



CDSS

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July 27, 2011

ALL-COUNTY LETTER NO.: 11-55

TO: ALL COUNTY WELFARE DIRECTORS
IHSS PROGRAM MANAGERS

SUBJECT: **IN-HOME SUPPORTIVE SERVICES (IHSS) MEDICAL CERTIFICATION
FORM SOC 873**

REASON FOR THIS TRANSMITTAL

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

The purpose of this All-County Letter is to instruct counties on the implementation of Senate Bill (SB) 72 as it relates to obtaining certification from a licensed health care professional for all In-Home Supportive Services (IHSS) applicants and recipients.

BACKGROUND

SB 72 added Section 12309.1 to the Welfare and Institutions Code (WIC) that requires the development of a medical certification form. The completed medical certification form must be received prior to the authorization of IHSS services for new applicants and to allow the continuation of IHSS services for recipients. In order for IHSS to be authorized or continued, WIC section 12309.1 requires the medical certification form include a declaration from a licensed health care professional that the applicant/recipient is unable to independently perform some activity of daily living and that without the assistance of IHSS services, the applicant/recipient would be at risk of placement in out-of-home care. The form must also include a description of any condition or functional limitation that has resulted in, or contributed to, the applicant/recipient's need for assistance. The California Department of Social Services (CDSS), in consultation with the Department of Health Care Services and stakeholders, developed the In-Home Supportive Services Program Medical Certification Form (SOC 873) to meet the requirements of WIC section 12309.1.

COUNTY RESPONSIBILITIES

For IHSS applicants, beginning August 1, 2011, counties must inform each applicant or their authorized representative of the new certification requirements using SOC 874 the "IHSS Program Notice to Applicant of Medical Certification Requirement" (attached).

Applicants have 45 calendar days from the date the county requests the SOC 873, to provide the county with a completed and signed SOC 873 or alternative documentation in lieu of the SOC 873. Before IHSS services can be authorized counties must ensure that both questions 5 and 6 on the SOC 873 are answered "yes." If both questions 5 and 6 are answered "yes", the county may continue to assess the applicant's need for IHSS and determine eligibility. Once the applicant is determined eligible for services, eligibility may go back to the effective date of the application. If either question 5 or 6 is answered "no", then the application must be denied based on no need for services using Notice of Action (NOA) code 443. If the SOC 873 or alternative documentation is not provided within the 45 calendar day timeframe the application for IHSS services must be denied using NOA message 507.

For IHSS recipients beginning August 1, 2011, counties must inform each recipient or their authorized representative of the new certification requirements using SOC 875 the "IHSS Program Notice to Recipient of Medical Certification Requirement" (attached) at or before the first in-home reassessment). Recipients will have 45 calendar days from the date of the in-home reassessment to provide the completed and signed SOC 873 or alternative documentation to the county. In order to complete the reassessment and reauthorize hours, counties must ensure that both questions 5 and 6 on the SOC 873 are answered "yes." If both questions 5 and 6 are answered "yes" the county may complete the reassessment following normal procedures. If either question 5 or 6 is answered "no" IHSS services must be terminated based on no need for services using NOA code 443. If the SOC 873 or alternative documentation is not provided within the 45 calendar day timeframe, and good cause does not exist, services must be terminated using NOA message 507.

After the initial SOC 873 or alternative documentation is received and the county finds the applicant/recipient eligible for IHSS services, a new SOC 873 is not required at subsequent reassessments. Counties may request a new SOC 873 or their own county medical certification form at their discretion but a new SOC 873 is not required for continued eligibility.

The SOC 873 must be signed by a licensed health care professional. In accordance with WIC section 12309.1(a), "Licensed health care professional" means an individual licensed in California by the appropriate regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. A licensed health care professional includes, but is not limited to, a physician, physician's assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist or public health nurse.

Counties must give the applicant/recipient the option to take the SOC 873 to their licensed health care professional to be completed and returned to the county. However, if the applicant requests assistance in obtaining the SOC 873 from the licensed health professional, the county must assist; this includes sending the SOC 873 directly to the applicant/recipient's licensed health care professional. In either case, the applicant/recipient is ultimately responsible for ensuring the completed SOC 873 is returned to the county within the appropriate timeframes. An applicant/recipient, legal guardian, conservator, or a person with power of attorney for medical purposes (who is recognized by the licensed health care professional) may sign "Part B" of the SOC 873. Counties may contact the licensed health care professional for clarification or additional information if the SOC 873 is not completed properly. Questions 5, 6, and 7 (when questions 5 and 6 are answered "yes") on the SOC 873 are pivotal for determining eligibility and are required to be answered to meet the requirements in WIC section 12309.1.

