

**IN-HOME SUPPORTIVE  
SERVICES  
SPECIAL NOTICE  
ARCHIVES  
2013**





**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**

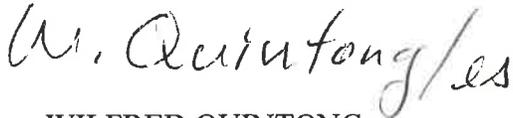
IHSS Special Notices are being archived at the following link:

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

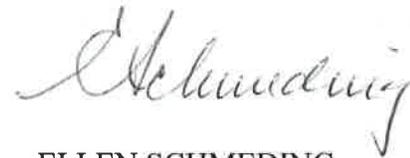
And at the County intranet at:

<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  <b>Note:</b> 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
<b>DOMESTIC SERVICES (per MONTH):</b>					
<b>RELATED SERVICES (per WEEK):</b>					
Prepare Meals					
Meal Clean-up					
Routine Laundry					
Shopping for Food					
Other Shopping/Errands					
<b>NON-MEDICAL PERSONAL SERVICES (per WEEK):</b>					
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					
<b>ACCOMPANIMENT (per WEEK):</b>					
To/From Medical Appointments					
To/From Places You Get Services in Place of IHSS					
<b>PROTECTIVE SUPERVISION (per WEEK):</b>					
<b>PARAMEDICAL SERVICES (per WEEK):</b>					
<b>TOTAL WEEKLY HOURS:MINUTES OF SERVICE YOU CAN GET:</b>					
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS:MINUTES: x 4.33 =					
<b>SUBTOTAL MONTHLY HOURS:MINUTES OF SERVICE YOU CAN GET:</b>					
ADD MONTHLY DOMESTIC HOURS:MINUTES OF SERVICE YOU CAN GET (from above):					
<b>TOTAL HOURS:MINUTES OF SERVICE YOU CAN GET PER MONTH:</b>					
<b>TIME LIMITED SERVICES (per MONTH):</b>					
Heavy Cleaning:					
Yard Hazard Abatement					
Remove Ice, Snow					
Teaching and Demonstration					
<b>TOTAL HOURS:MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:</b>					

**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 (PRORATION)	AMOUNT OF SERVICE YOU NEED	SERVICES YOU REFUSED OR YOU GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET		
					HOURS:MINUTES	NOW	WAS +/-
<b>Note:</b> See the back of the next page for a short description of each service.							
<b>DOMESTIC SERVICES (per MONTH):</b>							
<b>RELATED SERVICES (per WEEK):</b>							
Prepare Meals							
Meal Clean-up							
Routine Laundry							
Shopping for Food							
Other Shopping/Errands							
<b>NON-MEDICAL PERSONAL SERVICES (per WEEK):</b>							
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							
<b>ACCOMPANIMENT (per WEEK):</b>							
To/From Medical Appointments							
To/From Places You Get Services in Place of IHSS							
<b>PROTECTIVE SUPERVISION (per WEEK):</b>							
<b>PARAMEDICAL SERVICES (per WEEK):</b>							
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:							
<b>TIME LIMITED SERVICES (per MONTH):</b>							
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 13-01**

**April 11, 2013**

**SUBJECT: Oster/Dominguez Settlement Agreement**

**EFFECTIVE DATE: Immediately**

**REFERENCES: All County Information Notice (ACIN) NO. 1-18-13**

**I. PURPOSE**

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with instructions on distributing information to IHSS stakeholders on the settlement agreement for the Oster v. Lightbourne and Dominguez v. Schwartzenegger lawsuits.

**II. CLERICAL INSTRUCTIONS**

The attached documents must be made available for IHSS recipients and their family members, and for those who work with and assist IHSS recipients. The following material is to be made available in all IHSS district office locations as follows:

Attachment A – Settlement Notice (4 pages)

Display in prominent location(s) in the waiting room and/or public area of each IHSS district office location in English and Spanish. Display translated notices in the additional languages prevalent in the regional area, if available. As an example, Tagalog, Vietnamese, and/or Farsi are languages needed for San Diego County.

Attachment B – Notice Flyer (1 page)

Display in prominent location(s) in the waiting room and/or public area of each IHSS district office location in English and Spanish. Display translated notices in the additional languages prevalent in the regional area, if available. As an example, Tagalog, Vietnamese, and/or Farsi are languages needed for San Diego County.

