yes - *Sí* No
 Will you be 18 or older by the next election? - *¿Tendrá 18 años de edad o más en la próxima elección?* Yes - *Sí* No
 A "No" answer to either question means you CANNOT register to vote. *Si responde "No" a cualquiera de estas preguntas, NO PUEDE registrarse para votar.*

16 Read and sign below. - *Lea y firme a continuación.*
 I am a U.S. citizen and will be at least 18 years old on election day. I am not in prison or on parole for a felony. I understand that it is a crime to intentionally provide incorrect information on this form. I declare under penalty of perjury under the laws of the State of California that the information on this form is true and correct. - *Soy ciudadano estadounidense y tendré al menos 18 años de edad el día de las elecciones. No estoy en prisión o en libertad condicional por haber cometido un delito grave. Entiendo que brindar información incorrecta de manera intencional en el presente formulario constituye un delito. Declaro bajo pena de perjurio según las leyes del Estado de California que la información de este formulario es verdadera y correcta.*

Optional - *Opcional*
 A. Check here if you can be a poll worker. - *Marque aquí si puede trabajar como funcionario electoral.*
 (If bilingual, indicate language: - *(Si es bilingüe indique el idioma: _____)*
 Check here if you can provide a polling place on election day. - *Marque aquí si puede brindar un centro electoral el día de las elecciones.*
 B. Your ethnicity/race: - *Su etnia/raza: _____*
 C. Check your language preference: - English Spanish Chinese Vietnamese Korean Tagalog Japanese
Marque el idioma de su preferencia: Español
 中文 Việt ngữ 한국어 Tagalog 日本語

Voter Signature - *Firma del Votante* _____
 Month - *Mes* Day - *Día* Year - *Año* _____/_____/_____

37 BQ 390395 130002

Important! To vote in the next election, you must mail or deliver this card at least 15 days before the next election. New voters who register by mail may have to show their ID at the polling place the first time they vote. - *¡Importante!* Para votar en la próxima elección, debe enviar por correo o entregar esta tarjeta al menos 15 días antes de la próxima elección. Los votantes nuevos que se inscriban por correo quizá deban presentar su

Did someone help you fill out or deliver this form? - *¿Alguien lo ayudó a completar o a entregar este formulario?*
 If yes, the person who helped you must fill out and sign both parts of this green box. - *En caso de que haya sido así, la persona que lo ayudó debe completar y firmar ambas partes de este casillero verde.*
 Signature - *Firma* _____
 Name: - *Nombre:* _____
 Org. name, address, and tel. (if any): - *Nombre, dirección y número de teléfono de la organización (si corresponde):* _____

The bottom part is your receipt.
Keep it until you receive a Voter Notification Card in the mail. –
La parte inferior es su recibo.
Consérvelo hasta que reciba una Tarjeta de Notificación de Votante por correo.

(This part is the voter's receipt. – Esta parte es el recibo del votante.)

Signature – Firma

____/____/____
Month–Mes Day–Día Year–Año

Name: – Nombre: _____

Org. name, address, and tel. (if any): –

Nombre, dirección y número de teléfono de la organización (si corresponde): _____

The law protects your voter registration information against commercial use. Report any problems to the Secretary of State's Voter Hotline: (800) 345-8683 –

La ley protege su información de inscripción como votante del uso comercial. Informe cualquier problema a la línea directa para votantes de la Secretaría de Estado al: (800) 345-8683

For Elections Information Contact:

Deborah Seiler
Registrar of Voters
PO Box 85093
San Diego, CA 92186-5093
(858) 565-5800

Para obtener información sobre las elecciones, comuníquese con el:

Deborah Seiler
Registrar of Voters
PO Box 85093
San Diego, CA 92186-5093
(858) 565-5800

**Questions, problems
or to report fraud:**

Contact the Secretary of State.
Call: **(800) 345-VOTE (8683)**
Email: **elections@sos.ca.gov**
Web site: **www.sos.ca.gov**

Or contact your county elections office.

**Si tiene alguna pregunta,
problema o desea informar un fraude:**

Comuníquese con la Secretaría de Estado.

Llame al: **(800) 345-VOTE (8683)**

Dirección de correo electrónico: **elections@sos.ca.gov**

Sitio web: **www.sos.ca.gov**

O comuníquese con la oficina electoral del condado.

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Would You Like to Register to Vote?

You may register to vote in California if:

1. You are a United States citizen.
2. You are a resident of California.
3. You are at least 18 years of age (or will be by the date of the next election).
4. You are not in prison or on parole for a felony conviction.
5. You have not been judged by a court to be mentally incompetent.

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
2. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.
3. If you decline to register to vote here today, that information is confidential and may not be used for any purpose other than voter registration. If you register to vote here today, the agency or office at which you are registering is confidential.
4. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.
5. If you move to a new address, or if you change your name or want to change your political party preference, you must fill out a new voter registration card.
6. We will retain this Voter Preference Form with this agency. If you choose to register today, we will send your completed voter registration card to the county elections office.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Check One)

- Already registered. I am registered to vote at my current residence address.
- Yes. I would like to register to vote. (Please fill out the attached voter registration card.)
- No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applicant Name

Date

¿Quiere inscribirse para votar?

Se puede inscribir para votar en California si:

1. Es ciudadano de los Estados Unidos.
2. Es residente de California.
3. Tiene por lo menos 18 años de edad (o los tendrá en la fecha de la elección).
4. No está en prisión o en libertad condicional debido a una condena por delito mayor.
5. Una corte no lo declaró mentalmente incompetente.

Avisos importantes

1. Si solicita su inscripción para votar, o decide no hacerlo, ello no afectará la cantidad de ayuda provista por esta agencia.
2. Si necesita ayuda para llenar el formulario de solicitud de inscripción para votar, lo ayudaremos a hacerlo. La decisión de solicitar o aceptar ayuda es sólo suya. Puede llenar el formulario de solicitud en privado.
3. Si decide no inscribirse para votar hoy, dicha información será confidencial y no se puede usar para ningún otro fin que para inscribirse para votar. Si se inscribe para votar hoy, la información sobre la agencia u oficina donde se inscribió permanecerá confidencial.
4. Si cree que alguien interfirió con su derecho a inscribirse para votar, o a no inscribirse, su derecho a privacidad para decidir si se inscribe o solicita inscribirse para votar, o su derecho a elegir el partido político u otra preferencia política, puede presentar una queja ante el Secretario de Estado llamando sin cargo al (800) 232-VOTA (8682), o escribiendo a: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. Para obtener más información sobre las elecciones y la votación, visite el sitio web del Secretario de Estado en www.sos.ca.gov.
5. Si se muda a una nueva dirección, o si cambia de nombre o quiere cambiar su preferencia de partido político, tendrá que llenar una nueva tarjeta de inscripción para votar.
6. Este Formulario de preferencia del votante quedará en esta agencia. Si decide inscribirse hoy, enviaremos su tarjeta de inscripción para votar completada a la oficina electoral del condado.

Si no está inscrito para votar donde vive ahora, ¿quiere solicitar su inscripción para votar hoy aquí?
(Marque uno)

- Ya estoy inscrito. Estoy inscrito para votar en mi dirección residencial actual.
- Sí. Me quiero inscribir para votar. (Llene la tarjeta adjunta de inscripción para votar.)
- No. No me quiero inscribir para votar.

NOTA: SI NO MARCA UNA CASILLA, SE CONSIDERARÁ QUE HA DECIDIDO NO INSCRIBIRSE PARA VOTAR EN ESTE MOMENTO.

Nombre del solicitante _____

Fecha _____

Gusto Mo Bang Magparehistro Upang Makaboto?

Maaari kang magparehistro upang makaboto sa California kung:

1. Ikaw ay isang mamamayan ng Estados Unidos.
2. Ikaw ay isang residente ng California.
3. Ikaw ay hindi kukulangin sa 18 taong gulang (o magiging ganito ang edad sa petsa ng susunod na halalan).
4. Ikaw ay wala sa bilangguan o hindi parolado para sa napatunayang felony.
5. Ikaw ay hindi pinagpasiyahan ng hukuman na walang kakayahan ang isipan.

Mahahalagang Paunawa

1. Ang pag-aaplay upang magparehistro o pagtanggap magparehistro upang makaboto ay **hindi** makakaapekto sa antas ng tulong na ipagkakaloob sa iyo ng ahensiyang ito.
2. Kung gusto mong tumulong sa pagkumpleto ng porma ng aplikasyon sa pagpaparehistro ng botante, tutulungan ka namin. Ang desisyon kung hihingi o tatanggap ng tulong ay nasa iyo. Maaari mong kumpletuhin ang porma ng aplikasyon nang pribado.
3. Kung tumanggi kang magparehistro upang makaboto rito ngayon, ang impormasyong iyon ay kompidensiyal at hindi maaaring gamitin para sa anumang layunin na iba sa pagpaparehistro ng botante. Kung magpaparehistro ka rito ngayon, ang ahensiya o opisina kung saan ka nagpaparehistro ay kompidensiyal.
4. Kung naniniwala ka na may humadlang sa iyong karapatan na magparehistro o upang tumanggap magparehistro upang makaboto, ang iyong karapatan sa pagkapribado sa pagpapasiya kung magpaparehistro o sa pag-aaplay upang magparehistro upang makaboto, o sa iyong karapatang pumili ng iyong sariling kinakatigang partidong pampulitika o ibang kinakatigang pampulitika, maaari kang magsampa ng reklamo sa Kalihim ng Estado sa pamamagitan ng pagtawag nang walang-bayad sa (800) 339-2957 o maaari kang sumulat sa: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. Para sa karagdagang impormasyon tungkol sa mga halalan at pagboto, mangyaring bisitahin ang website ng Kalihim ng Estado sa www.sos.ca.gov.
5. Kung lumipat ka sa isang bagong tirahan, o kung pinalitan mo ang inyong pangalan o gustong baguhin ang iyong kinakatigang partidong pampulitika, dapat mong kumpletuhin ang isang bagong kard ng pagpaparehistro ng botante.
6. Pananatilihin namin itong Porma ng Kinakatigan ng Botante sa ahensiyang ito. Kung pinili mong magparehistro ngayon, padadalhan ka namin ka ng kinumpletong kard ng pagpaparehistro ng botante sa opisina sa mga halalan ng county.

Kung hindi ka nakarehistro upang makaboto kung saan ka naninirahan ngayon, gusto mo bang mag-aplay upang magparehistro upang makaboto rito ngayon?
(Lagyan ng Tsek ang Isa)

- Nakarehistro na. Ako ay nakarehistro upang makaboto sa aking kasalukuyang direksiyon ng tirahan.
- Oo. Gusto kong magparehistro upang makaboto. (Mangyaring kumpletuhin ang kalakip na kard ng pagpaparehistro ng botante.)
- Hindi. Hindi ko gustong magparehistro upang makaboto.

TALA: KUNG HINDI KA MAGLALAGAY NG TSEK SA ISANG KAHON, ITUTURING NA IKAW AY NAGPASIYANG HINDI MAGPAREHISTRO UPANG MAKABOTO SA PANAHONG ITO.

Pangalan ng Aplikante _____

Petsa _____

您希望進行選民登記嗎？

如果符合以下條件，您可以在加州登記投票：

1. 您是美國公民。
2. 您是加州居民。
3. 您至少18歲（或到下次選舉日年滿18歲）。
4. 您未因被判重罪正在監獄服刑或處於假釋期內。
5. 您未被法院判定因精神原因沒有行為能力。

重要通知

1. 申請進行選民登記或拒絕登記，不會影響本機構將向您提供的幫助多寡。
2. 如果您希望在填寫選民登記申請表時得到幫助，我們將會幫助您。由您決定是否尋求或接受幫助。您可以私下填寫申請表。
3. 如果您拒絕今天在此進行選民登記，此資訊屬於機密，不得用於選民登記以外的用途。如果您今天在此進行選民登記，您辦理登記的機構或辦公室屬於機密。
4. 如果您認為有人干預您進行選民登記或拒絕進行選民登記的權利，您決定是否登記或申請進行選民登記的私下權利，或是您選擇自己的政黨傾向或其他政治傾向的權利，您可以透過以下方式向州務卿提出投訴：撥打免費電話(800) 339-2857或寫信寄至：Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814。欲獲取關於選舉和投票的更多資訊，請瀏覽州務卿網站www.sos.ca.gov。
5. 如果您搬到新地址，或是變更您的姓名或是希望變更您的政黨傾向，您必須填寫新的選民登記卡。
6. 我們將把本選民傾向表保存在本機構。如果您選擇今天登記，我們會將您填好的選民登記卡寄至縣選舉辦公室。

如果您沒有在現居住地進行選民登記，您是否希望今天在此申請選民登記？
(勾選一項)

- 已經登記。 我已在現住址進行選民登記。
- 是。 我希望進行選民登記。(請填寫所附的選民登記卡。)
- 否。 我不想進行選民登記。

注意： 如果您不在一個方格打勾，將會被視為您已決定不在此時進行選民登記。

申請人姓名 _____

日期 _____

Quý Vị Có Muốn Ghi Danh Bỏ Phiếu Hay Không?

Quý vị có thể ghi danh bỏ phiếu tại California nếu:

1. Quý vị là công dân Hoa Kỳ.
2. Quý vị là cư dân tại California.
3. Quý vị đã đủ ít nhất là 18 tuổi (hoặc sẽ đủ 18 tuổi vào ngày bầu cử kỳ tới).
4. Quý vị không ở tù hoặc được phóng thích có điều kiện sau khi bị kết tội đại hình.
5. Quý vị không bị tòa án nào phán quyết là tâm thần không minh mẫn.

