



CDSS

WILL LIGHTBOURNE
DIRECTOR

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

744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



EDMUND G. BROWN JR.
GOVERNOR

July 24, 2012

ALL-COUNTY LETTER NO.: 12-36

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: PROGRAM POLICY FOR THE CASE MANAGEMENT
INFORMATION AND PAYROLLING SYSTEM II (CMIPS II)

- INQUIRY, REFERRAL AND APPLICATION
- PERSON NOTES/CASE NOTES/CASE (ASSESSMENT) NARRATIVE
- PERSONAL CARE SERVICES PROGRAM/IHSS PLUS OPTION/IHSS RESIDUAL
- SOCIAL SECURITY NUMBER REQUIREMENTS
- IHSS RECIPIENT RESIDENCE
- USE OF RANK 6
- INTER-COUNTY TRANSFER

REFERENCE: All County Letter No. 88-118
All County Letters Nos. 06-34 and 06-34E2
All County Letter No. 09-30

This All-County Letter (ACL) explains the difference between an inquiry, a referral and an application for In-Home Supportive Services (IHSS) and provides policy direction related to Medi-Cal eligibility, pending Disability Evaluation Determinations (DEDs), loss of Medi-Cal eligibility and eligibility for IHSS Residual (IHSS-R). In addition, it will define the use for the following in CMIPS II: Use of new Person Note/Case Note/Narrative functionality; Social Security Number (SSN) requirements; Recipient Primary Residence; Rank 6 and Inter-County Transfer (ICT) process. In this letter, all references to IHSS shall be recognized to include the Personal Care Services Program (PCSP), IHSS Plus Option (IPO), and IHSS-R unless specified otherwise.

INQUIRY, REFERRAL AND APPLICATION

With the impending transition to CMIPS II, this ACL will explain the enhanced referral and application functionality that counties will be required to complete in CMIPS II as

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 system is implemented in each county. It will also clarify the differences between an inquiry, a referral and an application that exist today, as well as describe the required county actions related to these activities in both Legacy CMIPS and CMIPS II. In the case of CMIPS II activities, this letter will direct counties to the appropriate CMIPS II screens, but will not provide directions for screen entry; those step-by-step directions will be covered in CMIPS II training. When a county receives an initial contact regarding the IHSS program, the county may determine the nature of the contact based on the direction provided in this ACL.

Inquiry:

If a county receives a call from an individual making an informational inquiry regarding the IHSS program only, e.g., what kinds of services does IHSS provide, it is considered an inquiry and does not merit a referral or qualify as an application. During an inquiry, the county will generally not receive or respond to any person-specific information. The county is not required to take any further action.

Referral:

A referral is a contact about the IHSS program received by the county from a third party who does not have legal authority to make decisions on behalf of the potential applicant, e.g., a health care professional, neighbor, friend or religious affiliate, or a person who is not the authorized representative of the individual they are referring. The county must record the contact as a Referral until the county has contacted the individual or their authorized representative to determine whether the referred individual or their authorized representative is interested in applying for IHSS.

Legacy CMIPS: For the time that a county remains on Legacy CMIPS, the county is encouraged to enter the referral information in Record (R) status; however, counties using external tools to record and track referrals may continue to do so.