Attachment C – Settlement Agreement and Class Notice (66 pages)

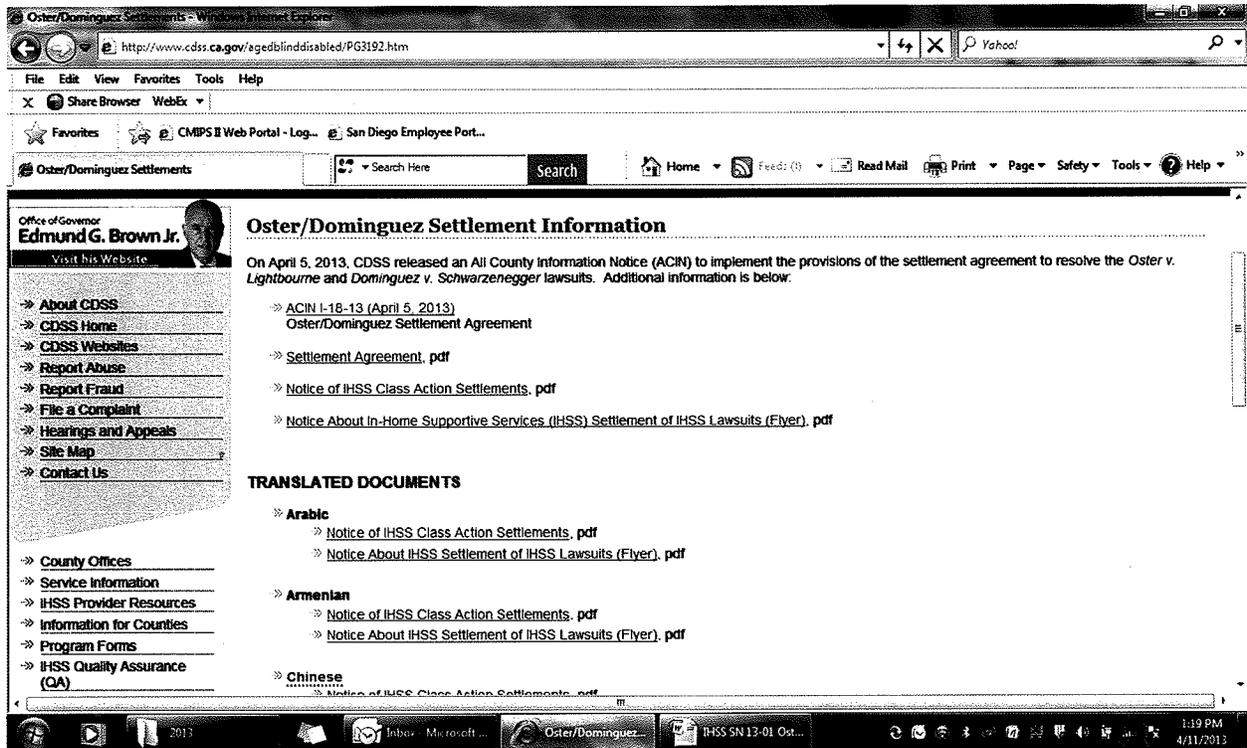
Must be available upon request and provided by the office receptionist.

Translated materials are available at the following web site:

<http://www.cdss.ca.gov/agedblinddisabled/P3192.htm>

In addition, translations of the settlement notice and the notice flyer must be available in the languages that are not posted, and provided upon request by the office receptionist.

**IN-HOME SUPPORTIVE SERVICES  
SPECIAL NOTICE 13-01  
Oster/Dominguez Settlement Agreement**



### III. REVIEW STATEMENT

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

### IV. FILING STATEMENT

IHSS Special Notices are archived at the following link:

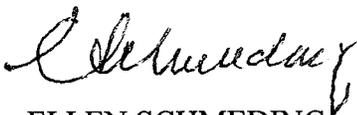
S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure – Automated

And at the County intranet at:

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

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

Attachments A - C

**IN-HOME SUPPORTIVE SERVICES  
SPECIAL NOTICE 13-01  
Oster/Dominguez Settlement Agreement**

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES  
SPECIAL NOTICE 13-03**

**June 20, 2013**

**SUBJECT: In-Home Supportive Services (IHSS) 8% Service Reduction**

**EFFECTIVE DATE: Immediately**

**EXPIRATION DATE: July 1, 2014**

**REFERENCE: All-County Letter No. 13-47 issued June 7, 2013**

**I. PURPOSE**

To provide IHSS staff with instructions and information on the implementation of a new state law which increases the current IHSS service reduction from 3.6 % to a total of 8 %.

**II. BACKGROUND**

Senate Bill (SB) 67 increases the IHSS 3.6% reduction in IHSS authorized services to 8% effective July 1, 2013. The California Department of Social Services (CDSS) will mail Notices of Action (NOAs) informing all recipients of the 8% reduction and of the recipient's ability to choose how this reduction is applied to his/her specific authorized services.