Các Thông Báo Quan Trọng

1. Việc nộp đơn xin ghi danh hoặc từ chối ghi danh bỏ phiếu sẽ **không** ảnh hưởng đến mức trợ giúp mà quý vị sẽ được cơ quan này cung cấp.
2. Nếu quý vị muốn được giúp điền mẫu đơn ghi danh cử tri, chúng tôi sẽ giúp quý vị. Tùy quý vị quyết định có muốn nhờ giúp hay chấp nhận được giúp hay không. Quý vị có thể điền mẫu đơn trong chỗ riêng tư.
3. Nếu quý vị từ chối ghi danh bỏ phiếu ở đây ngày hôm nay, chi tiết đó được giữ kín và không được dùng cho bất cứ mục đích nào khác ngoài việc ghi danh cử tri. Nếu quý vị ghi danh bỏ phiếu ở đây ngày hôm nay, cơ quan này hoặc văn phòng nơi quý vị ghi danh sẽ được giữ kín.
4. Nếu quý vị tin rằng có người đã xâm phạm đến quyền ghi danh hoặc từ chối ghi danh bỏ phiếu, quyền riêng tư của quý vị để quyết định có ghi danh hoặc nộp đơn ghi danh bỏ phiếu hay không, hoặc quyền chọn chính đảng hoặc chọn lựa chính trị nào khác của mình, quý vị có thể nộp đơn khiếu nại với Tổng Thư Ký Tiểu Bang bằng cách gọi số miễn phí (800) 339-8163 hoặc quý vị có thể viết thư đến: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. Muốn biết thêm chi tiết về các cuộc bầu cử và bỏ phiếu, xin đến website của Tổng Thư Ký Tiểu Bang tại www.sos.ca.gov.
5. Nếu quý vị dọn đến một địa chỉ mới, hoặc nếu quý vị đổi tên hoặc muốn đổi chính đảng của mình, quý vị phải điền một thẻ ghi danh cử tri mới.
6. Chúng tôi sẽ giữ lại Mẫu Ý Muốn Ghi Danh Cử Tri ở cơ quan này. Nếu quý vị quyết định ghi danh ngày hôm nay, chúng tôi sẽ gửi thẻ ghi danh cử tri đã điền của quý vị cho văn phòng bầu cử quận.

**Nếu quý vị chưa ghi danh bỏ phiếu tại nơi quý vị sinh sống hiện nay,
quý vị có muốn ghi danh bỏ phiếu ở đây hôm nay hay không?
(Đánh Dấu Vào Một Ô)**

- Đã ghi danh. Tôi đã ghi danh bỏ phiếu tại địa chỉ cư ngụ hiện nay của tôi.
- Có. Tôi muốn ghi danh bỏ phiếu. (Xin điền thẻ ghi danh cử tri đính kèm.)
- Không. Tôi không muốn ghi danh bỏ phiếu.

GHI CHÚ: NẾU QUÝ VỊ KHÔNG ĐÁNH DẤU VÀO MỘT Ô, QUÝ VỊ SẼ ĐƯỢC XEM LÀ QUYẾT ĐỊNH KHÔNG GHI DANH BỎ PHIẾU VÀO LÚC NÀY.

Tên Đương Đơn

Ngày

投票登録をご希望ですか？

カリフォルニア州有権者になるための要件:

1. 米国民であること。
2. カリフォルニア州居住者であること。
3. 18歳以上であること (または次回の選挙までにこの年齢に達していること)。
4. 重罪犯罪による禁固刑受刑者または仮釈放者でないこと。
5. 精神的無能力者として裁判所によって判断された者でないこと。

重要な注意事項

1. 当局で提供する支援レベルが、投票登録申請の有無によって影響されることはありません。
2. 投票者登録申請用紙の記入時に支援を希望される方は、お手伝いいたします。支援要請または支援受け入れの決定はあなたに委ねられています。プライバシーのある場所で申請用紙を記入できます。
3. 今日ここで投票登録されない場合、その情報は機密扱いとされ、投票登録以外の目的には使用されません。今日ここで投票登録される場合、登録場所である当該機関または事務所は明かされません。
4. 投票登録権もしくは投票登録拒否権、投票登録もしくは投票登録申請の決定についてのプライバシー権、または所属政党選択権もしくはその他の政治的選択権を何者かに侵害された方は州務長官に苦情を申し立てることができ、フリーダイヤル (800) 339-2865 にお電話いただくか、Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814までお手紙をお寄せください。選挙および投票についての詳細は、www.sos.ca.govの州務長官ウェブサイトをご覧ください。
5. 新住所への引越し、氏名の変更、所属政党の変更を行った場合は、新たに投票者登録用紙を記入完了する必要があります。
6. この投票者選好用紙は当局で保管します。今日投票登録される場合、ご記入いただいた投票者登録用紙は郡選挙事務所に送付します。

現在お住まいの場所で投票登録されていない場合、今日ここで投票登録の申請をご希望ですか？
(チェックマークを1つ付けてください)

- 登録済みです。 現住所で投票登録済みです。
- はい。 投票登録を希望します。(添付されている投票者登録用紙を記入完了してください。)
- いいえ。 投票登録しません。

注記: チェックマークが付いていない場合、今回投票登録をしないものと見なされます。

申請者名 _____

日付 _____

유권자 등록을 원하십니까?

귀하가 다음에 해당되는 경우 캘리포니아 주에서 유권자 등록을 하실 수 있습니다.

1. 미국 시민권자
2. 캘리포니아 주민
3. 18세 이상 된 사람(또는 다음 선거일까지 18세가 되는 사람)
4. 중죄로 유죄 판결을 받아 복역 또는 가석방 중이 아닌 사람
5. 법원으로부터 정신적 무능력자라는 판결을 받지 않은 사람

중요 통지문

1. 유권자 등록을 신청 또는 거부하더라도 당 기관이 제공하는 지원의 수준에는 영향을 미치지 않습니다.
2. 유권자 등록 신청서 양식을 작성할 때 도움이 필요하시면 저희가 도와 드립니다. 도움을 요청하거나 받는 것에 대한 결정은 귀하에게 달려 있습니다. 신청서 양식은 비공개적으로 작성할 수도 있습니다.
3. 지금 이곳에서 유권자 등록을 거부하는 경우, 이와 관련된 정보는 비밀로 유지되고, 유권자 등록 이외에 어떤 목적으로도 사용되지 않습니다. 지금 이곳에서 유권자 등록을 하는 경우, 귀하가 등록을 하는 당 기관이나 사무소는 공개되지 않습니다.
4. 어떤 사람이 귀하가 유권자 등록을 하거나 등록을 거부할 권리, 유권자 등록 여부를 결정하거나 등록을 신청하는 것에 대한 프라이버시 권리, 또는 자신의 정당 선호 또는 다른 정치적 선호를 선택할 권리를 방해했다고 생각하는 경우에는 무료 전화번호 (866) 575-1558로 연락하거나 다음의 주소로 서신을 보내어 총무처장관에게 불만을 신청하실 수 있습니다: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. 선거와 투표에 대한 더 자세한 정보를 원하시면 총무처장관의 웹사이트 www.sos.ca.gov를 방문하십시오.
5. 새 주소지로 이사하거나, 이름을 변경하거나, 또는 정당 선호를 변경하기를 원하는 경우에는 유권자 등록 카드를 새로 작성하셔야 합니다.
6. 이 유권자 선호 양식은 당 기관이 보관합니다. 지금 유권자 등록을 하기로 결정하시는 경우, 저희는 귀하가 작성한 유권자 등록 카드를 카운티 선거관리 사무소로 보낼 것입니다.

귀하가 현재 거주지에서 유권자 등록을 하지 않은 경우, 지금 이곳에서 유권자 등록을 신청하시겠습니까?
(한 항목에만 표시)

- 이미 등록했음. 현재 거주하고 있는 주소지에서 이미 유권자 등록을 했습니다.
- 예. 유권자 등록을 하겠습니다. (첨부된 유권자 등록 카드를 작성해 주십시오.)
- 아니요. 유권자 등록을 하지 않겠습니다.

주: 위의 네모칸에 표시하지 않는 경우에는 지금 유권자 등록을 하지 않기로 결정한 것으로 간주됩니다.

신청자 이름 _____

날짜 _____

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-04**

February 27, 2012

SUBJECT: New Notice for In-Home Supportive Services (IHSS) Providers

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All County Information Notice I-05-12

I. PURPOSE

The purpose of this special notice is to provide information and instructions on the implementation of the SOC 858 *"In-Home Supportive Services Provider Notification"*.

II. BACKGROUND

The Welfare & Institutions Code (WIC) now requires that each IHSS provider receive a list specifying the services that have been approved for each recipient for whom he/she provides services, and a complete list of the tasks that are available under the IHSS program.

III. POLICY

Effective February 1, 2012, the SOC 858 *"In-Home Supportive Services Provider Notification"* form is mailed to all IHSS providers notifying him/her of the services authorized for the IHSS recipient. The SOC 858 will be mailed when a provider is initially designated and whenever there is a change to the authorized services.

IV. PROCEDURE CHANGES

Case Management Information and Payrolling System (CMIPS)

On February 6, 2012, a one-time mailing began that will issue a notice to all active status (E or L) providers that are associated to recipients who are also in active status (E, I, or L). Subsequent provider notices will generate through CMIPS when one or more of the following occurs:

- A new service/task is added to the SOC 293 grid (Lines AA through YY)
- A service/task is deleted from the SOC 293 grid (Lines AA through YY)
- A Provider Eligibility Screen (PELG) status is updated from "P" to "E" (Line "B" Field "4" of the SOC 311)
- A PELG status is updated from "L" to "E"

**IHSS SPECIAL NOTICE 12-04
NEW NOTICE FOR IHSS PROVIDERS**

- A PELG status is updated from “T” to “E”

A notice will not generate:

- When a service with zero “*Authorized Hours*” is deleted
- Because of an increase or decrease in the service time, only when a service is added or deleted.

A notice will not include a service when the “*Authorized Hours*” is zero because of entries under “*Alternate Resources*” and/or “*Adjustments*”.

The provider notice is only available in English and cannot be reprinted.

IHSS Clerical Procedures

IHSS clerical staff will no longer need to complete and include the 12-24 HSSA “*Provider Instructions*” in the initial timesheet packet. Instead, the IHSS provider will be informed of a possible Share-of-Cost (SOC) immediately by including the attached informational flyer when appropriate (*Attachment A*).

V. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by an Organizational Review Committee (ORC).

VI. FILING STATEMENT

IHSS Special Notices are being archived at the following link:

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

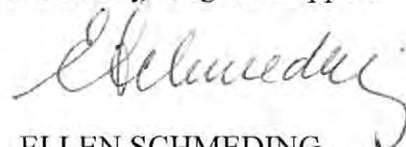
And at the county intranet at:

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

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

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

Attachment

Distribution Codes 7 & 8

PAYMENT INFORMATION IN-HOME SUPPORTIVE SERVICES

The initial timesheet(s) for your employment as an In-Home Supportive Services (IHSS) care provider is enclosed. You will also receive a letter with additional information about the services that have been authorized for the recipient who is your employer.

The recipient you are working for has a share-of-cost. You and the recipient will receive an “Explanation of the IHSS Share of-Cost” letter each pay period. The letter will indicate the amount that the recipient should pay you for the pay period. *It is the responsibility of the recipient to pay the share-of-cost directly to you.*

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-03**

February 21, 2012

SUBJECT: REVISED FORMS FOR DIRECT DEPOSIT

EFFECTIVE DATE: Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

REFERENCE: All County Information Notice 1-10-12

I. PURPOSE

The purpose of this Special Notice is informational only and does not require any action by In-Home Supportive Services (IHSS) staff.

II. POLICY

The SOC 404 *"IHSS Program Direct Deposit Enrollment/Change/Cancellation Form"* for "Advance Pay" recipients and the SOC 829 *"IHSS Provider Direct Deposit Enrollment/Change/Cancellation Form"* for IHSS Individual Providers has been revised.

Questions regarding direct deposit for "Advance Pay" recipients can be directed to IHSS Public Authority at 866-351-7722.

Direct deposit for IHSS Individual Providers is provided through the State Controller's Office (SCO). Questions regarding direct deposit for IHSS providers may be referred to the Direct Deposit Help Desk at (866) 376-7066.

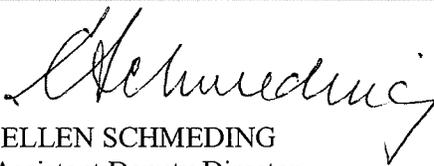
III. REVIEW STATEMENT

Due to the informational nature of this Special Notice, it was not reviewed by an Organizational Review Committee (ORC).

IV. FILING STATEMENT

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


WILFRED QUINTONG
Assistant Deputy Director


ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Gina Brown (858) 495-5554
Attachment
Distribution Codes 7 & 8

**SPECIAL NOTICE 12-03
REVISED FORMS FOR DIRECT DEPOSIT**

**SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-02**

February 17, 2012

**SUBJECT: SSI/SSP AND CAPI PAYMENT STANDARDS, NEW BENEFIT
LEVEL FOR SHARE-OF-COST (SOC) CASES**

EFFECTIVE DATE: January 1, 2012

EXPIRATION DATE: When incorporated into the IHSS Program Guide

**REFERENCE: All County Information Notice (ACIN) No. I-76-11, ACIN No.I-76-
11E and EBB 12001 January 6, 2012**

I. PURPOSE

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff of the new payment standards for Supplemental Security Income/State Supplementary Payment (SSI/SSP), Cash Assistance Program for Immigrants (CAPI), and the Share-of-Cost (SOC) benefit level for 2012.

II. BACKGROUND

A 3.6 percent increase cost-of-living adjustment (COLA) in federally funded SSI has been paid to Social Security recipients, but not in State-funded SSP amount for 2012. As a result of the increase in the SSI payment, the payment standard for Cash Assistance Program for Immigrants (CAPI) has also increased. As required by Welfare and Institutions Code (WIC) Section 18941, the CAPI payment standards are based on the SSI/SSP payment standards, minus \$10.00 for an individual and \$20.00 for a couple.

III. SSI/SSP AND CAPI PAYMENT STANDARDS

The new payment standards for SSI/SSP and CAPI recipients are effective January 1, 2012. The new payment standard chart is attached. (Attachment A).

