

**IN-HOME SUPPORTIVE  
SERVICES  
SPECIAL NOTICE  
ARCHIVES  
2014**





**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES  
SPECIAL NOTICE 14-06**

**December 29, 2014**

**SUBJECT: Expedited Registry Services Referrals**

**EFFECTIVE DATE: Immediately**

**I. PURPOSE**

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff information about Expedited Registry Services that are available through the IHSS Public Authority (PA) Registry.

**II. BACKGROUND**

Expedited Registry Services are available to IHSS recipients who have critical care needs, and require assistance in finding a care provider. Referrals for Expedited Registry Services can be accepted for an IHSS applicant/recipient who:

- Was recently referred to IHSS by a Health Plan representative as an expedited referral
- Has requested, and been temporarily approved for care through Urgent Services and needs help hiring a long-term provider

Expedited Registry Service providers are available twenty-four (24) hours a day, seven (7) days a week, including holidays. The recipient may at his/her discretion, hire an Expedited Registry Services caregiver.

Expedited Registry Services are not meant to duplicate or replace services provided by the IHSS Urgent Services contract vendor. Expedited Registry Services are to be utilized as a resource when a high risk recipient has exhausted all other plans for the provision of IHSS services and/or there is no one available to provide care. Providers selected from the Expedited Registry Services are not able to provide Paramedical Services. Paramedical Services require written authorization and training of the caregiver by a medical professional before paramedical services can be authorized for payment.

**III. PROCEDURES**

**IHSS Social Worker Responsibilities**

IHSS eligibility must be approved and authorized in CMIPS II by the IHSS Social Worker prior to submitting an Expedited Registry Services referral. The IHSS Social Worker will initiate a referral using the *Expedited Registry Services Referral* form (Attachment A). In order for the request to be processed properly, the referral form must be emailed to [registry.hhsa@sdcounty.ca.gov](mailto:registry.hhsa@sdcounty.ca.gov) with the subject line of "Expedited Registry Services Referral".

## IHSS Public Authority Registry Process

Upon receiving the referral for Expedited Registry Services, Registry staff will contact the recipient and attempt to match him/her with a provider. In order to share the recipient's information with potential providers, the recipient must complete a PA Release of Information (ROI) authorization form. If no ROI is presently on file, Registry staff will obtain a one-time verbal permission from the recipient to release his/her information, and will immediately follow up by obtaining a written ROI the same business day. After obtaining verbal or written permission, Registry staff will contact one or more providers and share the recipient's relevant demographic information and service needs and determine the best match.

Once a provider has been identified, Registry staff will attempt to contact the recipient directly again, and provide information on the provider's arrival. Registry staff will contact the IHSS Social Worker for assistance if unable to reach the IHSS recipient. Once contact is made with the recipient, the provider is required to be at the recipient's residence within two (2) to six (6) hours of the time indicated on the referral form.

During normal business hours, Monday through Friday, 8:00 a.m. to 4:30 p.m., Registry staff will call the recipient within one (1) hour of the provider's anticipated start time to verify the arrival of the provider. If the provider's anticipated start time is after normal business hours, Registry staff will call the recipient on the following PA business morning to confirm the provider's arrival. If the recipient is not matched with a provider, Registry staff will re-start the process, attempting to find the recipient a match until all Registry provider options are exhausted. If no match can be found, Registry staff will confer with the IHSS Social Worker to explore other options.

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

This Special Notice has been reviewed by an 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\IHSS Special Notices>

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



WILFRED QUINTONG  
Deputy Director



MARK SELLERS  
Deputy Director

Attachments  
Contact: Wendy Contreras  
(858) 505-6366



# County of San Diego IHSS Public Authority Provider Registry

## EXPEDITED REGISTRY SERVICES REFERRAL FORM

Special Note: Please type “**Expedited Registry Services Referral**” in the subject line and e-mail referral as an attachment to the following email address: [registry.hhsa@sdcounty.ca.gov](mailto:registry.hhsa@sdcounty.ca.gov)

**IMPORTANT: We can only process referrals for IHSS Consumers that are in “eligible” status in CMIPS II**

*Note: Public Authority Expedited Registry Services Referrals can be submitted at any time, but will only be processed between 8:00 AM - 4:30 PM, Monday – Friday.*

### IHSS Consumer (CSR): (required)

Name (Last, First):  
 Address:  
 City:                      Zip Code:  
 Ph#:                      SSN#:  
 DOB:                      Gender:  M     F  
 Email Address:  
 Primary Language:  
 Additional comments regarding Consumer’s mental, health, or living conditions:  
 Which health plan does the Consumer belong to:  
 Care 1st  Community Health Group   
 Health Net  Kaiser  Molina   
 Reason for referral: Expedited Application   
 Follow Up to Urgent Services Request

### IHSS Social Worker (SW): (required)

Date of Referral:  
 SW Name:  
 Ph#:  
 Fax#:  
 Email:  
 IHSS Duty Worker (if you are unavailable for ques.):  
 Name:    Phone#:

### IHSS Consumer Service Needs: (required)

Enter # Authorized hours per month:  
 Frequency: #                      /days per week  
 # Authorized IHSS Hrs. Remaining for Month:  
 Consumer’s Provider Gender Preference:  
 Male  Female  No Preference  
**Date and Time Registry Provider Needed At the Consumer’s Home:** \_\_\_/\_\_\_/\_\_\_ at \_\_\_ AM/PM

### Authorized Representative: (if applicable)

**Please complete the information below so that we can contact this individual in order to have them complete a Public Authority Registry Release of Information (ROI) if they will be assisting the Consumer.**

#### Name of 3<sup>rd</sup> Party/Authorized Rep. or Case Mgr. (Non-County):

Address:                      City:                      State:                      Zip Code:  
 Ph.#:                      Fax#:                      Email:                      Comments:

### FOR PUBLIC AUTHORITY STAFF ONLY

Date Referral Received:                      Date Referral Completed:  
 Time Referral Received:                      Time Referral Completed:  
 Assigned RC:                      Date Referral processed by assigned RC on (date):  
 Provider Name:                      Provider Ph# :  
 Provider Start Date:                      Provider Start Time:  
 Unable to Process Referral Due to:                      Date Referral Was Forwarded to SW for Urgent Services:

## **Instructions for Emailing the Expedited Registry Services Referral Form**

Prior to sending the referral to Public Authority, please be sure that all required fields are complete and that you are using the most current referral form.

Required fields include:

- 1) IHSS Consumer demographic and health plan information
- 2) SW contact information
- 3) IHSS Consumer service needs including the date and time that a Registry Provider is needed at the Consumer's home
- 4) Authorized Representative information that will assist the Public Authority in contacting a 3<sup>rd</sup> Party (if applicable)

Reminder: Registry Providers selected from the Expedited Registry Services are not able to provide Paramedical Services. Paramedical Services require authorization and training by a medical professional before they can be provided.

Please also note that all Provider Registry referrals must be sent via email to: [registry.hhsa@sdcountry.ca.gov](mailto:registry.hhsa@sdcountry.ca.gov).

***The Public Authority will not process referrals that are sent via fax or County mail.***

To send the referral, please complete the following steps:

- 1) Once the form has been completed, go to "File" at the top menu bar
- 2) Click on "Send To" and arrow over to "Mail Recipient (**as attachment**)"
- 3) The Outlook email window appears, with the Referral Form in the lower window (as an attached file)
- 4) In the "To" field, send the referral to: [registry.hhsa@sdcountry.ca.gov](mailto:registry.hhsa@sdcountry.ca.gov)
- 5) In the "Subject" field, please include Consumer's first and last name
- 6) Click on "Send" in order to submit form

Following your e-mail to the Registry, we recommend saving the referral form for your records.

Once the referral has been processed, Public Authority will email you the assigned Registry Coordinator's name and telephone number.

**COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES (IHSS)  
SPECIAL NOTICE 14-05**

**December 12, 2014**

**SUBJECT: Provider Wage Reimbursement for Unpaid Medi-Cal Share of Cost Deductions**

**EFFECTIVE DATE: Immediately**

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

**REFERENCE: All-County Letter No. 14-40; County Fiscal Letter No. 14/15-15**

**I. PURPOSE**

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with instructions on requesting reimbursement from the State for providers who have had incorrect Medi-Cal Share-of-Cost (SOC) deductions. This specifically applies to situations where the recipient has not paid the deducted SOC to the provider.

**II. BACKGROUND**

When a provider for a SOC recipient submits a timesheet, the Case Management, Information, and Payrolling System (CMIPS) II interfaces with the Medi-Cal Eligibility Data System (MEDS) to determine if the recipient has an outstanding Medi-Cal SOC before initiating a payment. If there is an outstanding Medi-Cal SOC, that amount is deducted from the provider's pay warrant(s) for that time period. CMIPS II then generates letters to the recipient and provider indicating that the recipient is required to pay the deducted amount to the provider.

If the Medi-Cal SOC listed in MEDS is incorrect when the timesheet is processed, this will cause an erroneous deduction from the provider's pay warrant(s). When the recipient has paid the provider the greater, incorrect SOC amount, the recipient is able to submit a claim for reimbursement using the Conlan II process. There is now a process to directly reimburse the provider if the recipient has failed to pay the SOC using the GEN 1384 – IHSS Provider Wage Reimbursement Claim Form (Attachment A).

**III. PROCEDURES**

When the IHSS Social Worker is contacted by a recipient or provider regarding an incorrect SOC deduction from a provider's pay warrant(s), the IHSS Social Worker will:

1. Review both MEDS and CMIPS II to determine if the provider is due reimbursement for an incorrect Medi-Cal SOC deduction.

**IHSS SPECIAL NOTICE 14-05  
Provider Wage Reimbursement for  
Unpaid Medi-Cal Share of Cost Deductions**

- a. If the IHSS Social Worker determines that the correct SOC was deducted, the IHSS Social Worker will notify the requestor that the SOC amount deducted from the provider's warrant(s) for the pay period in question was correct.
    - i. If the requestor disputes the IHSS Social Worker's determination, the recipient should be directed to contact his/her Medi-Cal eligibility worker.
  - b. If the amount taken from the provider's warrant is greater than the verified Medi-Cal SOC for the pay period, it will be considered that the SOC amount that was deducted was incorrect. When this occurs, the IHSS Social Worker will:
    - i. Send page one (Sections A and B) of the GEN 1384 to the provider or recipient. (The GEN 1384 should be given to the provider or recipient only after it has been determined that there has been an incorrect SOC deducted.)
    - ii. Upon receipt of the returned page one of the GEN 1384, verify that it has been completed fully, correctly, and signed by both the recipient and provider.
2. Complete page two of the GEN 1384 as follows:
    - a. Fill in the **Claimant / IHSS Provider Name** and **IHSS Case Number** located toward the top of the form.
    - b. Complete all fields in Section C:
      - **Name of Medi-Cal Eligibility Worker:** Enter the phrase *worker of the day*.
      - **Telephone # of Medi-Cal Eligibility Worker:** Enter **1-866-262-9881**.
      - **Name/Title of Staff Completing Verification:** Enter the name and title of the Social Worker completing Section C.
      - **Telephone # of Staff Completing Verification:** Enter the telephone number of the Social Worker completing Section C.
      - **MEDS Month/Year of Service & SOC Displayed:** Enter the month and year for the pay period reimbursement is being requested, as well as the corresponding SOC amount as reflected in MEDS.
      - **CMIPS Warrant Month/Year & SOC Deducted:** Enter the warrant month and year for the pay period reimbursement is being requested, as well as the corresponding SOC amount deducted as reflected in CMIPS II.
      - **Total Amount Claimed by Provider:** Enter the dollar amount indicated by the provider in Section A-6 on page one of the GEN 1384.
      - **Amount Verified for Payment to Provider:** Enter the verified SOC amount withheld from the provider's warrant for the pay period reimbursement being requested.
  3. Submit to the Social Work Supervisor for approval.
  4. Once approved by the Social Work Supervisor, send scanned copies of the completed GEN 1384 to CDSS within 10 business days of receipt to the following secure email address: [ProviderReimbursement@dss.ca.gov](mailto:ProviderReimbursement@dss.ca.gov).
  5. Notify the requestor that the claim has been forwarded to CDSS for review.

**IHSS SPECIAL NOTICE 14-05**  
**Provider Wage Reimbursement for**  
**Unpaid Medi-Cal Share of Cost Deductions**

- Maintain a copy of the GEN 1384 to be included with other documents that will be scanned into the case record.

CDSS will determine if the provider is eligible for reimbursement and, when applicable, will issue payment of any monies owed to the provider. If the requestor has any questions regarding the status of their claim, they should be directed to contact CDSS at 1-877-508-1327. A copy of the final decision will be mailed to the recipient, the provider, and the County.

Claim form GEN 1384 is available in six languages – English, Spanish, Vietnamese, Chinese, Russian, and Armenian. Portable document format (PDF) versions of the GEN 1384 in all six languages will be available for IHSS staff at the following location: <S:\AIS\Operations\IHSS\Automated Forms\SW Forms>.

#### IV. TIME STUDY INSTRUCTIONS

The program code description for time study codes **1034 PCSP/Plus Option – Case Management** and **1042 IHSS – Non-HR/PCSP/Plus Option** have been updated to capture activities performed by IHSS staff when processing provider reimbursements using the new process. Both codes now include the following activity in their descriptions: “...managing provider reimbursements for incorrect Medi-Cal SOC pay warrant deductions”. IHSS staff may not time study for this activity retroactively, but must begin time studying for this activity immediately as of the date of this Special Notice.

#### V. REVIEW STATEMENT

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

#### VI. FILING STATEMENT

IHSS Special Notices are located at the following link:  
<S:\AIS\Operations\IHSS\Automated Forms\IHSS Policy and Procedure - Automated\IHSS Special Notices>

At the County intranet at:  
<http://hhsa-pg.sdcountry.ca.gov/AisIhss/default.asp?Guide=AIStHSS>

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



WILFRED QUINTONG  
Deputy Director



MARK SELLERS  
Deputy Director

Contact: Vicki Macedo (858) 495-5726

**IHSS SPECIAL NOTICE 14-05**  
**Provider Wage Reimbursement for**  
**Unpaid Medi-Cal Share of Cost Deductions**

**IN-HOME SUPPORTIVE SERVICES (IHSS)  
RETROACTIVELY ADJUSTED MEDI-CAL SHARE OF COST (SOC)  
IHSS PROVIDER WAGE REIMBURSEMENT CLAIM FORM**

*NOTE: This form must be returned to the county IHSS office for verification. **DO NOT** mail this form directly to the State as it will be returned to you unprocessed.*

**SECTION A: PROVIDER INFORMATION  
(MUST BE COMPLETED BY PROVIDER)**

1. NAME (PRINT CLEARLY):	2. ADDRESS:
3. TELEPHONE NUMBER:	4. DATE OF BIRTH:
5. PAY PERIOD (DATES/MONTH/YEAR) SOC WAS INCORRECTLY DEDUCTED (ONLY ONE PAY PERIOD PER CLAIM FORM):	6. AMOUNT CLAIMED: \$

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief and that the recipient has not paid me for the amount claimed herein.

\_\_\_\_\_  
SIGNATURE OF PROVIDER

\_\_\_\_\_  
DATE

**SECTION B: RECIPIENT INFORMATION  
(MUST BE COMPLETED BY RECIPIENT)**

7. NAME (PRINT CLEARLY):	8. ADDRESS:
9. TELEPHONE NUMBER:	10. COUNTY IHSS CASE NUMBER:

I declare under penalty of perjury under the laws of the State of California that all of the information on this Claim Form is true and accurate to the best of my knowledge and belief. I authorize Medi-Cal to receive and release such information in connection with processing claims and any other lawful purpose related to participation in the IHSS Program. I understand that all personal health information will be treated as confidential and will not be disclosed for any other purpose. **I have not previously and do not intend to file a Conlan II claim, assuming a satisfactory resolution is reached pursuant to this procedure, and I have not paid and do not intend to pay this provider for the amount claimed herein.**

\_\_\_\_\_  
SIGNATURE OF RECIPIENT

\_\_\_\_\_  
DATE

**IN-HOME SUPPORTIVE SERVICES (IHSS)  
RETROACTIVELY ADJUSTED MEDI-CAL SHARE OF COST (SOC)  
IHSS PROVIDER WAGE REIMBURSEMENT CLAIM FORM**

\*\*\*COUNTY USE ONLY\*\*\*

**Claimant / IHSS Provider Name (Print)** \_\_\_\_\_

**IHSS Case Number** \_\_\_\_\_

**SECTION C: COUNTY VERIFICATION**

1. NAME OF MEDI-CAL ELIGIBILITY WORKER:	2. TELEPHONE # OF MEDI-CAL ELIGIBILITY WORKER:
3. NAME/TITLE OF STAFF COMPLETING VERIFICATION:	4. TELEPHONE # OF STAFF COMPLETING VERIFICATION:
5. MEDS MONTH/YEAR OF SERVICE & SOC DISPLAYED:	6. CMIPS WARRANT MONTH/YEAR & SOC DEDUCTED:
7. TOTAL AMOUNT CLAIMED BY PROVIDER: \$	8. AMOUNT VERIFIED FOR PAYMENT TO PROVIDER: \$

I have reviewed the CMIPS warrant data and MEDS and hereby verify that the amount taken from the pay warrant is greater than the Medi-Cal SOC for the period of time in question, and that a discrepancy exists between the recipient's actual SOC and the SOC deducted from the above-named provider's pay warrant in the amount listed in number 8, above.

\_\_\_\_\_  
SIGNATURE OF COUNTY STAFF (SUPERVISORY LEVEL)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES  
SPECIAL NOTICE 14-04**

**December 1, 2014**

**SUBJECT: Implementation of the IHSS Overtime Assistance Unit**

**EFFECTIVE DATE: November 14, 2014**

**REFERENCE: All County Letter 14-76, All County Program Managers Letter 11/3/2014**

**I. PURPOSE**

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with instructions and information on the implementation of the IHSS Overtime Assistance Unit and on changes to the IHSS program that will be effective January 1, 2015.

**II. BACKGROUND**

As a result of changes in the interpretation of the Fair Labor Standards Act (FLSA) rules, effective January 1, 2015 IHSS Individual Providers (IPs) will be eligible to receive overtime pay. Overtime pay will be paid at a rate equal to one and one-half times the regular rate of hourly pay when time worked exceeds 40 authorized hours per *workweek*. IHSS IPs must also be compensated for traveling between multiple recipients as well as for certain periods of wait time when specific requirements for payment have been met. Additional information and changes to procedure will be issued as subsequent All County Letters (ACLs) are issued by the California Department of Social Services (CDSS).

A recipient's *weekly* authorized hours will be determined by dividing the *monthly* authorized number of hours by 4.33. CDSS will notify recipients and providers of the recipient's weekly authorized hours using form SOC 2271 – IHSS Program Provider Notice of Recipient Authorized Hours (Attachment A) and form SOC 2271A – IHSS Program Recipient Notice of Weekly Hours Authorized Hours (Attachment B).

Effective November 14, 2014, a centralized unit of IHSS Social Workers was created to assist with implementation of the program changes and the resulting workload.