**III. PROCEDURES**

CMIPS II Updates

CMIPS II will perform a one-time update that will reduce the *Authorized to Purchase* hours to 8% on all existing recipient cases in "Eligible" and "Presumptive Eligible" status. The reduction will first be applied to any hours of documented unmet need (excluding protective supervision). This reduction in hours will apply to both the recipient's *Authorized to Purchase* hours and to any provider whose hours have not been assigned in CMIPS II.

- CMIPS II will automatically add an end date to any existing cases with "open" (no end date) authorization segments, and create a new assessment (authorization segment) with a beginning date of July 1, 2013.
- If the end date of the current authorization is in the past, CMIPS II will automatically bring the authorization current with an end date of June 30, 2013, and then build a new assessment (authorization segment) with a beginning date of July 1, 2013.

**IHSS SPECIAL NOTICE 13-03  
IN-HOME SUPPORTIVE SERVICES 8% SERVICE REDUCTION**

- CMIPS II will delete all *Pending Evidence* and a new authorization segment will be created for every active case with an effective date of July 1, 2013.

The number of authorized to purchase and unmet need hours before and after the reduction and the number of reduced hours will display on the *Authorization Summary* screen. There will be no actual change to the number of hours the recipient will receive, if the only adjustment is to the unmet need hours.

Authorization Summary	
Authorization Segment Start Date:	7/1/2013
Authorization Segment End Date:	7/31/2013
Total Auth to Purchase Before LMA (HH:MM):	276:54
Unmet Need Before LMA (HH:MM):	00:00
LMA (HH:MM):	-22:09
Unmet Need After LMA (HH:MM):	00:00
Total Auth to Purchase After LMA (HH:MM):	254:45
Adjusted Hours (HH:MM):	00:00
Unmet Need After Adjusted Hours (HH:MM):	00:00
Total Auth to Purchase After Adjusted Hours (HH:MM):	254:45
Application Date:	8/5/2009
IHSS Determination Date:	6/8/2013
Impairment Level:	NSI
Functional Index Score:	3.083
Restaurant Meals Allowance:	No
Advance Pay:	No
IHSS SOC:	0.00
SOC Compare Cost:	2,630.55
Funding Source Aid Code:	2M - PCSP
24 Hour Protective Supervision Care Plan Need (HH:MM):	104:03

### ***Notice of Action (NOA)***

CDSS will mail all of the initial NOAs generated by the implementation of the 8% reduction between June 10, 2013 and June 13, 2013. Copies of all NOAs generated as part of the initial implementation of the 8% reduction will be viewable in *Forms and Correspondence* in CMIPS II. The new NOA message LM02 (Attachment A) has been included in the initial NOAs mailed by CDSS in June 2013. For new or reactivated cases and other assessments, CMIPS II will generate the normal 10-day NOA with the new NOA message LM03 (Attachment A). Recipients with documented unmet need (other than for protective supervision) will receive the existing CMIPS II NOA message for unmet need that will specify the number of unmet need hours after the 8% reduction. All ongoing NOAs will be printed locally at the CMIPS II printers.

### ***Provider Hours***

If there are no assigned hours on a case:

CMIPS II will automatically update the provider hours with the recipient's authorized hours after the 8% reduction has been applied.

If a provider has assigned hours:

The case owner will receive a task if the provider's assigned hours do not equal the total of the recipient's authorized hours after the 8% reduction.

### **Social Worker Responsibilities**

The assigned IHSS Social Worker will continue to conduct assessments and reassessments, and enter case information into CMIPS II in the current manner. CMIPS II will automatically calculate the 8% reduction and apply the reduction to the total monthly authorized hours. Severely impaired and non-severely impaired categories for recipients will not change, since individual services will not be reduced.

CMIPS II will not allow the creation of an eligibility segment that spans the July 1, 2013 implementation date. Case information entered after June 7, 2013 and any changes to existing authorizations that begin prior to July 1, 2013, will require two authorizations:

- An authorization for any days of service provided prior to July 1, 2013 with an ending date of June 30, 2013.
- A second authorization created with a beginning date of July 1, 2013.

Social Workers will create two eligibility segments for cases that are in “Leave” status when the case is returned to an “Eligible” status. CMIPS II will apply the 8% reduction to all newly created and reactivated recipient cases that have authorizations that span the July 1, 2013 date.

### ***Request for Reassessment***

If the Social Worker receives a request for a reassessment within 90 days of being notified of the 8% reduction, 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, a change in household, or a change in living situation)
- Request additional information (if necessary) from the recipient to document the change (a copy of a discharge plan, rental agreement etc.)