IV. NEW BENEFIT LEVEL

The SOC benefit level has been updated with an effective date of February 1, 2012 through December 31, 2012.

**SPECIAL NOTICE 12-02
SSI/SSP AND CAPI PAYMENT STANDARDS, NEW BENEFIT
LEVEL FOR SHARE-OF-COST (SOC) CASES**

There will be no automatic update in CMIPS for SOC cases until the Senate Bill (SB) 73 decision on the 2012 State COLA is implemented.

Benefit Level Code	Benefit Level
01	\$ 854.40
02	909.40
03	761.40
04	625.17
05	680.17
06	532.17
07	938.40
08	1444.20
09	1591.20
10	1535.20
11	1100.00
12	1247.00
13	1191.00
14	1612.20
15	722.10
16	795.60
17	767.60
18	806.10
19	550.00
20	623.50
21	595.50

The update will also apply to the exclusion amounts. The exclusion amount for one parent for parent-to-child deeming is \$698.00, for two parents is \$1048.00, and the ineligible child exclusion is \$350.00

VI. IHSS STAFF PROCEDURES

Social Workers and clerical staff must ensure that the correct SSI/SSP payment amount information is given to IHSS clients and indicated on appropriate documents. Additionally, the new benefit level must be correctly entered on line "J", field "3" of the SOC 293 when processing SOC cases for reassessment or any changes effective February 2012.

Additional instructions will be given to staff when new information on the CMIPS SOC update is received.

**SPECIAL NOTICE 12-02
SSI/SSP AND CAPI PAYMENT STANDARDS, NEW BENEFIT
LEVEL FOR SHARE-OF-COST (SOC) CASES**

VI. REVIEW STATEMENT

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

VII. FILING STATEMENT

Notices are archived at the following link:

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

IHSS Special Notices are also archived on the County intranet at:

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

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Susan Pullido (858)505-6366
Attachment
Distribution Codes 7 & 8

**SPECIAL NOTICE 12-02
SSI/SSPAND CAPI PAYMENT STANDARDS, NEW BENEFIT
LEVEL FOR SHARE-OF-COST (SOC) CASES**

STATE OF CALIFORNIA
DEPARTMENT OF SOCIAL SERVICES
ADMINISTRATION DIVISION

CAPI PAYMENT STANDARDS
EFFECTIVE JANUARY 1, 2012
BASED ON JANUARY 2012 SSI/SSP STANDARDS
Includes Pass-Through of the CPI COLA and Suspension of the CMI COLA

ESTIMATES BRANCH
NOVEMBER 2011

CPI: 3.8% (a)
CMI: N/A

	INDEPENDENT LIVING		REDUCED NEEDS		NON-MEDICAL OUT-OF-HOME CARE (NMOHC)		IN LICENSED FACILITY OR HOUSEHOLD OF RELATIVE WITHOUT IN-KIND ROOM & BOARD	
	RESIDING IN OWN HOUSEHOLD	HOUSEHOLD OF ANOTHER WITH IN-KIND ROOM & BOARD	HOUSEHOLD OF RELATIVE WITH IN-KIND ROOM & BOARD AND CERTIFIED NMOHC	IN LICENSED FACILITY OR HOUSEHOLD OF RELATIVE WITHOUT IN-KIND ROOM & BOARD	TOTAL CAPI	TOTAL SSI/SSP	TOTAL CAPI	TOTAL SSI/SSP
INDIVIDUAL:								
AGED OR DISABLED - without cooking facilities (RMA) 1/	844.40 828.40 889.40	854.40 938.40 809.40	815.17 870.17 822.17	825.17 680.17 532.17	862.34 862.34 862.34	872.34 872.34 872.34	1,100.00 1,100.00 1,100.00	1,110.00 1,110.00 1,110.00
BLIND - living with parent(s) - living with non-parent relative or non-relative guardian	751.40	761.40	622.17	532.17	862.34	872.34	1,100.00	1,110.00
COUPLE:								
AGED OR DISABLED - per couple - without cooking facilities (RMA) 1/	1,424.20 1,582.20	1,434.20 1,602.20	1,080.00	1,100.00	1,724.33 1,724.33	1,744.33	2,200.00	2,210.00
BLIND - per couple	1,571.20	1,581.20	1,227.00	1,247.00	1,724.33	1,744.33	2,200.00	2,210.00
BLIND/AGED OR DISABLED - per couple	1,515.20	1,525.20	1,171.00	1,191.00	1,724.33	1,744.33	2,200.00	2,210.00

TITLE XXX MEDICAL FACILITY

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

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

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE 12-01**

February 16, 2012

SUBJECT: IHSS FRAUD REFERRAL TRACKING SYSTEM (FRTS)

EFFECTIVE DATE: March 1, 2012

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 procedures for use of the Fraud Referral Tracking System (FRTS) when submitting a referral to the Public Assistance Fraud Division (PAFD) and/or the IHSS Program Integrity Unit (PIU).

II. POLICY

The FRTS system will be used to track the following:

- Referrals from IHSS to PAFD
- Referrals from IHSS to PIU
- Unannounced home visits conducted by PIU staff, and the results
- IHSS Social Worker Response to PIU reports

III. IHSS PROCEDURES

IHSS staff must use FRTS when making a referral to PAFD, and PIU. Referrals to the Department of Health Care Services (DHCS) will be tracked in the FRTS system, but DHCS will not receive or respond to referrals using FRTS. The system will be used to track the progress of a referral, the response to the results of an investigation or unannounced home visit, and to view and update reports on the referrals entered in the system. For additional information and instructions on referring to PIU is available in Special Notice 11-03 and 11-03 Addendum.

Social Worker Responsibilities

IHSS Referral Screen

When entering a fraud referral into FRTS for PAFD or PIU, the Social Worker is responsible for entering the following information for each and every referral:

- Recipient information
- Provider(s) information
- Allegation(s)
- Information on any other individual who is involved

When completing the “*Provider*” section in the IHSS Referral screen, enter only the information for the provider(s) who are implicated in the fraud allegation. If information for more than three providers is being submitted, include the additional information in hard copy in the fraud referral packet. Enter the information for the other provider(s) on a separate document and submit any additional documentation. The Social Worker must ensure that all of the provider information required by FRTS is included.

The following information must be included in the “*Narrative*” section:

- A description of the suspected fraud
- Names of all individuals suspected to be involved
- Applicable dates
- Any other relevant information that will aid in the investigation
- Unfamiliar acronyms should be “spelled out”.
- Hospitals, skilled nursing facilities and reporting parties listed by name

After completing the IHSS Referral screen, store the information in FRTS by clicking “*Save*”. This will allow FRTS to retain the information without sending it to PAFD or PIU.

Note: Once a referral has been saved, it must be processed within seven days or it will not process correctly.

Supervisor Approval

Supervisory approval is required for all referrals entered into FRTS. The IHSS Social Worker will print a copy of the completed IHSS Referral screen, and submit to his/her supervisor for review and approval. After the referral has been approved by the supervisor, the worker will add the following information to the “*Narrative*” section in FRTS:

“Referral reviewed and approved by Supervisor on Date”

PAFD or PIU will not accept referrals if approval information has not been included.

Completing the Referral

Complete the referral in FRTS by clicking “*Process*” and then note the “*Referral Tracking Number*” in the narrative of the IHSS case file.

Note: The referral cannot be updated once “*Process*” has been selected.

Program Integrity Unit - After the referral has been completed in FRTS, the IHSS Social Worker will immediately submit the following documents to PIU:

- SOC 293A “*IHSS Face Sheet*”
- 12-43 HHSA and/or 12-43(A) HHSA “*Service Activities Narrative*”
- The HHSA 12-42 “*IHSS Worksheet*”
- Any other document deemed relevant by the IHSS Social Worker

Scan and forward the documents by email to the following address:

appealsclerk.hhsa@sdcounty.ca.gov

Include all of the following information in the email address:

- In the subject line enter “*IHSS - PIU Referral*”
- In the Cc: line include the PIU supervisor’s name
- In the body of the email include Case Name, Case Number, the FRTS “*Referral Tracking Number*”, the IHSS Social Worker name and worker number

Public Assistance Fraud Division - After the referral has been completed in FRTS, scan the following documents and include them in the PAFD fraud referral packet.

- Photo Identification (Recipient and Provider)
- Social Security Card (Recipient and Provider)
- SOC 293 “*IHSS Assessment*”
- SOC 293A “*IHSS Face Sheet*”
- SOC 311 *IHSS Provider Update*
- 12-43 HHSa and/or 12-43(A) HHSa “*Service Activities Narrative*”
- The HHSa 12-42 “*IHSS Worksheet*”
- The HHSa 12-58 “*Employer/Provider Responsibilities*”
- Any documents the social worker identifies as relevant to the specific allegation of fraud

Scan and forward the PAFD packet to the designated IHSS Account Clerk as an email attachment. Include all of the following information:

- In the subject Line “*IHSS-PAFD Referral Attachments*”
- In the Cc: line include the name of the IHSS clerical supervisor
- In the body of the email, include the Case Name, Case Number, and the FRTS “*Referral Tracking Number*”

Social Workers in the South Bay District Office may submit the hard copies of the documents to the designated Account Clerk instead of the scanned copies via email.

PIU Referral to PAFD

The PIU supervisor may determine that a referral to PIU is more appropriate as a referral to PAFD. PIU will close the original referral and enter the information into FRTS as a referral to PAFD. A new “*Referral Tracking Number*” will be generated for the PAFD referral. The PIU supervisor will then notify the IHSS Social Worker and his/her supervisor, and provide the new “*Referral Tracking Number*”.

The IHSS In-Basket

After an investigation has been completed and a disposition has been completed on the referral, the findings are entered into FRTS. The IHSS Social Worker is responsible for checking the “*Individual In-Basket*” on a daily basis and responding to any new information as appropriate. Priority must be given to referrals that are designated as critical and requesting immediate action.

Entries in the “*Individual In-Basket*” are sorted based on the urgency of response needed. The color of the entry indicates the response status.

- Red – Critical (immediate action is needed)
- Green – Action Required within 45 days
- Blue – Completed
- Black – Default color (No Severity)

Response to PIU Results

The IHSS Social Worker will review and respond to the results of a PIU referral or home visit through the “*IHSS Resolution*” screen as follows:

- Complete the “*Describe Action Taken*” section of the “*IHSS SW Response*” screen by entering the actions that have been taken.
- If the response cannot be completed, any information entered can be retained by using “*Save*”. This will store the information in the FRTS database where it can be retrieved for revision and/or completion later.
- When the response has been completed and is final, click “*Process*” on the IHSS SW Response screen.

Note: The referral can no longer be changed or updated once “*Process*” has been selected.

The IHSS Social Worker is responsible for responding to the recommendations from PIU in a timely manner. The standard response time is 45 days. If immediate action is indicated, the maximum response time is 10 days. Response times are included in the “*IHSS Resolution*” screen. If necessary PIU may request a clarification of the response received.

Response to PAFD Referral Results

The disposition on a PAFD referral will initially appear in the “*Individual In-Basket*” of the IHSS Account Clerk. It will appear in the IHSS Social Worker’s “*Individual In-Basket*” only when the Account Clerk has completed the response to PAFD and the response has been accepted.

The IHSS Social Worker can check to see if the investigation has been completed by selecting “*Investigator Final Report*” and entering the “*Referral Tracking Number*” If the report has been completed, the results will be available for review.

IHSS Account Clerk Procedures

After a PAFD referral has been entered into FRTS by the IHSS Social Worker, it is the responsibility of the designated IHSS Account Clerk to complete and forward the PAFD referral packet, respond in FRTS to the results of the PAFD investigation, and complete the required actions for any resulting overpayment. The IHSS Account Clerk will check his/her “*Individual In-Basket*” in FRTS daily.

PAFD Referral Packet

The designated IHSS Account Clerk will print the following screens from the IHSS Case Management Information and Payrolling System (CMIPS) and include them in the PAFD referral packet before forwarding the packet to PAFD:

- PSUM
- RELA
- RELB
- RELC
- PELG
- WARR

The IHSS PAFD Fraud Referral coversheet (Attachment A) will be used when submitting the fraud referral packet to PAFD. The fraud referral must also be recorded in fraud referral tracking log until further notice.

FRTS Response

The IHSS Account Clerk will enter the response to the PAFD disposition under the “*Describe Action Taken*” section of the IHSS Response screen. Print a copy of the completed “*IHSS Response*” screen and the “*IHSS Resolution*” screen. Scan and forward the information to the referring Social Worker and to his/her supervisor as an email attachment.

Overpayments

Follow the standard IHSS procedures for the processing of any identified overpayments for IHSS services. Scan any supporting documents that have been requested by PAFD (for example, the 12-86 HHSA “*Overpayment Notice of Action*”) and forward to PAFD as an email attachment to:

PAFFraudReferrals@sdca.org

Include all of the following information:

- In the subject line - IHSS-PAFD Referral – Overpayment Information
- In the body of the email - Case Name, Case Number, and FTRS Referral Tracking Number

Complete the fraud referral tracking log by entering the PAFD Disposition, Disposition Date, and Response Date.

IV. REVIEW STATEMENT

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

V. FILING STATEMENT

Notices are archived at the following link:

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

IHSS Special Notices are also archived on the County intranet at:

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

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

Contact: Susan Pullido (858)505-6366

Attachments

Distribution Codes 7 & 8



IHSS Fraud Referral to PAFD

To: Nancyrose Mapanao
Public Assistance Fraud Division (W-413)

CC: Cynthia Bernier, Department of Health Care Services

From: IHSS Accounts Clerk
Mail Stop: W-253
Telephone Number: [Click here to enter Telephone Number](#)

Date: [Click here to enter a date.](#)

Re: IHSS Fraud Referral

The following In-Home Supportive Services (IHSS) fraud referral documents are being forwarded for your review and consideration.

