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

October 28, 2009

ALL COUNTY LETTER NO. 09-63

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: REVISED SOC 295 IN-HOME SUPPORTIVE SERVICES (IHSS)
RECIPIENT APPLICATION FORM

Reason 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

The purpose of this All-County Letter (ACL) is to inform counties that the In-Home Supportive Services (IHSS) Application for Social Services (SOC 295) form has been revised. AB X4 4 (Chapter 4, 2009 4th Extraordinary Session) and AB X4 19 (Chapter 17, 2009, 4th Extraordinary Session), created new requirements for an individual to be eligible and paid as an IHSS provider (W&IC 12301.24) and established fraud detection and prevention activities including targeted mailings and unannounced home visits with which recipients and providers are required to comply to avoid possible termination from the IHSS program (W&IC 12305.82(f)).

The Application has been revised to inform recipients of these program requirements and their responsibilities as an IHSS applicant/recipient. The revised Application is to be implemented by the counties commencing November 1, 2009, and all other versions should be destroyed.

AB 4X 19 also created requirements for recipient fingerprinting for purposes of identity, notices to providers of recipient authorized services and hours, and recipient and provider fingerprints on timesheets. The Application will be further updated and an ACL issued with each of the new requirements as they are implemented.

The California Department of Social Services (CDSS) has identified the Application as a "required" form. Forms in this category may not be modified, reconstructed, or substituted.

CAMERA-READY COPIES AND TRANSLATIONS OF FORMS

Counties may access camera-ready versions of English forms referenced in this ACL on CDSS' Forms/Brochures web page at:

<http://www.dss.cahwnet.gov/cdssweb/PG183.htm>.

ACL No. 09-63
Page Two

Questions about accessing the forms may be directed to Forms Management Unit at FMUdss@dss.ca.gov, or via telephone, at (916) 657-1907.

CDSS is in the process of translating the Application for Social Services (SOC 295). Language Translation Services (LTS) will make available camera-ready copies of Spanish, Armenian, and Chinese translated forms and letters as soon as they have been completed. You may access these translated forms and letters at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

Your County Forms Coordinator should distribute translated forms to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English or limited English proficient populations as required by the Dymally Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and by State regulation (MPP Division 21, Civil Rights Nondiscrimination, section 115).

Any questions regarding this form should be directed to Marti Tosta, Manager of the CMIPS II Policy Support Unit, at (916) 229-4000.

Sincerely,

Original Document Signed By:

EVA L. LOPEZ
Deputy Director
Adult Programs Division

Attachment

APPLICATION FOR SOCIAL SERVICES

To The Applicant: This form is subject to verification.

Note: Retain your copy of this application.

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

		Case Number:	Date of Application:
1. Name		*Social Security Number	
Address		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	Zip code	Telephone ()	Birth Date

2. Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a Spouse / Child of a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", give veteran Name and Claim Number
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3. Do you receive SSI/SSP benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", Check your type of living arrangement: <input type="checkbox"/> Independent Living <input type="checkbox"/> Board and Care <input type="checkbox"/> Home of Another	
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Services being requested:

4. Have you received In-Home Supportive Services (IHSS) in the past? Yes No

If "Yes", complete the following:

Date and county where service was last received	Total Monthly Hours	Name used (if different from above)
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5. List Family Members in Household	Birth Date	*Social Security Number
Name of Spouse <input type="checkbox"/> Name of Parent <input type="checkbox"/>		
Child/Other Relative		
Child/Other Relative		

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

A. My ethnic origin is (see reverse side for correct code) <input type="checkbox"/>	B. I speak and understand English: <input type="checkbox"/> Yes <input type="checkbox"/> No My primary language is (see reverse side for correct code) <input type="checkbox"/>
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I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

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

- 1) Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
- 2) Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.

- 3) Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
- 4) Notifying the County IHSS office when I hire or fire a provider.

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

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

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

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

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

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

Signature of Applicant:	Date:	Signature of Applicant's Representative (only if applicable)	Date: (only if applicable)
Representative's Relationship to Applicant: (only if applicable)	Representative's Address: (only if applicable)		Representative's Telephone Number: (only if applicable) ()

To report suspected fraud or abuse in the provision or receipt of IHSS services please call the fraud hotline 1-800-822-6222 or go to www.stopmedicalfraud@dhcs.ca.gov.

For Agency Use Only

Income Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Status Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification:	Signature of Social Worker or Agency Representative:	Telephone Number: ()
Recipient Status: <input type="checkbox"/> Refugee <input type="checkbox"/> Cuban/Haitian Entrant		Source of Verification for Refugee or Entrant Status (Explain)		