

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



January 6, 1993

ALL-COUNTY LETTER NO. 93-02

TO: ALL-COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

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

SUBJECT: IMPLEMENTATION OF WELFARE RIGHTS ORGANIZATION V. MCMAHON (WRO)

REFERENCE: ALL-COUNTY LETTER REGARDING IMPLEMENTATION OF MILLER V. WOODS II

The Superior Court of San Diego entered an amended judgment in the Welfare Rights Organization v. McMahon (WRO) case on July 19, 1991. The purpose of this letter is to provide you with an overview of the court case as well as specific instructions and materials necessary to plan for its implementation. Attached are the following materials:

1. A copy of the WRO final court judgment.
2. A copy of the proposed draft regulations.
3. A copy of the Explanatory Flyer, the Provider Standard Claim Form, the Provider Supplemental Claim Form and the Eligibility Determination Worksheets.
4. IHSS Monthly Unearned Maximum Income and Resources Table.

Basis for Implementation of WRO Court Order

The reason for the WRO court case was the failure to immediately implement the 1983 amendment to Welfare and Institutions Code (WIC) 12301 which allowed payment to spouses for the provision of protective supervision and medical accompaniment services. While this "spouse provider" legislation passed in July of 1983, regulations were not issued until the middle of September 1984. This is now the retroactive payment period in the WRO court case. The court also awarded payment of prejudgment interest on retroactive payments due. Further, after regulations were issued in September 1984 many IHSS cases were not updated to reflect this new policy of payment to spouses for providing protective supervision and medical accompaniment services. As a result, October 1984 through September 1985 has been deemed the underpayment period in the WRO court case. On July 19, 1991 the

Superior Court of California approved a Joint Motion to Approve Amended Judgments which authorized the joint implementation of the Miller II and WRO court orders. Please refer to the All-County Letter referring to the Miller II implementation.

Proposed Emergency Regulations

Attached for your information and implementation planning purposes is a copy of the proposed draft regulations. The regulations are based upon the terms in the attached court judgment and are intended to provide a system by which retroactive and underpayment eligibility for protective supervision can be determined and payments made to eligible claimants.

It is anticipated that these regulations will become effective on, or near, February 1, 1993. Counties will receive an approved version of the emergency regulations through normal distribution procedures upon approval by the Office of Administrative Law and filing with the Secretary of State. In the meantime, Counties are encouraged to use the proposed draft regulations as a means for planning for the February 1, 1993 implementation of the WRO court case. It is anticipated that CDSS will provide training on the claim processing procedures for County Welfare Departments (CWDs), as well as for Administrative Law Judges (ALJs). Counties may contact Ms. Rosa Estes of the IHSS Policy Unit at (916) 657-2157 for any specific clarification or procedural instructions which may be needed.

Definition of "Claimant"

A claimant is defined as any person who files for retroactive payments under the WRO court case. What will distinguish those claimants who may be eligible for payments from those who will not is whether the claimant is found to be "class eligible." The "class eligible" criteria is defined in detail in the attached draft regulations. Briefly, class eligibles can be either recipients who, because they were denied protective supervision, paid a friend, relative or spouse to provide protective supervision during the retroactive period. Or, they can be friends, relatives or spouses who provided the service without IHSS compensation. Counties are instructed to accept all claims. If it is determined that the person filing the claim is not "class eligible," Counties are instructed to issue a Notice of Action (NOA) denying the claim with an explanation of why the individual was not determined to be class eligible.

Explanatory Flyers and Standard Claim Forms

Attached is a copy of the Explanatory Flyer (TEMP 2040), in English on one side and Spanish on the other, which will be sent to potential WRO claimants informing them of their potential entitlement to retroactive payments and underpayments. The TEMP 2040 and the Provider Standard Claim Form (TEMP 2007) will be sent to all IHSS providers who have been identified through the Case Management Information and Payrolling System (CMIPS) as having lived at the same address with their spouse as an IHSS recipient at any time from July 1983 through November 1988.