**III. IHSS OVERTIME ASSISTANCE UNIT**

The IHSS Overtime Assistance Unit is located at 5500 Overland Avenue, Ste. 430, San Diego CA 92123, Mail Stop W-438. IHSS Overtime Assistance (OA) Social Workers provide assistance and answer questions from IHSS applicants, recipients, and staff regarding restrictions to overtime compensation for IHSS IPs and the related responsibilities of IHSS recipients. Staff will refer related recipient inquiries to the OA Unit at the toll free number below:

**IHSS SPECIAL NOTICE 14-04  
IMPLEMENTATION OF THE IHSS OVERTIME ASSISTANCE UNIT**

**1 (844) 347-4357**  
**Monday – Friday, 8:00 a.m. to 5:00 p.m.**  
**FAX (858) 505-6683**

Inquiries from IPs will be referred to the IHSS Public Authority at the toll free number below:

**1 (866) 351-7722**

### Notices and Forms

CDSS mailed informing notices and required forms to all IHSS Recipients and IPs starting on November 1, 2014. The mailer provided information on program changes and instructions requiring that the enclosed, mandated forms be completed, signed and returned to the local IHSS district office. It is anticipated that there will be a significant increase in phone calls and office visits from providers, recipients and/or recipients' authorized representatives.

### ***Recipient Forms***

The IHSS Overtime Assistance Unit is responsible for receiving and processing the following recipient forms:

- TEMP 3000 – Overtime and Workweek Requirements Recipient Declaration  
Attachment C - This form provides the recipient with information on overtime and workweek requirements. The recipient's signature indicates agreement and understanding.
- SOC 2256 – IHSS Recipient Workweek Agreement  
Attachment D - The SOC 2256 is for recipients with multiple IPs and will be used to document the IHSS hours that each provider will work for the recipient each workweek. The recipient must complete the form, sign it, and have each of his/her IPs sign it, or complete and submit a separate agreement for each provider.

Recipients must sign and return the TEMP 3000 and SOC 2256 by December 15, 2014. Recipients who fail to return the SOC 2256 by March 1, 2015 will be found ineligible for the IHSS program. CDSS has not issued instructions in regard to the action(s) that will be taken when this happens.

### ***Provider Forms***

The San Diego IHSS Public Authority is responsible for receiving and processing the following provider forms:

- SOC 846 – Provider Enrollment Agreement (revised version)  
Attachment E - This form provides the IP with information on overtime and workweek requirements. The provider's signature indicates agreement and understanding.

- SOC 2255 – Provider Workweek and Travel Time Agreement

Attachment F - The SOC 2255 is for IPs who provide services to more than one recipient and is used to document which recipients the provider works for, the number of hours the provider will work for each recipient each day, the total number of hours the provider will work for all recipients each workweek, and the amount of travel time the provider will engage in each workweek.

IPs must sign and return the revised SOC 846 and SOC 2255 by December 15, 2014.

- IPs who do not submit the completed and signed SOC 2255 by December 15, 2014 will not receive payment for any compensable travel time until they submit the completed and signed form to the County.
- Any IP who does not submit the SOC 846 and SOC 2255 by March 1, 2015 will be terminated as a provider as of April 1, 2015.

Overtime Assistance Unit Social Worker Responsibilities

IHSS Overtime Assistance (OA) Social Workers are responsible for responding to questions from recipients and IHSS staff regarding provider overtime limitations and recipient responsibilities. OA Social Worker responsibilities may include, but are not limited to, the following:

- Ensuring that all correspondence received is date stamped immediately upon receipt (if it has not been dated already).
- Reviewing forms such as the TEMP 3000 and the SOC 2256 to ensure that they are properly completed and signed.
- Signing and entering his/her worker number on any forms that have been reviewed, determined to be correct, and data entered into CMIPS II.
- Making photocopies of forms.
- Mailing a copy of the completed and signed TEMP 3000 and SOC 2256 to the recipient and each of the recipient's IPs.
- Scanning and emailing a copy of the completed forms to the assigned IHSS Social Worker.
- Copying the IHSS Social Work Supervisor on all emails to the IHSS Social Worker.
- Retaining the hard copy of the completed TEMP 3000 and SOC 2256.
- Authorizing adjustments in weekly authorized hours that result in overtime compensation for an IP.
- Conducting reviews of IP violations to ensure correct procedures were followed once a review process has been created.
- Entering information into CMIPS II as instructed as required by the IHSS Program.

***Home Visits***

OA Social Workers are available to assist recipients that require help with the completion of forms when necessary. The following criteria may indicate the need for a home visit, but other criteria may also indicate or confirm the need. A home visit may be required if a recipient is having difficulty as a result of:

- A cognitive impairment
- Physical limitations
- A visual impairment
- Isolated and/or without a support system to assist.

A home visit will be conducted only if absolutely necessary and after attempting to assist the recipient by phone. Any home visits coordinated by an OA Social Worker must be approved by the OA Supervisor.

#### OA Clerical Staff

Clerical staff responsibilities may include, but are not limited to the following:

- Ensuring that all correspondence received is date stamped immediately upon receipt (if it has not been dated already)
- Screening and assigning the email received for the IHSS Overtime Assistance Unit through the generic email account
- Screening telephone calls and answering general inquiries regarding the IHSS Overtime Assistance Unit
- Assisting with language interpretation, if bilingual
- Making photocopies of forms
- Mailing a copy of the completed and signed TEMP 3000 and SOC 2256 to the recipient and each of the recipient's IPs if/when requested
- Scanning and emailing a copy of the completed forms to the assigned IHSS Social Worker
- Copying the IHSS Social Work Supervisor on all emails to the IHSS Social Worker
- Retaining the hard copy of the completed TEMP 3000 and SOC 2256
- Entering information into CMIPS II as instructed and as required by the IHSS Program.
- Other duties as assigned to meet the operational needs of the unit

#### OA Supervisor

The IHSS Overtime Assistance (OA) Supervisor is responsible for supervising the social workers and clerical staff in the IHSS Overtime Assistance Unit. The OA Social Work Supervisor is responsible for:

- Ensuring that there is coverage for the unit Monday through Friday from 8:00 a.m. to 5:00 p.m.
- Ensuring that the generic email assigned to the IHSS Overtime Assistance Unit is cleared daily even when designated staff is unavailable
- Training of OA Social Workers and clerical staff
- Tracking and reviewing statistical information
- Ensuring that incoming mail and forms are appropriately tracked and logged until the information is data entered into CMIPS II
- Separately tracking incoming completed recipient forms with insufficient identifying information

- Other duties as assigned to meet the needs of the IHSS Program.

#### **IV. IHSS DISTRICT OFFICE STAFF RESPONSIBILITIES**

##### Clerical Staff

Clerical staff in all IHSS district offices are responsible for date stamping all overtime/travel time related correspondence and forms (including envelopes) received in the district office, and then forwarding recipient forms to the IHSS Overtime Assistance Unit and IP forms to the IHSS Public Authority. Return envelopes must not be discarded and must be stapled to the correspondence prior to forwarding.

The following recipient forms and envelopes are forwarded to the IHSS Overtime Assistance Unit at mailstop W-438, Attention: IHSS Overtime Assistance Unit:

- TEMP 3000 – IHSS Program Overtime and Workweek Requirements Recipient Declaration
- SOC 2256 – IHSS Recipient and Provider Workweek Agreement

The following provider forms and envelopes are forwarded to the IHSS Public Authority at mailstop W-256, Attention: Marcus Gartrell:

- SOC 846 – IHSS Program Enrollment Agreement
- SOC 2255 – IHSS Program Provider Workweek & Travel Time Agreement

##### ***Returned (Undeliverable) CDSS Mail***

The following are procedures for CDSS recipient packets that have been returned to the IHSS district offices as “undeliverable” by the United States Post Office (USPO). Designated clerical staff will:

1. Open and then “clear” the returned CDSS recipient packet in CMIPS II, using the available information on the envelopes (such as the name or address).
2. Re-mail the entire packet to the recipient at the new address if a new address for the recipient has been entered into the system.
3. Forward the packet to the assigned district office Social Worker for appropriate action If the address in CMIPS II is the same as the address on the mail that was undeliverable.
4. Forward any returned CDSS packets for IPs to Marcus Gartrell at Public Authority.
5. Forward returned mail (where there is insufficient identifying information) to the OA Unit for retention and tracking

##### District Office Social Worker Responsibilities

Forms received in error by the district Social Worker must be promptly handed to district office clerical staff so that the form(s) can be date stamped and forwarded as appropriate. Forms received in error do not need to be signed by the district Social Worker before forwarding to the

OA unit. The designated worker in the OA unit will sign the forms as certification that the form is correct, complete, and has been data entered into CMIPS II.

IHSS district Social Workers can provide recipients and IPs who have questions related to the new overtime forms and procedures with the appropriate number for the OA Unit or for Public Authority. It is recommended that the phone numbers be included on the outgoing phone message for each Social Worker to limit the number of messages received.

### ***Recipient Inquiries***

IHSS Recipients requesting information related to the new provider work hour limitation requirements will be transferred/referred to the IHSS Overtime Assistance Unit at 1 (844) 347-4357. This includes assistance with the completion of forms such as the TEMP 3000 and SOC 2256. Prior to transferring the call, the Social Worker will provide the caller with the telephone number.

### ***Provider Inquiries***

The Social Worker will transfer/refer IHSS IPs requesting information related to the new provider work hour limitation requirements to the IHSS Public Authority at 1 (866) 351-7722. This includes assistance with the completion of forms such as the SOC 846, SOC 2255, and provider timesheets.

### ***Document Retention***

Forms must be retained in the IHSS case file as follows:

- The assigned IHSS Social Worker will be responsible for printing, and retaining completed copies of the TEMP 3000 and the SOC 2256 in the IHSS hard copy case file or scanning folder
- Public Authority staff will be responsible for retaining completed copies of the SOC 846 and the SOC 2255 and scanning into IHSS WebTop

### ***New Forms***

The form Temp 3000 is not required for individuals who applied for IHSS after the initial CDSS mailing to current IHSS recipients and pending applicants on November 1, 2014. Effective immediately IHSS district Social Workers will provide the following forms at the initial home visit for IHSS applicants:

- The SOC 426A - IHSS Program Recipient Designation of Provider (Attachment G) dated 09/14 replaces previous versions of the form and includes language and information on IHSS program requirements for limiting overtime payments to providers. This form will replace the TEMP 3000 - IHSS Program Overtime and Workweek Requirements Recipient Declaration.

- The SOC 2256-IHSS Program Recipient and Provider Workweek Agreement is for use by applicants/recipients who employ multiple providers at the same time. A recipient with multiple providers who does not want each provider to know the other providers' hours can use multiple SOC 2256 forms (one for each provider). The information will then be compiled and entered into CMIPS II by the assigned district office Social Worker.

**V. REVIEW STATEMENT**

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

**VI. FILING STATEMENT**

IHSS Special Notices are at the following link:

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

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



WILFRED QUINTONG  
Deputy Director



MARK SELLERS  
Deputy Director

Attachments  
Contact: Wendy Contreras/Mary Harrison  
(858) 505-6366

## ATTACHMENTS

<b>ATTACHMENT A - <u>SOC 2271 – IHSS Program Provider Notice of Recipient Authorized Hours</u></b>	
English and Spanish .....	<b>Page 8</b>
<b>ATTACHMENT B - <u>SOC 2271A – IHSS Program Recipient Notice of Weekly Hours Authorized Hours</u></b>	
English and Spanish .....	<b>Page 15</b>
<b>ATTACHMENT C - <u>TEMP 3000 – Overtime and Workweek Requirements Recipient Declaration</u></b>	
English and Spanish .....	<b>Page 17</b>
<b>ATTACHMENT D - <u>SOC 2256 – IHSS Recipient Workweek Agreement</u></b>	
English and Spanish .....	<b>Page 21</b>
<b>ATTACHMENT E - <u>SOC 846 – Provider Enrollment Agreement</u> (revised version)</b>	
English and Spanish .....	<b>Page 27</b>
<b>ATTACHMENT F - <u>SOC 2255 – Provider Workweek and Travel Time Agreement</u></b>	
English and Spanish .....	<b>Page 35</b>
<b>ATTACHMENT G - <u>SOC 426A - IHSS Program Recipient Designation of Provider</u></b>	
English and Spanish .....	<b>Page 49</b>
<b>ATTACHMENT H - Sample <u>Timesheet No Travel</u></b>	
English Only .....	<b>Page 55</b>
<b>ATTACHMENT I - Sample <u>Travel Timesheet</u></b>	
English Only .....	<b>Page 57</b>
<b>ATTACHMENT J - <u>Claim Form and Instructions for Claim Form</u></b>	
English Only .....	<b>Page 59</b>

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER NOTICE OF RECIPIENT AUTHORIZED HOURS AND SERVICES

County of: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_

IHSS Office Address: \_\_\_\_\_

IHSS Office Telephone Number: \_\_\_\_\_

You are receiving this notice because you are a provider of IHSS for

\_\_\_\_\_.

The notice is to inform you of your recipient's monthly and weekly authorized hours and the services you are allowed to perform for your recipient.

Your recipient's monthly authorized hours are \_\_\_\_\_.

Since the number of days in each month is different, your recipient's weekly authorized hours will be different for each month. If a month ends in the middle of a week, the authorized hours for the partial week will be calculated based on the days remaining in the month. The chart below shows the weekly authorized hours that your recipient will have each month:

Month	Weekly Authorized Hours	Month	Weekly Authorized Hours
January		July	
February		August	
March		September	
April		October	
May		November	
June		December	

The chart on the following page lists the services that have been authorized for your recipient (which have been marked with an X), along with a brief description of the types of work that may be performed as part of each service. You will only be paid for providing the authorized services that have been marked. Your recipient is responsible for creating a work schedule with you within his/her weekly and monthly authorized hours.

Auth*	Service Types	Description of Services
	Domestic Services	Household chores to maintain the cleanliness of the home including sweeping, vacuuming, washing and waxing of floor surfaces, dusting, and picking up. MPP 30-757.11
	Meal Preparation	Planning menus, preparing food, cooking and serving meals. MPP 30-575.131
	Meal Clean-Up	Cleaning up the cooking area and washing, drying and putting away cookware, dishes and utensils. MPP 30-757.132
	Laundry	Washing, drying, folding and putting away clothes and linens. If in-home laundry facilities are not available, this service will include travel to an out-of-home laundromat. MPP 30-575.134
	Shopping for Food	Making a grocery list, traveling to/from the store, shopping, loading, unloading and storing food purchased. MPP 30-757.135(b)
	Other Shopping and Errands	Includes, 1) Shopping for other necessary supplies, and 2) Performing small and necessary errands, e.g., picking up prescription. MPP 757.135(c)
	Respiration Assistance	Assisting recipient with nonmedical breathing related services such as self-administration of oxygen and cleaning breathing machines. MPP 30-757.14(b)
	Bowel and/or Bladder Care	Assisting the recipient with using the toilet, bed pans/bedside commode or urinal; emptying/cleaning ostomy, enema and/or catheter receptacles; applying diapers, disposable undergarments and disposable barrier pads, wiping/cleaning recipients; washing/drying recipient's hands. MPP 30-757.14(e)
	Feeding	Assisting the recipient to eat meals, including cleaning his/her face and hands before and after meals. MPP 30.757.14(c)
	Routine Bed Baths	Giving a recipient who is confined to bed a routine sponge bath. MPP 30-757.14(d)
	Dressing	Assisting the recipient to put on and take off his/her clothes as necessary. MPP 30-757.14(f)
	Menstrual Care	Assistance with the external placement of sanitary napkins and barrier pads. MPP 30-757.14(j)
	Ambulation	Assisting the recipient with walking or moving about the home, including to/from the bathroom and to/from and into/out of the car for transporting to medical appointments and/or alternative resources. MPP 30-757-14(k)
	Transfer	Assisting recipient from standing, sitting, or prone position to another position and/or from one piece of furniture or equipment to another. MPP 30-757.14(h)
	Bathing, Oral Hygiene and Grooming	Assisting the recipient with: bathing or showering, brushing teeth, flossing, and cleaning dentures; shampooing, drying, combing/brushing hair; shaving; applying lotion, powder and deodorant. MPP 30-757.14(e)
	Rubbing Skin and Repositioning	Rubbing skin to promote circulation and/or prevent skin breakdown; turning in bed and other types of repositioning; and supervising range of motion exercises. MPP 30-757.14(g)
	Care and Assistance w/Prosthetics & Medication	Taking off/putting on and maintaining and cleaning prosthetic devices, including vision/hearing aids; reminding the recipient to take prescribed and/or over-the-counter medications, and setting up medi-sets. MPP 30-757.14(i)
	Accompaniment to Medical Appointments	Accompanying the recipient during necessary travel to and from health related appointments. If you are required to stay to provide authorized services for your recipient during the appointment and the length of the appointment is not known, you will be paid for the time that you are "engaged to wait" for the services that must be provided. MPP 30-757.151
	Accompaniment to Alternative Resources	Accompanying the recipient during necessary travel to and from alternative resources. MPP 30-757.174
	Heavy Cleaning	Thorough cleaning of the home to remove hazardous debris and dirt. (One time only) MPP 30-757.12
	Yard Hazard Abatement	Light work in the yard to remove high grass or weeds, and rubbish when these materials pose a fire hazard. MPP 30-757.16
	Removal of Ice and Snow	Light work in the yard to remove ice and snow or other hazardous substances from entrances and essential walkways when these materials make access to the home hazardous. MPP 30-757.16
	Protective Supervision	Observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill recipient and intervening as appropriate to safeguard the recipient against injury, hazard or accident. MPP 30-757.17
	Teaching and Demonstration	Teaching and demonstrating services handled by the IHSS provider to help the recipient perform these services on his or her own. MPP 30-757.18
	Paramedical Services	Services meeting the following conditions: 1) Activities which recipients would normally perform themselves if they did not have functional limitations, 2) Activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health, and 3) Activities which include the administration of medications, puncturing the skin, or inserting a medical device into a body orifice, activities requiring sterile procedures, or requiring judgment based on training given by a licensed health care professional. MPP 30-757.19

**Important Things to Remember:**

- If you need any additional information on the services that have been authorized for your recipient and the work you must provide to him/her beyond what has been provided to you in the chart on the previous page, you may view the Manual of Policies and Procedures (MPP) sections referenced in the chart on the CDSS website at <http://www.cdss.ca.gov/ord/PG310.htm> or contact your county IHSS office.
- It is your responsibility to follow the workweek schedule created by your recipient.
- If your recipient's monthly hours change, you will receive another notification of your recipient's weekly authorized hours reflecting the change in hours.
- If your recipient has more than one provider, it is the responsibility of your recipient to set a schedule for each provider so that the total hours worked by all providers is not more than the recipient's authorized weekly or monthly hours.
- If more than the recipient's authorized monthly hours are worked, it is the responsibility of your recipient to provide payment for those hours.
- If you work more than your recipient's authorized weekly hours without your recipient receiving county approval, you may incur a violation. However, your recipient may adjust the weekly authorized hours in specific circumstances without county approval.
- The hours you can claim on your timesheet will be reduced if you start or stop work in the middle of a month.
- It is the responsibility of the recipient to make payment of any share of cost deducted from your paycheck.
- Contact your county IHSS office immediately if your recipient is hospitalized or passes away. Without county approval, you cannot claim hours for work done while the recipient is hospitalized or after the date-of-death.
- Social Security taxes and State Disability are automatically deducted from your paycheck. To have State or Federal income tax withholding deducted from your paycheck, you must turn in a W-4 and/or DE-4 to your county IHSS office.
- If the recipient for whom you work is your parent, spouse, or minor child, you may not be eligible for withholding of Social Security or Medicare taxes.
- If you are injured while providing IHSS services, contact your county IHSS office immediately.