Counties are expected to use the SOC 873 or alternative documentation submitted by the applicant/recipient as a factor in assessing the need for IHSS, but it shall not be the sole determining factor, unless questions 5 or 6 are answered "no". The SOC 873 or alternative documentation is used to help the social worker evaluate the applicant/recipient's present condition and the need for out-of-home care if IHSS services are not provided. The social worker must consider all relevant documentation in making the IHSS determination.

ALTERNATIVE DOCUMENTATION

In lieu of obtaining the SOC 873, applicants/recipients may provide alternative documentation to the county. Acceptable alternative documentation must be dated no earlier than 60 calendar days prior to submission and include all the following elements:

- A statement or description indicating the applicant/recipient is unable to independently perform one or more activities of daily living,
- A description of the applicant/recipient's condition or functional limitation that has contributed to the need for assistance, and
- A signature from a licensed health care professional.

Alternative documentation may include, but is not limited to, hospital or nursing facility discharge plans, minimum data set forms, and individual program plans, all of which must meet the criteria shown above. County designed medical certification forms are not acceptable alternative documentation. Counties must accept alternative documentation that they determine meet all the conditions listed above.

GOOD CAUSE

The timeframe for recipients to obtain the SOC 873 or alternative documentation may be extended for good cause. Good cause extensions, however, cannot be granted for applicants. Good cause means a substantial and compelling reason beyond the recipient's control, and in order to be granted, the recipient must show good faith efforts in trying to obtain the SOC 873 or alternative documentation. Counties have the discretion to determine on a case-by-case basis when good cause exists. Recipients must notify the county of the need for a good cause extension no later than 35 calendar days from the in-home assessment. After the 35th day, a good cause extension can no longer be granted. Examples of good cause may include, but are not limited to; serious illness or hospitalization of the recipient or the county confirms with the licensed health care professional that additional time is needed to complete the SOC 873.

Timeframe extensions granted for good cause should not be extended for more than 45 calendar days beyond the mandated 45-day timeframe for a maximum total of 90 days.

CMIPS AND CMIPS NOTICE OF ACTION (NOA) MESSAGES

To meet the mandated requirements SB 72, Legacy Case Management, Information, and Payrolling System (CMIPS) will be modified to include two new fields on the RELA screen to allow entry and tracking of the required data. A Medical Certification Date (MC DATE) field and associated Medical Certification Reason Code (MC CODE) field will be used to track the date the medical certification was requested and received and what type of documentation was received. Counties will be required to enter in the date when they request and subsequently receive the documentation and use the appropriate type code. The reason codes for the MC CODE field include:

- M – Medical Certification Received
- A – Alternative Documentation Received
- E – Exception
- P – Pending (to be used when waiting for documentation to be received)

For new applicants, counties will not be able to authorize services on the case unless a date is entered in the MC DATE field and the MC CODE field has an "M", "A" or "E" indicated. When entering the case into CMIPS counties should enter the date they requested the medical certification and enter a "P". If the county has already received the medical certification they should enter the receipt date in the MC DATE field and appropriate reason code in the MC CODE field.

For existing recipients, the MC DATE and MC CODE field must contain a valid value (M, A, E or P) for the system to allow the user to move forward to RELC and authorize the new hours after a reassessment. When entering the reassessment into CMIPS counties must enter the face-to-face date in the MC DATE field and enter a "P" in the MC CODE field if they have not received the medical certification documentation. Once the county receives the medical certification they should update the MC DATE field and MC CODE fields with the receipt date and appropriate reason code. Counties should continue to utilize the Face to Face Date field on RELB when entering authorization information for both initial assessments and reassessments.

Counties should be aware that certain actions are either required or not allowed once the new medical certification fields are used. The following effects should be noted:

- The system will not allow a user to delete a "P" from the MC CODE field. The field will only accept one of the other valid types of "M", "A" or "E".
- A soft edit has been added to the RELA screen that will be triggered if the MC DATE and/or MC TYPE field are blank. The user will be able to override this edit.
- A hard edit has been added to the RELB field that is triggered when a change has been made to the FACE-TO-FACE DATE field and the MC DATE and/or MC TYPE fields are blank. A user cannot override this edit and must return to the RELA screen and fill in the MC DATE and MC CODE fields with the appropriate values.

To assist counties with the tracking of cases that are delinquent in submitting their medical certification, a new file will be added to the existing county download which includes a list of recipients who are in danger of losing their services due to non-compliance with the medical certification requirement. This file will provide the necessary data and allow counties the flexibility to incorporate it into their existing business processes. In order for this report to be useful to the counties, it is imperative that counties utilize the MC DATE and MC CODE fields to identify which cases are "pending" medical certification so they may be identified on the monthly file.