**Note: A new SOC 873 IHSS Health Certification Form, or a doctor’s note must not be requested by the Social Worker to verify the change in need.**

If there has been a change in circumstance, the Social Worker must reassess the individual’s service needs. An increase and/or decrease in an existing need may be evaluated by phone without supervisor approval. Supervisor approval is required when assessing a need over the phone for a task that has not been previously assessed.

If the Social Worker has determined that there has not been a change in the recipient’s need for IHSS, he/she will:

- Document the reassessment in CMIPS II as a *Change Assessment*
- Enter an *Assessment Narrative*
- Update the *Authorization Start Date*, with the date the reassessment occurred, in the *Program Evidence* screen

A NOA must be sent to the recipient to notify the recipient of the results of the assessment. If the *Program Evidence* is updated without a change in *Service Evidence*, CMIPS II will generate NOA HR01 – Auth to Purchase No Change (Attachment A).

**Note: Phone assessments do not replace the required annual face-to-face reassessment.**

If the request is solely in response to the 8% reduction, the Social Worker will:

- Explain the hearing process to the recipient

- Deny the request for a reassessment using form SOC 885 – Notice of Denial of Request for Reassessment Based on State Law Change (Attachment B)
- Document, as a *Case Note* in CMIPS II, the date of the request and the reason the reassessment was denied. The documentation must indicate that there was no reported change in circumstances or assessed need.

### ***State Hearings***

Hearing requests based solely on the 8% 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 regarding the 8% reduction, he/she must refer the recipient to the State Hearings Division at number:

**TELEPHONE NUMBER 1-800-952-5253**

**HEARINGS OR SPEECH IMPAIRED PERSONS WHO USE TDD 1-800-952-8349**

<http://www.cdss.ca.gov/cdssweb/PG27.htm>

If the Social Worker receives a written request for a State hearing regarding the 8% reduction, he/she must fax the request to the State Hearings Division at fax number:

**1 (916) 651-2789**

If the documentation contained in the IHSS case is insufficient, or the recipient is now stating a change to his/her assessed need, an Out of Hearing (OHR) resolution may be negotiated by Health and Human Services Agency (HHS) appeals staff, after communicating the issue to the IHSS Supervisor.

### **IHSS Recipient Responsibilities**

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

- The Recipient is not required to report the above information to the Social Worker.
- A Recipient with multiple providers must submit an updated form SOC 838 – Recipient Request for Assignment of Authorized Hours to Providers (Attachment C) to re-assign provider assigned hours.

### **IV. REVIEW STATEMENT**

This Special Notice has been reviewed by an organizational review committee.

### **V. 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:

**IHSS SPECIAL NOTICE 13-03  
IN-HOME SUPPORTIVE SERVICES 8% SERVICE REDUCTION**

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



WILFRED QUINTONG  
Assistant Deputy Director



ELLEN SCHMEDING  
Assistant Deputy Director

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

## CMIPS II NOA MESSAGES

### LM02 – Temporary Message

This notice is about a new state law that affects your IHSS hours.

Starting July 1, 2013, a new state law (Section 12301.01 of the Welfare and Institutions Code) says the California Department of Social Services must cut all IHSS recipients total authorized hours by 8 percent. This means that the current temporary cut of 3.6 percent will be increased by an additional 4.4 percent starting July 1, 2013. The 8 percent cut will remain in effect for 12 months. Starting July 1, 2013, your new monthly IHSS hours will be ###.##.

You can choose which of your specific authorized IHSS services, shown on the front of your IHSS Notice of Action, will be cut. For example, if you lose three hours of service per month, you can choose to cut three hours from one type of service or choose to split up those hours among different services. You must tell your provider(s) of the cut in total hours and which specific service hours you choose to cut. You do not have to tell the county which hours you choose to cut. This is between you and your provider.

The new law also applies to all reassessments. Starting July 1, 2013, when a reassessment changes a recipient's authorized hours, the 8 percent cut applies to the new total authorized monthly hours. If your condition gets worse or your circumstances change before your annual reassessment you may call the county to ask for a reassessment of your IHSS needs. The county will not ask you to provide a medical certification form or a doctor's note to show the change in your condition. A request for a reassessment only about the new cuts to IHSS will be denied by the county. If you are denied a reassessment for any other reason, you may request a state hearing. Your hearing rights are included with this message. However, requests for a state hearing only about the new state law requiring the 8 percent cut in service hours will be dismissed.

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

### LM03 – Ongoing Message

As a result of a new state law your total monthly authorized hours of ###.## have been cut by 8 percent to ###.## (WIC Section 12301.01). Here is why:

A new state law (Section 12301.01 of the Welfare and Institutions Code) says the California Department of Social Services must cut all IHSS recipients' total authorized monthly hours by 8 percent. The 8 percent cut will remain in effect for 12 months. You can choose which of your specific authorized IHSS services, shown on the front of your IHSS Notice of Action, will be cut. For example, if you lose three hours of service per month, you can choose to cut three hours from one type of service or choose to split up those hours among different services. You must tell your provider(s) of the cut in

total hours and which specific service hours you choose to cut. You do not have to tell the county which hours you choose to cut. This is between you and your provider.