Should you have any questions regarding any of the information provided on this notice or if you are no longer working as an IHSS provider, please contact your county IHSS office at the number on the first page.

**PROGRAMA DE SERVICIOS DE APOYO EN EL HOGAR (IHSS)  
 NOTIFICACIÓN PARA EL PROVEEDOR ACERCA DE LAS  
 HORAS Y SERVICIOS AUTORIZADOS DEL BENEFICIARIO**

Condado de: \_\_\_\_\_

Fecha que entra en vigor: \_\_\_\_\_

Nombre del proveedor: \_\_\_\_\_

Número del proveedor: \_\_\_\_\_

Dirección de la Oficina de IHSS: \_\_\_\_\_

Número de teléfono de la Oficina de IHSS: \_\_\_\_\_

Usted está recibiendo esta notificación porque es un proveedor de IHSS para

\_\_\_\_\_.

Esta notificación es para informarle de las horas autorizadas mensual y semanalmente para su beneficiario y qué servicios usted puede hacer para su beneficiario.

Las horas mensuales autorizadas para su beneficiario son \_\_\_\_\_.

Ya que el número de días en cada mes es diferente, las horas semanales autorizadas serán diferentes para cada mes. Si un mes termina a mitad de la semana, las horas autorizadas para parte de la semana se calcularán en base a los días que queden en el mes. La tabla a continuación muestra las horas semanales autorizadas que su beneficiario tendrá cada mes:

Mes	Horas semanales autorizadas	Mes	Horas semanales autorizadas
Enero		Julio	
Febrero		Agosto	
Marzo		Septiembre	
Abril		Octubre	
Mayo		Noviembre	
Junio		Diciembre	

La tabla en la siguiente página indica los servicios que se han autorizado para su beneficiario (los cuales están marcados con una "X"), junto con una breve descripción de los tipos de trabajo que se pueden hacer como parte de cada servicio. Solamente se le pagará a usted por proporcionar servicios autorizados que estén marcados. Su beneficiario es responsable de crear un horario de trabajo con usted dentro de sus horas autorizadas semanal y mensualmente.

Autorizado	Tipos de servicio	Descripción de los servicios
	Servicios domésticos	Quehaceres en el hogar para mantenerlo limpio, incluyendo barrer, aspirar, lavar y encerar los pisos, sacudir y recoger. MPP 30-757.11
	Preparación de las comidas	Planear menús, preparar los alimentos, cocinar y servir las comidas. MPP 30-575.131
	Limpieza después de las comidas	Limpiar el área donde se cocina y lavar, secar, y guardar los trastes y utensilios de cocina. MPP 30-757.132
	Lavado rutinario de la ropa	Lavar, secar, doblar y guardar la ropa (incluyendo la ropa de cama). Si no hay lavandería dentro de la casa, este servicio incluirá el traslado a una lavandería fuera de la casa. MPP 30-575.134
	Compras de alimentos	Hacer una lista de los comestibles que se van a comprar; ir y venir a la tienda; y hacer las compras, cargar, descargar, y guardar los comestibles que se compraron. MPP 30-757.135(b)
	Compras de otras cosas y diligencias	Incluye: 1) ir de compras de otros artículos que son necesarios, y 2) hacer otros pequeños encargos necesarios; por ejemplo, recoger medicinas recetadas. MPP 757.135(c)
	Ayuda en lo relacionado a la respiración	Ayudar al beneficiario con servicios no médicos relacionados a la respiración, tales como la autoadministración de oxígeno y la limpieza de máquinas de respiración. MPP 30-757.14(b)
	Limpieza de evacuaciones intestinales y de la vejiga	Ayudar al beneficiario cuando use el baño, bacinilla de cama/inodoro portátil o urinal; vaciar y limpiar recipientes de ostomía, enema, y/o catéter; poner pañales, prendas interiores desechables, y protectores desechables; limpiar al beneficiario; y lavar y secar las manos del beneficiario. MPP 30-757.14(e)
	Alimentación	Ayudar al beneficiario a comer sus alimentos, incluyendo lavar la cara y manos antes y después de las comidas. MPP 30.757.14(c)
	Baños de rutina en la cama	Darle al beneficiario que está en cama un baño regular de esponja. MPP 30-757.14(d)
	Ayuda para vestirse	Ayudarle al beneficiario a ponerse y quitarse su ropa cuando sea necesario durante el día. MPP 30-757.14(f)
	Cuidado en relación a la menstruación	Ayudar a colocar (en la parte externa) toallas sanitarias y protectores. MPP 30-757.14(j)
	Ayuda para caminar	Ayudar al beneficiario a caminar y desplazarse en el hogar, incluyendo ir y venir al baño y subir y bajar de un carro para llevarlo a citas médicas y/o recursos alternativos. MPP 30-757-14(k)
	Ayuda con traslados	Ayudar al beneficiario a pararse, sentarse, o cambiar de una posición a otra; y/o moverse de un mueble o equipo a otro. MPP 30-757.14(h)
	Ayuda para bañarse, higiene bucal y arreglo personal	Ayudarle al beneficiario: a bañarse en tina o regadera, cepillarse los dientes, usar el hilo dental, y limpiar dentaduras; lavarse con champú el pelo, secarlo, y peinarlo/cepillarlo; afeitarse; y ponerse loción, talco, desodorante. MPP 30-757.14(e)
	Frotamiento de la piel y cambios de posición	Frotar la piel para estimular la circulación y/o cambiar de posición en la cama, u otro lugar, para prevenir que la piel se dañe; y supervisar ejercicios del arco de movimiento. MPP 30-757.14(g)

Autorizado	Tipos de servicio	Descripción de los servicios
	Cuidado y ayuda con dispositivos protéticos (prótesis) y medicinas	Poner, quitar, y dar mantenimiento y limpiar aparatos de prótesis, incluyendo aparatos para la vista/aparatos del oído; recordarle al beneficiario que se tome sus medicinas recetadas y sus medicinas sin receta, y poner las medicinas en grupos. MPP 30-757.14(i)
	Acompañamiento a citas médicas	Acompañar al beneficiario durante viajes necesarios de ida y venida a citas relacionadas a la salud. Si se requiere que usted se quede para proporcionar servicios autorizados para su beneficiario durante la cita y no se conoce la duración, se le pagará por el tiempo que usted "tenga que quedarse" para los servicios que se tienen que proporcionar. MPP 30-757.151
	Acompañamiento a recursos alternativos	Acompañar al beneficiario durante viajes necesarios a recursos alternativos. MPP 30-757.174
	Limpieza profunda	Limpieza minuciosa de la casa para eliminar escombros y basura peligrosos. (Una sola vez) MPP 30-757.12
	Eliminación de peligros en el patio/jardín	Trabajo ligero en el patio/jardín para quitar pasto demasiado grande o hierbas malas, y desperdicios que pudieran ser un peligro de incendio. MPP 30-757.16
	Eliminación de hielo y nieve	Trabajo ligero en el patio/jardín para quitar el hielo y nieve u otras sustancias peligrosas de las entradas y pasillos esenciales, si es que estos materiales hacen peligroso el acceso a la casa. MPP 30-757.16
	Supervisión protectora	Observar el comportamiento de un beneficiario que no se puede dirigir por sí mismo, está confuso, está afectado mentalmente o está enfermo mental e intervenir como sea apropiado para proteger al beneficiario para prevenir lesiones, peligros, o accidentes. MPP 30-757.17
	Servicios de enseñanza y demostración	Servicios de enseñanza y demostración que lleva a cabo el proveedor de IHSS para ayudarle al beneficiario a que pueda hacerlo por sí mismo. MPP 30-757.18
	Servicios paramédicos	Servicios que cumplen con las siguientes condiciones: 1) actividades que los beneficiarios normalmente podrían hacer por sí mismos si no tuvieran limitaciones funcionales, 2) actividades que debido a la condición física o mental del beneficiario son necesarias para mantener la salud del beneficiario, y 3) actividades que incluyen la administración de medicinas, pinchan la piel, o introducen un aparato médico en un orificio del cuerpo, actividades que requieren procedimientos estériles, o que requieren una determinación basada en un entrenamiento proporcionado por un profesional en el cuidado de la salud con licencia. MPP 30-757.19

**Cosas importantes que recordar:**

- Si necesita información adicional acerca de los servicios que han sido autorizados para su beneficiario y el trabajo que usted tiene que proporcionarle a él/ella aparte de lo que se ha indicado en la tabla que aparece en las páginas anteriores, puede revisar las secciones del Manual de Prácticas y Procedimientos (*Manual of Policies and Procedures* - MPP) que se usan como referencia en la tabla. Este Manual está en la página web del CDSS en <http://www.cdss.ca.gov/ord/PG310.htm> También se puede comunicar con la Oficina de IHSS del Condado.
- Es su responsabilidad seguir el horario de la semana laboral que desarrolló su beneficiario.
- Si cambian las horas mensuales de su beneficiario, usted recibirá otra notificación sobre las horas semanales autorizadas indicando el cambio en las horas.
- Si su beneficiario tiene más de un proveedor, es la responsabilidad de su beneficiario establecer un horario para cada uno de los proveedores para que el total de horas trabajadas por todos los beneficiarios no sea más que las horas semanales o mensuales autorizadas para el beneficiario.
- Si se trabajan más de las horas mensuales autorizadas del beneficiario, es la responsabilidad de su beneficiario hacer el pago por esas horas.
- Si trabaja más de las horas semanales autorizadas de su beneficiario sin que el beneficiario reciba aprobación del Condado, usted puede recibir una infracción. Sin embargo, su beneficiario puede ajustar las horas semanales autorizadas bajo circunstancias específicas sin tener la aprobación del Condado.
- Las horas que usted puede reclamar en su reporte de horas trabajadas (*timesheet*) se reducirán si usted empieza o deja de trabajar a mitad del mes.
- Es la responsabilidad del beneficiario pagar cualquier parte del costo (*share of cost*) que se haya deducido del cheque de pago de usted.
- Comuníquese inmediatamente con la Oficina de IHSS del Condado si su beneficiario es hospitalizado o si él/ella fallece. Sin la aprobación del Condado, usted no puede reclamar horas de trabajo mientras el beneficiario está hospitalizado o después de la fecha que fallece.
- Los impuestos del Seguro Social y los impuestos del Estado para Discapacidad se descuentan automáticamente de su cheque de pago. Para que le descuenten de su cheque de pago los impuestos estatales o federales sobre los ingresos, usted tiene que entregar los formularios W-4 y/o DE-4 a la Oficina de IHSS del Condado.
- Si el beneficiario para quien usted trabaja es su padre/madre, esposa(o), o hijo menor, es posible que no sea elegible para que le descuenten los impuestos para el Seguro Social ni los impuestos de Medicare.
- Si usted se lesiona mientras está proporcionando servicios de IHSS, comuníquese inmediatamente con la Oficina de IHSS del Condado.

Si tiene alguna pregunta acerca de la información en esta notificación, o si ya no está trabajando como un proveedor de IHSS, por favor comuníquese con la Oficina de IHSS del Condado al número que aparece en la primera página.

# IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM RECIPIENT NOTICE OF WEEKLY AUTHORIZED HOURS

County of: \_\_\_\_\_

Notice Date: \_\_\_\_\_

Recipient Name: \_\_\_\_\_

Recipient Case Number: \_\_\_\_\_

IHSS Office Address: \_\_\_\_\_

IHSS Office Telephone Number: \_\_\_\_\_

You are receiving this notice to inform you of your weekly authorized hours for the IHSS program.

You were sent a notice of action indicating, as of \_\_\_\_\_, your **monthly authorized hours** are \_\_\_\_\_.

DATE

Since the number of days in each month is different, your weekly authorized hours will be different for each month. If a month ends in the middle of a week, the authorized hours for the partial week will be calculated based on the days remaining in the month. The chart below shows the weekly authorized hours you will have each month:

Month	Weekly Authorized Hours	Month	Weekly Authorized Hours
January		July	
February		August	
March		September	
April		October	
May		November	
June		December	

If a month has an asterisk (\*) after it, that means that one-time services (heavy cleaning, yard hazard abatement, teaching and demonstration, etc.) have been authorized for that month and there will be more weekly and monthly authorized hours for that month only.

If your monthly hours change, you will receive a notice of action detailing the increase or decrease in hours. You will also receive another notification of weekly authorized hours reflecting the change in hours.

Should you have any questions regarding the above notice, please contact your county IHSS office at the number above.

**PROGRAMA DE SERVICIOS DE APOYO EN EL HOGAR (IHSS)  
NOTIFICACIÓN PARA EL BENEFICIARIO  
HORAS SEMANALES AUTORIZADAS**

Condado de: \_\_\_\_\_

Fecha de la notificación: \_\_\_\_\_

Nombre del beneficiario: \_\_\_\_\_

Número de caso del beneficiario: \_\_\_\_\_

Dirección de la Oficina de IHSS: \_\_\_\_\_

Número de teléfono de la Oficina de IHSS: \_\_\_\_\_

Está recibiendo esta notificación para informarle de sus horas semanales autorizadas para el Programa de IHSS.

Se le envió una notificación de acción indicando que a partir de \_\_\_\_\_, sus **horas mensuales autorizadas** son \_\_\_\_\_. FECHA

Ya que el número de días en cada mes es diferente, sus horas semanales autorizadas serán diferentes cada mes. Si un mes termina a la mitad de la semana, las horas autorizadas para parte de la semana se calcularán basándose en los días que quedan en el mes. La tabla a continuación muestra las horas semanales autorizadas que tendrá cada mes:

Mes	Horas semanales autorizadas	Mes	Horas semanales autorizadas
Enero		Julio	
Febrero		Agosto	
Marzo		Septiembre	
Abril		Octubre	
Mayo		Noviembre	
Junio		Diciembre	

Si el mes tiene un asterisco (\*), eso significa que para ese mes se han autorizado "servicios de una sola vez" (limpieza profunda, eliminación de peligros en el patio/jardín, enseñanza y demostración, etc.) y habrá más horas autorizadas por semana y por mes solamente para ese mes.

Si sus horas mensuales cambian, usted recibirá una notificación de acción detallando el aumento o la disminución en sus horas. También recibirá otra notificación de las horas semanales autorizadas indicando el cambio en las horas.

Si tiene alguna pregunta acerca de esta notificación, por favor comuníquese con la Oficina de IHSS del Condado al número que aparece arriba.

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM OVERTIME AND WORKWEEK REQUIREMENTS RECIPIENT DECLARATION

---

This document provides information about IHSS program overtime and workweek requirements that are based on state law (Welfare and Institutions Code section 12300.4). I must read the information and sign this form to show that I understand and agree to follow these requirements.

- Under state law, the maximum amount of time an IHSS provider can work providing authorized services in a workweek is 66 hours (less any required reduction). The workweek starts at 12:00 a.m. (midnight) on Sunday and ends at 11:59 pm on the following Saturday.
- My total authorized service hours for the month will be broken out into a weekly authorized amount.
- I can authorize my provider to adjust his/her schedule to work more than his/her normal work hours during the workweek without asking the county for approval as long as it does not cause my provider to:
  1. work for me more than 40 hours in a workweek; and
  2. work more than my total authorized monthly hours.
- If my provider normally works for me more than 40 hours in a workweek, I can authorize him/her to work more overtime hours for me in a workweek without asking the county for approval as long as I have him/her work less hours in the next workweek(s) of the month so I do not go over my authorized monthly hours.
- I have to ask the county for an exception if I need my provider to work for me more than 40 hours in a workweek, and he/she does not normally work for me more than 40 hours in a workweek.
- If I do not get an approved exception, my provider will get a violation.
- Even if the county approves my request for an exception, I will need to have my provider work less hours in the next workweek(s) of the month so that I don't go over my authorized monthly hours.

- I cannot ever authorize my provider to work more than 61 to 66 hours (less any required reduction) in a workweek unless my provider and I are in a one-to-one recipient/provider relationship and I receive the maximum monthly authorized service hours.
- The county will send me a notice each time my provider gets a violation. If my provider gets three violations, he/she will be suspended from providing IHSS for three months. If he/she gets another violation after being reinstated from the three-month suspension, he/she will be terminated as a provider for one year.
- My provider is not eligible to get paid for his/her meal periods (lunch breaks) while he/she is working to provide authorized services for me. I will not allow him/her to take a meal period (lunch break) unless it is at least 30 minutes long and I completely release him/her from his/her work duties during that time.

---

**RECIPIENT ACKNOWLEDGMENT**

---

**I understand and agree to follow all of the requirements listed in this form.**

RECIPIENT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE:	DATE:
---	-------

PRINTED NAME:

---



---

**FOR COUNTY USE ONLY**

---

WORKER NAME:	DATE:
--------------	-------

---

## PROGRAMA DE SERVICIOS DE APOYO EN EL HOGAR (IHSS) REQUISITOS DE LAS SEMANAS DE TRABAJO Y HORAS EXTRAS DECLARACIÓN DEL BENEFICIARIO

Este documento provee información acerca de los requisitos de las semanas de trabajo y horas extra del Programa de IHSS que están basados en una ley estatal (Sección 12300.4 del Código de Bienestar e Instituciones [W&IC]). Tengo que leer la información y firmar este formulario para demostrar que entiendo y estoy de acuerdo en seguir estos requisitos.

- Bajo la ley del Estado, la cantidad máxima de tiempo que un proveedor de IHSS puede trabajar proporcionando servicios autorizados en una semana de trabajo es de 66 horas (menos cualquier reducción requerida). La semana de trabajo empieza a las 12:00 a.m. (media noche) el domingo y termina a las 11:59 p.m. el siguiente sábado.
- El total de mis horas de servicio autorizadas para el mes se dividirá en una cantidad autorizada para cada semana.
- Yo puedo autorizar a mi proveedor para que ajuste su horario para que trabaje más de sus horas normales de trabajo durante la semana de trabajo sin tener que pedirle aprobación al Condado, siempre y cuando esto no ocasione que mi proveedor:
  1. trabaje para mí más de 40 horas en una semana de trabajo; y
  2. trabaje más del total de mis horas autorizadas para el mes.
- Si mi proveedor normalmente trabaja para mí más de 40 horas en una semana de trabajo, yo puedo autorizar que él/ella trabaje más horas extra para mí en una semana de trabajo sin tener que pedirle aprobación al Condado, siempre y cuando él/ella trabaje menos horas la siguiente semana(s) del mes para que no sobrepase la cantidad mensual de mis horas autorizadas.
- Tengo que pedirle al Condado una excepción si necesito que mi proveedor trabaje para mí más de 40 horas en una semana de trabajo, y él/ella normalmente no trabaja para mí más de 40 horas en una semana de trabajo.
- Si no recibo la aprobación para una excepción, mi proveedor recibirá una infracción.
- Aunque el Condado apruebe mi petición para una excepción, necesitaré que mi proveedor trabaje menos horas en la siguiente semana(s) del mes para que no sobrepase la cantidad mensual de horas autorizadas.