1. FRTS Tracking Number: [Enter FRTS Tracking Number here](#)
Case Name: [Enter Case Name here](#)
Case Number: [Enter Case Number here](#)
PCSP Provider: [Select Yes or No](#)
Multiple Providers: [Select Yes or No](#)

2. FRTS Tracking Number: [Enter FRTS Tracking Number here](#)
Case Name: [Enter Case Name here](#)
Case Number: [Enter Case Number here](#)
PCSP Provider: [Select Yes or No](#)
Multiple Providers: [Select Yes or No](#)

3. FRTS Tracking Number: [Enter FRTS Tracking Number here](#)
Case Name: [Enter Case Name here](#)
Case Number: [Enter Case Number here](#)
PCSP Provider: [Select Yes or No](#)
Multiple Providers: [Select Yes or No](#)

[Click to Include Additional Information](#)

Fraud Referral Tracking System (FRTS) In-Home Supportive Services (IHSS)

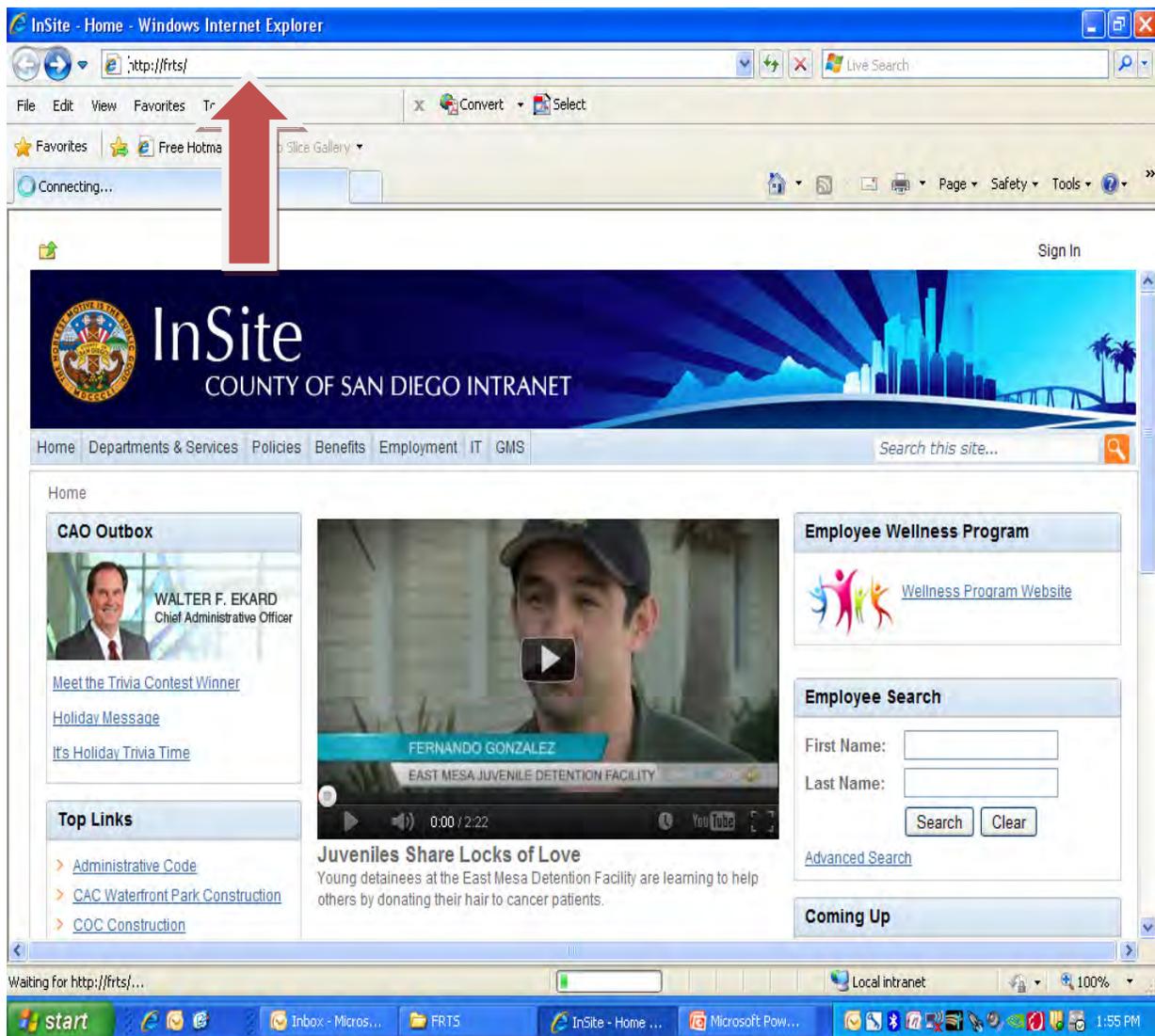
FRTS is a web-based program used to track Public Assistance Investigations for potential fraud. IHSS will be using FRTS to track potential fraud referrals to the Public Assistance Fraud Division (PAFD), referrals to the IHSS Program Integrity Unit (PIU) and the results of PIU's unannounced home visits.

Accessing the FRTS Website

Double click on the Internet Explorer icon on your county computer desktop.

Enter <http://FRTS/> in the browser.

Hit Enter.



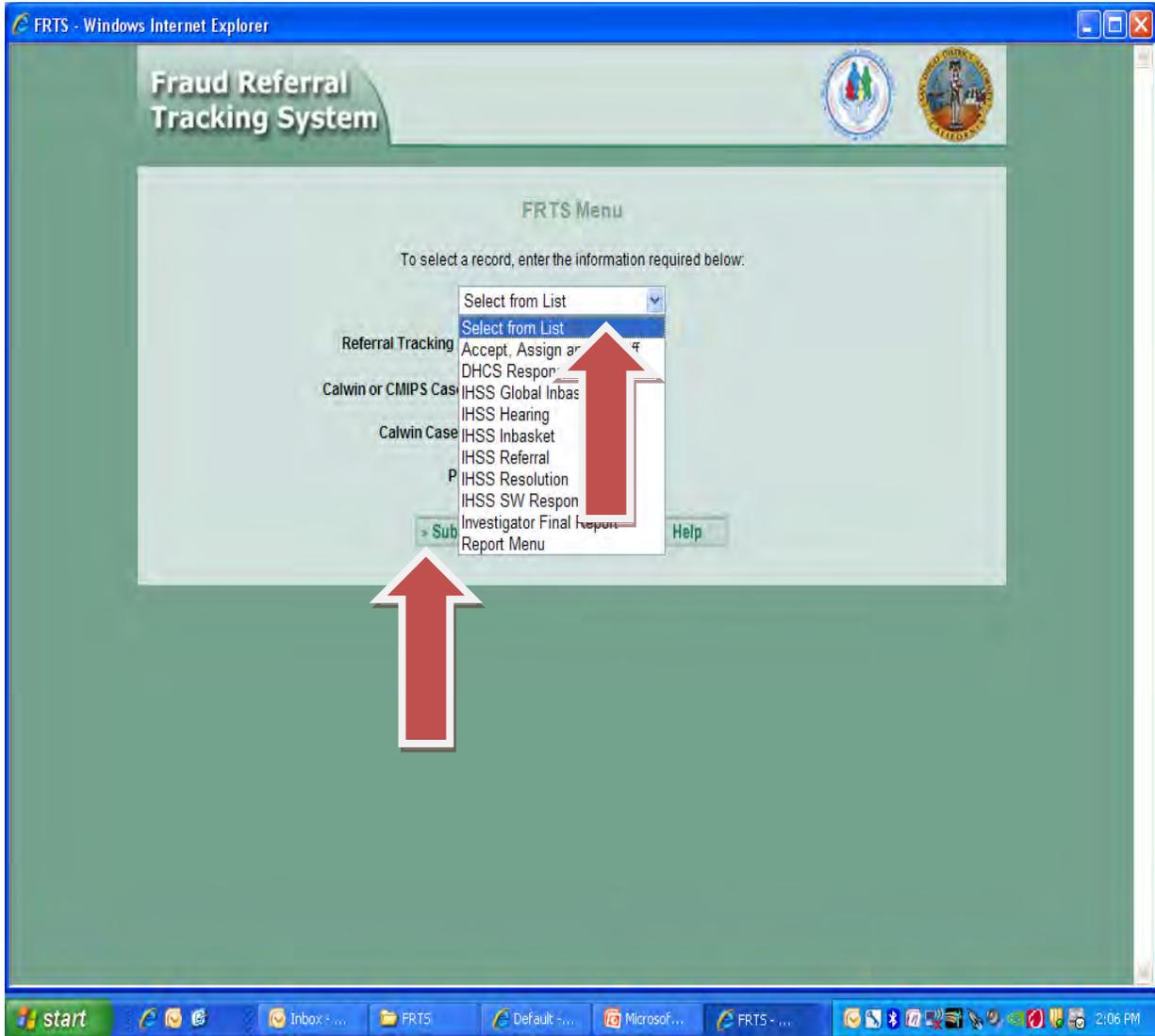
FRTS Menu Screen

The FRTS Menu allows the user to select the record he/she would like to take action on or to view.

Click on the drop down menu and select the menu item.

Enter the FRTS Tracking Number (or the 10 – digit CMIPS case number) where appropriate.

Click “Submit”.

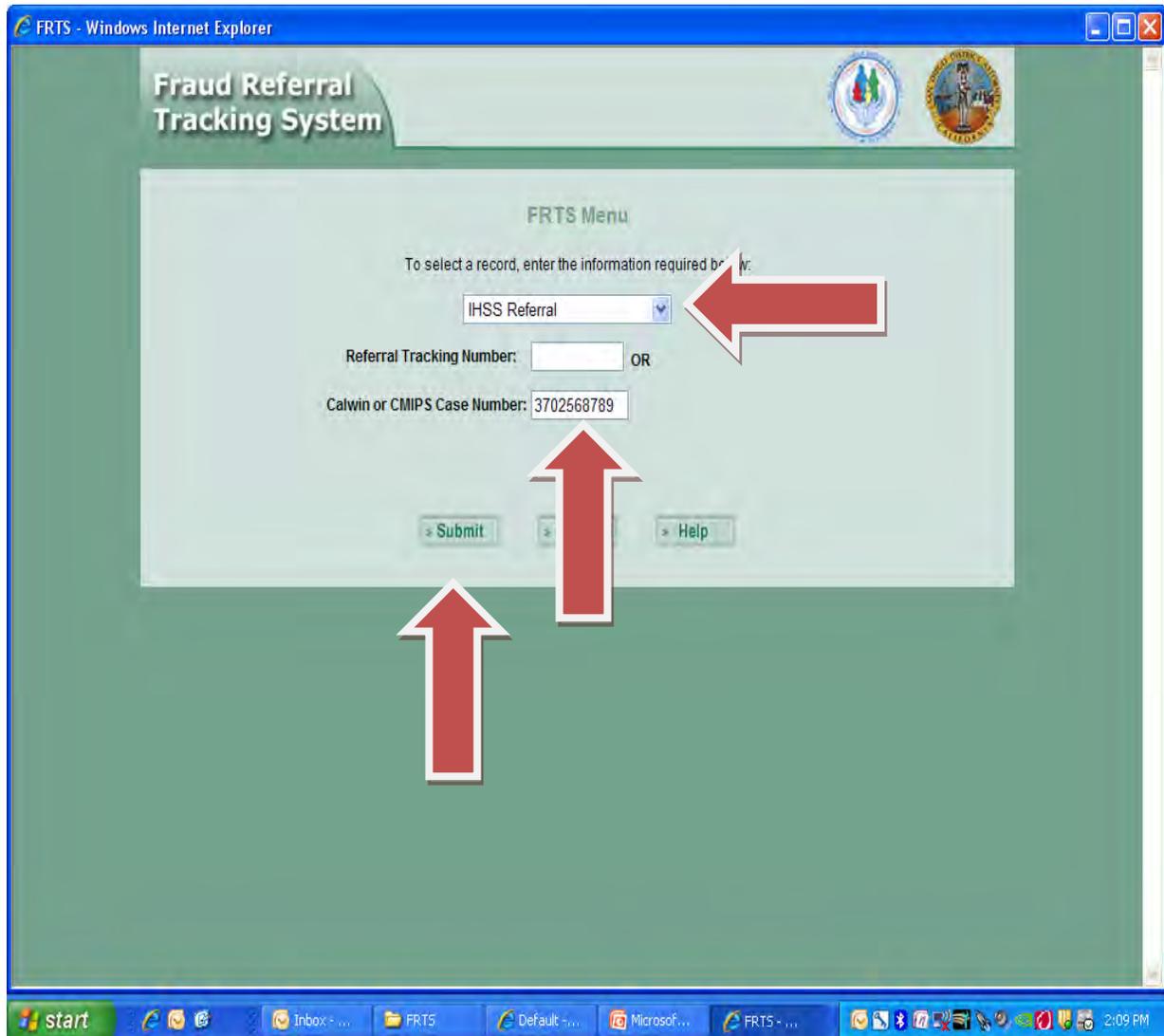


IHSS Referrals

On the FRTS Menu screen, select “*IHSS Referral*” from the drop down menu.

Enter the 10-digit CMIPS case number in the designated box.

Click “*Submit*”



IHSS Referral Screen

The “*IHSS Referral*” screen appears after clicking “*Submit*” in the FRTS Menu screen. The recipient case information will pre-populate the screen when the information is available. For newer cases, the information must be entered by the referring party.

