

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, MS 19-95, Sacramento, CA 95814



December 27, 2006

ALL-COUNTY INFORMATION NOTICE NO.: I-97-06

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERSReason For This Transmittal

- State Law Change
- Federal Law or Regulation Change
- Court Order or Settlement Agreement
- Clarification Requested by one or More Counties
- Initiated by CDSS

SUBJECT: PROTECTIVE SUPERVISION 24-HOURS-A-DAY FORM (SOC 825)

REFERENCE: SENATE BILL (SB) 1104 (CHAPTER 229, STATUTES of 2004)  
WELFARE AND INSTITUTIONS CODE SECTION (WIC) 12301.21

The purpose of this All-County Information Notice is to inform counties of the new Protective Supervision 24-Hours-A-Day form SOC 825 for optional use (copy attached). This form is available in English and Spanish and can be accessed at our Forms Website address: <http://www.dss.cahwnet.gov/pdf/SOC825.PDF>.

The Protective Supervision 24-Hours-A-Day Coverage Plan form was developed by California Department of Social Services in conjunction with the California Welfare Directors Association and various other stakeholders. The SOC 825 form was designed as an optional tool to be utilized by the county worker to identify how the 24-Hours-A-Day Coverage Plan will be attained in order for the recipient to remain safely in his/her home.

Any questions regarding this form should be directed to Adult Programs Division, Quality Assurance Bureau, at (916) 229-3494.

Sincerely,

*Original Document Signed By:  
Eva L. Lopez on 12/27/06*

EVA L. LOPEZ  
Deputy Director  
Adult Programs Division

Attachment

c: CWDA

## PROTECTIVE SUPERVISION 24-HOURS-A-DAY COVERAGE PLAN

PLEASE PRINT

NAME OF IHSS RECIPIENT:	RECIPIENT'S TELEPHONE #:
ADDRESS OF IHSS RECIPIENT:	
NAME OF PRIMARY CONTACT RESPONSIBLE:	CONTACT'S TELEPHONE #:
RELATIONSHIP TO RECIPIENT:	

As the primary contact for arranging the 24-hour-a-day coverage plan for the above named Recipient, I acknowledge my understanding of the following:

- A 24-hour-a-day coverage plan has been arranged and is in place.

*The continuous 24-hour-a-day coverage plan can be met regardless of paid In-Home Supportive Service (IHSS) hours along with various alternate resources (i.e.; Adult or Child Day Care Centers, community resource centers, Senior Centers, respite centers, etc.)*

- The 24-hour-a-day coverage plan will be provided at all times.
- If there is any change to the 24-hour-a-day coverage plan (i.e. hospitalization, attendance in day-care programs, travel, etc.) I will immediately **notify the IHSS social worker**.
- The above name Recipient has an established need for 24-hour-a-day Protective Supervision if he/she is to remain safely in the home. The IHSS social worker has also discussed with me the appropriateness of out-of-home care as an alternative to 24-hour-a-day Protective Supervision.

NAME OF CARE PROVIDER (1):	CONTACT PHONE #:
NAME OF CARE PROVIDER (2):	CONTACT PHONE #:
NAME OF CARE PROVIDER (3):	CONTACT PHONE #:

### **Describe the implementation of the Protective Supervision 24-Hour-A-Day Coverage Plan:**

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SIGNATURE OF PRIMARY CONTACT RESPONSIBLE:	DATE:
SIGNATURE OF IHSS SOCIAL WORKER:	CONTACT PHONE #:

## INSTRUCTIONS

The IHSS Protective Supervision 24-Hours-A-Day Coverage Plan (SOC 825) is an optional form for County use. The SOC 825 is intended to ensure that recipients who need Protective Supervision have the 24-hours of care needed for their health and safety 24 hours a day. The recipient's social service worker and the IHSS care provider(s), whether a family member, friend, or no relation at all, should discuss together a plan or schedule of 24 hours a day of coverage for the recipient.

**NAME OF IHSS RECIPIENT:** Enter the full name of the IHSS recipient.

**RECIPIENT'S TELEPHONE NUMBER:** Enter the contact telephone number for the recipient.

**ADDRESS OF IHSS RECIPIENT:** Enter the recipient's home address where the majority of the 24-hours-a-day coverage will be performed.

**NAME OF PRIMARY CONTACT RESPONSIBLE:** Enter the name of the person with primary responsibility for coordinating the recipient's 24-Hours-A-Day Coverage Plan.

**PRIMARY CONTACT'S TELEPHONE NUMBER:** Enter the telephone number for the primary contact responsible.

**RELATIONSHIP TO RECIPIENT:** Enter the relationship of the primary contact to the recipient, (i.e., family member, IHSS care provider, friend, etc.).

**NAME OF CARE PROVIDER(S) (1), (2), (3), and CONTACT TELEPHONE NUMBER(S):** Enter the name(s) of each care provider responsible for the recipient's care during the 24 hours a day of coverage. Enter a contact telephone number for each care provider.

If more than three (3) care providers are responsible for this recipient, an additional sheet of paper can be attached with name(s) and contact telephone number(s).

**Describe the implementation of the Protective Supervision 24-Hours-A-Day Coverage Plan:**

Enter the planned schedule, or explanation of the plan in which the above provider(s) will ensure the recipient is cared for the entire 24-hour period. An additional sheet of paper can be attached if more space is needed to describe the 24-Hours-A-Day Coverage Plan.

**SIGNATURE OF PRIMARY CONTACT RESPONSIBLE and DATE:** Once the 24-Hours-A-Day Coverage Plan is developed, the primary contact responsible will sign and date the form when the Plan is discussed with the social worker authorizing the need for Protective Supervision.

**SIGNATURE OF IHSS SOCIAL WORKER and CONTACT TELEPHONE NUMBER:** When the 24-Hours-A-Day Coverage Plan is discussed and signed and dated by the primary contact, the county social service worker will sign the form and add their contact telephone number.

A copy of the form is to be provided to the primary contact and retained in the County case file.