The new law also applies to all reassessments. Starting July 1, 2013, when a reassessment changes a recipient's authorized hours, the 8 percent cut applies to the new total authorized monthly hours. If your condition gets worse or your circumstances change before your annual reassessment you may call the county to ask for a reassessment of your IHSS needs. The county will not ask you to provide a medical certification form or a doctor's note to show the change in your condition. A request for a reassessment only about the new cuts to IHSS will be denied by the county. If you are denied a reassessment for any other reason, you may request a state hearing. Your hearing rights are included with this message. However, requests for a state hearing only about the new state law requiring the 8 percent cut in service hours will be dismissed.

If you do not understand this new cut or have questions about the new law please contact your county IHSS

HR01 – 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)

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
NOTICE OF DENIAL OF REQUEST FOR  
IN-HOME REASSESSMENT BASED ON STATE LAW CHANGE**

TO:

Notice Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
IHSS Office Address: \_\_\_\_\_  
\_\_\_\_\_  
IHSS Office Telephone: \_\_\_\_\_

Your request for an in-home reassessment has been denied because:

On \_\_\_\_\_ / \_\_\_\_ / 20\_\_ you asked for a reassessment based on a change in state law which requires all IHSS recipients' authorized services hours to be reduced by \_\_\_\_ percent. Your need for IHSS services has not changed. It has been determined that there has been no change to your physical or mental condition nor has there been a change in your living situation.

Your State Hearings rights are included with this message.

**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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**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES  
SPECIAL NOTICE 13-04**

**September 5, 2013**

**SUBJECT:** MC 223C – Supplemental Statement of Facts for Medi-Cal Child Only – Under Age 18

**EFFECTIVE DATE:** Immediately

**EXPIRATION DATE:** When incorporated into the IHSS Policy & Procedure Handbook

**REFERENCE:** All County Welfare Directors Letter No. 12-02 issued January 2, 2012

**I. PURPOSE**

The purpose of this Special Notice is to provide IHSS staff with instructions and information on the implementation of Medi-Cal form MC 223C – Supplemental Statement of Facts for Medi-Cal Child Only – Under Age 18 (Attachment A).

**II. BACKGROUND**

The California Department of Social Services (CDSS) Disability Determination Service Division (DDSD) is responsible for evaluating medical and employment data to determine if an applicant/beneficiary meets the federal definition of disability. A referral packet is sent to DDSD, by the Social Worker, for a determination of disability within 10 days of the face-to-face interview when an applicant/beneficiary claims he/she is disabled and is receiving full-scope Medi-Cal through a program such as Aid to Families with Dependent Children (AFDC) – 1931(b) Non-CalWORKs (Medi-Cal Aid Code 3N).

**III. SOCIAL WORKER PROCEDURES**

The IHSS Social Worker is responsible for following the DDSD referral procedure for applicants/recipients. The form MC 223C is to be used for applicants filing for Medi-Cal based on a disability, who have not yet reached their 18th birthday. The MC 223C is a supplemental form to the MC 210 – Application for Medi-Cal and any other Department of Health Care Services approved application used to apply for Medi-Cal. The form replaces the MC 223 – Applicant's Supplemental Statement of Facts for Medi-Cal. The MC 223 will only be required for applicants, age 18 and older, filing for Medi-Cal based on a disability.

**IHSS SPECIAL NOTICE 13-04  
MC 223C – SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL  
CHILD ONLY – UNDER AGE 18**

The forms are available in the threshold languages on the California Department of Health Care Services website at:

<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/Index-MC200.aspx>

**IV. REVIEW STATEMENT**

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

**V. 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=AISIHSS>  
Program Support will not distribute hard copies of this Special Notice.

  
WILFRED QUINTONG  
Assistant Deputy Director

  
MARK SELLERS  
Assistant Deputy Director

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

## **SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL CHILD APPLICANT ONLY — UNDER AGE 18 (MC 223C) INSTRUCTIONS**

**Read ALL of the information below BEFORE you start. If you have any questions about this form, or if you need help filling it out, please call your county social services agency.**

The information that you provide on this form will be used by the California Department of Social Services, Disability Determination Service Division. That agency will make the disability decision on the child's Medi-Cal application. To help process the child's case faster, fill out as much of this form as you can.

All questions on this form refer to the child - provide information about him/her, not about yourself.

