

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



April 23, 2008

ALL-COUNTY LETTER NO. 08-18

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS**REASON FOR THIS TRANSMITTAL**

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

SUBJECT: PHASE ONE IN-HOME SUPPORTIVE SERVICES SOCIAL WORKER TRAINING QUESTIONS/COMMENTS AND ANSWERS

The purpose of this All-County Letter (ACL) is to provide policy clarification to the attached questions/comments that were raised throughout the course of Phase One training of the In-Home Supportive Services (IHSS), Social Worker Training Academy (SWTA) conducted by the California State University, Sacramento (CSUS), College of Continuing Education (CCE). The California Department of Social Services (CDSS) contracted with CSUS to develop and deliver training curricula, materials, and work aids as mandated by Welfare and Institutions Code (WIC) Section 12305.72, enacted by Senate Bill 1104 (Chapter 229, Statutes of 2004) that requires ongoing statewide training pertaining to IHSS activities.

The SWTA was established in the summer of 2005. Phase One training was held September through December of 2005. Subsequently, Hourly Task Guidelines regulations were implemented as of September 2006, and some of the questions and answers have been updated for consistency with these regulations. Attached are updated additional questions/comments and answers resulting from the Phase One segment of the SWTA.

If you have any questions regarding this ACL, please contact the Adult Programs Branch, at (916) 229-4000 or via e-mail at IHSS-QA@dss.ca.gov.

Sincerely,

Original Signed By**Eva L. Lopez**

EVA L. LOPEZ

Deputy Director

Adult Programs Division

Attachment

c: CWDA

ATTACHMENT A

SOCIAL WORKER TRAINING ACADEMY PHASE ONE ANSWERS TO QUESTIONS/COMMENTS

1. Q: Are there plans to implement an open flow of information regarding the State's Quality Assurance (QA) activities and the counties?

A: Yes. Currently the In-Home Supportive Services (IHSS) QA website contains meeting notes from all of the QA workgroups which were utilized in developing QA policies and implementation strategies. It also contains links to forms and other pertinent resources, tools, and program information. The website can be accessed at: <http://www.cdss.ca.gov/agedblinddisabled/>. The California Department of Social Services (CDSS) will continue to provide information regarding the State's QA activities on the website.

2. Q: Is there a minimum number of assessed hours required in order to receive IHSS?

A: There is no minimum number of hours required to authorize a case for IHSS. The regulations at the Manual of Policies and Procedures (MPP) Section 30-761.1 specify the conditions to be eligible for services which include meeting specific eligibility requirements and having a needs assessment to determine the services that would enable an individual to remain safely in his/her home without regard to any minimum standard of time.

3. Q: Can hours be increased for services which have time per task guidelines if a social worker believes the recipient will not be safe with the hours assessed under the time guideline?

A: Yes. The social workers have the responsibility to assess hours based on the recipient's needs. In accordance with Welfare and Institutions Code (WIC) Section 12301.2, time per task guidelines can be used only if appropriate in meeting the individual's particular circumstances. Exceptions to time per task guidelines shall be made when necessary to enable the recipient to establish/maintain an independent living arrangement and/or remain safely in his/her home or abode of his/her own choosing. When an exception to a time per task guideline is made in an individual case, the reason for the exception shall be documented in the case file. Hourly task guidelines regulations, which include exception criteria, were implemented September 1, 2006. These regulations are located at MPP Section 30-757 and were transmitted to counties by All-County Letter (ACL) 06-34 which included implementing instructions and subsequent Errata.

4. Q: What is the ranking for a recipient with an “able and available spouse”? Do social workers rank as usual based on the recipient’s functional ability? In the past, some have been ranked as a Rank 1 because no hours were authorized for Domestic and Related chores.

A: Functional Index (FI) scores should always be ranked based on the recipient’s functional ability (MPP Section 30-756.1) regardless of whether the spouse is “able and available.” The assessed time is listed under “Total Need” on the SOC 293. If the recipient lives with an “able and available spouse,” Domestic and Related Services are shown as being met under an “Alternative Resource” and no time is listed under “Authorized to Be Purchased.”