Posters

The language on the posters (TEMP 2041), in English and Spanish, is modeled after the Explanatory Flyer. The central office in each County, as well as Social Security Administration (SSA) offices, legal aid organizations, independent living centers, Area Agencies on Aging (AAA), and Multipurpose Senior Services Program (MSSP) site locations will receive a supply of posters, as well as Explanatory Flyers and Standard Claim Forms. These organizations are instructed to distribute a poster to each office having contact with the public and to ensure that the posters are placed in locations where they can easily be seen by the public, and distribute an Explanatory Flyer and Standard Claim Form upon request. Counties are also instructed to distribute the poster to offices which administer Adult Services programs and have public contact, insure that the posters are placed where they may be viewed by the public, distribute the appropriate forms upon request, and provide assistance to claimants needing help completing the claim forms.

Supplemental Claim Forms

The Supplemental Claim Forms (TEMP 2006) are to be kept on hand in those offices where it has been determined that claims will be processed. The Supplemental Claim Form is to be issued to claimants only after a Standard Claim Form has been completed and the County is unable to locate either a record of an approved or a denied IHSS case, or the available case record does not contain sufficient information for determining retroactive IHSS eligibility.

Part III on the form asks the claimant for the average monthly income and resources of the person who received protective supervision. Counties are instructed to compare the monthly amounts provided by the claimant with the amounts on the income and resources table described below. Any period(s)

claimed in which either the income and/or resources are above the amounts on the attached table would constitute a denial for that period(s).

Mailing of Court Case Materials

A supply of the forms, flyers and posters will be sent to the WRO contact person in each County during January 1993. Each County contact is responsible for distributing the Posters, Explanatory Flyers and Standard Claim Forms to district offices which administer Adult Services programs and have public contact. Counties needing additional quantities may order through the CDSS warehouse by completing a GEN 727B and identifying the material(s) needed by form number. The surplus of materials being stored in the warehouse is limited. Counties are therefore instructed to request only those amounts actually needed. Pending the receipt of any ordered materials, Counties may wish to photo copy any of the flyers and/or forms as needed. Below is a list of all forms used in the implementation of WRO by the claimant and the CWD in processing the claims:

Temp 2041	<u>WRO</u> Poster
Temp 2040	<u>WRO</u> Explanatory Flyer
Temp 2007	<u>WRO</u> Provider Standard Claim Form
Temp 2006	<u>WRO</u> Provider Supplemental Claim Form
Temp 2009	<u>WRO</u> Provider Retroactive Payment Eligibility Determination Worksheet
Temp 2008	<u>WRO</u> Provider Underpayment Eligibility Determination Worksheet

IHSS Maximum Unearned Income and Resources Table

Attached as page 7 of this ACL is an IHSS Maximum Unearned Income and Resources Table for the retroactive payment and underpayment claim periods. Counties are instructed to use these income and resource limits when retroactive and underpayment eligibility for IHSS must be established through the use of the Supplemental Claim Form. If, for any period claimed, the amounts on the Supplemental Claim Form indicate that the income and/or resources of the person claimed to have received protective supervision are higher than the income/resource amounts on the Table, Counties are to deny the claim for the period in which the amounts are higher. Counties are instructed to limit the use of the Table to WRO cases only.

Authorized Representatives

An authorized representative is defined as a legal conservator, an executor, or any other individual having a written statement signed by the claimant verifying that he/she has been given written authorization to act on behalf of the claimant. It is possible that a recipient may be deceased and his/her estate could be potentially eligible for retroactive payments and underpayments. In these instances, the executor of the estate must act as the deceased claimant's authorized representative. Counties are instructed to obtain written verification from the individual claiming to be the legal/authorized representative.

County Transfer Procedures

Counties which receive a WRO claim where services were provided or received either fully or partially in another County shall transfer the full or partial claim to the other County(ies) by sending a copy of the claim to each affected County. The CWD shall also send a Notice of Action to the claimant within ten calendar days of the filing date notifying the claimant of the transfer. CMIPS procedures regarding County transfers will be transmitted under separate cover.

County Statistical Reporting

The WRO amended judgment requires CDSS to compile monthly statistical information on claims for retroactive payments and underpayments. The information required will be collected through CMIPS. It is therefore important that Counties carefully follow the CMIPS instructions, which will soon be released, so that accurate counts may be obtained.