Complete the following information:

- “*Referral Type*” (IHSS PI or PAFD)
- “*IHSS Referral Source*” (IHSS Social Worker Number and Name)
- “*Case Status*”

Fraud Referral Tracking System

Referral
TRACKING NO:

Referral Type: IHSS PI IHSS Referral Source: IHSS SW

CMIPS Case Number: 37023194F2 Case Worker Number: LS11

Recipient Last Name: First Name:

Aid Code: Disabled, SSI/SSP Case Status: Eligible

Address: PO BOX 152

City: POTRERO

State/Zip: CALIFORNIA 91963 0152

Phone: Language: English

Date of Birth: 5/4/2004 Social Security Number:

Sex: M Worker Making Referral: SP10-Pullido Susan

Save Date: Referral Process Date:

Allegation Information

Allegation: Select from List

Who is Involved: Select from List

Does this Referral Have Any Attachments? Y N

Refer to IHSS/DHCS/PAF Status: Select from List

Provider 1 Information

Provider Last Name: Provider First Name:

Provider Number: Provider Active: Y N

License/ID: Provider Date of Birth(mm/dd/yyyy):

Provider Address: City:

State: Select from List Zip Code: -

IHSS Referral Screen - Allegation Section

Select the appropriate information for “Allegation” from the drop down menu.

Select the appropriate information for “Who is Involved”.

Select “Y” for “Does this Referral Have Any Attachments”.

If the referral is addressed to the PIU select “Refer to IHSS/PAF Status” and select “Pending PI” from the drop down menu.

If the referral is addressed to the PAFD, select “Refer to PAF”

The screenshot shows a web browser window titled "FRTS - Windows Internet Explorer" displaying the "Allegation Information" section of the IHSS Referral Screen. The form contains several fields and dropdown menus. Red arrows point to the following elements:

- The "Allegation:" dropdown menu.
- The "Who is Involved:" dropdown menu.
- The "Does this Referral Have Any Attachments?" radio buttons, with the "N" option selected.
- The "Refer to IHSS/DHCS/PAF Status:" dropdown menu.

The form also includes sections for "Provider 1 Information", "Provider 2 Information", and "Provider 3 Information", each with fields for Last Name, First Name, Number, License/ID, Address, State, Phone, Date of Birth, City, Zip Code, Recipient Name, Days Worked, and Hours Worked. The "Provider Active" radio buttons are also visible, with the "N" option selected for each provider.

IHSS Referral - Provider Information Section

Enter only the information for the provider(s) who are implicated in the allegation.

The “*Provider Number*” is the last six digits of his/her Social Security number.

If there are more than three providers involved in the allegation, information for the additional provider(s) will be included in the hard copy fraud referral packet.

Enter all available information.

The screenshot shows a web browser window titled "FRTS - Windows Internet Explorer" displaying a form for "Provider Information". The form is organized into three identical sections for "Provider 1 Information", "Provider 2 Information", and "Provider 3 Information". Each section contains the following fields:

- Provider Last Name:
- Provider Number:
- License/ID:
- Provider Address:
- State: (dropdown menu)
- Provider Phone:
- Recipient Last Name:
- Days Worked:
- Provider First Name:
- Provider Active: Y N
- Provider Date of Birth(mm/dd/yyyy):
- City:
- Zip Code: -

Below these sections is a "Narrative" section with a text area. A red arrow points to the "Provider 1 Information" section.

IHSS Referral - Narrative Section

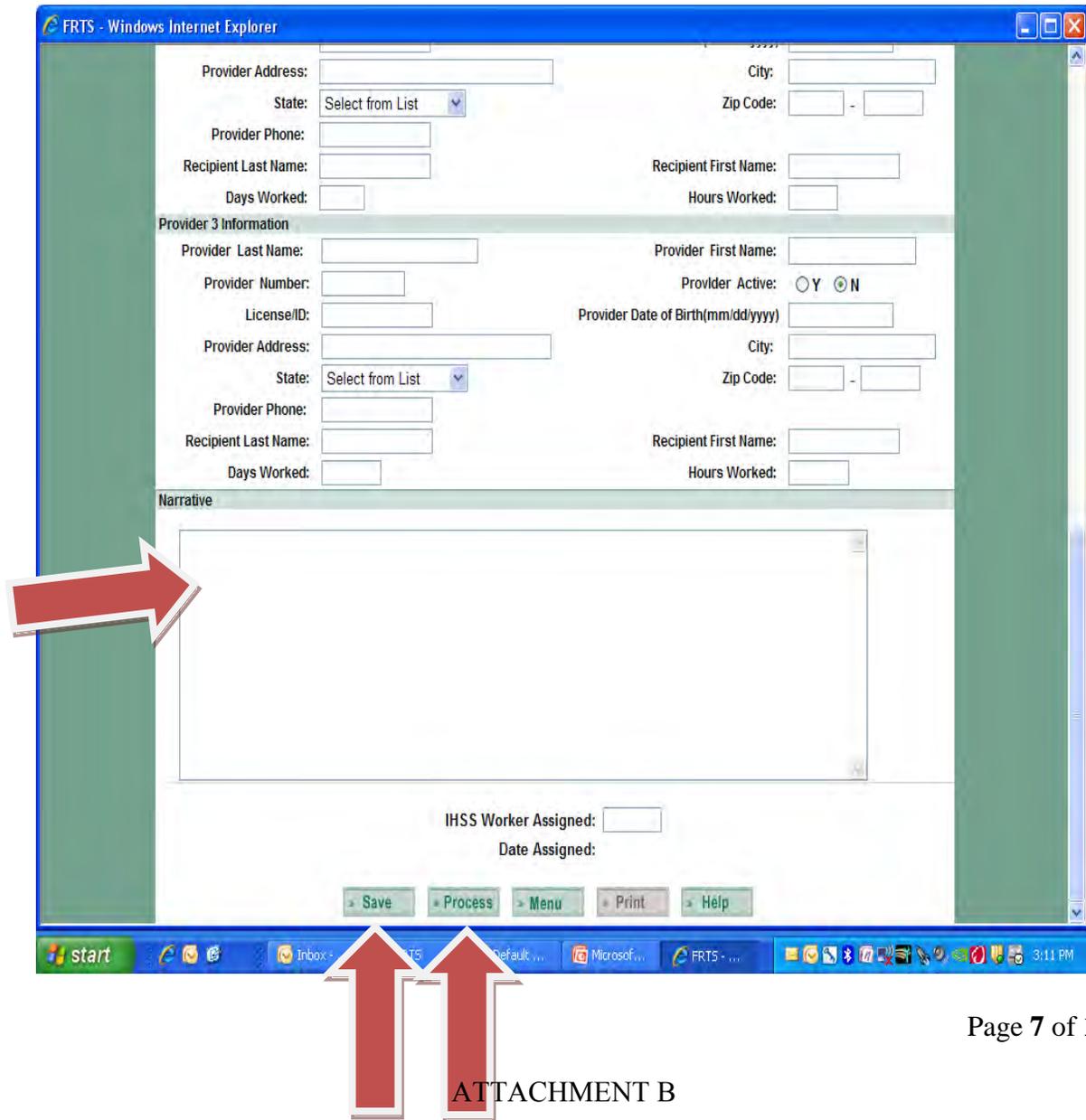
“Save” – Information is stored in FRTS without sending it to the PAFD or PIU. Changes can still be made in the report.

“Process” – Information is stored in FRTS and sent to PAFD or PIU. No changes can be made in the report after it has been processed.

“Referral reviewed and approved by _____ on _____.” This information must be added to the narrative section before clicking “Process”.

The following information must be included in the “Narrative” section:

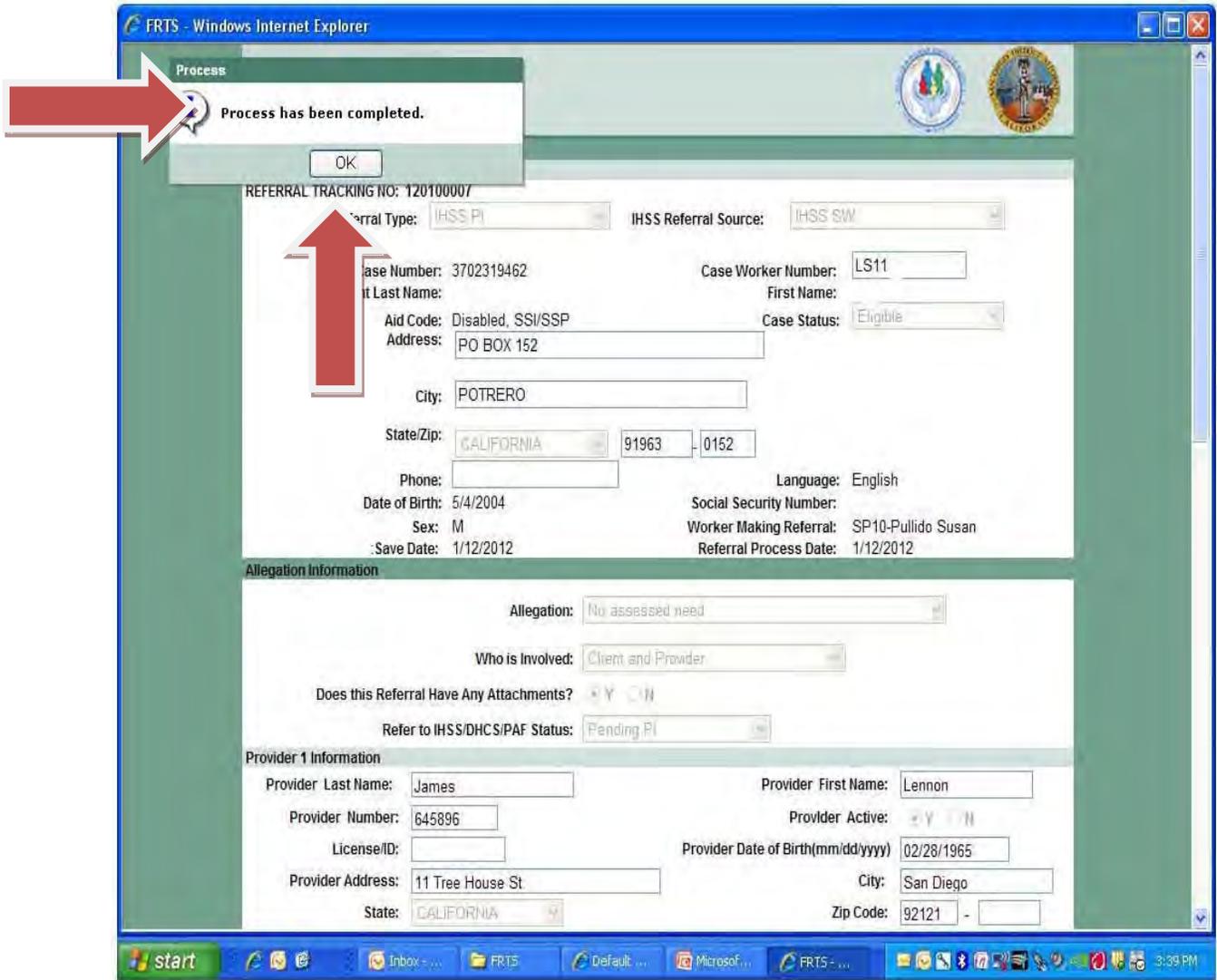
- A description of the suspected fraud
- Names of all individuals suspected to be involved
- Applicable dates
- Any other relevant information that will aid in the investigation
- Unfamiliar acronyms should be “spelled out”.
- List hospitals, skilled nursing facilities and reporting parties by name



Completed IHSS Referral

After clicking “Process”, a FRTS “Referral Tracking Number” will be generated and a dialogue box indicating, “Process has been completed” will appear.

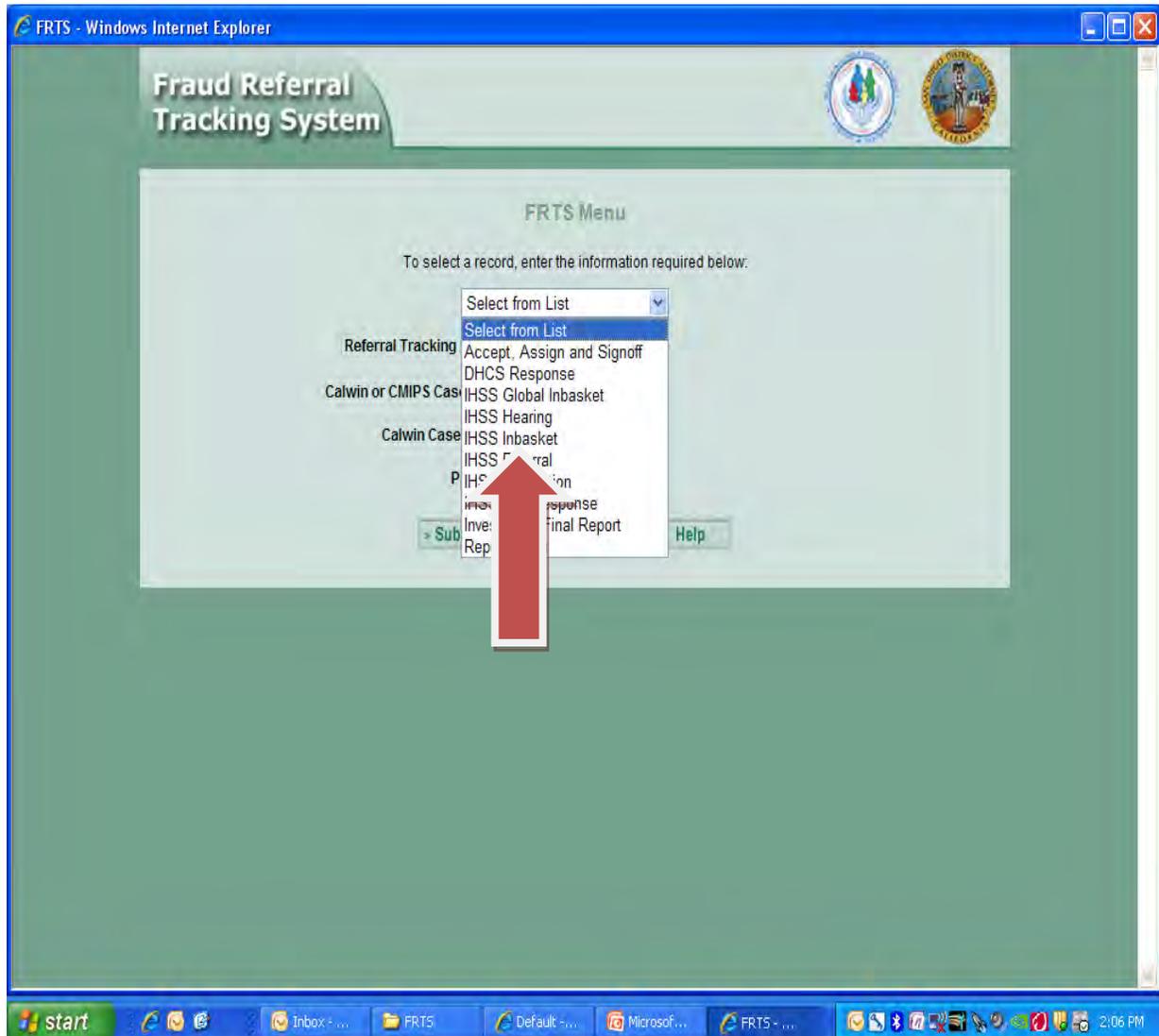
Take note of the FRTS “Referral Tracking Number” and include in the narrative of the case file. Click “OK” to close the dialogue box.