5. Q: Are Common Law Spouses considered spouses for purposes of IHSS?

A: In accordance with MPP Section 30-701(s) (4), a spouse is defined in accordance with the Supplemental Security Income/State Supplementary Program (SSI/SSP) definition (42 USC Section 1382c (d)). For purposes of SSI, a spouse is someone: (1) legally married under the laws of the state where the permanent home is located; (2) entitled to husband or wife’s Social Security Insurance benefits as the spouse of the other; or (3) persons of the opposite sex living together in the same household holding themselves out to their community as husband and wife. Therefore, if any of the above circumstances apply, the person would be considered a spouse for purposes of IHSS. However, for purposes of determining Personal Care Services Program (PCSP) and Independence Plus Waiver (IPW) eligibility, MPP Section 30-701(s)(4) defines a spouse more narrowly as a person legally married under the laws of the state of the couple’s permanent home at the time they lived together.

6. Q: If SSI still shows a couple as married, yet the recipient has divorce documents in hand, are they considered an “able and available spouse” for IHSS purposes until they show up divorced in SSI system?

A: Consult with county counsel to determine if the Divorce Decree is a valid final Decree. If so, the recipient should not be considered married for IHSS purposes. Additionally, the recipient should be referred to Social Security Administration (SSA) for the SSA to make the appropriate change.

7. Q: We have a recipient who is legally married. His spouse moved out of the house, yet continues to be his IHSS provider. Do the “able and available spouse” regulations apply in this case?

A: No. Per MPP Section 30-763.4, the “able and available spouse” regulations under MPP Section 30-763.41 only apply in a shared-living situation where the spouses live together. If a spouse is living outside the home and still desires to be the IHSS

provider, the “able and available spouse” regulations do not apply. (See MPP Sections 30-763.3 and 30-763.4.)

8. Q: Would children who are not the recipient’s children living in the home that are under the age of 14 be counted in household composition?

A: Children who are not the recipient’s children living in the home (regardless of age) would be counted in the household composition for purposes of proration for Domestic and Related services. Only children of the recipient (not grandchildren, foster children or other minor relatives for whom the recipient may have guardianship) are excluded (MPP Section 30-763.46). The CMIPS Manual, Page V-A-12, Field G2 defines Number in Household as “The total number of people living in the recipient’s household, including other IHSS recipients. Exclude recipient’s non-IHSS children under 14 years of age.”

9. Q: Is there a written regulation addressing the issue of a parent provider signing time sheets for the minor child?

A: The MPP regulations do not address this particular issue. However, the CMIPS Users Manual, Section VII, Page H-2, Section D reads: “A parent provider of a minor child may sign the time sheet.”

10. Q: Can Meal Preparation and Meal Cleanup be performed outside of the recipient’s home?

A: Meal preparation and cleanup must be done in the recipient’s home. It is inferred from the language of the statute and regulations that the intent is to provide these services in the home of the recipient.

11. Q: If an IHSS recipient chooses to eat meals separately from other family members residing in the home, must the IHSS recipient's needs be prorated unless the recipient has a health and safety need requiring his/her meals to be prepared separately?

A: No, these services do not have to be prorated. MPP Section 30-763.32 discusses when it is appropriate to prorate related services, which includes meal preparation. The regulation states that meal preparation should not be prorated, “when the service is not being provided by a housemate and is being provided separately to the recipient.” This regulation does not speak to the issue of a housemate preparing separate meals. However, the intent of the regulation is to prorate hours when the needs of multiple persons are being met. When a housemate prepares food it does not automatically follow that the food prepared is meeting the needs of multiple individuals. Therefore, when a housemate prepares food separately for a recipient, the hours are not prorated because they are not meeting multiple needs. The

regulation does not require that there be a health and safety reason for the recipient to eat meals separately. Consequently, the recipient may have meals provided separately in this situation solely because he/she chooses to eat separately.