Case Record Retention

Counties were advised in All-County Information Notice No. 1-37-84 to avoid destroying any case files, applications, denials or other records pertinent to cases which may be eligible for retroactive payments (i.e., recipients with housemates). For ease in locating case records once the claim period begins, Counties may now wish to retrieve any case records or documents which may have been identified as potentially eligible WRO cases.

Related to this is a requirement contained in the WRO regulations which instructs Counties to retain any and all information received and/or obtained regarding WRO claims in case related files.

It is anticipated that CDSS will conduct WRO case reviews in late 1993 or early 1994. Counties are instructed to retain all approved and denied WRO case files for at least the normal three-year retention period. This includes any claims which may be filed after the end of the claim period. If it is determined that a need exists to retain these cases/claims beyond the three-year period, Counties will be notified through a future All-County Letter.

Funding for County Administration of Court Case Related Activities

Statewide funds for the administration of each of the court cases will be allocated using the same methodology as that used for Miller I described in ACL No. 88-101, or on the basis of each County's percent to statewide total of IHSS caseload activity with each County guaranteed a minimum allocation of \$100.

Additionally, when performing case related activities including receiving applications, researching case records to determine eligibility, calculating payments and capturing data involving CMIPS, County workers will time study to IHSS staff activities and not to a separate line item.

The CMIPS instructions and procedures will be mailed to Counties under separate cover. In the meantime, information needed for planning purposes should be directed to Wayman Hindsman at (916) 657-2134.

Any questions regarding WRO policy and implementation of the regulations should be directed to Rosa Estes at (916) 657-2157.



JAMES W. BROWN
Acting Deputy Director
Adult and Family Services

Attachments

cc: CWDA

WRO VS. MCMAHON COURT CASE

IHSS MONTHLY UNEARNED INCOME MAXIMUM TABLES

FOR INDIVIDUALS

<u>PERIOD COVERED</u>	<u>AGED/DISABLED</u>		<u>BLIND</u>	
	NSI	SI	NSI	SI
7/83 thru 12/83	\$1085.00	\$1353.00	\$1140.00	\$1408.00
1/84 thru 6/84	\$1101.00	\$1369.00	\$1159.00	\$1427.00
7/84 thru 12/84	\$1135.00	\$1418.00	\$1193.00	\$1476.00
1/85 thru 6/85	\$1162.00	\$1445.00	\$1223.00	\$1506.00
7/85 thru 9/85	\$1198.00	\$1498.00	\$1259.00	\$1559.00

FOR COUPLES

PERIOD COVERED	AGED/DISABLED		BLIND	
	NSI	SI	NSI	SI
7/83 thru 12/83	\$1477.00	\$1745.00	\$1568.00	\$1836.00
1/84 thru 6/84	\$1510.00	\$1778.00	\$1606.00	\$1874.00
7/84 thru 12/84	\$1544.00	\$1827.00	\$1640.00	\$1923.00
1/85 thru 6/85	\$1594.00	\$1877.00	\$1695.00	\$1978.00
7/85 thru 9/85	\$1630.00	\$1930.00	\$1731.00	\$2031.00

The resource limit for the period 1/79 through 12/84 was \$1500 for an individual and \$2250 for a couple. From 1/85 through 9/85, the resource limit was \$1600 for an individual and \$2400 for a couple.

These tables are to be used only in determining eligibility for WRO v. McMahon cases.

F KENNETH E. MARTONE
Clerk of the Superior Court
JUL 19 1991
By: P. BEHNSTEIN, Deputy

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN DIEGO

10	WELFARE RIGHTS ORGANIZATION OF)	CASE NO. 531015
	SAN DIEGO, INC., LORRAINE)	
11	JACKSON, and PAUL JACKSON by)	AMENDED JUDGMENT
	LORRAINE JACKSON, his guardian)	
12	ad litem, individually and on)	
	on behalf of all others)	
13	similarly situated,)	
)	
14	Plaintiffs-Petitioners,)	
)	
15	v.)	
)	
16	LINDA S. McMAHON, Director of)	
	State Department of Social)	
17	Services; and STATE DEPARTMENT)	
	OF SOCIAL SERVICES,)	
18)	
)	
19	Defendants-Respondents.)	