- Type or print clearly
- Answer all questions fully
- Do not skip questions. If you do not know the answers do not leave it blank. Write "none," "don't know," or "does not apply".

List only one hospital/clinic or one doctor/therapist in each section of Part 5 - Medical Information. Be sure to give the following information:

- Full name of hospital/clinic and doctor/therapist
- Address
- The child's hospital/clinic number.

**If the applicant is not a child under the age of 18, you must use the form that is specifically for adults (MC 223), which you can get from your county social services agency.**

### **Information about the *Authorization for Release of Information* (MC 220)**

- Please provide one Authorization for Release of Information (MC 220) for each doctor, hospital, clinic, or therapist that you have listed on this form.
- You must sign your name (not the child's name) on the "Individual Authorizing Disclosure" line of the MC 220 and check the appropriate box (Parent of minor, Guardian, or Other personal representative). Sign every MC 220—do not sign one and photocopy it.
- If you make a mistake, you must contact the county for a new release form. Do not use whiteout or make corrections on the Authorization for Release of Information (MC 220).
- If the person signing the release must sign with an "X" or a "mark", the "X" or "mark" must include the signature of a witness and state the relationship of the witness to the person releasing the information.
- Any child who has attained the age of 12 must sign his or her own Authorization for Release of Information (MC 220) if their disability is linked to services available through the Minor Consent program. The minor must sign the MC 220 and the "Minor Consent Services Only" box must be checked.

**A separate MC 223C is required for each child applying for Medi-Cal based on a disability. Begin filling in the form on Page 2.**

# SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL CHILD APPLICANT ONLY - UNDER AGE 18

<i>County Use Only</i>		
County Number	Aid Code	Case Number

## PART 1—PERSONAL INFORMATION

<b>A. Child's Name</b> (first, middle, last)	<b>B. Social Security Number</b>	<b>C. Date of Birth</b>
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<b>D. Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>E. Height</b> Feet _____ Inches _____	<b>F. Weight in Pounds</b>
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**G. Who does the child live with?**

Name	Relationship	Phone Number	<input type="checkbox"/> No Phone
Home Address (number, street)	City	State	Zip Code

**H. Mailing Address** (if different than home address)

Address (number, street)	City	State	Zip Code
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**I. Person applying for the child**

Name	Relationship	Phone Number	<input type="checkbox"/> No Phone
Message Phone Number	Name of person to leave message with		

**J. What language/dialect does the person applying for the child speak and read best?**

---

## PART 2—THE CHILD'S ILLNESSES, INJURIES, OR MEDICAL CONDITIONS

A. What are the child's illnesses, injuries or medical conditions?	When did it start? (month/year)	<i>County Use Only</i>

**PART 3—SOCIAL SECURITY/SSI INFORMATION**

County Use Only

**A. Has the child applied for Social Security disability or Supplemental Security Income (SSI) disability benefits in the last two years?**

Yes  
 No  
 If Yes, please answer the following, if No, skip to Part 4.

**B. Was/is the Social Security or SSI disability application:**

Approved Date: \_\_\_\_\_  Denied Date: \_\_\_\_\_  Unknown  
 On Appeal Date: \_\_\_\_\_  Pending Date: \_\_\_\_\_

**C. Has the child’s medical problem(s) worsened since the decision?**

Yes  
 No  
 If Yes, please explain:

**D. Does the child have any new medical problems since the date of the Social Security/SSI disability denial?**

Yes  
 No  
 If Yes, what problems and when did they start?

**PART 4—SPECIAL SOURCES AND SCHOOL INFORMATION**

**A. Has the child ever been tested or evaluated by any of the following agencies, or do any of these agencies have medical records or information about the child?**

Regional Centers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
California Children’s Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Developmental Evaluation Center	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Women, Infants, and Children (WIC) Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Health Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any Other Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No

(MC 220) signed

**B. If Yes to any of the above questions, complete the following information.**

1. Agency Name		Agency Phone Number	
Address (number, street)	City	State	Zip Code
Counselor, Caseworker, Therapist, etc. Name		Phone Number	
Type of test or evaluation, if any (for example, vision, hearing, speech, physical, psychological)			
Date of Test or Evaluation		Child’s ID Number or Claim Number	

2. Agency Name		Agency Phone Number	
Address (number, street)		City	State      Zip Code
Counselor, Caseworker, Therapist, etc. Name		Phone Number	
Type of Test or Evaluation, if any (for example, vision, hearing, speech, physical, psychological)			
Date of Test or Evaluation		Child's ID Number or Claim Number	

*County Use Only*

(MC 220) signed

**C. Does/did the child attend any type of preschool, day care, and/or after school program?**

Yes      If Yes, please complete the following information:  
 No

Program Name		Phone Number	
Address (number, street)		City	State      Zip Code
Contact Person		Dates Attended	