12. Q: Is there a Rank 6 for Bowel and Bladder?

A: No. Bowel, Bladder and Menstrual Care are Ranks 1 through 5, with Rank 1 being “independent” and able to manage Bowel, Bladder and Menstrual Care with no assistance from another person. Rank 5 requires physical assistance in all areas of care (MPP Section 30-756.35). If the recipient’s Bowel and Bladder needs include catheter insertion, ostomy irrigation, or a bowel program; they are assessed as Paramedical Services (MPP Section 30-757.191(c)).

13. Q: The Paramedical form (SOC 321) needs revision, as it is unclear and many doctors do not understand the IHSS definition of Paramedical services. Can the county fill out the form for the physician to sign for completion if he/she concurs?

A: The CDSS has modified the Paramedical form (SOC 321) for clarity. The new version was released in April 2006. Counties may have social workers identify the IHSS Paramedical services by filling out the form and then having the physician sign for completion. Additionally, some counties with Public Health Nurses (PHNs) have their PHNs contact the recipient’s physician’s office and speak with his/her nurse to explain the SOC 321 form and suggest timeframes for the Paramedical Services being requested. The PHN then faxes a partially completed SOC 321 to the doctor’s office where she/he can review and sign it for completion. The fact the physician signs as the appropriate licensed health care professional complies with the requirements of MPP Section 30-757.19.

14. Q: Do we need a Paramedical form annually even if the recipient has no change in Paramedical needs?

A: At this time, renewing the Paramedical form (SOC 321) is not required annually. However, it should be a county “best practice” to insure that the Paramedical form is reviewed at each reassessment for any health changes (improvements or deteriorations). The ending dates (if any) of authorized Paramedical Services should also be noted.

15. Q: Is toenail clipping for the recipient an eligible task in the IHSS program?

A: No, toenail clipping is not a covered service by IHSS. According to the California Code of Regulations regulation Section 51183 (a) (2) and Section 51350 (f), grooming includes fingernail and toenail care, but excludes cutting with scissors or clipping toenails. Therefore, for consistency, the toenail care specified at MPP

Section 30-757.14 (e), does not include cutting with scissors or clipping toenails. Toenail cutting or clipping is covered under Medi-Cal when performed by a Podiatrist and if it is a medical necessity.

16. Q: Is brushing teeth considered a Paramedical Service?

A: No, brushing teeth is considered “oral hygiene” and would be assessed under Bathing, Oral Hygiene and Grooming (MPP Section 30-780.1(a) (2)). Paramedical Services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional (MPP Section 30-757.191 (c)).

17. Q: Is crushing pills into food/liquid due to dysphasia considered Paramedical?

A: Yes. Paramedical Services are activities which due to the recipient’s physical or mental condition, are necessary to maintain the recipient’s health (MPP Section 30-757.191). The services may include administration of medications, puncturing the skin, inserting a medical device into a body orifice, activities requiring sterile procedures or other activities requiring judgment based on training given by a licensed health care professional.

18. Q: Where on the SOC 293 is time for catheter insertion authorized?

A: Time for catheter insertion is authorized as a Paramedical Service (MPP Section 30-757.19). The recipient’s FI score would be ranked on the H Line under Bowel, Bladder and Menstrual Care. If the recipient is “independent” in bowel movements and all urination is done with the catheter, the recipient would rank a “1” in Bowel, Bladder and Menstrual Care. However, if the recipient uses intermittent catheterization and urinates between those catheterizations (number of times a day), the recipient’s dependence with urination and with bowel movements would affect the recipient’s FI ranking in Bowel, Bladder, and Menstrual Care.

19. Q: Can time be authorized for a provider to “shadow/follow” the recipient for ambulation if they have an unsteady gait or experience dizziness?

A: Yes. County staff would determine the recipient’s level of ability and dependence upon verbal or physical assistance by another (MPP Section 30-756.1). If a recipient has an unsteady gait or experiences dizziness, the social worker would not assess him/her as “independent” in these tasks and time for assistance with ambulating. Per ACL 06-34, the regulations at MPP Section 30-757.14 (k), as well as the Annotated Assessment Criteria, describe “Ambulation inside” as assisting a recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or

descending stairs; moving and retrieving assistive devices such as a cane, walker, or wheelchair, etc; and washing/drying hands before and after performing these tasks. Ambulation also includes assistance to/from the front door to the car (including getting in and out of the car) for medical accompaniment and/or alternative resource travel. As taught in Phase One of the training, county practices should be followed in communicating with the recipient's doctor about prescribing Durable Medical Equipment (DME).