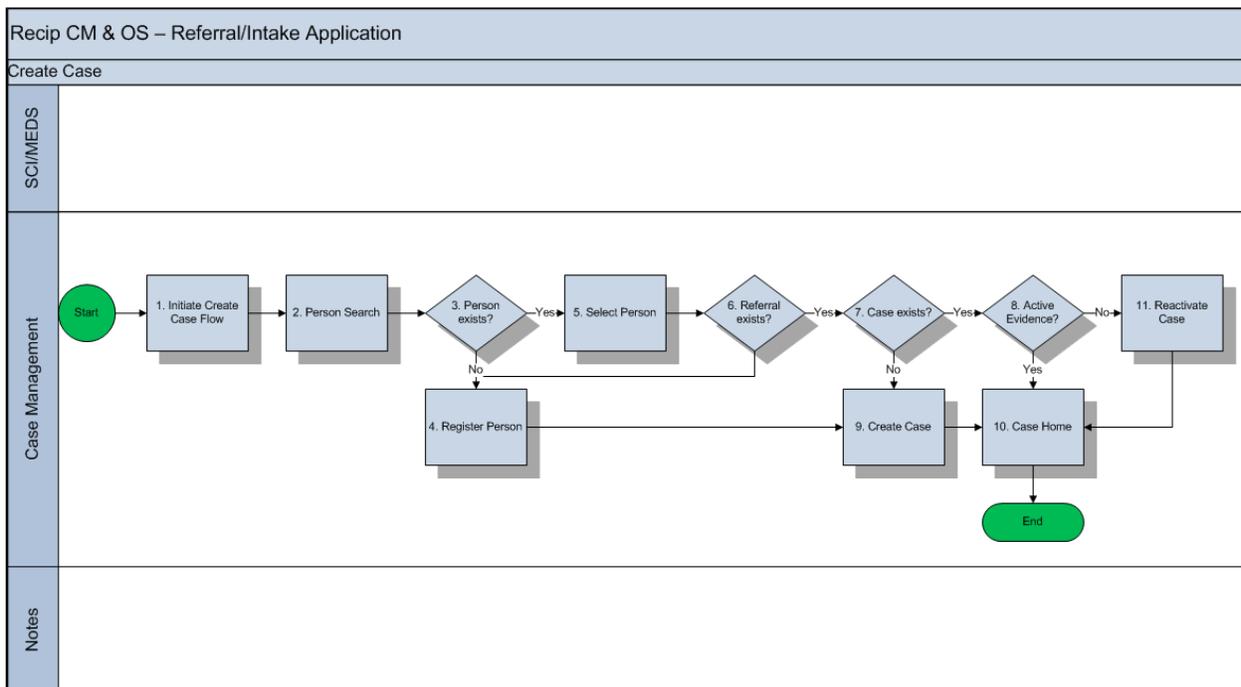
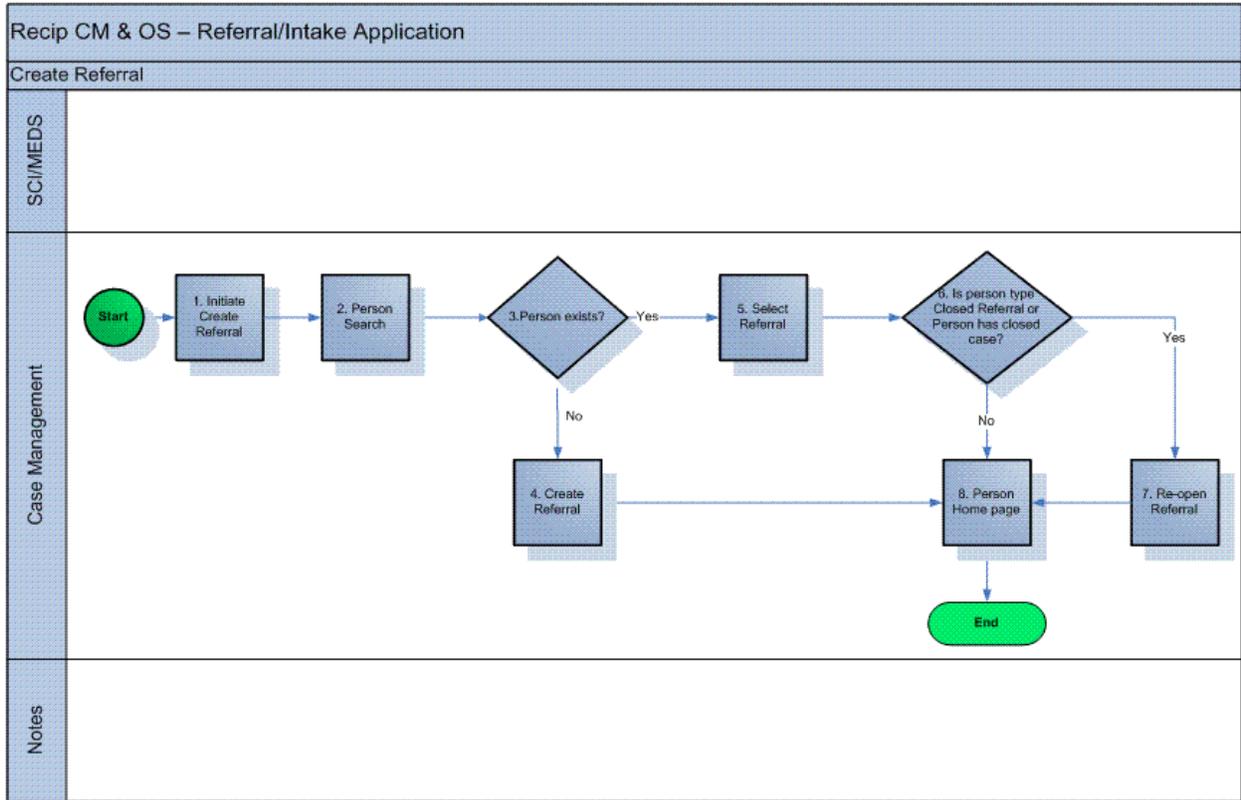
CMIPS II:

- The county shall initiate a Person Search to determine if the individual calling or being referred to IHSS is already known to CMIPS II. An individual shall exist only once in CMIPS II.
- If the person calling is the individual seeking services or their authorized representative, the county shall proceed to the Create Application screen and initiate the application process. (See Create Application Flowchart below.)
- If the person calling is a third party not authorized to open an application on the referred individual's behalf, the county must initiate the Referral using the Create Referral screen. (See Create Referral Flowchart below.) The Create Referral screen allows the entry of minimal referral data regarding the individual being referred. These data include the first and last names, the referral source, and either the person's address or telephone number. When the record is saved, the Person Type is indicated as Referral.

The outcome of either the Create Referral or Create Application process in CMIPS II is the creation of a single Person Record in CMIPS II. All persons are registered and are identified with one of the following Person Type Indicators: Referral, Applicant, Recipient, or Provider. An individual may have more than one Person Type, i.e., a person can be both a Recipient and a Provider.

CMIPS II uses a new case number configuration for both Applicants/Recipients and Providers. An Applicant will be assigned a random Case Number consisting of seven (7) digits, e.g., 1234567. This number is part of the Person Record and will remain as the Case Number for an Applicant/Recipient for the life of the case record, even if the Recipient moves to another county. The county numeric identifier is no longer directly associated with the Recipient Case Number. The county that owns the Recipient case can be found on the Case Home page using the same numeric county identifiers as were used in Legacy CMIPS.

Providers will be assigned random Provider numbers consisting of nine (9) digits, e.g., 123456789. These numbers will be random and not associated in any way with the Providers SSN as they were in Legacy. Like Recipient Case Numbers, this assigned Provider identifier will be the same regardless of the number of Recipients for whom the Provider works or the number of counties in which the Provider works. This number will remain associated to the Provider for the duration of their CMIPS II record.



Application:

Manual of Policies and Procedures (MPP) section 30-009.221 states “Any person shall have the right to apply for services or to make application through another person on his behalf.” Once an individual or their authorized representative indicates that they wish to apply for IHSS, an application shall be taken immediately (MPP section 30-009.222). The county shall not deny or in any way dissuade the individual or their representative from making an application for IHSS based on information communicated during a phone call or face-to-face visit. The individual must be afforded due process by being allowed to make an application for IHSS if they are so inclined, and have that application assessed for eligibility based on program rules. The applicant shall receive a Notice of Action detailing the outcome of the county’s determination.

An application for IHSS may be made over the phone or in writing by submitting an Application for Social Services (SOC 295). The following data about the applicant is required to complete the Create Applicant process:

- Name;
- SSN or verification that the applicant has applied for an SSN;
- Date of Birth;
- Applicant’s preferred spoken and written languages;
- Gender;
- Ethnicity;
- County of Residence;
- Residence and mailing addresses; and
- Applicant’s primary phone number.