(MC 220) signed

**D. Is/was the child in school?**

Yes      If Yes, please complete the following information:  
 No      If No, skip to Section H

1. Name of School		Phone Number	
Address (number, street)		City	State      Zip Code
Teacher's Name			
2. Name of School		Phone Number	
Address (number, street)		City	State      Zip Code
Teacher's Name			

(MC 220) signed

(MC 220) signed

**E. Does the school make any special accommodations for the child (for example: adaptive furniture, wheelchair ramps, extra assistance, or attention)?**

Yes      If Yes, what type of accommodation?  
 No

**F. Is the child in a special education program?**

Yes      If Yes, what type of special education program?  
 No

**G. Do you have a copy of the child’s Individualized Education Plan (IEP—the report in which the teacher outlines the child’s problems and lists the plans for correcting them)?**

*County Use Only*

<input type="checkbox"/> Yes	If Yes, please provide a copy.
<input type="checkbox"/> No	

(MC 220) signed

**H. Does the child receive any special counseling or tutoring?**

<input type="checkbox"/> Yes	If Yes, please complete the following information (if you need more spaces, you may add pages):
<input type="checkbox"/> No	

Is counseling or tutoring received at school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is counseling or tutoring received outside of school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please complete the following:		

Counselor or Tutor’s name	Phone Number
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Street Address (number, street)	City	State	Zip Code
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Frequency of Visits	Date Therapy began	Date Therapy ended (if completed)
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**I. Does/did the child receive any special therapy (physical, speech and language, occupational) or any other services for his/her illnesses or injuries? Include information about any therapy the child receives from parent, guardian, caregiver, or in school.**

<input type="checkbox"/> Yes	If Yes, please complete the following information about therapy:
<input type="checkbox"/> No	

1. Therapist’s Name	Phone Number
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Street Address (number, street)	City	State	Zip Code
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(MC 220) signed

Person who prescribed/designed the therapy	Type of Therapy
--	-----------------

Frequency of Visits	Date Therapy began	Date Therapy ended (if completed)
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2. Therapist’s Name	Phone Number
---------------------	--------------

Street Address (number, street)	City	State	Zip Code
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(MC 220) signed

Person who prescribed/designed the therapy	Type of Therapy
--	-----------------

Frequency of Visits	Date Therapy began	Date Therapy ended (if completed)
---------------------	--------------------	-----------------------------------

**PART 5—MEDICAL INFORMATION**

County Use Only

**A. Has the child been in a clinic or hospital for any illness, injury or medical condition in the last 12 months?**

- Yes
- No

If No, go to Part 6. If Yes, please fully answer the following:

1. Name of Hospital/Clinic	Type of Visit(s)		Dates	
	<input type="checkbox"/> Inpatient Stay (stayed at least overnight)	Date in	Date out	
	<input type="checkbox"/> Outpatient Visit (sent home same day)			
	<input type="checkbox"/> Emergency Room Visit			
Street Address (number, street)	City	State	Zip Code	
Phone Number	Hospital/Clinic File Number			

(MC 220) signed

Reason for Visits

What treatment did the child receive?

What doctor(s) did the child see at this hospital on a regular basis?

2. Name of Hospital/Clinic	Type of Visit(s)		Dates	
	<input type="checkbox"/> Inpatient Stay (stayed at least overnight)	Date in	Date out	
	<input type="checkbox"/> Outpatient Visit (sent home same day)			
	<input type="checkbox"/> Emergency Room Visit			
Street Address (number, street)	City	State	Zip Code	
Phone Number	Hospital/Clinic File Number			

(MC 220) signed

Reason for Visits

What treatment did the child receive?

What doctor(s) did the child see at this hospital on a regular basis?

**If you need more space, please use Part 9—Remarks (page 9). Please remember to sign an *Authorization for Release of Information* (MC 220) for the hospital(s)/clinic(s) you listed on page 6.**

*County Use Only*

**B. Has the child been seen in the last 12 months by any doctor/therapist, not listed in Section A?**

(MC 220) signed

1. Name of Doctor or Therapist		Phone Number	
Street Address (number, street)	City	State	Zip Code
First Visit Date	Last Visit Date	Next Appointment Date	

Reason(s) for Visits

What treatment did the child receive?

2. Name of Doctor or Therapist		Phone Number	
Street Address (number, street)	City	State	Zip Code
First Visit Date	Last Visit Date	Next Appointment Date	

(MC 220) signed

Reason(s) for Visits

What treatment did the child receive?