20. Q: Can the maintenance exercise of assistive walking (MPP 30-757.14(g)(2) (A)) be performed outside of the recipients home?

A: Yes, the maintenance exercise of assistive walking can be provided outside the recipient's home if necessary to meet the needs of the recipient. In accordance with MPP Section 30-757.14 (g) (2) (A) and MPP Section 30-780.1(a) (5) (B) "such exercises shall include the carrying out of maintenance programs, i.e., the performance of repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking." Usually, the carrying out of maintenance programs including assistive walking can be accomplished on the recipient's premises. If not, then other locations may be utilized if they are necessary and reasonable. However, if the maintenance therapy/exercise takes place away from the home, no travel time may be authorized, although time for assistance into and out of a vehicle may be authorized under MPP Section 30-757.15.

21. Q: When doctors request exercise, is it authorized under Ambulation or Paramedical?

A: It would depend on the type of health care professional providing the supervision of the exercise. If the exercise is assistive walking around inside the home, the services would be assessed as Range of Motion (MPP Section 30-757.14 (g) (2) (A)). However, if the provider is performing an exercise that requires the provider to receive training by a medical doctor or other medical professional authorized to do so, the service would be assessed under Paramedical. The controlling issue is the level of skill involved (MPP Section 30-757.19).

22. Q: Is time allowed to accompany recipients to medical appointments that are not local?

A: If the appointment is medically necessary and the health care professional is not local, the time to drive the recipient to the appointment and home would be allowed. The social worker needs to document the case file with the frequency and distance of the appointment (MPP Section 30-757.15). Providers may only claim this time when the services are actually performed.

23. Q: Are translation services for medical appointments covered under the program?

A: No. This service is not covered under IHSS.

24. Q: How do we assess people with seizures who are unable to do anything after they have one?

A: Assessing time for this service would be based on the severity and frequency of the seizures. Although the recipient is unable to do anything during and immediately after a seizure, the amount of time for recuperation varies. This is why accurate case documentation is crucial. Social workers should document the frequency of seizures, as well as the severity and duration of functional impairment following seizures. The amount of assistance required by the provider should also be documented. It is also important to note that the providers may only claim time for the service when it is actually performed.

25. Q: How and where do we assess stand-by time?

A: Stand-by is not allowed. For those recipients with a Functional Index rank of 2, which requires encouragement and reminding only, time to encourage and remind the recipient is allowed under the specific task where the recipient has this need (MPP Section 30-756.12). For example, if the recipient is ranked 2 in Feeding due to needing verbal assistance, such as reminding; the time would be assessed under Feeding. Remember when assessing time for encouragement and reminding, the provider can often be performing another task. Therefore, the assessed time may be minimal.

26. Q: For Teaching & Demonstration, is the provider paid by IHSS to teach the recipient skills to live independently?

A: The provider is paid to teach a particular task to the recipient so that once the recipient is trained IHSS assistance for that particular task will no longer be needed. Tasks are limited to instruction in Domestic and Related Services, non-medical personal care services, and Yard Hazard Abatement (MPP Section 30-757.18). Please note, Teaching and Demonstration is not an allowable task under the PCSP.

27. Q: How should the counties handle recipients who are living on the riverbanks and request IHSS? They claim this is their cultural right, but they are living in the open with no shelter.

A: The purpose of IHSS is to enable recipients to remain safely in their own "home." In accordance with MPP Section 30-755.11, "a person is eligible for IHSS who is a California resident living in his/her own home." Living in the

open with no shelter would not be considered “living safely,” and the riverbank would not be considered a “home.”

28. Q: How do we deal with non-compliance (i.e., applicant/recipient will not make information available) when attempting to conduct needs assessments to determine IHSS service authorizations?

A: If the social worker is unable to obtain the required information, the case should be closed for non-compliance, and the applicant/recipient must be sent a Notice of Action. The applicants/ recipients must provide all pertinent information to enable the county to determine eligibility and need for services (MPP Sections 30-760.1, 30-763.11 and .12).