At the time the application information is entered in either Legacy CMIPS or CMIPS II, a case number will be assigned to the applicant. Legacy counties, to the extent that current business practice allows, and all CMIPS II counties shall provide the case number to the applicant or their authorized representative before the end of the telephone call during which the application is taken, or before they leave the IHSS office so the applicant or their authorized representative will be able to refer to the case number in any communications with the county. For counties still using Legacy CMIPS where current county practice is for key data entry of the application information by a person other than the person taking the application, the county shall enter the application into CMIPS as expeditiously as possible and if the case number is requested, the county will provide it to the applicant as soon as possible.

Applications always require a signature. However, social services staff or the applicant's authorized representative can sign on the applicant's behalf to preserve the application date (MPP section 30-009.224). For those individuals who apply by phone, the SOC 295 may be signed at the IHSS face-to-face assessment.

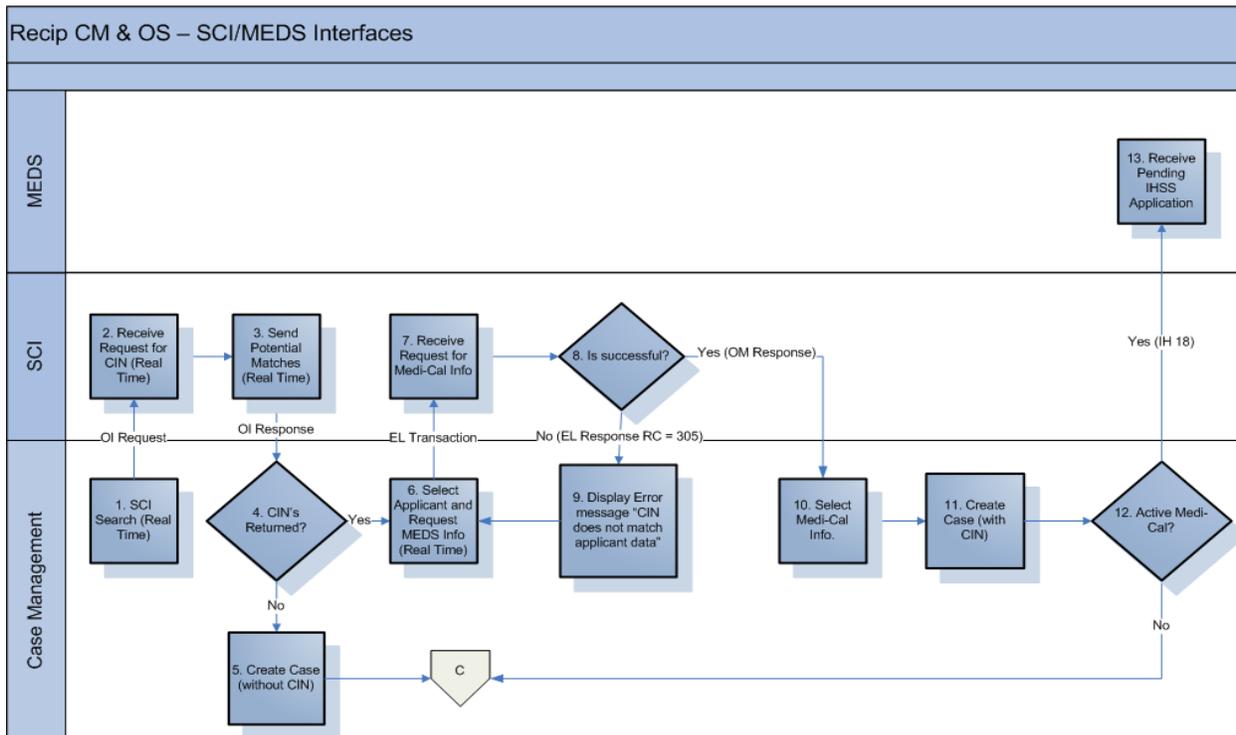
The date the services are requested either by phone or submission of the SOC 295, whichever is earlier, shall be the applicant's "protected date of eligibility". If the applicant is not already a Medi-Cal beneficiary, the county must create the IHSS application to establish the "protected date of eligibility". While counties are still on Legacy CMIPS, non-Medi-Cal applicants should be referred to the local Medi-Cal office to apply for Medi-Cal. At the point a county goes live on CMIPS II, the system will automatically check for Medi-Cal eligibility and generate a referral if no eligibility exists. If the applicant is ultimately determined to be eligible for IHSS, the applicant may be authorized services back to the "protected date of eligibility".

LEGACY CMIPS:

- The county shall initiate a name or social security number search to determine if the individual calling or being referred to IHSS is already known to CMIPS.
- The county shall determine if the potential applicant is currently a Medi-Cal beneficiary. If not, the county shall take the application for IHSS and refer the applicant to the local Medi-Cal office to apply for Medi-Cal.
- The county shall enter into CMIPS the information necessary to establish an application and provide the assigned case number to the applicant for use in future communication with the county.

CMIPS II:

- The county shall initiate a Person Search to determine if the individual calling or being referred to IHSS is already known to CMIPS II. An individual shall exist only once in CMIPS II.
- From the Person Search, if the person does not exist, the user will access the Create Application screen and proceed with the application to the Create Case screen.
- The county shall provide the assigned case number to the applicant for use in future communications with the county,
- When an application is opened in CMIPS II, the system will check to see if the applicant has active Medi-Cal. If none exists, CMIPS II will generate a referral through an interface with the SAWS system requesting a Medi-Cal eligibility determination be completed. When the Medi-Cal eligibility determination is completed, the information will be sent back to CMIPS II through the interface. (See SCI/MEDS Flowchart below..)



PERSON NOTES/CASE NOTES/CASE (AUTHORIZATION) NARRATIVE

CMIPS II will provide counties with several areas to enter electronic notes and case narratives related to referrals, applicants, recipients and providers that were not available to counties in Legacy CMIPS. The following paragraphs will explain the use of each of these functions as they relate to IHSS case management. The technical aspects of accessing and using each of the functions will be addressed during CMIPS II Training.

CMIPS II has 2 types of notes for an individual – Person and Case. Person Notes should be used when only a referral exists for the individual. Once an application has been taken and a case created all notes regarding the individual shall be entered in Case Notes.