- Nunca puedo autorizar que mi proveedor trabaje más de 61 a 66 horas (menos cualquier reducción que se requiera) en una semana de trabajo a menos que mi proveedor y yo estemos en una relación de beneficiario/proveedor (uno a uno) y yo recibo la cantidad mensual máxima de horas de servicio autorizadas.
- El Condado me enviará una notificación cada vez que mi proveedor reciba una infracción. Si mi proveedor recibe tres infracciones, él/ella recibirá una suspensión y no podrá proporcionar IHSS durante tres meses. Si recibe otra infracción después de regresar de la suspensión de tres meses, él/ella dejará de ser proveedor durante un año.
- Mi proveedor no es elegible para que se le pague por los periodos de comidas (*lunch breaks*) mientras esté trabajando para proporcionar servicios autorizados para mí. No permitiré que tome un descanso para comer (*lunch break*) al menos que ese periodo dure por lo menos 30 minutos y yo le permita que deje completamente sus obligaciones de trabajo durante ese tiempo.

---

**CONFIRMACIÓN DEL BENEFICIARIO**

---

**Entiendo y estoy de acuerdo en seguir todos los requisitos anotados en este formulario.**

FIRMA DEL BENEFICIARIO O DEL REPRESENTATNE AUTORIZADO:	FECHA:
--	--------

NOMBRE ESCRITO EN LETRA DE MOLDE:

---

**FOR COUNTY USE ONLY (SOLAMENTE PARA USO DEL CONDADO)**

---

WORKER NAME:	DATE:
--------------	-------

**IN-HOME SUPPORTIVE SERVICES PROGRAM  
 RECIPIENT AND PROVIDER  
 WORKWEEK AGREEMENT**

IHSS RECIPIENT CASE NUMBER
----------------------------

RECIPIENT NAME (FIRST, MIDDLE, LAST)
--------------------------------------

My total authorized hours are \_\_\_\_\_ per week and \_\_\_\_\_ per month.

I understand that I have to assign hours to my provider(s) which is why I must complete this form. This schedule helps to ensure that my provider(s) stay(s) within my monthly authorized hours. Under certain circumstances I may be able to adjust the hours I have assigned.

**INSTRUCTIONS:**

1. In Column A below, enter the **names** of all the providers you wish to receive services from.
2. In Column B below, enter the **identification number** of each of your providers.
3. In Column C below, enter the total hours assigned **per week** to each of your providers.
4. The **TOTAL** authorized hours per week for all of your providers (Column C) must add up to your total weekly authorized service hours.

<b>A</b>	<b>B</b>	<b>C</b>
PROVIDER NAME (FIRST, MIDDLE, LAST)	PROVIDER IDENTIFICATION NUMBER	HOURS ASSIGNED PER WEEK
1.		
2.		
3.		
4.		
5.		
<b>RECIPIENT'S TOTAL AUTHORIZED HOURS</b>		<b>PER WEEK:</b>

**RECIPIENT ACKNOWLEDGMENT:**

- 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(s).
- I understand that I have received information on the workweek requirements and overtime limitations which I must follow.
- I understand that if I want the weekly assigned hours of my provider(s) to stay the same and the timesheets of my provider(s) to always be processed for the hours I have assigned to him/her, I will request and complete a Recipient Request for Assignment of Authorized Hours to Providers (SOC 838) form and submit it to the county.

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

**PROVIDER ACKNOWLEDGMENT:**

- I understand that by signing this form I agree to work the number of authorized hours assigned to me on this form.
- I understand that I must follow the program requirements that are stated on the Provider Enrollment Agreement (SOC 846).

1. PROVIDER SIGNATURE	DATE
PROVIDER #1 PRINTED NAME	TELEPHONE NUMBER
2. PROVIDER SIGNATURE	DATE
PROVIDER #2 PRINTED NAME	TELEPHONE NUMBER
3. PROVIDER SIGNATURE	DATE
PROVIDER #3 PRINTED NAME	TELEPHONE NUMBER
4. PROVIDER SIGNATURE	DATE
PROVIDER #4 PRINTED NAME	TELEPHONE NUMBER
5. PROVIDER SIGNATURE	DATE
PROVIDER #5 PRINTED NAME	TELEPHONE NUMBER

**FOR COUNTY USE ONLY**

WORKER NAME (FIRST MIDDLE LAST):	WORKER PHONE:
----------------------------------	---------------

**PROGRAMA DE SERVICIOS DE APOYO EN EL HOGAR (IHSS)  
ACUERDO ENTRE BENEFICIARIO Y PROVEEDOR  
ACERCA DE LA SEMANA DE TRABAJO**

NÚMERO DE CASO DEL BENEFICIARIO DE IHSS

NOMBRE DEL BENEFICIARIO (PRIMER NOMBRE, NOMBRE QUE USA EN MEDIO, APELLIDO)

El total de mis horas autorizadas son \_\_\_\_\_ por semana y \_\_\_\_\_ por mes.

Entiendo que tengo que asignar horas a mi(s) proveedor(es) y es por eso que tengo que completar este formulario. Este horario ayuda a asegurar que mi(s) proveedor(es) no se pase(n) de mis horas mensuales autorizadas. Bajo ciertas circunstancias, es posible que pueda ajustar las horas que he asignado.

**INSTRUCCIONES:**

1. A continuación, en la Columna A, escriba los **nombres** de todos los proveedores que usted quiere que le proporcionen servicios.
2. A continuación, en la Columna B, escriba el **número de identificación** de cada uno de sus proveedores.
3. A continuación, en la Columna C, escriba el total de las horas asignadas **por semana** a cada uno de sus proveedores.
4. El **TOTAL** de las horas autorizadas por semana para todos sus proveedores (Columna C) tiene que ser la misma suma del total de sus horas autorizadas de servicio.

<b>A</b>	<b>B</b>	<b>C</b>
NOMBRE DEL PROVEEDOR (PRIMER, NOMBRE QUE USA EN MEDIO, APELLIDO)	NÚMERO DE IDENTIFICACIÓN DEL PROVEEDOR	HORAS ASIGNADAS POR SEMANA
1.		
2.		
3.		
4.		
5.		
<b>TOTAL DE HORAS AUTORIZADAS DEL BENEFICIARIO</b>		<b>POR SEMANA:</b>

**CONFIRMACIÓN DEL BENEFICIARIO:**

- Entiendo que al completar y presentar este formulario al Programa de Servicios de Apoyo en el Hogar (IHSS) del Condado, estoy solicitando al Programa de IHSS que asigne el número indicado de mis horas autorizadas para el proveedor(es) mencionado(s) a continuación.
- Entiendo que he recibido la información que debo seguir sobre los requisitos de la semana de trabajo y las limitaciones de horas extras de trabajo.
- Entiendo que si quiero que las horas semanales asignadas a mis proveedores permanezcan iguales y que los reportes de trabajadas (*timesheets*) de mis proveedores siempre sean procesados con las horas que les he asignado, pediré y completaré el formulario "Petición del beneficiario para la asignación de horas autorizadas para proveedores" (SOC 838) y se lo entregaré al Condado.

FIRMA DEL BENEFICIARIO		FECHA
REPRESENTANTE AUTORIZADO (SI EL BENEFICIARIO NO PUEDE FIRMAR POR SÍ MISMO)	PARENTESCO CON EL BENEFICIARIO	NÚMERO DE TELÉFONO
FIRMA DEL REPRESENTANTE AUTORIZADO		FECHA

**CONFIRMACIÓN DEL PROVEEDOR:**

- Entiendo que al firmar este formulario estoy de acuerdo en trabajar el número de horas autorizadas asignadas a mí en este formulario.
- Entiendo que tengo que cumplir con los requisitos del programa que están escritos en el formulario "Acuerdo de inscripción para proveedores" (SOC 846).

1. FIRMA DEL PROVEEDOR	FECHA
NOMBRE DEL PROVEEDOR #1 EN LETRA DE MOLDE	NÚMERO DE TELÉFONO
2. FIRMA DEL PROVEEDOR	FECHA
NOMBRE DEL PROVEEDOR #2 EN LETRA DE MOLDE	NÚMERO DE TELÉFONO
3. FIRMA DEL PROVEEDOR	FECHA
NOMBRE DEL PROVEEDOR #3 EN LETRA DE MOLDE	NÚMERO DE TELÉFONO
4. FIRMA DEL PROVEEDOR	FECHA
NOMBRE DEL PROVEEDOR #4 EN LETRA DE MOLDE	NÚMERO DE TELÉFONO
5. FIRMA DEL PROVEEDOR	FECHA
NOMBRE DEL PROVEEDOR #5 EN LETRA DE MOLDE	NÚMERO DE TELÉFONO

**FOR COUNTY USE ONLY (SOLAMENTE PARA USO DEL CONDADO)**

WORKER NAME (FIRST MIDDLE LAST):	WORKER PHONE:

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT AGREEMENT

IHSS PROVIDER CASE NUMBER
---------------------------

PROVIDER NAME (FIRST, MIDDLE, LAST)
-------------------------------------

1. I attended the required orientation for IHSS providers and I understand and agree to the following:
  - I was given information about being a provider in the IHSS program.
  - I was informed of my responsibilities as an IHSS provider.
  - I was informed of the consequences of committing fraud in the IHSS program.
  - I was given the Medi-Cal toll-free telephone fraud hotline number, 1-800-822-6222 and web site, <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx> for reporting suspected fraud or abuse in the IHSS program.
  
2. I received training on, and understand how to complete my timesheet.
  - I understand that I should report on my timesheet only the time I worked providing authorized services for the recipient.
  - I understand that by signing my timesheet I am saying that the information I reported on it is true and correct.
  - I understand that I must submit my timesheet (signed by both my recipient and me) within two weeks after the end of each pay period. If I submit my timesheet on time, I will get paid within 10 days of the day it is received at the timesheet processing facility. If I do not submit my timesheet on time, my pay will be delayed.
  - I understand that if I am convicted of fraudulently reporting information on my timesheet, in addition to any criminal penalties, I may be required to pay civil penalties of at least \$500, and not more than \$1,000, for each violation of fraud.
  
3. I received information and training regarding the workweek and travel time requirements. This information and training included the following topics:

### Overtime Pay

- Beginning January 1, 2015, IHSS providers will get paid overtime (one and a half times the regular pay rate) when they work more than 40 hours in a workweek. The workweek begins at 12:00 a.m. (midnight) on Sunday and ends at 11:59 p.m. on the following Saturday.

## **Workweek Limit**

- Beginning April 1, 2015, the maximum number of hours IHSS providers will be allowed to work in a workweek will be 66 (less any required reduction). The exact number of hours I will be allowed to work will depend on:
  - o How many hours of authorized services my recipient gets each week;
  - o How many recipients I work for; and
  - o Whether my recipient has any other providers.
- Both my recipient and I will get a notice telling us how many authorized service hours he/she gets each month and each week.
- If I work for more than one recipient, the combined hours I work for all my recipients cannot add up to more than 66 hours (less any required reduction) each workweek.

## **Working More Than Your Recipient's Weekly Hours**

- A recipient can authorize me to work more than his/her weekly hours without asking the county for approval as long as the authorization does not cause me to work:
  - o More than 40 hours for him/her in a workweek; and
  - o More than his/her total authorized monthly service hours.
- If I only work for a single IHSS recipient that gets the maximum number of monthly authorized service hours and I am the recipient's only provider, my recipient can allow me to work more than his/her weekly authorized hours. My recipient needs to ask the county for approval for an adjustment for that week's hours and also make sure that I work less hours the following week(s) and that I do not work more than my recipient's total authorized monthly service hours.
- A recipient cannot authorize me to work more than his/her total authorized monthly service hours. If a recipient asks me to work more than his/her weekly hours in one week, he/she must reduce my hours the following week(s) so that I do not work more than his/her total monthly service hours.

## **Limit on Travel Time**

- Also beginning April 1, 2015, the maximum amount of time I will be allowed to travel during a workweek is seven hours. Travel time means the time I spend on the same workday traveling directly from one location where I provide authorized services for a recipient to another location where I provide authorized services for a different recipient.

- Travel time will not be counted as part of the 66 maximum hours (less any required reduction) I can work in a workweek.

### **Violations for Going Over Workweek & Travel Time Limits**

- Beginning April 1, 2015, if I submit a timesheet reporting hours that go over the workweek or travel time limits, I will get a violation. Each time I do any of the following I will get a violation:
  - I work more than 40 hours in a workweek for a recipient without the recipient getting approval from the county (when I would not normally work more than 40 hours in a workweek for that recipient);
  - I work more than a total of 66 hours (less any required reduction) in a workweek for a recipient that I am not in a one-to-one recipient/provider relationship with; or
  - my travel time is more than seven hours in a workweek.

#### First Violation:

- I will get a written warning notice.

#### Second Violation:

- I will get a second written warning notice, and I will have to complete special training about the workweek and travel time limits. (I will get paid for the time I spend attending the training.)
- If I do not complete the training within 14 calendar days of the date of the violation notice, I will automatically get my third violation.

#### Third Violation:

- I will be suspended as an IHSS provider for three months.

#### Fourth Violation (upon being reinstated after the three-month suspension):

- I will be terminated as an IHSS provider for one year.
- Once I have received a violation, the violation will remain on my record. However, after one year, if I do not receive another violation, the number of violations I have received will be reduced by one. As long as I do not receive any additional violations, each year after the last violation, my number of violations will be reduced by one.
- If I receive a fourth violation and am terminated as a provider for one year, when the year is up and I apply again to be an IHSS provider, my violations count will be reset to zero.

- If I get terminated as a provider because I get multiple violations, when the one year termination ends, I will have to complete all of the provider enrollment requirements again, including the criminal background check, provider orientation, and completing all required forms, before I can be reinstated.
4. I understand that I am required to complete the Employment and Eligibility Verification (Form I-9), a form kept on file by the recipient, which states that I have the legal right to work in the United States.
  5. I understand I have the option to submit an Employee’s Withholding Allowance Certification (Form W-4) to request federal income tax withholding and/or California Employee’s Withholding Allowance Certification (Form DE 4) to request state income tax withholding from my wages. I understand that if I do not submit Form W-4 and/or DE 4, no federal or state taxes will be withheld from my wages.
  6. I understand that authorized IHSS services cannot be performed when the recipient is away from his/her home unless my recipient gets approval from his/her social worker for such services.
  7. I understand that in the future I will receive the In-Home Supportive Services (IHSS) Program Provider Notification of Recipient Authorized Hours and Services (SOC 2270) that names the recipient and the services I am authorized to perform for that recipient.
  8. I will cooperate with state or county staff to provide requested information related to the evaluation of a recipient’s IHSS case.

**I UNDERSTAND THE IHSS PROGRAM RULES EXPLAINED AT THE PROVIDER ORIENTATION OR INFORMATION GIVEN TO ME BY THE COUNTY IHSS OFFICE. I ACCEPT THE RESPONSIBILITY TO FOLLOW THE INFORMATION PROVIDED BY THE COUNTY. I UNDERSTAND THAT FAILURE TO FOLLOW THE REQUIREMENTS PROVIDED TO ME MAY RESULT IN BEING TERMINATED AS AN IHSS PROVIDER.**

---

IHSS Provider’s Signature

Date

## PROGRAMA DE SERVICIOS DE APOYO EN EL HOGAR (IHSS) ACUERDO DE INSCRIPCIÓN PARA PROVEEDORES

NÚMERO DE CASO DE IHSS DEL PROVEEDOR
--------------------------------------

NOMBRE DEL PROVEEDOR (PRIMER NOMBRE, NOMBRE QUE USA EN MEDIO, APELLIDO)
---

1. Asistí a la orientación que se requiere para proveedores de IHSS y entiendo y estoy de acuerdo con lo siguiente:
  - Me dieron información sobre lo que significa ser un proveedor en el Programa de IHSS.
  - Me informaron de mis responsabilidades como un proveedor de IHSS.
  - Me informaron acerca de las consecuencias de cometer fraude en el Programa de IHSS.
  - Me dieron el número de teléfono sin costo de la línea de información de Medi-Cal (Programa de Asistencia Médica de California), 1-800-822-6222 y el sitio web, <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx> para reportar la sospecha de fraude o abuso en el Programa de IHSS.
  
2. Recibí entrenamiento sobre cómo completar mi reporte de horas trabajadas (*timesheet*) y entiendo cómo hacerlo.
  - Entiendo que debo reportar en mi reporte de horas trabajadas solamente el tiempo que trabajé proporcionando servicios autorizados para el beneficiario.
  - Entiendo que al firmar mi reporte de horas trabajadas, estoy diciendo que la información que reporté es verdadera y correcta.
  - Entiendo que tengo que presentar mi reporte de horas trabajadas (firmado por el beneficiario y por mí) antes de que pasen dos semanas después del final de cada periodo de pago. Si presento a tiempo mi reporte de horas trabajadas, recibiré mi pago antes de que pasen 10 días contados a partir del día que se reciba mi reporte de horas trabajadas en el centro de procesamiento.
  - Entiendo que si me encuentran culpable de reportar información fraudulentamente en mi reporte de horas trabajadas, además de sanciones penales, es posible que se requiera que pague sanciones civiles de al menos \$500, y no más de \$1,000, por cada infracción de fraude.
  
3. Recibí información y entrenamiento acerca de la semana laboral (*workweek*) y los requisitos para el tiempo de traslado (*travel time*). Esta información y entrenamiento incluyó los siguientes temas:

### **Pago de horas extras trabajadas (*Overtime Pay*)**

- A partir del 1° de enero, 2015, a los proveedores de IHSS se les pagará por horas extras trabajadas (uno y medio del pago regular) cuando trabajen más de 40 horas en una semana laboral. La semana laboral empieza a las 12:00 a.m. (media noche) el domingo y termina a las 11:59 p.m. del siguiente sábado.

**Límite para la semana laboral (*workweek*)**

- A partir del 1° de abril, 2015, el número máximo de horas que los proveedores de IHSS pueden trabajar será 66 (menos alguna reducción que se requiera). El número exacto de horas que se me permitirá trabajar dependerá de:
  - o Cuántas horas de servicios autorizados el beneficiario recibe cada semana;
  - o Para cuántos beneficiarios yo trabajo; y
  - o Si el beneficiario tiene otros proveedores.
- El beneficiario y yo recibiremos una notificación que nos diga cuantas horas de servicio están autorizadas para cada mes y para cada semana.
- Si yo trabajo para más de un beneficiario, la combinación de todas las horas que trabajo para todos los beneficiarios no puede ser más de 66 horas (menos alguna reducción que se requiere) cada semana laboral.