IHSS Inbasket

To access the “*Individual Inbasket*”, go to the FRTS “*Menu*” and select “*IHSS Inbasket*” from the drop down menu.

The “*Individual Inbasket*” displays only the referrals for cases assigned to the IHSS Social Worker who is accessing the inbasket.



IHSS Inbasket - Continued

Click on the checkbox opposite the referral tracking number to view the record or respond to the disposition.

The “*Individual Inbasket*” indicates where the referral is in relation to the workflow.

Red – Critical (immediate action is needed)

Green – Action required within 45 days

Blue – Completed

Black – Default color (No Severity)

The screenshot shows the 'Fraud Referral Tracking System' interface. At the top, it says 'Individual Inbasket for: IH90'. Below that is a search bar with 'Enter another Worker ID:' and a 'Search Again' button. A table of referral records is displayed below. The table has columns for 'Select', 'Referral One Number', 'Case Last Name', 'Case First Name', 'Case Load Number', 'Referral Type', 'Referral Process Date', 'Last Action', 'Last Action Date', and 'Action Required'. The table contains 7 rows of data. Below the table is a 'Select from List' dropdown menu and three buttons: 'Menu', 'Default View', and 'Help'. The browser window title is 'FRTS - Windows Internet Explorer'. The taskbar at the bottom shows the Start button, several application icons, and the system tray with the time '10:27 AM'.

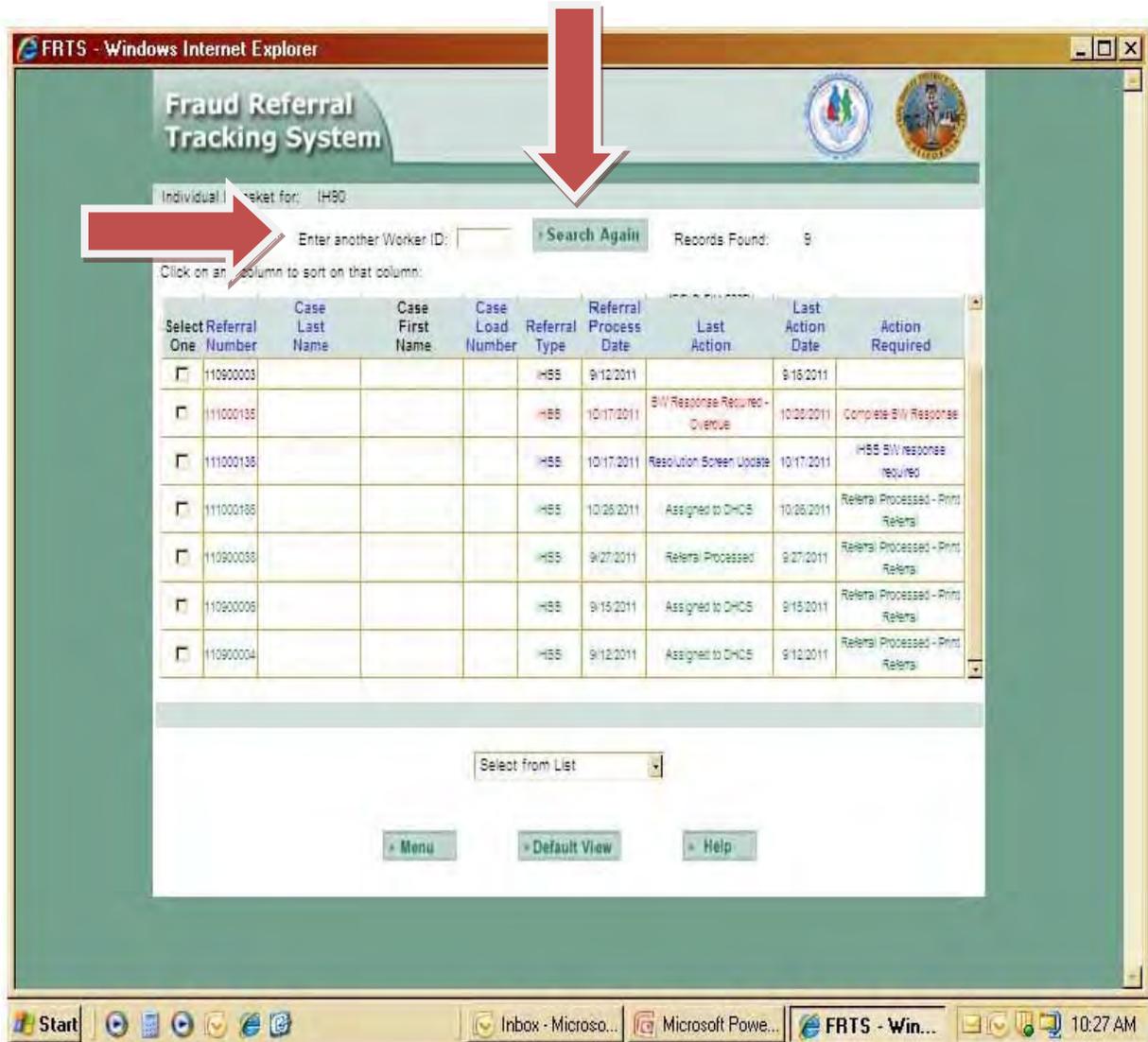
Select	Referral One Number	Case Last Name	Case First Name	Case Load Number	Referral Type	Referral Process Date	Last Action	Last Action Date	Action Required
<input type="checkbox"/>	110900003				IHSS	9/12/2011		9/16/2011	
<input type="checkbox"/>	111000135				IHSS	10/17/2011	BIW Response Required - Overdue	10/20/2011	Complete BIW Response
<input type="checkbox"/>	111000136				IHSS	10/17/2011	Resolution Screen Update	10/17/2011	IHSS BIW response required
<input type="checkbox"/>	111000186				IHSS	10/26/2011	Assigned to DMCS	10/26/2011	Referral Processed - Print Refers
<input type="checkbox"/>	110900038				IHSS	9/27/2011	Referral Processed	9/27/2011	Referral Processed - Print Refers
<input type="checkbox"/>	110900006				IHSS	9/15/2011	Assigned to DMCS	9/15/2011	Referral Processed - Print Refers
<input type="checkbox"/>	110900004				IHSS	9/12/2011	Assigned to DMCS	9/12/2011	Referral Processed - Print Refers

IHSS Inbasket - Continued

The IHSS Supervisor’s “*Individual Inbasket*” displays all the referrals assigned to the Social Workers that he/she supervises.

To view the individual Social Worker’s inbasket, enter the Social Worker’s number in the textbox “*Enter another Worker ID*”.

Click “*Search Again*”



IHSS Resolution Screen

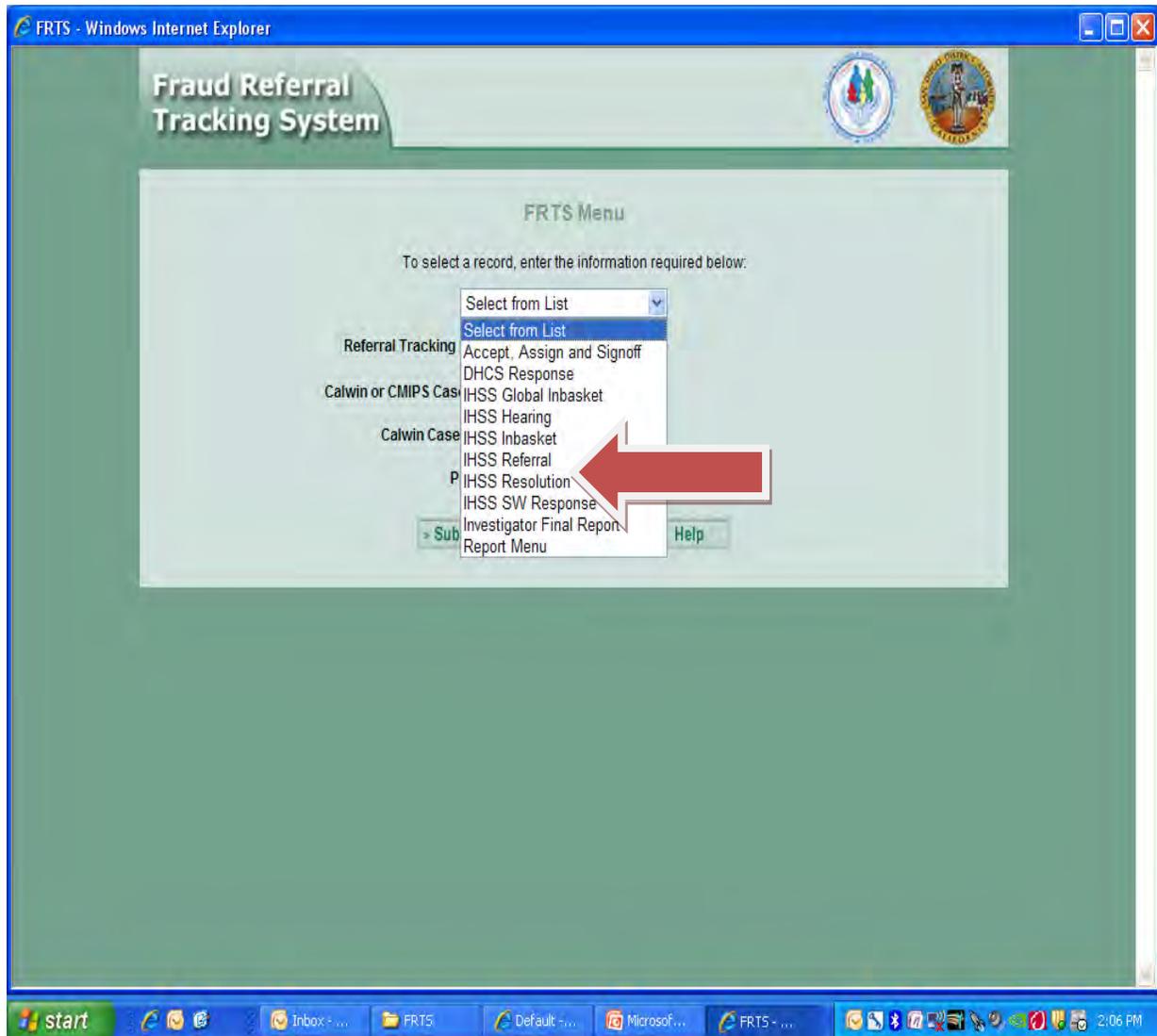
To access the “*IHSS Resolution*” screen,

Go to the FRTS Menu screen.

Select “*IHSS Resolution*”

Enter the “*Referral Tracking Number*”

Click “*Submit*”



IHSS Resolution Screen – Continued

The “IHSS Resolution Screen” can also be accessed through the “Individual Inbasket” by checking the box next to the referral and selecting the “IHSS Resolution Screen” from the drop down menu.

The screenshot shows the 'Fraud Referral Tracking System' interface in a browser window. At the top, it says 'Individual Inbasket for: IH90'. Below that is a search bar with 'Enter another Worker ID:' and a 'Search Again' button. A 'Records Found: 9' indicator is present. A table lists referrals with columns for 'Select Referral One', 'Referral Number', 'Case Last Name', 'Case First Name', 'Case Load Number', 'Referral Type', 'Referral Process Date', 'Last Action', 'Last Action Date', and 'Action Required'. A red arrow points to the 'Select Referral One' column. Below the table is a dropdown menu labeled 'Select from List' with a red arrow pointing to it. At the bottom are buttons for 'Menu', 'Default View', and 'Help'. The Windows taskbar at the bottom shows the Start button, taskbar icons, and system tray with the time 10:27 AM.

Select Referral One	Referral Number	Case Last Name	Case First Name	Case Load Number	Referral Type	Referral Process Date	Last Action	Last Action Date	Action Required
<input type="checkbox"/>	110900003				IHSS	9/12/2011		9/18/2011	
<input type="checkbox"/>	111000135				IHSS	10/17/2011	BIW Response Returned - Overdue	10/26/2011	Complete BIW Response
<input type="checkbox"/>	111000138				IHSS	10/17/2011	Resolution Screen Update	10/17/2011	IHSS BIW response required
<input type="checkbox"/>	111000138				IHSS	10/26/2011	Assigned to CHCS	10/26/2011	Referral Processed - Print Referral
<input type="checkbox"/>	110900038				IHSS	9/27/2011	Referral Processed	9/27/2011	Referral Processed - Print Referral
<input type="checkbox"/>	110900006				IHSS	9/15/2011	Assigned to CHCS	9/15/2011	Referral Processed - Print Referral
<input type="checkbox"/>	110900004				IHSS	9/12/2011	Assigned to CHCS	9/12/2011	Referral Processed - Print Referral

IHSS Resolution Screen – Continued

The resolution to a PAFD referral will be shown initially in the Account Clerk’s “*Individual Inbasket*”. It is only after the required action is completed by the Account Clerk and accepted by the PAFD that the disposition is shown in the Social Worker “*Individual Inbasket*”.