Person Notes and Case Notes entries are displayed in chronological order with the most recent entry displayed first. Counties are advised to instruct their staff to carefully review their entries before saving the entries in either Person Notes or Case Notes. Once an entry is saved, the system will not allow the entry to be edited and a new Person or Case Note must be initiated. CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

PERSON NOTES

Person Notes are entries made in association with a Person Record. Person Notes are specific to an individual before they apply for IHSS services, meaning that Person Notes should only be entered during the "Referral" process. Once an individual moves from being a referral to an applicant or a case, all notes entries should be made in Case Notes.

Person Notes entries are also used when the entry relates specifically to a provider and should be entered on the Notes page attached to that provider's Person Record. Notes related to the provider should only be entered in Person Notes on the provider's Person Record, not in Case Notes.

Examples of Person Notes are:

Received call from daughter inquiring about possible services for mother. Daughter didn't have sufficient information to open application and wasn't sure her mother will accept services. Daughter requested IHSS application and other appropriate paperwork be mailed to her. Mailed SOC 295 and Health Cert 12/12/12.

Or

Daughter wants to be a provider for her father who is an IHSS recipient. Explained provider enrollment requirements and mailed required documents 11/12/13.

CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

CASE NOTES

The Case Notes function allows users to enter information that is related to a case but not related to a specific assessment. Once the case is created, notes should be entered in Case Notes and no longer entered in Person Notes.

An example of a case note is:

Received a call from recipient's son stating recipient may be leaving to live with her daughter in Michigan and asking what steps needed to be taken to terminate her case if she decides to move. The move is still uncertain. Advised son to call when plans are firm.

CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

CASE (OR ASSESSMENT) NARRATIVE

The Case (or Assessment) Narrative is used to record information relating to an initial assessment or reassessment. Each time New Evidence is added to CMIPS II a new Assessment Narrative is created. Assessment Narratives are associated with Evidence and once evidence is authorized that Assessment Narrative is no longer editable

An example of an abridged Assessment Narrative is:

Reassessment home visit to the 75-year-old female recipient: The recipient lives with her husband in a small 2-BR ground floor apartment. She suffers from severe osteoporosis, but is ambulatory. She is unable to independently perform most domestic and related activities and needs minimal assistance with bathing and dressing; however, her condition has deteriorated since my last visit and I anticipate her need for service will increase over the next year. Her husband is currently able and available, but is also having more difficulty functioning and may need assistance soon himself."

Generally, the information in the Assessment Narrative will be similar to the narratives created by social workers today. The Assessment Narrative may include observations about the recipient, the recipient's functional abilities, living arrangements, others in the

household and any other information the social worker deems pertinent to the case. The Assessment Narrative is also the area in CMIPS II where information about the recipient's diagnoses may be recorded. The Assessment Narrative is limited to 13,500 characters.

PCSP/IPO/IHSS-R

Welfare and Institutions Code (WIC) section 12300 (g) states that an individual who is eligible to receive services under PCSP or IPO shall not be eligible to receive services under IHSS-R. Therefore, all applicants for IHSS must complete a Medi-Cal eligibility determination prior to being authorized PCSP/IPO/IHSS-R. The only exception to this requirement is if an applicant is complying with all Medi-Cal requirements, but the determination of their eligibility for Medi-Cal is pending a DED, and completion of the DED will require longer than the 45-day statutory maximum for processing a Medi-Cal application. These individuals may be evaluated for potential IHSS-R presumptive eligibility in accordance with MPP section 30-759.3. If eligible, the applicant may be authorized IHSS-R services prior to Medi-Cal completing the eligibility determination. If the Medi-Cal application is denied because the applicant's DED is turned down, IHSS-R services must be discontinued. No other applicants can be served in the IHSS-R program prior to completion of a Medi-Cal eligibility determination. An applicant who does not cooperate or fails to comply with Medi-Cal requirements during the application process is not eligible for IHSS-R.

Individuals who are eligible for Medi-Cal with full Federal Financial Participation (FFP) and who are currently linked to Medi-Cal as aged, blind or disabled; or who meet the MPP section 30-780.2 (b) criteria of a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or result in death within 12 months; and who are determined through an in-home assessment to be unable to remain safely at home without IHSS, may be authorized PCSP or IPO services. Those individuals are not required to have a DED.

IHSS applicants who are not eligible for FFP Medi-Cal or have been denied Medi-Cal eligibility for a reason other than failure to comply with Medi-Cal requirements, or failure to complete the Medi-Cal eligibility process, shall be considered for IHSS-R eligibility. These individuals shall complete a Statement of Facts for In-Home Supportive Services (SOC 310). The IHSS program staff may utilize resource and income information from the State Automated Welfare Systems (SAWS) eligibility system when determining IHSS-R financial eligibility and share of cost calculation so long as the non-FFP Medi-Cal case is active and the most current information in SAWS is used. All IHSS-R rules must be applied and any additional income and resource information required under IHSS-R rules must be collected and entered in CMIPS II. The CMIPS II system

will calculate the IHSS-R financial eligibility and share of cost based on IHSS-R rules. If services are authorized, the recipient is required to pay any IHSS-R share of cost (SOC) to their provider in accordance with MPP section 30-755.233. An IHSS-R recipient who receives non-FFP full scope Medi-Cal and has a Medi-Cal SOC may submit receipts for their IHSS-R SOC payments to Medi-Cal where they will be applied toward meeting their Medi-Cal SOC obligation.

If an IHSS recipient's Medi-Cal eligibility is discontinued, CMIPS II shall generate a task to the social worker/case owner notifying them of the reason for the discontinuance. If the reason for discontinuance is failure to comply with Medi-Cal eligibility, including the annual renewal, the social worker/case owner shall terminate IHSS services. If the Medi-Cal discontinuance is due to change in circumstance the recipient should be considered for IHSS-R eligibility.