**Trabajar más de las horas semanales del beneficiario**

- Un beneficiario puede autorizar que yo trabaje más de sus horas semanales sin pedirle aprobación al Condado, siempre y cuando la autorización no cause que yo trabaje:
  - o Más de 40 horas para él/ella en una semana laboral; y
  - o Más del total mensual autorizado de sus horas de servicio.
- Si solamente trabajo para un beneficiario de IHSS que recibe un número máximo mensual de horas de servicio autorizado y yo soy el único proveedor del beneficiario, el beneficiario puede permitir que yo trabaje más de sus horas autorizadas para la semana. El beneficiario necesita pedirle al Condado una aprobación para un ajuste en las horas de esa semana y también asegurarse que yo no trabaje más que el total mensual autorizado de horas de servicio del beneficiario.
- Un beneficiario no puede autorizarme a trabajar más del total mensual autorizado de sus horas de servicio. Si un beneficiario me pide que trabaje más de sus horas para una semana, él/ella tiene que reducir mis horas la siguiente semana(s) para que yo no trabaje más del total mensual de sus horas de servicio.

**Límite en el tiempo de traslado (*travel time*)**

- También a partir del 1° de abril, 2015, la cantidad máxima de tiempo de traslado que se permitirá durante la semana laboral será siete horas. “tiempo de traslado” quiere decir el tiempo que yo uso el mismo día de trabajo viajando directamente de un lugar donde proporciono servicios autorizados para un beneficiario a otro lugar donde proporciono servicios autorizados para un beneficiario diferente.

- El tiempo de traslado no se contará como parte del número máximo de 66 horas (menos cualquier reducción requerida) que yo puedo trabajar en una semana laboral.

### **Infracciones por sobrepasar los límites para la semana laboral y el tiempo de traslado**

- A partir del 1º de abril, 2015, si yo presento un reporte de horas trabajadas que sobrepase los límites para la semana laboral o el tiempo de traslado, se me impondrá una infracción. Cada vez que suceda alguno de los siguientes, se me impondrá una infracción:
  - Trabajo más de 40 horas en una semana laboral para un beneficiario sin que el beneficiario reciba aprobación del Condado (cuando yo normalmente no trabajaría más de 40 horas en la semana laboral para ese beneficiario);
  - Trabajo más de un total de 66 horas (menos alguna reducción requerida) en la semana laboral para un beneficiario y no estoy en una relación de un beneficiario/proveedor (uno a uno); o
  - Mi tiempo de traslado es más de siete horas en una semana laboral.

#### Primera infracción:

- Recibiré una notificación de advertencia por escrito.

#### Segunda infracción:

- Recibiré una segunda notificación de advertencia por escrito y tendré que completar un entrenamiento especial acerca de los límites para la semana laboral y el tiempo de traslado. (Recibiré pago por el tiempo que use para el entrenamiento.)
- Si no completo el entrenamiento antes de que pasen 14 días consecutivos a partir de la fecha de la notificación de la infracción, automáticamente recibiré el cargo de una tercera infracción.

#### Tercera infracción:

- Se me suspenderá como proveedor de IHSS por tres meses.

#### Cuarta infracción (una vez que regrese de la suspensión de tres meses):

- Dejaré de ser proveedor de IHSS durante un año.

- Una vez que reciba una infracción, esta infracción permanecerá en mi expediente. Sin embargo, después de un año, si es que no recibo otra infracción, el número de infracciones se reducirá por una. Mientras no reciba infracciones adicionales, cada año después de la última infracción, el número de infracciones se reducirá por una.
- Si recibo una cuarta infracción y dejo de ser proveedor durante un año, cuando se venza el año y solicite otra vez ser un proveedor de IHSS, el número de infracciones volverá a ser cero.

- Si dejo de ser proveedor debido a múltiples infracciones, cuando termine el año y antes de que pueda volver a ser proveedor, tendré que completar todos los requisitos de inscripción otra vez, incluyendo la revisión de antecedentes penales, orientación para proveedores, y completar todos los formularios que se requieren.
4. Entiendo que se requiere que yo complete el formulario *“Employment and Eligibility Verification (Form I-9)”* (Formulario de verificación de elegibilidad para trabajar), un formulario que el beneficiario tendrá archivado, el cual declara que yo tengo el derecho legal para trabajar en los Estados Unidos.
  5. Entiendo que tengo la opción de presentar el formulario W-4, *“Employee’s Withholding Allowance Certification (Form W-4)”* (Certificación del empleado para retención de ingresos) para solicitar la retención federal de los impuestos sobre los ingresos y/o el formulario DE 4, *“California Employee’s Withholding Allowance Certification (Form DE 4)”* (Certificación del empleado para retención de ingresos en California) para solicitar que se retengan los impuestos estatales sobre los ingresos. Entiendo que si no presento los formularios W-4 y/o DE 4, no se retendrán los impuestos federales o estatales de mis ingresos.
  6. Entiendo que los servicios autorizados de IHSS no se pueden hacer si el beneficiario no está en su casa, a menos que el beneficiario reciba aprobación de su trabajador social para tales servicios.
  7. Entiendo que en el futuro recibiré el formulario de IHSS *“Notificación para el proveedor sobre las horas y los servicios autorizados para el beneficiario”* (SOC 2271) y esta notificación tendrá el nombre del beneficiario y los servicios que estoy autorizado a dar para ese beneficiario.
  8. Yo cooperaré con el personal del Estado o del Condado para proporcionar la información que se solicite relacionada a la evaluación del caso del beneficiario de IHSS.

**ENTIENDO LAS REGLAS DEL PROGRAMA DE IHSS QUE ME EXPLICARON EN LA ORIENTACIÓN PARA PROVEEDORES O LA INFORMACIÓN QUE ME DIERON EN LA OFICINA DE IHSS DEL CONDADO. YO ACEPTO LA RESPONSABILIDAD DE CUMPLIR CON LA INFORMACIÓN QUE ME PROPORCIONÓ EL CONDADO. ENTIENDO QUE SI NO CUMPLO CON LOS REQUISITOS QUE ME DIERON, ESTO PUDIERA RESULTAR EN QUE YO DEJE DE SER UN PROVEEDOR DE IHSS.**

---

 Firma del proveedor de IHSS

Fecha

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
PROVIDER WORKWEEK & TRAVEL TIME AGREEMENT**

*(To be completed by a provider who provides authorized services to multiple recipients)*

PROVIDER NAME:

PROVIDER NUMBER:

**PART A. WORKWEEK SCHEDULE**

**PROVIDER REQUIREMENTS:**

- State law (Welfare and Institutions Code section 12300.4) does not allow providers in the IHSS and Waiver Personal Care Services (WPCS) programs to work more than 66 hours (less any required reduction) in one workweek providing authorized IHSS services to two or more recipients. This maximum weekly workweek does not include travel time as described below in Part B. The workweek starts on Sunday at 12:00 a.m. (midnight) and ends at 11:59 p.m. on the following Saturday. You will get a notice telling you how many authorized service hours each of your recipients gets weekly and monthly.
- A recipient may adjust his or her weekly authorized hours, but he/she must get approval from the county if the adjustment will result in you working over 40 hours in any workweek for him/her (when, based on your workweek agreement, you would not normally work more than 40 hours in a workweek for him/her).
- It is your responsibility as a provider to:
  - Make sure that the total combined hours you work in a workweek providing authorized services for all providers you work for do not total more than 66 hours (less any requires reduction) in one workweek.
  - Make sure that the hours you work providing services to any one of your recipients are not more than that recipient’s weekly authorized hours.
  - Make sure that if one of your recipients adjust your work schedule to give you more hours in a workweek than you normally get, that you work less hours in a following week to make sure you are not working more than his/her authorized monthly hours.

ATTACHMENT F

PAGE 35 of 60

- If you submit a timesheet in which you violate the workweek schedule in any of the following ways, you will receive a violation:
  - Work more than 40 hours in a workweek without county approval if you would normally work 40 hours or less in a workweek;
  - Work more than 66 hours (less any required reduction) in a workweek;
  - Claim more than seven hours of travel time (see Part B of this agreement).
- If you violate the workweek schedule in any of the ways described above, you will receive the following:
  - 1<sup>st</sup> Violation = You will receive a written warning notice;
  - 2<sup>nd</sup> Violation = You will receive a second written warning notice, and you will be required to complete training about workweek and travel time limits. If you do not complete the training within 14 calendar days of the date of the violation notice, you will automatically receive your third violation;
  - 3<sup>rd</sup> Violation = You will receive a three (3) month suspension from providing IHSS services;
  - 4<sup>th</sup> Violation = You will be terminated from providing IHSS services for a period of one (1) year. At that time, if you wish to return as an IHSS provider, you must complete all of the provider enrollment requirements again, including the criminal background check, the provider orientation, and completion of all required forms.

**INSTRUCTIONS:** You must complete the chart on the next page to help you plan your workweek schedule. Your schedule must include services provided to all recipients you work for and must not be more than 66 hours (less any statutory deduction) in one workweek. You will be notified of each of your recipients' total weekly authorized hours in a separate notice.

1. In Column A, write the **name** of each recipient you provide authorized IHSS services for.
2. In Column B, write the **case number** of each recipient listed in Column A.
3. In Column C, write the **address** of each recipient listed in Column A.

ATTACHMENT F

PAGE 36 of 60

4. In Column D, write the total number of hours per day (for each day of the week) you work or plan to work providing authorized IHSS services for each recipient listed in Column A.
5. For Column E, add the total number of hours from each day in Column D that you work or plan to work providing authorized IHSS services for each recipient listed in Column A and write the total number of hours for the week for each recipient in Column E.
6. At the bottom of Column E, add the total number of hours you work or plan to work providing authorized IHSS services for all of your recipients each week.

A	B	C			D							E
Recipient's Name	Recipient Case #	Recipient's Address			Total Number of Hours I Work or Plan to Work							Total Hours
		Street Address	City	Zip Code	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	

TOTAL HOURS I WORK OR PLAN TO WORK PROVIDING AUTHORIZED SERVICES FOR ALL RECIPIENTS:

## PART B. TRAVEL TIME

### PROVIDER REQUIREMENTS:

- If you travel from one recipient's location to another recipient's location on the same workday in order to provide authorized IHSS services to both recipients, you can get paid for that travel time, but that time cannot be more than seven hours per workweek. These seven hours are in addition to the above workweek limit of 66 hours (less any required reduction).
- To get paid for that travel time, you must travel directly from one recipient's location to the other recipient's location without stopping. If you make only a brief stop on your way to the second recipient's location, such as to fill your gas tank at a service station, you are still considered to be traveling directly. However, if you stop to conduct personal business or if you return to your own home, you can only be paid for the time that it would have taken to travel between the two locations where services are provided without the personal stops.
- If your total estimated travel time will be more than seven hours, you will need to adjust your work schedule so that your travel time is less than seven hours.

**Do you plan to travel from a location where you provide authorized services to one recipient to another location where you provide authorized services to a different recipient on the same day?**

YES     NO

*If you answer NO, you do not need to complete PART B, go directly to PART C.*

---

**INSTRUCTIONS:** You must complete this section to help you plan the travel time that you can be paid for so that your total weekly travel time is not more than 7 hours. Because you are traveling, it may be necessary for you to provide proof of time and mileage.

1. In Column A below, write the name(s) of the recipient(s) you will be traveling from.
2. In Column B below, write the name(s) of the recipient(s) you will be traveling to.
3. In Column C below, write how far (in miles) it takes to travel directly from one recipient's location to the next recipient's location.

4. In Column D below, write how long (in minutes) you estimate it takes to travel directly from one recipient's location to the next recipient's location.
5. In Column E below, write how many days each workweek you plan to travel from one recipient's location to another recipient's location on the same day?
6. In Column F, multiply the amount of time you estimate it takes to travel directly from one recipient's location to the next recipient's location (Column D) by the number of days you will travel between recipients' locations each workweek (Column E) to indicate your total travel time between the two recipients' locations (Column A and B).
7. Add up the total of all the time listed on the lines in Column F and write the total at the bottom of Column F.

**PART B. TRAVEL TIME**

A	B	C	D	E	F
Names of the Recipients You Will Be Traveling Between		Distance Between Recipients' Locations (in miles)	Estimated Travel Time Between Recipients' Locations (in minutes)	Number of Days You Will Travel Between Recipients' Locations Each Workweek	Total Estimated Travel Time Between Recipients' Locations Each Workweek (Col. D x Col. E)
From	To				
<b>TOTAL ESTIMATED TRAVEL TIME EACH WORKWEEK:</b>					

How will you travel between recipients' locations?

- CAR\*   
  PUBLIC TRANSIT   
  OTHER Specify: \_\_\_\_\_

***\* If you will be driving yourself to travel between recipients, you must have a valid California driver's license and proof of insurance, and your vehicle must have current registration. If you do not have a valid California driver's license, proof of insurance, or current vehicle registration, you are not legally allowed to drive your vehicle for the purpose of providing IHSS. You must choose a different form of transportation, such as public transit. If you have chosen to drive yourself and there is a negative change to the status of your legal right to drive your vehicle (i.e., your California driver's license, auto insurance, or vehicle registration expires or is no longer valid), you must inform the county and select a different form of transportation. If you fail to inform the county of this change in status, you will be considered in violation of IHSS program requirements and may be terminated.***

ATTACHMENT F

PAGE 40 of 60

**PART C. PROVIDER AGREEMENT**

**I declare that I have read and understand the requirements as stated in this document and I agree to comply with these requirements. I further declare that all of the information I have provided on this form is true and correct.** I agree to notify the county within 10 calendar days if any of the information I have provided in this Provider Workweek and Travel time Agreement changes, and depending on what information has changed, I may be required to complete a new SOC 2255.

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

PROVIDER'S PRINTED NAME:

**FOR COUNTY USE ONLY**

WORKER NAME:	DATE:
ESTIMATED TRAVEL TIME REVIEWED: YES <input type="checkbox"/> NO <input type="checkbox"/>	SOURCE USED TO VERIFY TRAVEL TIME:

NOTES:

**PROGRAMA DE SERVICIOS DE APOYO EN EL HOGAR (IHSS)  
ACUERDO DEL PROVEEDOR SOBRE LA SEMANA LABORAL Y EL TIEMPO DE TRASLADO**

*(Para ser completado por el proveedor que proporciona servicios autorizados a múltiples beneficiarios)*

NOMBRE DEL PROVEEDOR:

NÚMERO DEL PROVEEDOR:

**PARTE A. HORARIO DE LA SEMANA LABORAL (*WORKWEEK SCHEDULE*)**

**REQUISITOS PARA LOS PROVEEDORES:**

- La ley del Estado (Sección 12300.4 del Código de Bienestar e Instituciones) no permite que los proveedores del Programa de IHSS y los programas de servicios de cuidado personal por exención (*Waiver Personal Care Services* - WPCS) trabajen más de 66 horas (menos alguna reducción requerida) en una semana laboral proporcionando servicios de IHSS para dos o más beneficiarios. Esta cantidad máxima para cada semana laboral no incluye el tiempo de traslado como se describe a continuación en la Parte B. La semana laboral empieza el domingo a las 12:00 a.m. (media noche) y termina a la 11:59 p.m del siguiente sábado. Usted recibirá una notificación diciéndole cuantas horas de servicio autorizadas cada uno de sus beneficiarios recibirá semanal y mensualmente.
- Un beneficiario puede ajustar sus horas semanales autorizadas, pero él/ella tiene que recibir aprobación del Condado si es que el ajuste resultará en que usted trabaje mas de 40 horas en alguna de las semanas para él/ella (cuando, basándose en su acuerdo de su semana laboral, usted normalmente no trabajaría más de 40 horas en la semana laboral para él/ella).
- Como proveedor, su responsabilidad es:
  - Asegurarse de que el total de la combinación de horas que usted trabaja en una semana laboral proporcionando servicios autorizados para todos los beneficiarios para quien usted trabaja no es más de un total de 66 horas (menos alguna reducción requerida) en una semana laboral.
  - Asegurarse de que las horas que usted trabaja proporcionando servicios para alguno de sus beneficiarios no sean más que las horas de servicio autorizadas para la semana de ese beneficiario.
  - Asegurarse de que si uno de sus beneficiarios ajusta el horario de su trabajo para darle más horas en una semana laboral que las que normalmente tendría, que usted trabaje menos horas la siguiente semana para asegurarse de que usted no trabaje mas horas que sus horas autorizadas para el mes.

- Si usted presenta un reporte de horas trabajadas (*timesheet*) en el cual usted no cumple con el horario de la semana laboral en alguna de las siguientes maneras, usted recibirá un infracción:
  - Trabaja más de 40 horas en una semana laboral sin la aprobación del Condado, si es que usted normalmente trabajaría 40 horas o menos en una semana laboral;
  - Trabaja más de 66 horas (menos alguna reducción requerida) en una semana laboral;
  - Pone un reclamo por más de siete horas de tiempo de traslado (ver la Parte B de este acuerdo).
- Si usted comete una infracción en el horario de su semana laboral en alguna de las maneras descritas arriba, recibirá lo siguiente:
  - 1ª infracción = Usted recibirá una notificación de advertencia por escrito;
  - 2ª infracción = Usted recibirá una segunda notificación por escrito, y se requerirá que complete el entrenamiento relacionado a los límites en la semana laboral y el tiempo de traslado. Si no completa el entrenamiento antes de que pasen 14 días calendario contados a partir de la fecha de la notificación de infracción, usted automáticamente recibirá una tercera infracción;
  - 3ª infracción = Usted recibirá una suspensión de tres (3) meses para proporcionar servicios de IHSS;
  - 4ª infracción = Usted dejará de ser proveedor de servicios de IHSS por el periodo de un (1) año. En ese momento, si desea volver a ser un proveedor de IHSS, tendrá que completar otra vez todos los requisitos de inscripción para proveedores, incluyendo la revisión de antecedentes penales, la orientación para proveedores, y completar todos los formularios que se requieren.

**INSTRUCCIONES:** Tiene que completar la gráfica que aparece en la siguiente página para ayudarlo a planear su horario de la semana laboral. Su horario tiene que incluir servicios proporcionados a todos los beneficiarios para quien trabaja y no debe de ser por más de 66 horas (menos cualquier deducción estipulada) en una semana laboral. En una notificación por separado, se le notificará del total de horas autorizadas por semana para cada uno de los beneficiarios.

1. En la Columna A, escriba el **nombre** de cada uno de los beneficiarios a quien le proporciona servicios.
2. En la Columna B, escriba el **número de caso** para cada uno de los beneficiarios anotados en la Columna A.
3. En la Columna C, escriba la **dirección** de cada uno de los beneficiarios anotados en la Columna A.

4. En la Columna D, escriba el número total de horas por día (para cada día de la semana) que usted trabaja o planea trabajar proporcionando servicios autorizados de IHSS para cada uno de los beneficiarios anotados en la Columna A.
5. En la Columna E, sume el total de horas para cada día en la Columna D que usted trabaje o planea trabajar proporcionando servicios autorizados para cada uno de los beneficiarios anotados en la Columna A y en la Columna E escriba el total de número de horas por semana para cada uno de los beneficiarios.
6. En la parte de abajo de la Columna E, sume el número total de horas que trabaje o planea trabajar proporcionando servicios de IHSS autorizados para todos sus beneficiarios cada semana.