Fraud Referral Tracking System

IHSS Resolution

Referral Tracking Number: 111000136
 Cmips Case Number: 3702228588
 Case Last Name: PADILLA
 Case Status: Eligible
 IHSS Referral Source: IHSS (SW)

Case Worker: SS84
 First Name: LUZ
 Referral Process Date: 10/17/2011
 IHSS Worker Assigned IH90
 IHSS Date Assigned: 10/17/2011

If Appeals:

Total Overpayment Determination Resulting From This Investigation

IHSS Aid Type	Primary Disposition	Parties Involved	Amount
60	No Fraud SW Response 45 days Required	Select a Disposition	\$0.00
Increase/Decrease in Hours	Amount of hours Inc/Dec	Number of Overpayment Hours	
Select a Disposition	0.00	0.00	

Number of Unannounced Home visits: 0
 Date of Overpayment NOA Sent(mm/dd/yyyy):
 Collection Type: (R=Revenue & Recover, P = Pay Reduction)

Total Underpayment Determination Resulting From This Investigation

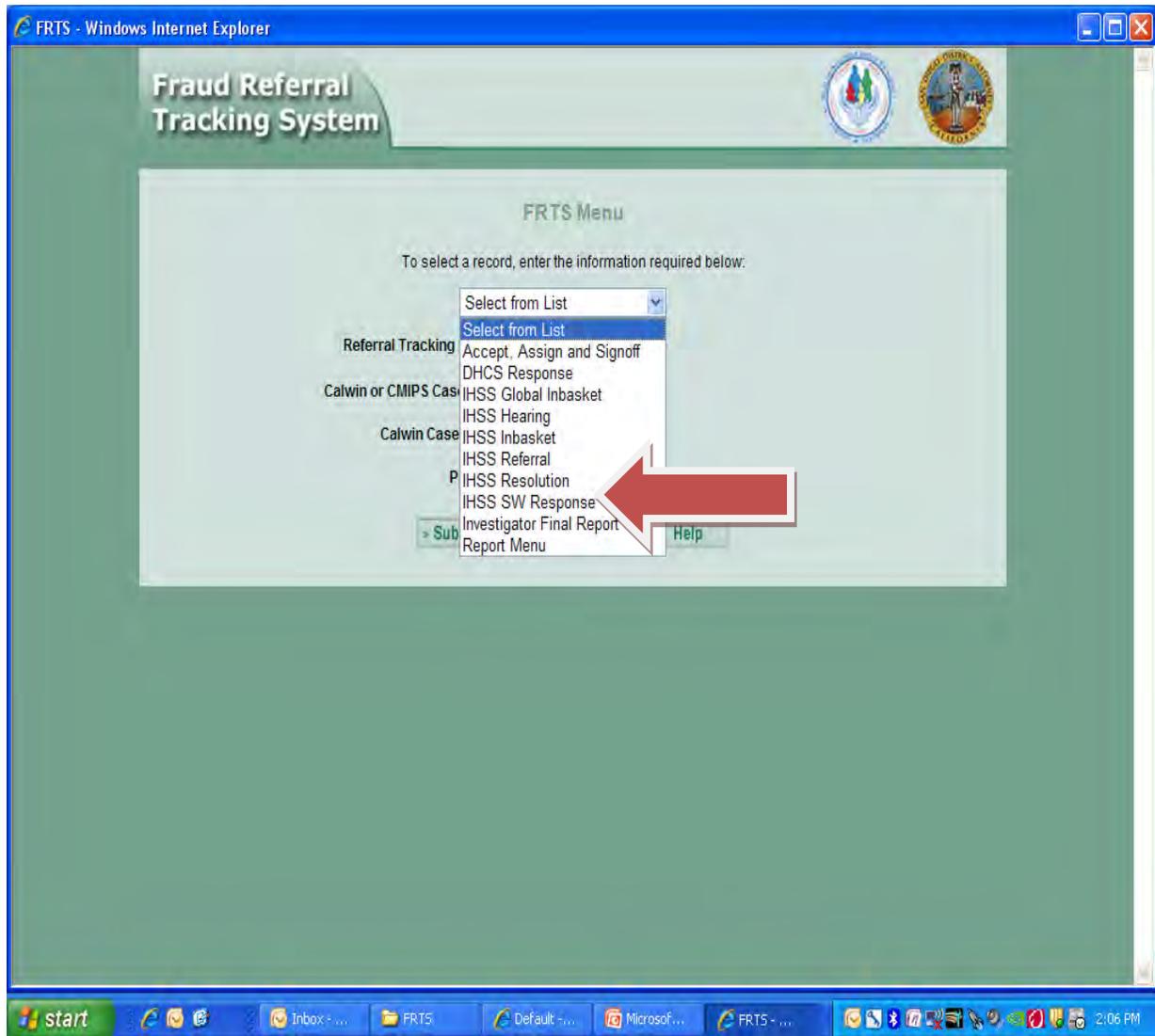
IHSS Aid Type	Primary Disposition	Parties Involved	Amount
60	Select a Disposition	Select a Disposition	\$0.00
Increase/Decrease in Hours	Amount of hours Inc/Dec	Number of Underpayment Hours	
Select a Disposition	0.00	0.00	

Number of Unannounced Home visits: 0
 Date of First Home Visit(mm/dd/yyyy):
 Date Client Notified of Underpayment(mm/dd/yyyy):
 Result in Case Close: Yes No

Narrative

IHSS SW Response Screen

To access the “*IHSS SW Response*” screen,
Go to the FRTS “*Menu*” screen
Select “*IHSS SW Response*”.
Enter the FRTS “*Referral Tracking Number*”
Click “*Submit*”.

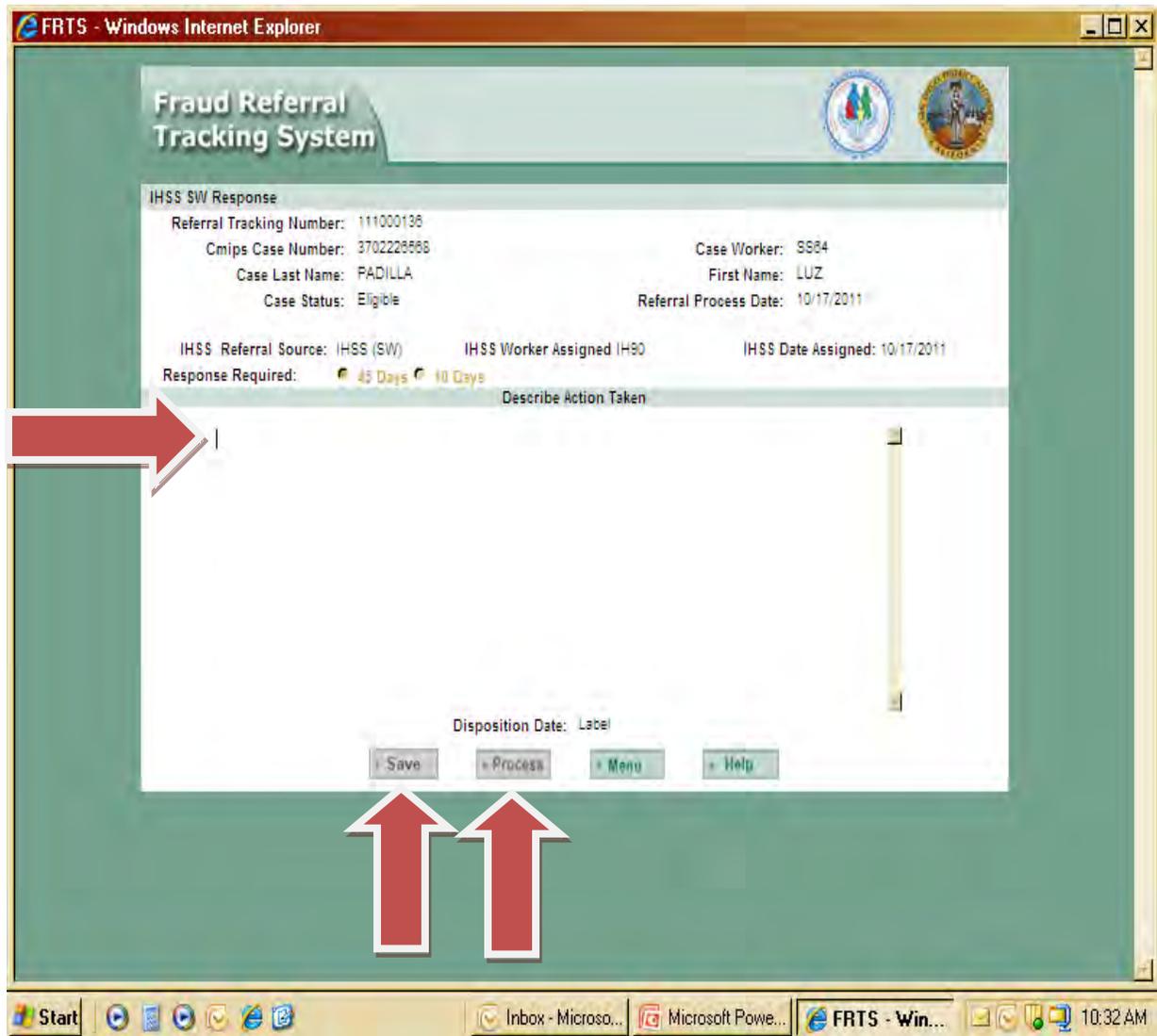


IHSS SW Response Screen - Continued

To reply to the disposition in the IHSS “Response screen”

Enter the actions that have been taken in the section “Describe Action Taken”.

Click “Save” or “Process”.



**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
AGING AND INDEPENDENCE SERVICES
IN-HOME SUPPORTIVE SERVICES
SPECIAL NOTICE-11-06
ADDENDUM A**

January 10, 2012

**SUBJECT: REVISIONS TO THE IN-HOME SUPPORTIVE SERVICES PROGRAM
HEALTH CARE CERTIFICATION FORM**

EFFECTIVE DATE: Effective Immediately

EXPIRATION DATE: When incorporated into the IHSS Program Guide

**REFERENCES: All-County Information Notice (ACIN) No. I-74-11
All-County Letter (ACL) No. 11-76**

I. PURPOSE

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with additional information and instructions on the SOC 873 *“In-Home Supportive Services (IHSS) Health Care Certification”* form.

II. POLICY

After August 1, 2011, a certification for all IHSS applicants and recipients by a Licensed Health Care Provider (LHCP) (or an acceptable alternative document) is required in order to begin or continue receiving IHSS services. The completed documentation must be on file and include the following information:

- A declaration from a Licensed Health Care Professional (LHCP) that the applicant/recipient is unable to independently perform some activity of daily living
- A statement that the applicant/recipient is at risk of placement in out-of-home care without the assistance of IHSS services
- A description of any condition or functional limitation that has resulted in, or contributed to, the individual’s need for assistance

Once the completed SOC 873 *“IHSS Health Certification”* form is received and IHSS services are approved, the SOC 873 is not required for subsequent reassessments or for continued eligibility to services.

III. PROCESS CHANGES

Form Revisions

The following forms have been revised and the updated versions are to be used immediately. All previous versions (hard copy or electronic) are to be recycled.

- SOC 873 “*IHSS Health Care Certification*” (Attachment A)
- SOC 874 “*IHSS Notice to Applicant of Health Care Certification Requirement*” (Attachment B)
- SOC 875 “*IHSS Notice to Recipient of Health Care Certification Requirement*” (Attachment C)

The revised forms are located at the following locations:

S Drive

S:\AIS\Operations\IHSS\Automated Forms\SW Forms\SOC Forms

California Department of Social Services (CDSS)

http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm

CDSS Translated forms

<http://www.cdss.ca.gov/agedblinddisabled/PG2086.htm>

Please note that the name of the form has been changed from “Medical Certification” to “Health Care Certification” form. All references to the term “Medical Certification” has been removed from all related forms. This change is more consistent with the language used in the Welfare and Institutions Code (WIC). The updated forms will be available in the following languages in addition to English:

- Spanish
- Armenian
- Chinese

SOC 873-Health Care Certification

- The definition of LHCP has now been included on the SOC 873.
- The items in Section C of the SOC 873 have been reordered and renumbered, items 5 – 8 are now listed first as items 1 – 4.
- At the beginning of Section C, the following note has been added: “*NOTE: ITEMS # 1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.*”
- Before Item #5, the following note has been added: “*Please complete Items # 5 – 8, to the extent you are able, to further assist the IHSS worker in determining this individual’s eligibility*”

Note: The renumbering alters the instructions for evaluating the completed form.

SOC 874-IHSS Notice to Applicant

- The form now states that alternative documentation must be signed by a LHCP within the last 60 days in order to be valid.
- Language has been added on the process of granting exceptions to allow temporary receipt of IHSS (see page 5 below for details on the exception process).

SOC 875-IHSS Notice to Recipient

- The form now states that alternative documentation must be signed by a LHCP within the last 60 days of receipt, in order to be valid.
- The sentence “*If the county does not receive the SOC 873 by the 35th day, a notice will be sent informing you that your IHSS will stop, unless you had previously contacted the county and were given more time to submit the form.*” has been deleted from SOC 875.*
- The recipient is now instructed to contact the IHSS Social Worker if he/she is unable to obtain the documentation within the 45 days. (The Social Worker must then evaluate for “good cause” and an extension of the deadline.)

*This will allow the IHSS Social Worker to follow the standard procedures used to discontinue a case (if there is no good cause) on the 45th day without the need for additional tracking. Timely notice is required.

Clarification of LHCP

For the purposes of completing the health care certification, a LHCP is a licensed individual whose primary responsibilities are to diagnose and/or provide treatment and care for physical or mental diseases or conditions that cause or contribute to an individual’s functional limitation. Based on this definition, counties may accept an SOC 873 or alternative documentation completed by a Marriage and Family Therapist (MFT) or a Licensed Clinical Social Worker (LCSW).