SOCIAL SECURITY NUMBER (SSN) REQUIREMENTS

Title 22 of the California Code of Regulations (CCR) section 50187 (22 CCR 50187(a) and (b)), requires that all beneficiaries of Medicaid services, which for purposes of this letter means PCSP or IPO recipients and non-FFP Full-Scope Medi-Cal (State-only Medi-Cal) beneficiaries who meet the eligibility requirements for IHSS-R, must have a valid SSN in order to receive services or show proof of an application for an SSN (form SSA 5028 Evidence of Application for SSN).

In order to be eligible for IHSS-R, applicants/recipients must meet the requirements for Supplemental Security Income (SSI) eligibility except for income. One requirement for SSI eligibility is that the applicant/recipient must have a valid SSN or must have submitted an application for an SSN before or at the same time they submit an application for SSI.

Counties must take an application from an individual requesting to apply who can provide the application criteria described above. However, in the event an applicant does not have a SSN, at the time of application the applicant must provide proof of having applied for an SSN by providing the county with a copy of an SSA 5028 form completed by the Social Security Administration (SSA). Thus, an application cannot be accepted unless it includes an SSN or proof of an application for an SSN (form SSA 5028 Evidence of Application for SSN).

SSA will issue SSN cards clearly marked "NOT VALID FOR EMPLOYMENT" to individuals who are lawfully admitted to the United States without work authorization from the Department of Homeland Security, but who have a valid non-work reason for

needing an SSN, such as a federal law requiring an SSN to get a benefit or service (<http://www.socialsecurity.gov/ssnumber/cards.htm>). Medicaid and SSI each require an SSN for an individual to be eligible.

Qualified aliens are eligible for SSNs that include the designation “NOT VALID FOR EMPLOYMENT” based on the law requiring an SSN to receive a benefit or service. Aliens who are not in a satisfactory immigration status, and who do not have an SSN, can still receive State-Only Medi-Cal, and potentially IHSS-R, if they meet all eligibility requirements. Please see All-County Information Notice Number I-18-08 for more information on IHSS-R Eligibility for Non-Citizens.

Although DHCS has historically assigned pseudo SSNs to Medi-Cal eligible adoptees, this practice is largely out-of-date due to the current strict confidentiality laws. Neither Legacy CMIPS nor CMIPS II will accept pseudo SSNs that include an alpha character as valid entries. Adoptive parents should be directed to use the valid SSN previously assigned to their child or to apply for a new SSN for the child under his/her adopted name.

After taking the IHSS application, counties still using Legacy CMIPS should refer applicants without an SSN or an active Medi-Cal record in the Medi-Cal Eligibility Data System (MEDS) to Medi-Cal to complete a Medi-Cal eligibility determination and to the Social Security Administration (SSA) to apply for an SSN.

In CMIPS II, the county must enter the applicant’s information into CMIPS II and conduct a Person Search to see if the applicant is already known to CMIPS II and perform a State Client Index (SCI) look-up to see if the applicant already has a Client Index Number (CIN) and active Medi-Cal. The CMIPS II user will be prompted to either select the correct CIN from any possible matches that are returned or send a Medi-Cal referral via interface to the local SAWS to initiate a Medi-Cal eligibility determination. If there is no CIN match, the user must select the option to send the referral to SAWS. When the Medi-Cal eligibility determination is completed, CMIPS II will receive notification through the interface of the outcome and, if approved, the aid codes assigned to the beneficiary and a notification will be sent to the case owner.

The response from MEDS will include both the MEDS Primary Aid Code and the FFP status indicator. The appropriate secondary Medi-Cal Aid Code (2L IHSS Plus Option – IPO; 2M Personal Care Services Program – PCSP; or 2N IHSS Residual Program – IHSS-R) will be determined by CMIPS II based on programmed eligibility criteria. Applicants cannot be approved for PCSP/IPO services until the individual has been

granted FFP Full-Scope Medi-Cal. Counties should be aware that although the CMIPS II case record may indicate a full-scope FFP primary Medi-Cal Aid Code when compared to the list of current Medi-Cal aid codes, it does not necessarily mean the Recipient has been granted full-scope FFP Medi-Cal. For IHSS program eligibility purposes, the county should rely on the FFP status indicator and the secondary Medi-Cal Aid Code determined by CMIPS II. If CMIPS II displays a secondary aid code of 2N (IHSS-R) it means the recipient/beneficiary has been authorized full-scope, State-only (non-FFP) Medi-Cal and must be evaluated for IHSS-R eligibility using IHSS-R rules before services can be authorized.

If an applicant for IHSS submits as their own an SSN that is already associated with a Person Record in CMIPS II and which has been provided by a different individual, the county must follow the system processes that will be described in detail as part of CMIPS II user training to take the application and potentially authorize services while the issue is researched and resolved. County staff should contact their Medi-Cal program staff to determine if Medi-Cal has completed a Social Security Administration Referral Notice (MC 194) form a copy of which is attached to this letter. This form is a request to SSA to research and resolve the conflict in SSN numbers. If Medi-Cal program staff has not initiated this process, IHSS program staff should request that it be initiated. When SSA has completed its research, it will return the MC 194 with the outcome to Medi-Cal. The IHSS program should take actions consistent with the outcome SSA provides to Medi-Cal, and deny or terminate services as appropriate to the applicant/recipient determined by SSA to have provided an SSN not issued to that person.

RECIPIENTS RESIDING IN MORE THAN ONE COUNTY

An IHSS recipient may reside and receive services in more than one county. As an example, a child recipient may live a portion of the time with their mother in one county and the remainder of the time with their father in a separate county. Similarly, an elderly parent who receives IHSS may divide their time between three adult children who live in separate counties and receive services in all three counties.

In Legacy CMIPS, the recipient would likely have had a case in each county in which they received services. However, in CMIPS II, a recipient will have one Person Record and thereby one case record regardless of the number of counties in which they receive services.

If an IHSS recipient has residence in more than one county a “primary county of residence” must be designated. The primary county of residence will be the county that carries the case. In general, the primary county of residence for the IHSS case should

be the same county where the recipient has active Medi-Cal. There may be exceptions to this, such as when the Medi-Cal case is carried by the county in which eligibility was initially determined regardless of the recipient's county of residence. In these types of circumstances, the recipient may choose the county they want to designate as the IHSS primary county of residence. Please note that it is perfectly acceptable for the Medi-Cal case and the IHSS case to be in different counties; it will not impact Medi-Cal eligibility or FFP for the IHSS case.