A  Nombre del beneficiario	B  Número de caso del beneficiario	C  Dirección del beneficiario			D  Número total de horas que yo trabajo o planeo trabajar						E  Total de horas	
		Dirección de la calle	Ciudad	Código postal	Domingo	Lunes	Martes	Miércoles	Jueves	Viernes		Sábado

**TOTAL DE HORAS QUE TRABAJO O PLANEO TRABAJAR  
PROPORCIONANDO SERVICIOS AUTORIZADOS PARA TODOS LOS BENEFICIARIOS:**

## PARTE B. TIEMPO DE TRASLADO (*TRAVEL TIME*)

### REQUISITOS PARA LOS PROVEEDORES:

- Si durante el mismo día de trabajo, usted viaja del lugar de un beneficiario al lugar de otro beneficiario para poder proporcionar servicios autorizados de IHSS a ambos beneficiarios, usted puede recibir un pago por ese tiempo de traslado, pero ese tiempo no puede ser más de siete horas por semana laboral. Estas siete horas son aparte, y no se incluyen en el límite para la semana laboral mencionado anteriormente que es de 66 horas (menos cualquier reducción requerida).
- Para recibir un pago por el tiempo de traslado, usted tiene que viajar directamente del lugar de un beneficiario al lugar de otro beneficiario sin parar en otros lugares. Si hace una parada breve en el camino para el segundo beneficiario, tal como para poner gasolina, tal viaje todavía se consideraría directo. Sin embargo, si usted se detiene para llevar a cabo cosas personales, o si regresa a su casa, usted solamente puede recibir pago por el tiempo que le tomaría viajar entre los dos lugares en donde proporcione servicios sin tomar en cuenta las paradas personales.
- Si el total de tiempo de traslado previsto será más de siete horas, usted necesitará ajustar su horario de trabajo para que su tiempo de traslado sea menos de siete horas.

**¿Tiene planes de viajar de un lugar donde proporciona servicios autorizados para un beneficiario a otro lugar donde proporciona servicios autorizados para un beneficiario diferente durante el mismo día?**

**SÍ**     **NO**

*Si su respuesta es "NO", no necesita completar la PARTE B, vaya directamente a la PARTE C.*

---

**INSTRUCCIONES:** Usted tiene que completar esta sección para ayudar a planear el tiempo de traslado para el cual puede recibir un pago y para que el total de tiempo de traslado para la semana no sea más de 7 horas. Debido a que usted está viajando, es posible que sea necesario que usted proporcione pruebas del tiempo y las millas.

1. En la Columna A a continuación, escriba el nombre(s) del beneficiario(s) donde va a empezar su viaje.
2. En la Columna B a continuación, escriba el nombre(s) del beneficiario(s) a donde va a viajar.
3. En la Columna C a continuación, escriba la distancia (en millas) para viajar directamente del lugar de un beneficiario al lugar del otro beneficiario.

4. En la Columna D a continuación, escriba cuánto tiempo (en minutos) usted calcula que se toma viajar directamente del lugar de un beneficiario al lugar del próximo beneficiario.
5. En la Columna E a continuación, escriba cuántos días en la semana laboral usted planea viajar del lugar de un beneficiario al lugar del otro beneficiario durante el mismo día.
6. En la Columna F, multiplique la cantidad de tiempo que usted calcula que se toma viajar directamente del lugar de un beneficiario al lugar del próximo beneficiario (Columna D) por el número de días que usted viajará entre los lugares de los beneficiarios cada semana laboral (Columna E) para indicar el total del tiempo de traslado entre los lugares de los dos beneficiarios (Columnas A y B).
7. Sume el total del tiempo anotado en la líneas de la Columna F y escriba el total en la parte de abajo de la Columna F.

**PARTE B. TIEMPO DE TRASLADO (TRAVEL TIME)**

A	B	C	D	E	F
<b>Nombre de los beneficiarios entre los cuales usted va a viajar</b>		<b>Distancia entre los lugares de los beneficiarios (en millas)</b>	<b>Cálculo del tiempo de traslado entre los lugares de los beneficiarios</b>	<b>Número de días que usted viajará entre los lugares de los beneficiarios cada semana laboral</b>	<b>Cálculo del total de tiempo de traslado entre los lugares de los beneficiarios cada semana de trabajo (Col. D x Col. E)</b>
<b>De</b>	<b>A</b>				
<b>CÁLCULO DEL TOTAL DE tiempo de traslado PARA CADA semana laboral:</b>					

¿Cómo va usted a viajar entre los lugares de los beneficiarios?

- VEHÍCULO\*   
  TRANSPORTE PÚBLICO   
  OTRO Especifique: \_\_\_\_\_

**\* Si va a manejar para viajar a los lugares de los beneficiarios, usted tiene que tener una licencia de manejar de California válida, pruebas de seguro, y su vehículo tiene que tener un registro válido. Si no tiene una licencia de manejar de California válida, prueba de seguro, o registro de vehículo válido, usted no puede legalmente manejar su vehículo para el propósito de proporcionar IHSS. Usted tiene que escoger una forma de transporte diferente tal como el transporte público. Si usted ha escogido manejar y hay un cambio negativo en su situación para el derecho legal de manejar su vehículo (es decir, su licencia de manejar de California, seguro de automóvil, o registro de vehículo se vence o ya no es válida), usted tiene que informar al Condado y seleccionar otra forma diferente de transporte. Si no le informa al Condado acerca de este cambio en su situación, usted se considerará en violación de los requisitos del Programa de IHSS y es posible que termine de ser proveedor.**

**PARTE C. ACUERDO DEL PROVEEDOR**

**Declaro que he leído y entiendo los requisitos como aparecen en este documento y estoy de acuerdo en cumplir con estos requisitos. Además, declaro que toda la información que he proporcionado en este formulario es verdadera y correcta.** Estoy de acuerdo en notificar al Condado antes de que pasen 10 días calendario si cambia alguna de la información que he proporcionado en este “Acuerdo del proveedor sobre la semana laboral y el tiempo de traslado”; es posible que se requiera que complete un nuevo formulario SOC 2255.

FIRMA DEL PROVEEDOR:	FECHA:
----------------------	--------

NOMBRE DEL PROVEEDOR ESCRITO CON LETRA DE MOLDE:

---

**(SOLO PARA USO DEL CONDADO) FOR COUNTY USE ONLY**

WORKER NAME:	DATE:
ESTIMATED TRAVEL TIME REVIEWED: YES <input type="checkbox"/> NO <input type="checkbox"/>	SOURCE USED TO VERIFY TRAVEL TIME:

NOTES:

---

ATTACHMENT F

PAGE 48 of 60

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

**INSTRUCTIONS:**

- Use black or blue ink. Print information clearly.
- You (or your authorized representative) must complete PART A of this form to let the county know who you have chosen to provide your authorized services.
- If you have multiple providers, you must fill out a separate form for each person who will be providing authorized services for you.
- You must sign the acknowledgement in PART C of this form.
- Please return this completed and signed form to the county. The county will keep the original form and give you a copy.

**PART A. RECIPIENT DESIGNATION OF PROVIDER**

1. Recipient's Name:	
2. County IHSS Case #:	
3. Provider's Name:	
4. Provider's Address:	
City, State, ZIP Code:	
5. Provider's Telephone Number:	
6. Provider's Date of Birth	
7. Provider's Social Security #*:	
8. Provider's Gender (check box):	<input type="checkbox"/> Male <input type="checkbox"/> Female
9. Provider's Relationship to Recipient (if any):	<input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Conservator <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____
10. Provider's Start Date:	

\*NOTE: The collection of the Social Security Number is required by the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a), for the purposes of verifying the individual's identity and authorization to work in the United States.

- I choose the person listed above to be my IHSS provider. This person will provide some or all of the services authorized by the county.

---

**PART B. RECIPIENT AGREEMENT**

---

**I UNDERSTAND AND AGREE THAT:**

- The person I have chosen to be my provider cannot be paid federal and/or state money for providing services to me until he/she completes all of the provider enrollment requirements, including completing, signing, and returning (in person) the Provider Enrollment Form (SOC 426), submitting fingerprints and being cleared of disqualifying crimes through a criminal background check, completing a provider orientation, and signing and returning the Provider Enrollment Agreement (SOC 846).
- The county will send me a notice telling me if the person I have chosen as my provider does not complete the provider enrollment requirements or if he/she is not eligible to be an IHSS provider.
- If I choose to have this person provide services for me before he/she is enrolled as an IHSS provider, and the county sends me a notice telling me that he/she is not eligible to be an IHSS provider, I will have to pay him/her with my own money for the services that he/she provided before he/she was determined ineligible to be a provider and for any services he/she provides after the county notifies me that he/she is ineligible.
- Neither the county nor the State will be held responsible for any claims and/or losses caused by the above-named person I choose to hire as my IHSS provider. I agree to hold harmless the State and county, their officers, agents, and employees, and to take responsibility for any and all claims and/or losses to any person caused by the named person I choose to hire as my IHSS provider.
- The county can provide information about my authorized services and service hours to the person I have chosen as my provider. The county will send my provider the IHSS Provider Notice of Recipient Authorized Hours and Services (SOC 2271).
- Under state law, the maximum amount of time an IHSS provider can work providing authorized services in a workweek is 66 hours (less any required reduction). The workweek starts at 12:00 a.m. (midnight) on Sunday and ends at 11:59 pm on the following Saturday.
- My total authorized service hours for the month will be broken out into a weekly authorized amount.
- I can authorize my provider to adjust his/her schedule to work more than his/her normal work hours during the workweek without asking the county for approval as long as it does not cause my provider to:
  1. work for me more than 40 hours in a workweek; and
  2. work more than my total authorized monthly hours.

- If my provider normally works for me more than 40 hours in a workweek, I can authorize him/her to work more overtime hours for me in a workweek as long as I have him/her work less hours in the next workweek(s) of the month so I do not go over my authorized monthly hours.
- I have to ask the county for an exception if I need my provider to work for me more than 40 hours in a workweek, and he/she does not normally work for me more than 40 hours in a workweek.
- If I do not get an approved exception, my provider will get a violation.
- Even if the county approves my request for an exception, I will need to have my provider work less hours in the next workweek(s) of the month so that I don't go over my authorized monthly hours.
- I cannot ever authorize my provider to work more than 66 hour (less any required reduction) in a workweek unless my provider and I are in a one-to-one recipient/provider relationship and I receive the maximum monthly authorized service hours.
- The county will send me a notice each time my provider gets a violation. If my provider gets three violations, he/she will be suspended from providing IHSS for three months. If he/she gets another violation after being reinstated from the three-month suspension, he/she will be terminated as a provider for one year.
- My provider is not eligible to get paid for his/her meal periods (lunch breaks) while he/she is working to provide authorized services for me. I will not allow him/her to take a meal period (lunch break) unless it is at least 30 minutes long and I completely release him/her from his/her work duties during that time.

---

**PART C. RECIPIENT ACKNOWLEDGMENT**

---

**I understand and agree to follow all of the requirements listed in this form.**

RECIPIENT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE:	DATE:
---	-------

PRINTED NAME:

---

**FOR COUNTY USE ONLY**

WORKER NAME:	DATE:
--------------	-------

## PROGRAMA DE SERVICIOS DE APOYO EN EL HOGAR (IHSS) DESIGNACIÓN DE UN PROVEEDOR ELEGIDO POR EL BENEFICIARIO

### INSTRUCCIONES:

- Use tinta negra o azul. Escriba claramente la información con letra de molde.
- Usted (o su representante autorizado) tiene que completar la PARTE A de este formulario para comunicarle al Condado a quién usted ha elegido para que le proporcione sus servicios.
- Si usted tiene más de un proveedor, tiene que llenar un formulario por separado para cada persona que le proporcionará los servicios autorizados.
- Usted tiene que firmar la confirmación en la PARTE C de este formulario.
- Por favor devuelva al Condado este formulario completado y firmado. El Condado se quedará con el formulario original y le dará una copia a usted.

### **PARTE A. DESIGNACIÓN DEL PROVEEDOR ELEGIDO POR EL BENEFICIARIO**

1. Nombre del beneficiario:	
2. Número del caso de IHSS del Condado:	
3. Nombre del proveedor:	
4. Dirección del proveedor:	
Ciudad, estado, código postal:	
5. Número de teléfono del proveedor:	
6. Fecha de nacimiento del proveedor:	
7. Número de Seguro Social* del proveedor:	
8. Sexo del proveedor (marque la casilla):	<input type="checkbox"/> Masculino <input type="checkbox"/> Femenino
9. Relación/parentesco del proveedor con el beneficiario (si hay alguna):	<input type="checkbox"/> Padre/Madre <input type="checkbox"/> Hijo(a) <input type="checkbox"/> Esposa(o)/Pareja doméstica <input type="checkbox"/> Curador legal <input type="checkbox"/> Tutor legal <input type="checkbox"/> Otra: _____
10. Fecha en que va a empezar el proveedor:	

\*NOTA: El Decreto de 1986 sobre la Reforma y el Control de la Inmigración, Ley Pública 99-603 (1324a del Código 8 de los Estados Unidos), requiere que se proporcione el número de Seguro Social con el propósito de verificar la identidad de la persona y su autorización para trabajar en los Estados Unidos.

- Elijo a la persona mencionada arriba para que sea mi proveedor de IHSS. Esta persona proporcionará algunos o todos los servicios autorizados por el Condado.

---

**PARTE B. ACUERDO DEL BENEFICIARIO**

---

**ENTIENDO Y ESTOY DE ACUERDO EN QUE:**

- A la persona que he elegido para que sea mi proveedor no se le puede pagar con fondos federales y/o estatales por proporcionar servicios para mí hasta que él/ella complete los requisitos de inscripción, incluyendo completar, firmar, y devolver (en persona) el “Formulario de inscripción para proveedores” (SOC 426), presentar las huellas dactilares y recibir aprobación sobre delitos que descalifican por medio de una revisión de antecedentes penales, completar una orientación para proveedores, y firmar y devolver el “Acuerdo de inscripción para proveedores” (SOC 846).
- El Condado me enviará una notificación si la persona que he elegido como mi proveedor no completa los requisitos de inscripción para proveedores o si él/ella no es elegible para ser un proveedor de IHSS.
- Si elijo que esta persona me proporcione servicios antes de que él/ella se haya inscrito como un proveedor de IHSS, y el Condado me envía una notificación avisándome que él/ella no es elegible para ser un proveedor de IHSS, yo tendré que pagarle a él/ella con mi propio dinero por los servicios que él/ella haya proporcionado antes de que determinara que no era elegible para ser un proveedor y por cualquier servicio que él/ella me proporcione después de que el Condado me notifique que él/ella no es elegible.
- Ni el Condado ni el Estado serán responsables de ningún reclamo y/o pérdidas causadas por la persona mencionada anteriormente a quién yo elijo contratar como mi proveedor de IHSS. Estoy de acuerdo en que el Estado y el Condado, sus oficiales, agentes, y empleados no tengan ninguna responsabilidad de ningún reclamo y/o pérdidas de ninguna persona causadas por la persona mencionada a quien elijo contratar como mi proveedor de IHSS.
- El Condado puede proporcionarle información a la persona que he elegido como mi proveedor acerca mis servicios autorizados y las horas de servicio. El Condado le enviará a mi proveedor el formulario de IHSS “Notificación para el proveedor sobre las horas y los servicios autorizados para el beneficiario” (SOC 2271).
- Bajo la ley del Estado, la cantidad máxima de tiempo que un proveedor de IHSS puede trabajar proporcionando servicios autorizados en una semana de trabajo es de 66 horas (menos cualquier reducción requerida). La semana de trabajo empieza a las 12:00 a.m. (media noche) el domingo y termina a las 11:59 p.m. el siguiente sábado.
- El total de mis horas de servicio autorizadas para el mes se dividirá en una cantidad autorizada para cada semana.
- Yo puedo autorizar a mi proveedor para que ajuste su horario para que trabaje más de sus horas normales de trabajo durante la semana de trabajo sin tener que pedirle su aprobación al Condado, siempre y cuando esto no ocasione que mi proveedor:
  1. trabaje para mí más de 40 horas en una semana de trabajo; y
  2. trabaje más del total de mis horas autorizadas para el mes.

- Si mi proveedor normalmente trabaja para mí más de 40 horas en una semana de trabajo, yo puedo autorizar que él/ella trabaje más horas extra para mí en una semana de trabajo siempre y cuando él/ella trabaje menos horas la siguiente semana(s) del mes para que no sobrepase la cantidad mensual de mis horas autorizadas.
- Tengo que pedirle al Condado una excepción si necesito que mi proveedor trabaje para mí más de 40 horas en una semana de trabajo, y él/ella normalmente no trabaja para mí más de 40 horas en una semana de trabajo.
- Si no recibo la aprobación para una excepción, mi proveedor recibirá una infracción.
- Aunque el Condado apruebe mi petición para una excepción, necesitaré que mi proveedor trabaje menos horas en la siguiente semana(s) del mes para que no sobrepase la cantidad mensual de horas autorizadas.
- Yo no puedo nunca autorizar que mi proveedor trabaje más de 66 horas (menos cualquier reducción que se requiera) en una semana de trabajo a menos que mi proveedor y yo estemos en una relación de beneficiario/proveedor y yo recibo la cantidad mensual máxima de horas de servicio autorizadas.
- El Condado me enviará una notificación cada vez que mi proveedor reciba una infracción. Si mi proveedor recibe tres violaciones, se le suspenderá de proporcionar IHSS durante tres meses. Si recibe otra infracción después de regresar de la suspensión de tres meses, será suspendido de ser proveedor durante un año.
- Mi proveedor no es elegible para que se le pague por los periodos de comidas (almuerzos) mientras esté trabajando para proporcionar servicios autorizados para mí. No permitiré que tome un descanso para comer (almuerzo), al menos que dure al menos 30 minutos y yo le permita que deje completamente sus obligaciones de trabajo durante ese tiempo.

**PARTE C. CONFIRMACIÓN DEL BENEFICIARIO**

**Entiendo y estoy de acuerdo en seguir todos los requisitos anotados en este formulario.**

FIRMA DEL BENEFICIARIO O DEL REPRESENTANTE AUTORIZADO:	FECHA:
--	--------

NOMBRE ESCRITO CON LETRA DE MOLDE:

**FOR COUNTY USE ONLY (SOLAMENTE PARA USO DEL CONDADO)**

WORKER NAME:	DATE:
--------------	-------

# Sample Sheet

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

San Bernardino Department of Human Services  
17270 Bear Valley RD, STE 108  
Victorville CA 92395

## IN-HOME SUPPORTIVE SERVICES(IHSS) INDIVIDUAL PROVIDER INITIAL / REPLACEMENT TIMESHEET

Record your daily hours and minutes like these samples.