CDSS has developed NOA messages for use on the NA 690 when an applicant/recipient fails to provide the SOC 873. As with any denial or termination, timely and adequate notice rules apply. The following NOA message 507 should be used in conjunction with the NA 690 to inform an applicant/recipient that his/her services have been denied or terminated for failure to provide the SOC 873:

Recipient Termination Message (MXX-XX):

As of _____ (DATE) _____, the In-Home Supportive Services (IHSS) you have been getting will stop. Here is why:

At your reassessment on _____ (DATE) _____, the county informed you that you had to provide a medical certification from a licensed health care professional stating that you cannot do some activities of daily living on your own and without help to do these activities you would be at risk of placement in out-of-home care.

The county asked you to provide a medical certification by _____ (DATE) _____.

You did not provide the county with a medical certification as required by state law to continue to receive IHSS services.

If you provide the county with a medical certification, the county will assess your need and/or eligibility for IHSS. (Please note that the appropriate regulation section (WIC 12309.1) will be inserted into the rules area at the bottom of the NOA).

TRANSLATIONS

CDSS is in the process of translating the SOC 873, SOC 874 and SOC 875. 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 forms and letters at:

<http://www.cdss.ca.gov/cdssweb/PG183.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).

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For questions, please contact Victoria Rodriguez, Analyst, Adult Programs Branch,
Operations and Technical Assistance Unit, at (916) 653-3850, or by e-mail at:
Victoria.Rodriguez@dss.ca.gov.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Attachments

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MEDICAL CERTIFICATION FORM

A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name: _____ Date of Birth: _____

Address: _____

County of Residence: _____ IHSS Case #: _____

IHSS Worker Name: _____

IHSS Worker Phone #: _____ IHSS Worker Fax #: _____

B. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (To be completed by the applicant/recipient)

I, _____, authorize the release of medical information
(PRINT NAME)
related to my physical and/or mental condition to the In-Home Supportive Services program as it
pertains to my need for domestic/related and personal care services.

Signature: _____ Date: ____/____/____
(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

Witness (if the individual signs with an "X"): _____ Date: ____/____/____

TO: LICENSED HEALTH CARE PROFESSIONAL –

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a medical certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This medical certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual's present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MEDICAL CERTIFICATION FORM

Applicant/Recipient Name:

IHSS Case #:

****ONLY A LICENSED HEALTH CARE PROFESSIONAL SHOULD COMPLETE THE REMAINDER OF THIS FORM.****

C. MEDICAL INFORMATION (To be completed by a Licensed Health Care Professional)

1. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

2. How long have you provided service(s) to this individual?

3. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

4. Indicate the date you last provided services to this individual: ____ / ____ / ____

5. Is this individual **unable** to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.), or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)? YES NO

6. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)? YES NO

If you answered "NO" to either Question #5 OR #6, skip Questions #7 and #8 below, and complete the certification in PART D at the bottom of the form.

If you answered "YES" to both Question #5 AND #6, respond to Questions #7 and #8 below, and complete the certification in PART D at the bottom of the form.

7. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program:

8. Is the condition(s) or functional limitation(s) expected to last more than 12 consecutive months? YES NO

NOTE: THE SOCIAL WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and all information provided above is correct.

Name:

Title:

Address:

Phone #:

Fax #:

Signature:

Date:

Professional License Number:

Licensing Authority:

PLEASE RETURN THIS FORM TO THE SOCIAL WORKER LISTED ON PAGE 1.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM

NOTICE TO APPLICANT OF MEDICAL CERTIFICATION REQUIREMENT

There has been a change in state law* that requires each person applying for IHSS to provide a medical certification from a licensed health care professional (LHCP) before they can get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinical supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Medical Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

Whether you give the Medical Certification Form to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within **45 days** from the date the county worker requested it.

The county may accept an alternate document in place of the Medical Certification Form as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP.

If you do not provide the Medical Certification Form or alternate document to the county within 45 days, your application for IHSS will be denied. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

If you have questions about the medical certification requirement, ask the social worker who has been assigned to your case.

Due By: ____/____/____

*Welfare and Institutions Code section 12309.1

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM NOTICE TO RECIPIENT OF MEDICAL CERTIFICATION REQUIREMENT

COUNTY OF: _____

(ADDRESSEE)

Notice Date: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

Social Worker Name: _____

Due By: _____

To: In-Home Supportive Services (IHSS) Recipient

There has been a change in state law* that requires each person getting IHSS to provide a medical certification from a licensed health care professional (LHCP) to continue to get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinical supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Medical Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

Whether you give the Medical Certification Form to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within 45 days following your reassessment. If the county does not receive the Medical Certification Form by the 35th day, a notice will be sent informing you that your IHSS will stop, unless you had previously contacted the county and were given more time to submit the form.

The county may accept an alternate document in place of the Medical Certification Form as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP.

If the county does not receive the completed Medical Certification Form or alternate document within 45 days following your reassessment, your IHSS may stop. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

If you are not able to get the medical certification from your LHCP within 45 days, call your social worker at the number listed above, as soon as possible.

*Welfare and Institutions Code section 12309.1