The primary county of residence is responsible for all aspects of the case including: conducting the needs assessment; authorizing services; enrolling providers; issuing timesheets; and funding the case. Other counties of residence should be viewed as "alternate service sites" similar to services received in the work place. The services received at the alternate service sites are limited to those currently authorized in the primary county of residence.

The case owner in the primary county of residence should work with the recipient to identify and designate a specific number of the authorized hours available for each alternate service site based on the time the recipient spends at that site. If the recipient chooses, the designated hours may be assigned to the provider at each alternate service site and the recipient should complete and sign an IHSS Recipient Request For Assignment Of Authorized Hours To Providers (SOC 838). The place of residence in each county must also meet the IHSS "own home" criteria. All Individual Providers for the recipient must complete the provider enrollment criteria in order to be enrolled on the case and will receive the wages of the primary county of residence and any benefits offered by that county for which they are eligible.

REINSTATEMENT OF RANK 6

In ACL 88-118 (issued September 6, 1988), the Assessment Standards specified the use of Rank 6 in the following service categories: Meal Preparation & Clean-up, Feeding and Respiration. ACL 88-118 directed counties to assess Rank 6 for these service categories when all services were exclusively paramedical. Legacy CMIPS has been programmed according to this direction since 1988. Design and development of CMIPS II has also incorporated the use of Rank 6 as described in this paragraph.

Manual of Policies and Procedures (MPP) section 30-756.41 currently states that county staff shall assess Rank 1 when all services are exclusively paramedical. It is unclear whether the MPP section has been written this way as far back as 1988, when the ACL was issued. It is uncertain if the need for Rank 6 was realized only after the regulations were promulgated and the regulations were never amended to include Rank 6, or if the MPP section was erroneously amended at some time subsequent to

the 1988 ACL. Regardless, the intent of the direction in ACL 88-118 has always been clear that Rank 6 was to be used when all Meal Preparation and Clean-up, Feeding and/or Respiration services are provided under Paramedical Services.

Please note that the instructions in this ACL supersede the instructions given in ACL 88-118 and ACLs 06-34 and 06-34E2. ACL 06-34 (issued August 31, 2006) included Rank 6 in the Annotated Assessment Criteria. However, ACL Errata 06-34E2 (issued May 4, 2007) eliminated Rank 6 for Meal Preparation & Clean-up , Feeding and Respiration in the Annotated Assessment Criteria. As a result, some counties discontinued using Rank 6 to identify Paramedical needs in these service categories. The elimination of Rank 6 precluded counties from accurately reflecting recipients' needs for Paramedical Services in cases where such services were authorized in addition to human assistance.

Upon receipt of this ACL, counties shall begin using Rank 6 for the following service categories, when applicable, during initial assessments and all reassessments:

- Meal Preparation & Clean-up
- Feeding
- Respiration
- Bowel, Bladder and Menstrual Care

In ACL 09-30, Question #12 asks if there is a Rank 6 for Bowel and Bladder care. The answer stated, "No, Rank 6 is not used for Bowel and Bladder. The recipient should be ranked from one to five based on level of function, irrespective of any related Paramedical Services."

CDSS has reconsidered its position and determined it is appropriate in certain instances for Bowel, Bladder and Menstrual Care to be provided only in the form of Paramedical Services. For instance, you have a recipient who does not need assistance toileting because he is able to get to the bathroom and urinate independently. However, he does need assistance maintaining his colostomy site (a paramedical service). He should be ranked a 6 in Bowel, Bladder and Menstrual Care because all his Bowel, Bladder and Menstrual needs are being met through a Paramedical Service. Therefore, the category of Bowel, Bladder & Menstrual Care has been added to the list of service categories where Rank 6 may be assessed if the need is met only by Paramedical Services. Please note this ACL supersedes the response provided to Question #12 in ACL 09-30.

Rank 6 will be added to the regulation sections for Meal Preparation & Clean-up, Feeding, Respiration and Bowel, Bladder & Menstrual Care in the next amendment to the MPPs. Until that time, ACL 88-118 and this ACL will serve as the authorities for including Rank 6 as part of the assessment criteria when conducting assessments and reassessments. Additionally, the Annotated Assessment Criteria will be modified to reflect these changes.

Functionality for the use of Rank 6 in Legacy CMIPS Rank 6 has not changed since the issuance of ACL 88-118. Counties should resume using Rank 6 based on the instructions in that ACL. Bowel, Bladder and Menstrual has just been added to the categories that are eligible for an assignment of Rank 6 and due to the imminent conversion to CMIPS II, Legacy CMIPS has not been modified to accept a Rank 6 for this service category.

CMIPS II expands the functionality of Rank 6 so social workers may assess and assign Rank 6, as needed, for the authorization of Paramedical Services in Meal Preparation/Clean-up, Feeding, Respiration and Bowel, Bladder and Menstrual Care.

Similar to Legacy CMIPS, CMIPS II will continue to display error messages when there are discrepancies between services authorized and its assigned functional rankings (i.e., Rank 6 has been assigned to a Service Type but there are no Paramedical Services authorized). These validation edits will appear on the screens and documents the error messages that will be displayed for each edit.

- When an attempt is made to save Create or Modify Service Type Feeding and the Functional Rank for Feeding is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Feeding is indicated as Paramedical.
- When an attempt is made to save a Service Type associated with Meal Prep & Clean-up and the Functional Rank for Meal Prep & Clean-up is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Meal Prep & Clean-up is indicated as Paramedical.
- When an attempt is made to save a Respiration Service Type and the Functional Rank for Respiration is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Respiration is indicated as Paramedical.
- When an attempt is made to save a Service Type associated with Bowel & Bladder Care and the Functional Rank for Bowel & Bladder Care is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Bowel & Bladder is indicated as Paramedical.

To resolve these error messages, the social worker will need to check the functional ranking for the Service Types and confirm a Rank 6 is needed and/or to reassess the functional ranking, if needed. Additionally, the social worker will need to determine why Paramedical Services have not been authorized on the Service Evidence screen if a Service Type has been assigned a Rank 6.