Did not work	H	M	M	M
6 hours 30 minutes	6	3	0	
4 hours 45 minutes	4	4	5	
10 hours	1	0		
<b>Total</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>5</b>

SAMPLE D NO-TRAVEL  
123 MAIN STREET  
ANYTOWN CA 12345-6789

**Important Instructions**

1. Use black ink only and press firmly. Numbers must be readable.
2. Your defined workweek is from Sunday, 12:00 AM to Saturday, 11:59 PM.
3. Do not send any other documents with the timesheet except a travel claim form.
4. Only write in the hours, minutes, signature, and date boxes. Do not write in any box with a preprinted 0. Any extra writing on the timesheet can delay your paycheck.
5. You will not be paid for hours claimed more than the recipient's IHSS Program authorized hours or the weekly allowed hours. Claiming extra hours can delay your paycheck.
6. You must enter hours for each day worked (Total line is optional).
7. You and your Recipient must sign and date the back of your timesheet.
8. Do not fold the timesheet. Do not use white out or correction tape on timesheet.
9. Time travelled from one recipient to another on the same day must be claimed on the timesheet for the recipient you travelled to and cannot exceed the 7 hour weekly travel cap.
10. **Claimed** = hours worked and claimed in previous pay period. **Travel** = hours travelled and claimed in previous pay period.

<b>Provider #:</b> 123456789	<b>Provider Name:</b> JOHN PROVIDER
<b>Case #:</b> 00 01 1234567	<b>Recipient Name:</b> JANE RECIPIENT
<b>Type:</b> IHSS	<b>Timesheet No:</b> 1234567890123456
<b>From:</b> 01/16/2014	<b>To:</b> 01/31/2014

<u>Workweek #1</u>		<u>Workweek #2</u>		<u>Workweek #3</u>		<u>Workweek #4</u>													
Claimed : 01:00		Claimed : 00:00		Claimed : 00:00		Claimed : 00:00													
S 0	0	0	0	S 19	6	0	0	S 26	H	6	0	0	S	0	0	0	0		
M 0	0	0	0	M 20	H	6	0	0	M 27	H	6	0	0	M	0	0	0	0	
T 0	0	0	0	T 21	H	6	0	0	T 28	H	6	0	0	T	0	0	0	0	
W 0	0	0	0	W 22	H	6	0	0	W 29	H	6	0	0	W	0	0	0	0	
T 16	H	6	0	0	T 23	H	6	0	0	T 30	H	6	0	0	T	0	0	0	0
F 17	H	6	0	0	F 24	H	6	0	0	F 31	H	6	0	0	F	0	0	0	0
S 18	H	4	0	0	S 25	H	4	0	0	S	0	0	0	0	S	0	0	0	0
<b>Total</b> 16:00	<b>Total</b> 40:00	<b>Total</b> 36:00	<b>Total</b>																



Turn over and sign. →

# Sample Sheet

<b>Instrucciones importantes</b>	<ol style="list-style-type: none"> <li>1. Su semana laboral definida es de domingo a las 12:00 AM a sábado a las 11:59 PM.</li> <li>2. Use solamente tinta negra y presione firmemente. Los números deben estar legibles.</li> <li>3. No envíe cualquier otro documento junto con su reporte de horas trabajadas excepto el registro de las horas de viaje.</li> <li>4. Escriba solamente en las casillas para las horas, los minutos, la firma y la fecha. No escriba nada en las casillas con un "0" ya impreso. Cualquier anotación adicional en el reporte de horas trabajadas puede atrasar su cheque de pago.</li> <li>5. No se le pagarán horas reclamadas que sobrepasen las horas autorizadas por el Programa IHSS del beneficiario, o las horas semanales permitidas. El reclamar horas adicionales podría atrasar su cheque de pago.</li> <li>6. Usted debe anotar las horas de cada día en que trabajó (la línea para el total es opcional).</li> <li>7. Usted y su beneficiario deben firmar y fechar en el dorso de su reporte de horas trabajadas.</li> <li>8. No doble su reporte de horas trabajadas. No use corrector líquido ni cinta correctora en el reporte de horas trabajadas.</li> <li>9. El tiempo que viaje entre dos beneficiarios durante el mismo día debe reclamarse en el reporte de horas trabajadas del <u>segundo beneficiario</u>, y no puede exceder el límite semanal de 7 horas de viaje.</li> <li>10. <b>Reclamadas</b> = horas que trabajó y reclamó en el periodo de pago anterior. <b>Viaje</b> = horas viajadas y reclamadas en el periodo de pago anterior.</li> </ol>
<b>重要指示</b>	<ol style="list-style-type: none"> <li>1. 請僅使用黑色水筆著重填寫。數字的填寫務必清晰可讀。</li> <li>2. 您的預設一週工作時間為週日凌晨 12:00 點至週六午夜 11:59。</li> <li>3. 除行進時間報銷表單之外，請不要隨工時單附寄任何其他文檔。</li> <li>4. 請僅填入小時數、分鐘數、簽名和日期方塊。無需填入任何預先印入 0 的方塊。工時單上出現其他字跡可能延遲薪資的發放。</li> <li>5. 您的索償時數不可超過居家支援服務 (IHSS) 方案接受方所獲授權之時數，或超過每週允許時數。超過一定時數的索償可能延遲薪資的發放。</li> <li>6. 請務必輸入每日工作時數 (總計線可選填)。</li> <li>7. 您和您的服務接受方務必在工時單的背面署名並簽署日期。</li> <li>8. 請不要折疊工時單。請不要使用修正液或修正帶塗改工時單。</li> <li>9. 當日，從一個接受方處行進至另一個接受方處所耗費的時間應計入後者之工時單一併索償，每週行進時間不得超過了小時。</li> <li>10. <b>索償時間</b> = 在上一個薪資結算週期內所工作並索償的時數。 <b>行進時間</b> = 在上一個薪資結算週期內所耗費並索償的行進時數。</li> </ol>
<b>Կարևոր ցուցումներ</b>	<ol style="list-style-type: none"> <li>1. Օգտագործեք միայն սև թանաք եւ ուժեղ սեղմեք: Քվեք պետք է ընթերցելի լինեն:</li> <li>2. Ձեր սահմանված աշխատանքային շաբաթն է կիրակի օրը ժամը զիջերկա 12:00-ից մինչև շաբաթ օրը ժամը զիջերկա 11:59-ը:</li> <li>3. Ճանապարհորդության հայցի ձեռից բացի* ժամանակացույցի հետ միասին որևէ այլ փաստաթղթեր մի ուղարկեք:</li> <li>4. Չրեք միայն ժամերի, րոպեների, ստորագրության եւ ամսաթվի վանդակներում: Մի զրեք որևէ վանդակում, որտեղ արդեն տպված է 0:</li> <li>5. Դուք չեք վճարվի այն ժամերի համար, որոնք գերազանցում են ստացողի IHSS ծրագրի կողմից հաստատված ժամերի քանակը կամ շաբաթական թույլատրելի ժամերի քանակը: Լրացուցիչ ժամեր ներկայացնելը կարող է ներգրծվել ձեր վճարման ստացումը:</li> <li>6. Դուք պետք է զրեք յուրաքանչյուր օր աշխատած ժամերը (ընդհանուր գումարի) զրեք կամավոր է:</li> <li>7. Դուք եւ ձեր ստացողը պետք է ստորագրեք ու ամսագրեք ձեր ժամանակացույցի հետևում:</li> <li>8. Ժամանակացույցը մի ծալեք: Ժամանակացույցի վրա սպիտակ հոլովակով կամ ուղղիչ ծաղկավանդակ ուղղումներ մի արեք:</li> <li>9. Մեկ ստացողից մյուսի մոտ կյուն օրը ճանապարհորդելու ժամանակը պետք է պահանջվի ժամանակացույցի վրա այն ստացողի համար, ում մոտ որ դուք գտում էիք, եւ չի կարող գերազանցել շաբաթական 7 ժամ:</li> <li>10. <b>Պահանջած</b> = աշխատած ու պահանջած ժամեր վճարման նախորդ ժամանակացույցում, <b>Ճանապարհորդություն</b> = ճամփորդած ու պահանջած ժամեր վճարման նախորդ ժամանակաշրջանում:</li> </ol>

I understand that any false claim relating to this timesheet may be prosecuted under Federal and State laws and that if convicted of fraud, I may also be subject to civil penalties. By signing as the recipient of services claimed on this timesheet, I declare that the information on the timesheet is true and correct, excluding time claimed by my provider relating to travel. By signing as the provider of services claimed on this timesheet, I declare that the information on this timesheet is true and correct.

<b>Recipient's Signature</b>	<b>Date</b>
<b>Provider's Signature</b>	<b>Date</b>

**Mail Detached Timesheet To:**  
**IHSS Timesheet Processing Facility • PO Box 272863 • Chico, CA 95927-2863**

San Bernardino Department of Human Services  
 17270 Bear Valley RD, STE 108  
 Victorville CA 92395

**IN-HOME SUPPORTIVE SERVICES(IHSS)  
 INDIVIDUAL PROVIDER  
 INITIAL / REPLACEMENT TIMESHEET**

Record your daily hours and minutes like these samples.

Did not work	H	H	M	M
6 hours 30 minutes	H	6	3	0
4 hours 45 minutes	H	4	4	5
10 hours	1	0	M	M
<b>Total</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>5</b>

SAMPLE D TRAVEL  
 123 MAIN STREET  
 ANYTOWN CA 12345-6789

**Important Instructions**

1. Use black ink only and press firmly. Numbers must be readable.
2. Your defined workweek is from Sunday, 12:00 AM to Saturday, 11:59 PM.
3. Do not send any other documents with the timesheet except a travel claim form.
4. Only write in the hours, minutes, signature, and date boxes. Do not write in any box with a preprinted 0. Any extra writing on the timesheet can delay your paycheck.
5. You will not be paid for hours claimed more than the recipient's IHSS Program authorized hours or the weekly allowed hours. Claiming extra hours can delay your paycheck.
6. You must enter hours for each day worked (Total line is optional).
7. You and your Recipient must sign and date the back of your timesheet.
8. Do not fold the timesheet. Do not use white out or correction tape on timesheet.
9. Time travelled from one recipient to another on the same day must be claimed on the timesheet for the recipient you travelled to and cannot exceed the 7 hour weekly travel cap.
10. **Claimed** = hours worked and claimed in previous pay period, **Travel** = hours travelled and claimed in previous pay period.

----- Cut along dotted line -----

<b>Provider #:</b> 123456789	<b>Provider Name:</b> JOHN PROVIDER
<b>Case #:</b> 00 01 1234567	<b>Recipient Name:</b> RECIPIENT PETER
<b>Type:</b> IHSS	<b>Timesheet No:</b> 1234567890123456
<b>From:</b> 01/16/2014	<b>To:</b> 01/31/2014

<u>Workweek #1</u>		<u>Workweek #2</u>		<u>Workweek #3</u>		<u>Workweek #4</u>																	
<b>Claimed</b> : 01:00	<b>Travel</b> : 01:15	<b>Claimed</b> : 00:00	<b>Travel</b> : 00:00	<b>Claimed</b> : 00:00	<b>Travel</b> : 00:00	<b>Claimed</b> : 00:00	<b>Travel</b> : 00:00																
Travel	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	Travel	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	Travel	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	Travel	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0
H	H	M	M																				
H	H	M	M																				
H	H	M	M																				
0	0	0	0																				
S	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0	S 19	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	S 26	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	S	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0
0	0	0	0																				
H	H	M	M																				
H	H	M	M																				
0	0	0	0																				
M	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0	M 20	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	M 27	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	M	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0
0	0	0	0																				
H	H	M	M																				
H	H	M	M																				
0	0	0	0																				
T	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0	T 21	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	T 28	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	T	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0
0	0	0	0																				
H	H	M	M																				
H	H	M	M																				
0	0	0	0																				
W	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0	W 22	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	W 29	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	W	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0
0	0	0	0																				
H	H	M	M																				
H	H	M	M																				
0	0	0	0																				
T 16	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	T 23	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	T 30	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	T	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0
H	H	M	M																				
H	H	M	M																				
H	H	M	M																				
0	0	0	0																				
F 17	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	F 24	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	F 31	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	F	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0
H	H	M	M																				
H	H	M	M																				
H	H	M	M																				
0	0	0	0																				
S 18	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	S 25	<table border="1"><tr><td>H</td><td>H</td><td>M</td><td>M</td></tr></table>	H	H	M	M	S	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0	S	<table border="1"><tr><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>	0	0	0	0
H	H	M	M																				
H	H	M	M																				
0	0	0	0																				
0	0	0	0																				
<b>Total</b> _____	<b>Total</b> _____	<b>Total</b> _____	<b>Total</b> _____																				

Turn over and sign. →



<b>Instrucciones importantes</b>	<ol style="list-style-type: none"> <li>1. Su semana laboral definida es de domingo a las 12:00 AM a sábado a las 11:59 PM.</li> <li>2. Use solamente tinta negra y presione firmemente. Los números deben estar legibles.</li> <li>3. No envíe cualquier otro documento junto con su reporte de horas trabajadas excepto el registro de las horas de viaje.</li> <li>4. Escriba solamente en las casillas para las horas, los minutos, la firma y la fecha. No escriba nada en las casillas con un "0" ya impreso. Cualquier anotación adicional en el reporte de horas trabajadas puede atrasar su cheque de pago.</li> <li>5. No se le pagarán horas reclamadas que sobrepasen las horas autorizadas por el Programa IHSS del beneficiario, o las horas semanales permitidas. El reclamar horas adicionales podría atrasar su cheque de pago.</li> <li>6. Usted debe anotar las horas de cada día en que trabajó (la línea para el total es opcional).</li> <li>7. Usted y su beneficiario deben firmar y fechar en el dorso de su reporte de horas trabajadas.</li> <li>8. No doble su reporte de horas trabajadas. No use corrector líquido ni cinta correctora en el reporte de horas trabajadas.</li> <li>9. El tiempo que viaja entre dos beneficiarios durante el mismo día debe reclamarse en el reporte de horas trabajadas del <u>segundo beneficiario, y no puede exceder el límite semanal de 7 horas de viaje.</u></li> <li>10. <b>Reclamadas</b> = horas que trabajó y reclamó en el periodo de pago anterior. <b>Viaje</b> = horas viajadas y reclamadas en el periodo de pago anterior.</li> </ol>
<b>重要指示</b>	<ol style="list-style-type: none"> <li>1. 請僅使用黑色水筆著重填寫。數字的填寫務必清晰可讀。</li> <li>2. 您的預設一週工作時間為週日凌晨 12:00 點至週六午夜 11:59。</li> <li>3. 除行進時間報銷表單之外，請不要隨工時單附寄任何其他文檔。</li> <li>4. 請僅填入小時數、分鐘數、簽名和日期方塊。無需填入任何預先印入 0 的方塊。工時單上出現其他字跡可能延遲薪資的發放。</li> <li>5. 您的索償時數不可超過居家支援服務 (IHSS) 方案接受方所獲授權之時數，或超過每週允許時數。超過一定時數的索償可能延遲薪資的發放。</li> <li>6. 請務必輸入每日工作時數 (總計線可選填)。</li> <li>7. 您和您的服務接受方務必在工時單的背面署名並簽署日期。</li> <li>8. 請不要折疊工時單。請不要使用修正液或修正帶塗改工時單。</li> <li>9. 當日，從一個接受方處行進至另一個接受方處所耗費的時間應計入後者之工時單一併索償，每週行進時間不得超過 7 小時。</li> <li>10. <b>索償時間</b> = 在上一個薪資結算週期內所工作並索償的時數。<b>行進時間</b> = 在上一個薪資結算週期內所耗費並索償的行進時數。</li> </ol>
<b>Կարևոր ցուցումներ</b>	<ol style="list-style-type: none"> <li>1. Օգտագործեք միայն սև թանաք եւ ուժեղ սեղմեք: Թվերը պետք է ընթերցելի լինեն:</li> <li>2. Ձեր սահմանված աշխատանքային շաբաթն է կիրակի օրը ժամը զիջերկա 12:00-ից մինչև շաբաթ օրը ժամը զիջերկա 11:59-ը:</li> <li>3. Ճանապարհորդության հայցի ձեւից բացի՝ ժամանակացույցի հետ միասին որեւէ այլ փաստաթղթեր մի ուղարկեք:</li> <li>4. Գրեք միայն ժամերի, րոպեների, ստորագրության եւ ամսաթվի վանդակներում: Մի գրեք որեւէ վանդակում, որտեղ արդեն տպված է 0: Ժամանակացույցում արված որեւէ լրացուցիչ գրություն կարող է երկարաձգել ձեր վճարման ստացումը:</li> <li>5. Դուք չէք վճարվի այն ժամերի համար, որոնք գերազանցում են ստացողի IHSS ծրագրի կողմից հաստատված ժամերի քանակը կամ շաբաթական թույլատրելի ժամերի քանակը: Լրացուցիչ ժամեր ներկայացնելը կարող է երկարաձգել ձեր վճարման ստացումը:</li> <li>6. Դուք պետք է գրեք յուրաքանչյուր օր աշխատած ժամերը (ընդհանուր գումարի գիծը կամավոր է):</li> <li>7. Դուք եւ ձեր ստացողը պետք է ստորագրեք ու ամսագրեք ձեր ժամանակացույցի հետևում:</li> <li>8. Ժամանակացույցը մի ծալեք: Ժամանակացույցի վրա սպիտակ հեղուկով կամ ուղղիչ ժապավենով ուղղումներ մի արեք:</li> <li>9. Մեկ ստացողից մյուսի մոտ կյուն օրը ճանապարհորդելու ժամանակը պետք է պահանջվի ժամանակացույցի վրա այն ստացողի համար, ում մոտ որ օրը Գ նույն էիք, եւ չի կարող գերազանցել շաբաթական 7 ժամ:</li> <li>10. <b>Պահանջած</b> = աշխատած ու պահանջած ժամեր վճարման նախորդ ժամանակաշրջանում, <b>Ճանապարհորդություն</b> = ճամփորդած ու պահանջած ժամեր վճարման նախորդ ժամանակաշրջանում:</li> </ol>

----- Cut along dotted line -----

I understand that any false claim relating to this timesheet may be prosecuted under Federal and State laws and that if convicted of fraud, I may also be subject to civil penalties. By signing as the recipient of services claimed on this timesheet, I declare that the information on the timesheet is true and correct, excluding time claimed by my provider relating to travel. By signing as the provider of services claimed on this timesheet, I declare that the information on this timesheet is true and correct.

<b>Recipient's Signature</b>	<b>Date</b>
<b>Provider's Signature</b>	<b>Date</b>

**Mail Detached Timesheet To:**  
**IHSS Timesheet Processing Facility • PO Box 272863 • Chico, CA 95927-2863**

### TRAVEL CLAIM FORM INSTRUCTIONS

1. A Travel Claim Form must be submitted along with your Timesheet in the same return envelope, otherwise you will not be paid for your travel time.
2. Time travelled from one recipient to another on the same day must be claimed on the Travel Claim Form for the recipient you travelled To.
3. In special situations where you travelled to the same recipient twice in the same day, enter the total amount of time travelled for that day. A comment is required in this situation.
4. Travel Hours claimed cannot exceed the 7-hour weekly travel cap.
5. Use black ink only and press firmly. Numbers must be readable.
6. In the "Case # From" column, please write the Recipient's case number you travelled from.
7. In the "Distance" column, write the distance you travelled from one recipient to another recipient on the same day.
8. Comments are required to explain the following:
  - If the total number of weekly Travel Hours exceeds the allowed hours.
  - If a special circumstance occurred to cause the travel time to be longer than expected.
9. The Provider must sign and date the back of Travel Claim Form.