20 The parties' Joint Motion To Approve Action Amended
21 Judgments was heard on July 19, 1991. Charles Wolfinger appeared
22 as counsel for plaintiffs/petitioners ("petitioners"). John H.
23 Sanders, Deputy Attorney General of the State of California,
24 appeared as counsel for defendants/respondents ("respondents").

25 The court has considered the pleadings and papers on file
26 herein and the arguments of counsel, and being fully advised in the
27 premises, now therefore,

28 HEREBY ORDERS, ADJUDGES AND DECREES:

1 I. THE PARTIES - This judgment binds the following parties:

2 A. Petitioners And The Class - Petitioners Welfare Rights
3 Organization of San Diego, Inc. and Lorraine and Paul Jackson, and
4 the class defined as "all spousal applicants for or recipients of
5 In Home Supportive Services and their spousal providers, who have
6 been since July 1, 1983 or will be denied medical transportation or
7 protective supervision services solely because the State Department
8 of Social Services and its Director failed to comply with the 1983
9 spouse provider legislation (Stats.1983, ch. 323, § 116.7 (amending
10 Welfare and Institutions Code § 12301) requiring compensation
11 beginning July 1, 1983 (§ 151.37)."

12 B. Respondents - Respondents State Department of Social
13 Services ("Department") and its Director, Linda S. McMahon, her
14 successors in office, officers, employees, agents, representatives,
15 and all other persons acting in her behalf or subject to her
16 control or supervision, including her statutory agents, the board
17 of supervisors of each county of California and the directors of
18 each county welfare department.

19
20 II. DECLARATORY JUDGMENT - This court makes the following
21 declaration of the parties' rights pursuant to Code of Civil
22 Procedure ("C.C.P.") § 1060:

23 A. Duty To Implement Spouse

24 Provider Legislation Retroactively

25 1. The respondents Department and its Director have at all
26 times relevant herein had a mandatory duty to implement the 1983
27 amendment to Welfare and Institutions Code § 12301 (Stats.1983, ch.
28 323, § 116.7) ("1983 spouse provider legislation") retroactively to

1 July 1, 1983 through the 58 county welfare departments, as defined
2 in Welfare and Institutions Code § 10058.

3 2. It is unnecessary to make a declaration on any
4 constitutional law claims since the declaration on the state
5 statutory claims is sufficient to provide the relief.

6 B. Entitlement To Retroactive Benefits - The individually
7 named petitioners Lorraine and Paul Jackson and the class are
8 entitled to restoration of all IHSS compensation for services
9 authorized by the 1983 spouse provider legislation and provided by
10 the IHSS spouse from July 1, 1983 to September 10, 1984.

11 C. Entitlement To Underpayments - Class members are entitled
12 to underpayments from October 1, 1994 through September 30, 1985
13 forward for county errors in failing to correctly pay for
14 protective supervision and/or medical transportation.

15 Underpayments shall be issued in accordance with Departmental
16 regulations found at MPP Section 30-768.4.

17 D. Entitlement To Prejudgment Interest - Those named
18 petitioners and the class members determined eligible for
19 retroactive benefits are entitled to prejudgment interest at the
20 statutory rate on the amount of such benefits. The period of
21 entitlement begins on the date when the payment was originally owed
22 if the 1983 spouse provider legislation had been implemented
23 retroactively to July 1, 1983, and ends on the last date of the
24 month following the month in which payment is authorized.

25 E. The Need For Immediate Implementation Of The Judgment - Any
26 delay in implementing the terms of this Judgment will:

27 1. deprive IHSS applicants and recipients of spouse
28 providers;

1 2. increase the risk of institutionalization of persons
2 otherwise able to remain in their homes with a spouse provider
3 compensated under the IHSS program; and

4 3. impose substantial economic hardship on spouse
5 providers who have provided and continue to provide uncompensated
6 services to eligible applicants and recipients.