INTER-COUNTY TRANSFER (ICT) PROCESS IN CMIPS II

Conversion to CMIPS II will not create a need for changes to the existing regulatory requirements related to ICTs (MPP sections 30-759.9 to .972). An ICT occurs when an IHSS recipient moves from one county to another and the originating county that has been responsible for the management of the recipient case transfers management of that case to the receiving county.

When an ICT is completed in Legacy CMIPS, the recipient is terminated in the transferring county and a new case is opened and a new case number assigned in the receiving county. The process is primarily a manual exchange between the sending and receiving counties.

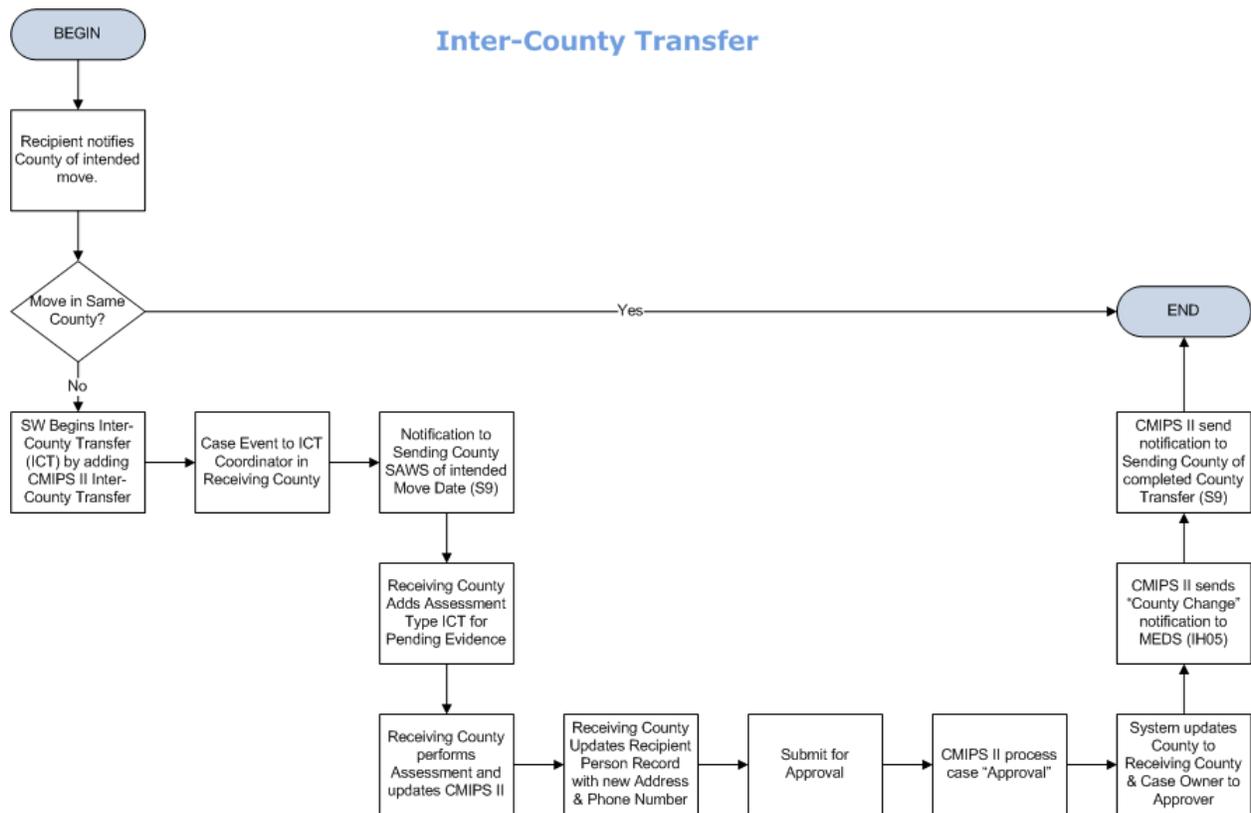
In CMIPS II, the ICT process is much more automated providing a more efficient process. For example, a recipient will have a single Person Record and case number for the life of the IHSS case that will follow the recipient during an ICT, rather than terminating the case in the sending county and creating a new case in the receiving county. In CMIPS II, when the receiving county accepts the ICT, the only change to the case number will be the numeric county indicator at the beginning of the case number. For example, in Fresno County the case number might be 10-123456; the 10 at the beginning representing the Fresno County code. After an ICT to Sacramento County, the 10 would change to 34, Sacramento County's code. The second portion of the case number, 123456, remains the same. Thus, the case number would change to 34-123456.

CMIPS II has functionality to support the ICT process including:

- Generating a referral from the transferring to receiving county;
- An assessment specific to ICT;
- Updating county and case owner upon receiving county authorization;
- Notifications to transferring county SAWS system;
- Not allowing an ICT when the case has an open state hearing record in the system; and
- Allowing an ICT to be canceled when necessary.

Although most ICT activities will be conducted within CMIPS II, the transferring county will still be required to fax or mail to the receiving county all completed forms/documents that are retained outside of CMIPS II, such as the Request for Order and Consent – Paramedical Services (SOC 321) form.

If the recipient moves from the receiving county to a third county during the transfer period, the original transferring county is responsible for canceling the transfer to the first receiving county and initiating the transfer to the second receiving county (MPP 30-759.922). The flow chart below documents the steps of the ICT process in CMIPS II. The CMIPS II ICT process is displayed in the flow chart below.



Inter-County Transfer (ICT) Process during CMIPS II Implementation Phase

During the period of statewide rollout of CMIPS II, ICTs may occur between two Legacy CMIPS counties, two CMIPS II counties or a Legacy CMIPS county and a CMIPS II county. The following chart provides the possible scenarios and the action to be taken in each scenario.