29. Q: When can the county close cases when there has been no provider for months?

A: There are no regulations that allow termination or discontinuance of IHSS/PCSP services when a recipient fails to hire a provider or there is no payroll activity. The county should determine why the recipient does not have a provider and refer the recipient to the Public Authority since the recipient has been determined to have a need for services. The key is determining if the recipient has a need for services, not whether there is a provider available. In accordance with MPP Section 30-761.219, needs assessments are performed when the county has “pertinent information which indicates a change in circumstances affecting the recipient’s need for supportive services.” If the recipient does not hire a provider, that may be an indication that the recipient’s physical/mental condition or living/social situation has changed and the county may conduct a reassessment. The reassessment will establish the need for continued services.

30. Q: Can the provider provide services to the recipient while the recipient is temporarily absent from the home?

A: Yes, provided the service has been authorized, the provider is in the accompaniment of the recipient, and/or the absence is not precluded by the out-of-state absence requirements at MPP Sections 30-770.444 and .461.

31. Q: Is there a limit to the number of providers a recipient can have?

A: There are no regulations that limit the number of providers that a recipient can have. Time is authorized based on the recipient’s needs without regard to the number of providers, and for this same reason, no additional time can be authorized on the basis of multiple providers.

32. Q: Can an individual who is not the parent of a minor have a full-time job and still work as a full-time IHSS provider?

A: The regulations do not prohibit a provider from working another job. However, the provider must complete and submit a timesheet (SOC 361) verifying that all of the reported service hours claimed were performed. There may be a reason to question whether hours are actually provided or are provided appropriately to meet the needs of the recipient. It may be appropriate to evaluate the adequacy of the plan or to make appropriate referrals related to possible fraud or client neglect.

33. Q: Can counties require a yearly medical form if a recipient's condition is not likely to change?

A: Although some counties may request that their social workers obtain a yearly medical form, it is not a State requirement. However, as part of the reassessment, the social worker should assess whether the medical information beyond a year is sufficient to determine the recipient's condition has not changed (improvements or deteriorations) and whether or not the recipient can still remain safely in his/her home with or without specific IHSS service needs. Pursuant to MPP Section 30-761.13, social services staff must have face-to-face contact with the recipient in the recipient's home at least once every 12 months to determine the recipient's level of need which would enable the recipient to remain safely in his/her own home.

(Note: The face-to-face may be beyond 12 months if the county has opted to extend the reassessment up to six months based on the requirements of MPP Section 30-761.215 through .217.) Additionally, MPP Section 30-761.263 specifies the need for services shall be based on the "available medical information."

34. Q: How do we prorate when meals are prepared for a large group (i.e., living in a temple)?

A: If the recipient is living with a large group, there needs to be a determination of whether the recipient is living in a community care facility or a board and care facility and, therefore, she/he might not be eligible for IHSS. In accordance with MPP Section 30-701 (o) (2), "own home" is defined as the place in which an individual chooses to reside. An individual's "own home" does not include an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or a board and care facility. However, if this is not the case and the individual is determined to be living in his/her "own home," normal proration procedures would apply as specified in MPP Section 30-763.321: "When the need is being met in common with those of other housemates, the need shall be prorated to all the housemates involved, and the recipient's need is his/her prorated share."

35. Q: What happens when the provider claims hours after recipient's death? (Example; recipient passes away on 27th of the month and the provider claims hours up until the 30th).

A: No services can be claimed after a recipient has passed away, as the purpose of the program is to allow recipients to remain safely in their own home. If payment for services is received after the death of the recipient, overpaid compensation is to be collected from the provider in accordance with MPP Section 30-769.9.

36. Q: Can we accept mental health diagnoses from other medical professionals or should it be diagnoses provided by mental health professionals only?

A: A mental health diagnosis can only be made by a mental health professional. To be eligible for Social Security Disability on the basis of a mental disorder, a variety of documentation consisting of symptoms, signs, and laboratory findings (including psychological test findings) is analyzed.