Out-of State/Military Providers

If an applicant/recipient is receiving, treatment from an out-of state LHCP in a bordering state (for example, Arizona) or an LHCP affiliated with military services, the Social Worker must evaluate each form on a case-by-case basis. The Social Worker may accept the completed SOC 873 or alternative documentation from the LHCP in this situation, only if the LHCP is an

approved Medi-Cal provider. All authorized Medi-Cal providers must use an assigned 10-digit unique identifier known as a National Provider Identifier (NPI). In this situation, the Social Worker must request written verification from the LHCP of their Medi-Cal Provider status before accepting the Health Certification form as valid.

Multi-Purpose Senior Services Program (MSSP)

MSSP recipients are individuals who have been certified by an MSSP Nurse Case Manager to need a Skilled Nursing Facility (SNF) level of care. The “*Level of Care*” (LOC) (Attachment D) certification from the MSSP assessment is acceptable alternative documentation for the SOC 873. If the LOC was not certified within the last 60 days, the MSSP Nurse Case Manager can note the status on the LOC, indicate the date, and re-sign the document. The MSSP Case Manager will contact the IHSS Social Worker when the individual becomes active with MSSP.

Procedure Changes

IHSS Clerical Responsibilities

There is no change to the procedures for IHSS clerical staff other than the requirement to use the updated forms.

IHSS Social Worker Responsibilities

Items # 5 and 6 on the SOC 873 were previously identified as being of primary importance in making the eligibility determination. Due to the renumbering of this section, ***items # 1 and 2 are now the most critical indicators.***

SOC 873 – Questions One and Two

Questions **1** and **2** (and questions 3 and 4 when 1 and 2 are answered “Yes”) on the SOC 873 are required for determining eligibility, and must be answered to meet the requirements in WIC section 12309.1.

The Social Worker must use the SOC 873 (or alternative documentation) submitted by the client as a factor in assessing the need for IHSS. When question **1** and/or question **2** have been answered “no”, then the application for IHSS services **must be denied**.

Before authorizing IHSS services, the IHSS Social Worker must ensure that the answers to both questions **1** and **2** on the SOC 873 are “Yes”, and questions **3** and **4** are complete. The Social Worker may contact the LHCP for clarification or additional information. The SOC 873 (or alternative documentation) **shall not be the sole determining factor when the answers to question 1 and 2 are yes.** The Social Worker will use the form to evaluate the client’s present condition and the need for out-of-home care if IHSS services are not provided. The Social Worker must consider all relevant documentation when making the final eligibility determination.

If both questions **1** and **2** are “yes” and questions **3** and **4** are complete, the Social Worker may **continue to assess** the need for IHSS and determine eligibility to services. Once the applicant has been determined eligible for services, eligibility (if appropriate) may go back to the effective date of the application.

If items **1** and **2** of the SOC 873 are unanswered or if the Social Worker cannot get the needed medical information for items **3** and **4** in the course of contact, he/she must send back the SOC 873 to the LCHP for completion.

If the Social Worker is able to contact the LCHP and obtain the missing information, the Social Worker will:

- Note the information directly on the SOC 873 form
- Include the outcome of the contact with the LCHP
- Initial the notation
- Document the contact in the case narrative

The time allowed for the LCHP to complete and/or to clarify the response on the SOC 873 will not be applied against the 45-day time limit. If the request for clarification is made in writing, the Social Worker will allow ten days for the response before taking additional action.

Exceptions

An IHSS applicant may be granted services temporarily without an SOC 873 if the Social Worker determines that either of the following conditions exists:

- IHSS services are needed by the applicant prior to being discharged from a hospital or nursing home in order to return his/her own home.
- The applicant is at immediate risk of out-of-home placement if services are not provided.

The SOC 873 must be requested as soon as administratively possible, but no later than the date of the face-to-face assessment.

CMIPS Entries

When entering the case into Case Management Information and Payrolling System (CMIPS), enter the following codes:

- Enter “E” (Exception) on the Medical (MC) Code field
- Enter the date the SOC 873 was requested in the MC “Date” field

Applicants Being Discharged from a Facility

When an exception is given to an IHSS applicant that is about to be released from a medical facility or nursing home, the Social Worker must:

- Schedule a face-to-face assessment in the facility prior to the applicant’s date of release.

- Complete a preliminary needs assessment.
- Complete and send the SOC 876 “*IHSS Program Notice of Provisional Approval Health Care Certification Exception Granted*” (Attachment E) in lieu of Notice of Action (NOA) 690.

The SOC 876 lists the provisional hours assessed for each service category. Appeal information is not included since the assessment is preliminary. A second assessment and issuance of the 690 NOA is required once the applicant has returned to their own home.

Applicants at Risk of Immediate Placement

When an exception to the SOC 873 is made because of the immediate risk of placement, the Social Worker must:

- Complete the needs assessment process
- Include message 508 in the 690 NOA

508 - *“Your application has been temporarily approved pending receipt of your health care certification form. Your eligibility will be discontinued if the form is not received within 45 days of the date it was requested or if the form indicated you have no need for In-Home Supportive Services. (WIC 1209.1)”*

Good Cause (Extending the 45-Day Due Date)

Good cause extensions cannot be approved for applicants unless an exception to the SOC 873 is being made. The Social Worker must evaluate the applicant’s reason for not providing the form and determine if there is “good cause”. Good cause means “a substantial and compelling reason beyond the recipient’s control”. Good cause must not exceed more than 45 days beyond the initial 45-day timeframe (for a maximum total of 90 days).

Discontinuance

Discontinue the case with 10-day notice using NOA code 443 when:

- The SOC 873 (or alternative documentation) is not provided by the date required or within 90 days if a good cause extension has been granted.
- The completed SOC 873 is received by the due date and indicates no need for services for services.

443 – *“You have no assessed need for services and you can remain safely in your own home without services and, if applicable, retain your employment. MPP 30-761”*

Inter-County Transfers (ICT)

The IHSS Social Worker will request an SOC 873 for an ICT when one has not been provided to the transferring county. If the SOC 873 has not been provided, the form must be requested from the client on or before the face-to-face assessment. The recipient has 45 days following the face-to-face date to provide the SOC 873. To prevent unnecessary interruptions in service, an "E" must be entered temporarily in the MC Field instead of a "P".

VII. REVIEW STATEMENT

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

VIII. FILING STATEMENT

Notices are archived at the following link:

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

IHSS Special Notices are also archived on the county intra-net at:

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

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



WILFRED QUINTONG
Assistant Deputy Director



ELLEN SCHMEDING
Assistant Deputy Director

For questions contact: Susan Pullido (858)505-6366
Attachment(s)
Distribution Codes 7 & 8

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
HEALTH CARE CERTIFICATION FORM**

A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name:		Date of Birth:
Address:		
County of Residence:	IHSS Case #:	
IHSS Worker Name:		
IHSS Worker Phone #:	IHSS Worker Fax #:	

**B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
(To be completed by the applicant/recipient)**

I, _____, (PRINT NAME), authorize the release of health care information related to my physical and/or mental condition to the In-Home Supportive Services program as it pertains to my need for domestic/related and personal care services.

Signature: _____ Date: ____/____/____
(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

Witness (if the individual signs with an "X"): _____ Date: ____/____/____

TO: LICENSED HEALTH CARE PROFESSIONAL* –

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This health care certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual's present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

*Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM HEALTH CARE CERTIFICATION FORM

Applicant/Recipient Name:	IHSS Case #:
---------------------------	--------------

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.	
1. Is this individual <u>unable</u> to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below, and complete the rest of the form including the certification in PART D at the bottom of the form.</p> <p>If you answered "YES" to both Question #1 AND #2, respond to Questions #3 and #4 below, and complete the certification in PART D at the bottom of the form.</p>	
3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program:	
4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

6. How long have you provided service(s) to this individual?

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

8. Indicate the date you last provided services to this individual: ____ / ____ / ____

NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and/or certified as a Medi-Cal provider, and all information provided above is correct.

Name:	Title:
Address:	
Phone #:	Fax #:
Signature:	Date:
Professional License Number:	Licensing Authority:

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM

NOTICE TO APPLICANT OF HEALTH CARE CERTIFICATION REQUIREMENT

State Law (Welfare and Institutions Code section 12309.1) requires that each person applying for IHSS provide a health care certification from a licensed health care professional (LHCP) before they can get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Health Care Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

The county may accept alternative documentation in place of the SOC 873 as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP within the last 60 days.

Whether you give the SOC 873 to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within **45 days** from the date the county worker requested it.

If you do not provide the SOC 873 or alternative documentation to the county within 45 days, your application for IHSS will be denied. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

Under certain limited circumstances, such as when services are requested because you are being discharged from a hospital or nursing facility and you need services to return safely to your home, or the county determines that you are at risk of placement in out-of-home care, the county may grant an exception that would allow you to get IHSS on a temporary basis before the county receives the completed SOC 873 or alternative documentation. However, even if an exception is granted, you will still be required to provide one of these documents for the county within the 45-day timeframe to determine if you can continue getting IHSS.

If you have questions about the health care certification requirement, ask the social worker who has been assigned to your case.

DUE BY: ___/___/___

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
NOTICE TO RECIPIENT OF HEALTH CARE
CERTIFICATION REQUIREMENT**

COUNTY OF: _____

Notice Date: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

Social Worker Name: _____

DUE BY: _____

(ADDRESSEE)

To: In-Home Supportive Services (IHSS) Recipient

There has been a change in state law (Welfare and Institutions Code section 12309.1) that requires each person getting IHSS to provide a health care certification from a licensed health care professional (LHCP) to continue to get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Health Care Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

The county may accept alternative documentation in place of the SOC 873 as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP within the last 60 days.

Whether you give the SOC 873 to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within **45 days** following your reassessment.

If the county does not receive the completed SOC 873 or alternative documentation within 45 days following your reassessment, your IHSS may stop. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

If you are not able to get the SOC 873 from your LHCP within 45 days, call your social worker at the number listed above **before the due date** to tell him/her why you are not able to meet the due date and ask if the county can grant you more time.

LEVEL OF CARE CERTIFICATION

Client Name	[REDACTED]	ID #	4893
<input type="checkbox"/> NF-A (ICF)	<input checked="" type="checkbox"/> NF-B (SNF)	Source of Information:	<input checked="" type="checkbox"/> Client Visit <input type="checkbox"/> Record Review
LOC Based on: SNF Avoidance			
<p>CI is oriented to person and space but not to time. He has limited mobility due to arthritis and dementia. He tries to be as independent as possible but he needs more help than he admits to. He is able to verbalize pain in both knees. He is very hard of hearing and is difficult to communicate with him. His wife answers questions for him. He ambulates very slowly indoors holding on to furniture or walls, he also uses w/c inside. He is shy to let someone help with bathing but needs a lot of help. Wife tries to help. IP is on stand-by assist. Needs help with dressing and grooming due to his low endurance and inability to bend and reach his feet. Independent for eating, transferring, toileting and bathing. Wife makes sure he bathes while IP is in. Unable to ambulate outdoors by himself. He needs to use the w/c and stand-by supervision. He is incontinent of urine and needs to wear pull ups.</p> <p>IP manages/orders, reorders his medications as he can not remember to do it by himself. IP is also helping with money management and phone calls.</p>			
He continues to be certified at SNF LOC			
Signature/Title:		Date of LOC: 08/09/2011	
[REDACTED]			

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
NOTICE OF PROVISIONAL APPROVAL
HEALTH CARE CERTIFICATION EXCEPTION GRANTED**

TO:

--

County of: _____

Notice Date: _____

Case Number: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

The county has provisionally approved your application for In-Home Supportive Services (IHSS). Here's what that means:

State law requires that before you can get IHSS, you have to provide the county with a health care certification completed and signed by a licensed health care professional, and you have to have an assessment of your needs completed in your own home.

The county has granted an exception so that you can get IHSS on a temporary basis **before** you meet these requirements, but you still have to provide the county with the health care certification (if you have not already provided it). You will temporarily get the services/hours shown below once you return to your own home. These services/hours are based on a preliminary assessment of your needs done while you were in a medical facility.

When you provide the county with the health care certification, the county will determine your eligibility to continue getting IHSS. If you are determined eligible, the county will do an in-home assessment to complete the determination of your services/hours.

The county asked you to provide the health care certification by _____
DATE

If you do not provide the county with a health care certification by this date, the IHSS you have been getting on a temporary basis will stop. If you cannot provide the certification by this date, contact your social worker before the due date to explain why and ask if the county can grant you more time.

If you have questions about the information in this notice, call your social worker.

SERVICES	AUTHORIZED # OF HOURS
DOMESTIC SERVICES (per month)	
RELATED SERVICES (PER WEEK)	
- Prepare meals	
- Meal clean-up	
- Routine laundry	
- Shopping for food	
- Other shopping/errands	
NON-MEDICAL PERSONAL SERVICES (PER WEEK)	
- Respiration assistance	
- Bowel and/or bladder care	
- Feeding	
- Routine bed baths	
- Dressing	
- Menstrual care	
- Assistance with walking (including getting in/out of vehicles)	
- Transferring: moving in/out of bed, on/off seats, etc.	
- Bathing, oral hygiene, grooming	
- Rubbing skin, repositioning	
- Assistance with prosthesis, help setting up medication	
ACCOMPANIMENT (PER WEEK)	
- To/from medical appointments	
- To/from alternative resources	
PROTECTIVE SUPERVISION (PER WEEK)	
TEACHING/DEMONSTRATION SERVICES (PER WEEK)	
PARAMEDICAL SERVICES (PER WEEK)	
HOURS OF SERVICE AUTHORIZED FOR ONE MONTH ONLY	
- Heavy cleaning	
- Yard hazard abatement	
Total weekly hours of service authorized	
Multiply by 4.33 (average # of weeks per month) to convert to monthly hours	
Add monthly authorized domestic services hours (from above)	
TOTAL HOURS OF SERVICE AUTHORIZED PER MONTH	