SCENARIO	ACTION TO BE TAKEN
Legacy CMIPS county is receiving an ICT from a Legacy CMIPS county	Follow current (pre-CMIPS II) procedure
Legacy CMIPS county is receiving an ICT from a CMIPS II county	Follow current (pre-CMIPS II) procedure
CMIPS II county is receiving an ICT from a Legacy CMIPS county	Open new application in CMIPS II
CMIPS II county is receiving an ICT from a CMIPS II county	Follow CMIPS II process to review ICT in CMIPS II and assign to worker (See flow chart above.)
CMIPS II county is sending an ICT to a Legacy CMIPS county	Terminate the case in CMIPS II and follow current (pre-CMIPS II) procedure
Legacy CMIPS county is sending ICT to a CMIPS II county	Follow current (pre-CMIPS II) procedure

Funding of the Case during Inter-County Transfer (ICT)

In accordance with existing regulations, the transferring county is responsible for the county share of the case funding until the effective date of authorization in the receiving county. MPP section 30-759.921 states, “The transferring county is responsible for authorizing and funding services until the transfer period expires, at which time the receiving county becomes responsible.” Which county maintains the Medi-Cal case is irrelevant to which county pays the county share of funding for the IHSS case. Communication between counties to ensure timely transfer of case responsibility is essential. CMIPS II produces a “Monthly Inter-County Transfer Report” to support communication between counties regarding ICT cases to help ensure ICTs are being completed timely.

If you have questions regarding this letter, contact Adult Programs at (916) 651-1069.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

c: CWDA

SOCIAL SECURITY ADMINISTRATION REFERRAL NOTICE

Instructions:

- **To CWD:** Please complete Part I. Retain original for your records, copy for recipient/SSA. Client must take this form to SSA.
- **To Recipients:** Read the back of this form. Take the necessary documentation to the Social Security Administration Office listed below in Part I.B.
- **To SSA:** This form is a request for the action noted in Part I.C. Please complete Part II of this form and distribute as noted in Part I.A. If you have any questions, the eligibility worker's name and phone number are provided.

PART I: TO BE COMPLETED BY THE COUNTY WELFARE DEPARTMENT

A. Please enter the complete county welfare office name and address within the brackets provided.

<div style="border: 1px solid black; width: 80%; margin: 5px auto; height: 20px;"></div>	<div style="border: 1px solid black; width: 80%; margin: 5px auto; height: 20px;"></div>
--	--

SSA, after completion:

- Mail this form to the county welfare office.
- Return this form to the recipient to be returned to CWD.

B. Social Security Office Information

Name of SSA District/Regional Office		
Address (number and street)		
City	State	ZIP code

D. Applicant/Recipient Information

Recipient's name (last, first, middle initial)																					
Date of birth (month/day/year)	Sex (M or F)																				
County ID per MEDS																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">X</td> <td style="width: 10%;"></td> </tr> </table>					X																
			X																		
Recipient's SSN (if applicable)																					
Case name																					

C. The bearer of this form is an applicant for, or recipient of, Food Stamps, Cash Aid, or Medi-Cal. The following service is required:

- Original SSN card
 - Duplicate SSN card SSN: _____
 - Info on SSA's Numident File needs to be verified.
 - Name DOB Sex
 - Info on SSA's Numident File needs to be corrected.
 - Name DOB Sex
- Note: Recipient must provide verification of change.*
- Recipient has been assigned two SSNs. Please take action to delete all but one.
 - Two recipients appear to have been assigned the same SSN. Please verify correct number for recipient from Numident File.

E. CWO Information

Name of Eligibility Worker		
Date form completed	E.W. Worker	E.W. phone number

F. Comments

PART II. TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION DISTRICT/REGIONAL OFFICE

A. Date received

C. Comments

<div style="border: 1px solid black; width: 95%; margin: 5px auto; height: 20px;"></div>
--

B. Result of Referral

- 1. Recipient has completed an SSN application (including Form SS-5 and other proof) and application is being processed.
 - 2. Insufficient ID.
 - 3. SSN application is not being processed. (Explain.)
-
- 4. Other. (Explain.)
-

D. SSA Representative—print name

Signature

Telephone number

**SSA REFERRAL INFORMATION SHEET
(For Medi-Cal, Food Stamp, and CalWORKs Recipients)**

YOU MUST CONTACT SOCIAL SECURITY

Public Law requires that each person who applies for or receives full-scope Medi-Cal, Food Stamps, or California Work Opportunity and Responsibility to Kids must have or apply for a social security number. For the applicant/ recipient noted on the reverse side, either (1) the Social Security Administration does not have a social security number on file, or (2) the information provided by the Social Security Administration and the information provided to the eligibility worker do not agree. To correct this situation, you must contact the Social Security Office indicated on the reverse side of this referral form. **DO NOT MAIL THESE FORMS TO THEM.**

NOTE: *Age, citizenship or alien status, and identity must all be documented.* One of the identification documents must be a **birth or baptismal certificate established BEFORE age 5.** If one is not obtainable, refer to **Column A** for acceptable substitutes. In addition, if the applicant/recipient is a U.S. citizen born outside of the U.S. or an alien, one of the items listed in **Column B** must be presented.

Column A

Column B

1. Evidence of Age/Citizenship

- School records
- Church records
- Census records (state or federal)
- Insurance policy
- Marriage records
- Draft card
- U.S. passport
- Other records indicating applicant's age or date and place of birth

1. If you are now a U.S. citizen born outside the U.S., take one of the following items in addition to the item(s) required in Column A:

- U.S. citizen identity card
- U.S. passport
- Naturalization certificate
- Certificate of citizenship
- Consular report of birth
- Form I-179 (U.S. citizen card)
- Form I-197 (U.S. citizen resident card)

2. Evidence of Identity

- Driver's license
- State identification card
- Voter's registration
- School records
- Health records (doctor's, hospital's, etc.)
- Any other document which shows applicant's signature, photograph, or description

2. If you are an alien, take one of the following items in addition to the item(s) listed in Column A:

- Form I-151 or I-551 (Alien Registration Receipt Card)
- Form AR3a, I-94, I-95a, I-84, I-85, I-86, or SW-434
- Letters from Immigration and Naturalization Service showing alien status

If you have a question concerning the two identification documents which you must take to the Social Security Office, please contact the Social Security Office.