**PART 6—MEDICATIONS**

*County Use Only*

**Does the child currently take any prescribed medication for illnesses, injuries, or medical conditions?**

<input type="checkbox"/> Yes	If Yes, tell us the following:
<input type="checkbox"/> No	

Prescribed Medication	Name of Doctor	Reason for Medication	Side Effects, if any

**If the child has additional prescribed medications, list them in Part 9—Remarks**

## PART 7—TESTS

*County Use Only*

**Has the child had, or will he/she have, any medical tests for illnesses, injuries, or medical conditions?**

(MC 220) signed

<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, tell us the following:
---	--------------------------------

Kind of Test	When was/will the test be done? (month, year)	Where was the test done? (name of the facility)	Who sent the child for this test?
EKG (Heart Test)			
Treadmill (Exercise Test)			
Cardiac Catheterization			
Biopsy (Name of Body Part)			
Speech/Language			
Hearing Test			
Vision Test			
IQ Test			
EEG (Brain Wave Test)			
HIV Test			
Blood Test (Not HIV)			
Breathing Test			
X-Ray (Name of Body Part)			
MRI/CAT Scan (Name of Body Part)			

**If the child has had other tests, list them in Part 9—Remarks**

## PART 8—WORK HISTORY

(MC 220) signed

**Has the child ever worked?**

<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, complete the following:
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Dates Worked

Employer Name

Street Address (number, street)	City	State	Zip Code
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Phone Number

Supervisor Name



**COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES (IHSS)  
SPECIAL NOTICE 13-05**

**October 28, 2013**

**SUBJECT: INDIVIDUAL PROVIDER WAGE INCREASE**

**EFFECTIVE DATE: OCTOBER 21, 2013**

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

**I. PURPOSE**

The purpose of this Special Notice is to inform In-Home Supportive Services (IHSS) staff of a wage increase for IHSS Individual Providers (IPs).

**II. POLICY**

Effective November 1, 2013, the hourly rate for Individual Providers in San Diego County will increase from \$9.50 per hour to \$9.85.

**III. PROCEDURES**

The Case Management Information and Payrolling System (CMIPS II) implemented the rate increase automatically on 10/20/2013 to be effective 11/1/2013. A Notice of Action (NOA) related to the change will not be generated.

On-going Eligible or Presumptive Eligible Cases

On 10/20/2013, CMIPS II deleted all *Pending Evidence* for cases in *Eligible* status.

***Overdue Reassessments***

If the *Authorization End Date* for a case is prior to 10/31/2013, then a *Wage Rate Update* with a 10/31/2013 *Authorization End Date* will be added to bring the case authorization current. A second *Wage Rate Update* will be added with an *Authorization Start Date* of 11/1/2013 and an *Authorization End Date* of 11/30/2013 to apply the wage rate change.

***Current Assessments***

If the *Authorization End Date* is after 10/31/2013, then a single *Wage Rate Update* will be added with an *Authorization Start Date* 11/1/2013 and the *Authorization End Date* of the active evidence.

Eligibility Segments

CMIPS II will not allow the creation of an authorization segment that spans the 11/1/2013 implementation date. Case information entered after 10/20/2013 and any changes to existing authorizations that begin prior to 11/1/2013 will require two authorization segments:

- An authorization segment for any days of service provided prior to 11/1/2013 with an *Authorization End Date* of 10/31/2013.
- A second authorization segment with an *Authorization Start Date* of 11/1/2013.

#### Provider Hours

A provider who is "Active" will have the *Provider Hours* segment updated to match the wage rate effective date of 11/1/2013. A provider who is added for a period that spans the 11/1/2013 implementation date will require two *Provider Hours* segments:

- A *Provider Hours* segment for any days of service provided prior to 11/1/2013 with an *End Date* of 10/31/2013.
- A second *Provider Hours* segment with a *Begin Date* of 11/1/2013.

#### Pending or Leave Status Cases

Cases in *Pending* or *Leave* status will not have the *Wage Rate Update* applied. If a case needs to be reinstated from leave status with an *Authorization Start Date* prior to 11/1/2013, create a *Change Assessment* to include an *Authorization Start Date* of when the recipient returned home and an *Authorization End Date* of 10/31/2013. A subsequent *Change Assessment* must be added with an *Authorization Start Date* of 11/1/2013 and an *Authorization End Date* to match the *Re-Assessment Due Date*.

#### **IV. REVIEW STATEMENT**

Due to the informational nature of this notice, it was not sent to the standard Organizational Review Committee (ORC).

#### **V. 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.sdcountry.ca.gov/AisIhss/default.asp?Guide=AI SIHSS>

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



WILFRED QUINTONG  
Assistant Deputy Director



MARK SELLERS  
Assistant Deputy Director

Contact: Wendy Contreras (858) 505-6366  
Dist. Codes 7 & 8