**Record your daily hours, minutes, case number, distance, and comments like this sample:**

Travel Week #1:	Case # From:				Distance:	Comments:
S	..	..	..	..		
M 13	H	H	1	5	1234567	1.1
T 14	H	H	2	0	1234567	1.7 Rerouted due to road construction.
W 15	H	H	1	5	1234567	1.1
T 16	H	H	1	5	1234567	1.1
F 17	H	H	2	5	1234567	1.1 Traffic jam due to car accident.
S	..	..	..	..		
TOTAL	H		1	3	0	

### Important Things to Remember:

1. The weekly total hours entered on the Travel Claim Form must match the weekly total Travel Hours entered on the corresponding Timesheet.
2. The total number of hours and the distance claimed on the Travel Claim Form will be compared to the Work Week Agreement.
3. Changes to your schedule may require a new Work Week Agreement.

**TURN OVER AND COMPLETE →**

## TRAVEL CLAIM FORM

<b>Provider Name:</b>	John	<b>Recipient Name:</b>	Peter
<b>Provider #:</b>	123456789	<b>Timesheet #:</b>	1234567890123456
<b>Case #:</b>	00 01 1234567		
<b>Pay Period From:</b>	01/16/2014	<b>Pay Period To:</b>	01/31/2014
<b>Program Type:</b>	IHSS		

<b>Travel Week #1:</b>	<b>Case # From:</b>	<b>Distance:</b>	<b>Comments:</b>
S	H H M M		
M	H H M M		
T	H H M M		
W	H H M M		
T	H H M M		
F	H H M M		
S	H H M M		
<b>TOTAL</b>	H H M M		

<b>Travel Week #2:</b>	<b>Case # From:</b>	<b>Distance:</b>	<b>Comments:</b>
S	H H M M		
M	H H M M		
T	H H M M		
W	H H M M		
T	H H M M		
F	H H M M		
S	H H M M		
<b>TOTAL</b>	H H M M		

<b>Travel Week #3:</b>	<b>Case # From:</b>	<b>Distance:</b>	<b>Comments:</b>
S	H H M M		
M	H H M M		
T	H H M M		
W	H H M M		
T	H H M M		
F	H H M M		
S	H H M M		
<b>TOTAL</b>	H H M M		

<b>Travel Week #4:</b>	<b>Case # From:</b>	<b>Distance:</b>	<b>Comments:</b>
S	H H M M		
M	H H M M		
T	H H M M		
W	H H M M		
T	H H M M		
F	H H M M		
S	H H M M		
<b>TOTAL</b>	H H M M		

Provider's Signature	Date
----------------------	------

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES  
SPECIAL NOTICE 14-03**

**October 20, 2014**

**SUBJECT: Implementation of the Community First Choice Option (CFCO) Program**

**EFFECTIVE DATE: Immediately**

**REFERENCE: All-County Letter No. 14-60 issued August 29, 2014**

**I. PURPOSE**

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with instructions and information on the implementation of California's CFCO Program.

**II. BACKGROUND**

The federal Patient Protection and Affordable Care Act (ACA) of 2010 was enacted March 23, 2010 and established CFCO as a new State Plan Option, which allows states to provide Home and Community-Based Attendant Services and Supports. IHSS will now operate four IHSS programs: IHSS-Residual (IHSS-R), PCSP, IPO and CFCO.

**III. PROCEDURES**

CFCO Eligibility

All CFCO participants must be eligible for Full-Scope, Federal Financial Participation (FS FFP) Medi-Cal (as in the PCSP and the IPO programs), and meet CFCO Nursing Facility Level of Care (NF LOC) eligibility based on one of the following criteria:

1. Have a total assessed need (excluding heavy cleaning and yard hazard abatement) of 195 or more IHSS hours per month.
2. Have a total assessed need (excluding heavy cleaning and yard hazard abatement) under 195 IHSS hours per month and:
  - Have 3 or more of the following services with the designated Functional Index (FI) Ranks:
    - Eating, FI Rank of 3-6
    - Bowel and bladder/menstrual care, FI Rank of 3-6
    - Bathing/grooming, FI Rank of 4-5
    - Dressing, FI Rank of 4-5
    - Mobility inside, FI Rank of 4-5
    - Transfer, FI Rank of 4-5
    - Respiration, FI Rank of 5-6

**IHSS SPECIAL NOTICE 14-03  
IMPLEMENTATION OF THE COMMUNITY FIRST CHOICE OPTION  
(CFCO) PROGRAM**

- Paramedical, (FI Rank not applicable)

OR

- Have a combined FI Rank of 6 or higher in mental functioning (memory, orientation, and judgment). FI Ranks for mental functioning can be 1, 2, or 5.
3. Have a combined “Individual Assessed Need” total of 20 hours or more per week in one or more of the following services:
- Preparation of meals
  - Meal clean-up (if preparation of meals and feeding are assessed needs)
  - Respiration
  - Bowel and bladder care
  - Feeding
  - Routine bed baths
  - Dressing
  - Menstrual care
  - Ambulation
  - Transfer
  - Bathing, oral hygiene, grooming
  - Repositioning and rubbing skin
  - Care and assistance with prosthesis
  - Paramedical services

#### Required Services in CFCO

The four required services in CFCO are:

1. Assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks.
  - **Activities of Daily Living (ADL):** Including Personal Care Services such as eating, toileting, grooming, dressing, bathing, and transferring.
  - **Instrumental Activities of Daily Living (IADL):** Including (but not limited to) performing essential household chores, meal planning and preparation, shopping for food and clothing, yard hazard abatement, protective supervision, medical accompaniment and other essential items.
  - **Health-related tasks:** Tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals such as paramedical services.
2. Assistance with acquisition, maintenance, and enhancement of skills necessary for recipients to perform ADLs, IADLs, and health-related tasks. The requirement is provided through the IHSS Teaching and Demonstration Service, as described in Manual of Policies and Procedures (MPP) Section 30-757.18.

**IHSS SPECIAL NOTICE 14-03  
IMPLEMENTATION OF THE COMMUNITY FIRST CHOICE OPTION  
(CFCO) PROGRAM**

- Teaching and demonstration services are provided by IHSS providers to enable recipients to perform for themselves services which they currently receive from IHSS.
- Services are only authorized when the provider has the necessary skills to do so effectively and safely.
- Services are authorized for no more than three months at the same hourly rate of provider compensation that is paid for other IHSS services.

A recipient training factsheet addressing "[Teaching and Demonstration](#)" is available online at the IHSS Consumer/Recipient Resources webpage at:

<http://www.cdss.ca.gov/agedblinddisabled/PG1829.htm>

3. A back-up system to ensure continuity of services and supports. The requirement is met through the use of the SOC 864 – IHSS Program Individualized Back-up Plan and Risk Assessment form.
  - The SOC 864 must be completed during initial assessments and reassessments.
  - In the event there have been no changes to the Individualized Back-up Plan from the prior year, the IHSS recipient and Social Worker may sign in the space provided on page three of the form confirming no changes.
  - Every IHSS recipient must have a new form completed every other year.
  - A new SOC 864 does not need to be completed for change assessments.
  - The SOC 864 can be generated using CMIPS II.

Effective immediately, the form SOC 827 – IHSS Program Individual Emergency Back-Up Plan is discontinued and must no longer be used.

4. Voluntary recipient training on managing care providers. The two training options available are:
  - The *In-Home Supportive Services Consumer Training Handbook* available at the California Department of Social Services (CDSS) website below. The information contained in the handbook is intended to assist recipients in selecting, managing and dismissing his/her homecare provider.

[http://www.cdss.ca.gov/agedblinddisabled/res/2011\\_IHSS\\_Consumer\\_Training\\_HB\\_v2.pdf](http://www.cdss.ca.gov/agedblinddisabled/res/2011_IHSS_Consumer_Training_HB_v2.pdf)

- *IHSS Recipient/Consumer Education Videos* are available at the CDSS website below. These videos address how an IHSS recipient may hire a care provider and includes tips on how to find, interview, and select a care provider.

<http://www.cdss.ca.gov/agedblinddisabled/PG3154.htm>

**IHSS SPECIAL NOTICE 14-03  
IMPLEMENTATION OF THE COMMUNITY FIRST CHOICE OPTION  
(CFCO) PROGRAM**

Systems and New Aid Code

CFCO was assigned the Medi-Cal Secondary Aid Code of 2K in CMIPS II. Effective September 1, 2014, those recipients who are considered Non-Severely Impaired (NSI) and receive protective supervision, will be eligible for 195 hours of protective supervision, plus hours for other services, up to a maximum of 283 hours per month.

**IV. REVIEW STATEMENT**

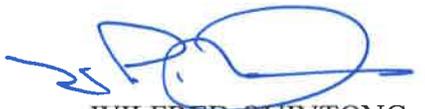
Because of its information nature, this Special Notice has not been reviewed by an Organizational Review Committee (ORC).

**V. FILING STATEMENT**

IHSS Special Notices are at the following link:

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

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

**COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES (IHSS)  
SPECIAL NOTICE 14-02**

**September 29, 2014**

**SUBJECT:** Documented Unmet Need

**EFFECTIVE DATE:** Immediately

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

**REFERENCE:** All-County Letter No. 13-66 issued September 30, 2013

**I. PURPOSE**

The purpose of this Special Notice is to provide In-Home Supportive Services (IHSS) staff with further clarification on assessing and documenting unmet need in the IHSS program.

**II. BACKGROUND**

Documented unmet need is a recipient's total need for non-Protective Supervision In-Home Supportive Service hours that are in excess of the statutory maximum of 283 hours monthly. A recipient is not considered to have a documented unmet need if his/her total authorized non-Protective Supervision hours are less than the statutory maximum.

Type of Case	In-Home Support Services-Residual (IHSS-R)	Personal Care Services Program (PCSP)	In-Home Supportive Services Plus Option (IPO)	Community First Choice Option (CFCO)
Non-Severely Impaired (NSI)	195 hours  The entire 195 hours can be for Protective Supervision.	283 hours  <ul style="list-style-type: none"> <li>• Only up to 195 hours can be for Protective Supervision.</li> <li>• Additional service hours, up to a maximum of 283, can be used for other PCSP services.</li> </ul>	195 hours  The entire 195 hours can be for Protective Supervision.	283 hours  <ul style="list-style-type: none"> <li>• Only up to 195 hours can be for Protective Supervision.</li> <li>• Additional service hours, up to a maximum of 283, can be used for other services.</li> </ul>

Severely Impaired (SI)	283 hours The entire 283 hours can be for Protective Supervision.	283 hours The entire 283 hours can be for Protective Supervision.	283 hours The entire 283 hours can be for Protective Supervision.	283 hours The entire 283 hours can be for Protective Supervision.
------------------------	--	--	--	--

When a recipient’s individually-assessed service needs exceed the statutory maximum, the IHSS Case Management, Information, and Payrolling System (CMIPS) automatically recognizes the documented unmet need, and prorates the total number of unmet need hours across all authorized non-Protective Supervision service categories.

### III. POLICY

The total number of documented unmet need hours will be reflected on the Notice of Action (NOA) along with a system-generated NOA message. (Attachment A). If the NOA does not have a message reflecting documented unmet need hours, the recipient does not have a documented unmet need.

### IV. PROCEDURES

IHSS Social Workers must assess the applicant/recipient’s need for any IHSS service, regardless of the statutory maximum, in order to ensure an accurate reflection of the recipient’s need for services.

- Social Workers must document in CMIPS II when the assessment includes unmet need.
- A determination by the Social Worker indicating an unmet need must be annotated in the case narrative and must include the total number of hours of unmet need.
- The Social Worker must identify other resources, as appropriate, that meet the unmet need elsewhere. This includes referring the applicant/recipient to other programs or community-based organizations.
- All referrals must be noted in CMIPS II.

A referral to an appropriate agency must be made when there are concerns about the ability of the individual to remain safely in his/her own home, even with IHSS. An IHSS recipient may request a reassessment any time that there has been a change in the recipient’s circumstances that affects the need for IHSS services.

### V. REVIEW STATEMENT

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

## 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.sdcountry.ca.gov/AisIhss/default.asp?Guide=AIHSS>

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

## CMIPS II Unmet Need Notice of Action Messages

UN01	Unmet Need PCSP (NSI)	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) You have a total of ### hours and ## minutes of unmet need.
UN02	Unmet Need PCSP (SI)	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) You have a total of ### hours and ## minutes of unmet need.
UN03	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.
UN04	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.
UN05	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.
UN06	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. You have a total of ## hours and ## minutes of unmet need.

**SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY  
AGING AND INDEPENDENCE SERVICES  
IN-HOME SUPPORTIVE SERVICES  
SPECIAL NOTICE 14-01**

**May 30, 2014**

**SUBJECT: 1% Restoration in IHSS Recipient's Total Authorized Monthly Service Hours**

**EFFECTIVE DATE: Immediately**

**REFERENCE: All-County Letter No. 14-35 issued May 27, 2014**

**I. PURPOSE**

To provide IHSS staff with instructions and information on the implementation of a new state law which implements a 7% reduction in each IHSS recipient's total monthly authorized service hours, effective July 1, 2014. The 7% reduction represents a one percent restoration in recipients' total authorized service hours from the 8% reduction currently in effect through June 30, 2014.

**II. BACKGROUND**

Senate Bill (SB) 67 implemented an 8% reduction in each IHSS recipient's total authorized service hours, effective July 1, 2013 that will remain in place through June 30, 2014. SB 67 also requires the California Department of Social Services (CDSS) to implement an ongoing 7% reduction in each IHSS recipient's authorized service hours effective July 1, 2014.

The 7% reduction will be applied first to any documented unmet need (excluding protective supervision), and each recipient will determine how the 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 by 7% 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 will be unavailable starting at 7:00 p.m. on Thursday, June 5, 2014, through 6:00 a.m. Monday, June 9, 2014 to accommodate the run of the 7% reduction to authorized hours.
- On June 6, 2014, **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, 2014.

**IHSS SPECIAL NOTICE 14-01  
1% RESTORATION IN IHSS RECIPIENT'S  
TOTAL AUTHORIZED MONTHLY SERVICE HOURS**

- 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, 2014.
- 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, 2014, and then build a new assessment (authorization segment) with a beginning date of July 1, 2014.
- A one-time notification for all active recipients in “Eligible” and “Presumptive Eligible” status, whose hours are being reduced, will be generated in CMIPS II.

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.

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

CDSS will mail all of the initial NOAs generated by the implementation of the 7% reduction. Copies of all NOAs generated as part of the initial implementation of the 7% reduction will be viewable in *Forms and Correspondence* in CMIPS II. Two new NOA messages have been created. The first new NOA message (LM04) will be displayed on the initial NOAs mailed by CDSS in June 2014 (Attachment A). The second new NOA message (LM05) will be used for cases that are new or reactivated on or after July 1, 2014, that were not impacted by the 8% reduction which ends June 30, 2014, and it will also be displayed on all subsequent NOA for all recipients (Attachment A). There is not a new message for unmet need. Recipients with documented unmet need (excluding protective supervision) will receive the existing CMIPS II NOA message for unmet need. All ongoing NOAs will be printed locally at the CMIPS II printers.

#### ***Provider Hours***

CMIPS II will automatically update the provider hours with the recipient’s authorized hours after the 7% reduction has been applied. The case owner will receive a task notification if the provider’s assigned hours do not equal the total of the recipient’s authorized hours after the 7% 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 7% 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, 2014 implementation date. Case information entered after June 5, 2014 and any changes to existing authorizations that begin prior to July 1, 2014, will require two authorizations:

- An authorization for any days of service provided prior to July 1, 2014 with an ending date of June 30, 2014.
- A second authorization created with a beginning date of July 1, 2014.

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 7% reduction to all newly created and reactivated recipient cases that have authorizations that span the July 1, 2014 date.

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

If the Social Worker receives a request for a reassessment within 90 days of being notified of the 7% 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 7% reduction, the Social Worker will:

- Explain the hearing process to the recipient

**IHSS SPECIAL NOTICE 14-01  
1% RESTORATION IN IHSS RECIPIENT’S  
TOTAL AUTHORIZED MONTHLY SERVICE HOURS**

- 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 7% 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 7% reduction, he/she must refer the recipient to the State Hearings Division at number:

**TELEPHONE NUMBER 1-800-743-8525**  
**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 7% 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 (HHSA) 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>

**IHSS SPECIAL NOTICE 14-01**  
**1% RESTORATION IN IHSS RECIPIENT'S**  
**TOTAL AUTHORIZED MONTHLY SERVICE HOURS**

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

## **CMIPS II NOA MESSAGES**

### **LM04 – Initial Message for Continuing Recipients**

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

On July 1, 2013, a state law went into effect which said that your total authorized hours had to be cut by 8 percent. Starting July 1, 2014, 1 percent of your authorized hours will be restored, which means that from now on your authorized hours will only be cut by 7 percent. This is because a state law says the California Department of Social Services must reduce all IHSS recipients total authorized hours by 7 percent (Section 12301.02 of the Welfare and Institutions Code). The 7 percent cut will stay in effect until further notice. Starting July 1, 2014, 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 to increase by 1 percent. For example, if you get two more hours of service per month, you can choose to add two hours from one type of service or choose to split up the two hours among different services. You must tell your provider(s) about the change in your service hours. You do not have to tell the county which hours you choose to change. This is between you and your provider.

The law also applies to all reassessments. Starting July 1, 2014, when a reassessment changes a recipient's authorized hours, the 7 percent reduction will be applied 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 7 percent reduction to your authorized hours 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, if you ask for a state hearing only to dispute the state law requiring the 7 percent reduction in service hours, your hearing request will be dismissed.

If you do not understand the information in this notice or have questions about the change in your hours contact your county IHSS office

### **LM05 – Initial Message for New Recipients (who apply on or after July 1, 2014) & Ongoing Message for All Recipients**

Your total authorized hours have been reduced by 7 percent. This is because a state law says that, starting July 1, 2014, the California Department of Social Services must reduce all IHSS recipients total authorized hours by 7 percent (Section 12301.02 of the Welfare and Institutions Code). The 7 percent cut will stay in effect until further notice. Your 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 to decrease by 7 percent. For example, if you get two less hours of service per month, you can choose to cut two hours from one type of service or choose to split up the two hours among different services. You must tell your provider(s) about the change in your service hours. You do not have to tell the county which hours you choose to change. This is between you and your provider.

The law also applies to all reassessments. Starting July 1, 2014, when a reassessment changes a recipient's authorized hours, the 7 percent reduction will be applied 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 7 percent reduction to your authorized hours 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, if you ask for a state hearing only to dispute the state law requiring the 7 percent reduction in service hours, your hearing request will be dismissed.

If you do not understand the information in this notice or have questions about the change in your hours contact your county IHSS office.

#### 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)
----------------	--------	--------	-------

PROVIDER NAME	(FIRST	MIDDLE	LAST)	PROVIDER IDENTIFICATION NUMBER	HOURS ASSIGNED PER MONTH
---------------	--------	--------	-------	--------------------------------	--------------------------

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
--------------------	--------	--------	-------	-------------------------------------