7
8 III. WRIT OF MANDATE FOR PROSPECTIVE ENFORCEMENT

9 Let the writ of mandate issue pursuant to C.C.P. § 1085 on
10 behalf of petitioners and the class commanding respondents to:

11 A. Enforce The 1983 Spouse Provider Legislation - Enforce the
12 1983 spouse provider legislation to compensate all such providers
13 retroactively from July 1, 1983 to September 30, 1984, and to
14 reimburse providers for any underpayments that may have occurred
15 subsequent to September 30, 1984 as a result of the failure to
16 implement it on a timely basis.

17 B. Provide Claim Information - For a period of eight (8)
18 months following the effective date of the beginning of the claim
19 period as contained in the regulations described in paragraph V,
20 supply any person who inquires about the eligibility for benefits
21 under this judgment, however described, a Claim Form, Supplemental
22 Claim Form and Explanatory Flyer.

23
24 IV. WRIT OF MANDATE FOR IDENTIFYING AND NOTIFYING

25 CLASS MEMBERS OF THEIR RIGHTS TO RETROACTIVE RELIEF

26 Let the writ of mandate issue pursuant to C.C.P. § 1085 on
27 behalf of the named petitioners and the class commanding
28 respondents to:

1 A. Identify All Individual Provider Class Members - Use the
2 IHSS Payrolling System (CMIPS Contractor) from July 1, 1983 to
3 November 30, 1988 to identify all individual providers, who at any
4 time lived at the same address with their spouse IHSS recipient.

5 B. Notify All Class Members Of
6 Their Right To Retroactive Relief

7 1. For each class member identified under subparagraph
8 IV.A:

9 a. determine the current mailing address by using
10 services provided by the Franchise Tax Board; and

11 b. by no later than the effective date of the
12 beginning of the claim period as contained in the regulations
13 promulgated to implement this decree, send to the current address
14 by first class mail a copy of the Explanatory Flyer and Claim Form
15 form set forth in subparagraphs IV.C.4 and 6 below.

16 2. Public Notices - Issue the Standard Claim Forms,
17 Explanatory Flyers, and posters in English and Spanish in the size
18 of 17" x 22" modeled after the Explanatory Flyer, in sufficient
19 numbers to each of the following:

20 a. Each county welfare department with instructions to
21 display the posters in prominent locations in every office having
22 contact with the public for the eight (8) month period beginning
23 with the effective date of the beginning of the claim period as
24 contained in the regulations described in paragraph V.

25 b. All interested organizations and groups listed in
26 Appendix A with a request to display posters in a prominent
27 location and to distribute the Explanatory Flyer and Standard Claim
28

1 Form on request for the eight (8) month period beginning with the
2 effective date of the regulations described in paragraph V.

3 c. Posters only will be sent to Federal Social
4 Security Administration offices with a request to display them in a
5 prominent location for the eight (8) month period beginning with
6 the effective date of the beginning of the claim period as
7 contained in the regulations described in paragraph V.

8 3. Standard Claim Form - The Standard Claim Form shall be
9 written in plain English and substantially conform to Attachment 1
10 hereto, except as amended in section V.E.2 below. A supply of
11 forms translated into Spanish shall be kept on hand and disbursed
12 upon request.

13 4. Supplemental Claim Form - The Supplemental Claim Form
14 shall be written in plain English and substantially conform to
15 Attachment 2 hereto and include proof of age, blindness or
16 disability and marriage. The Supplemental Claim Form shall be used
17 for claimants where the person requiring protective supervision
18 and/or medical transportation was not previously authorized IHSS
19 benefits. A supply of forms translated into Spanish shall be kept
20 on hand and disbursed upon request.

21 5. Explanatory Flyer - The Explanatory Flyer shall be
22 written in plain English and Spanish in substantial conformity to
23 Attachment 3 hereto.

24 C. Remailing Returned Notices - DSS will remail notices
25 returned as undelivered from the initial mailing in WRO as follows:

26 1. Seek to obtain approval of the plan from appropriate
27 State agencies (Department of Finance, Department of General
28 Services, Franchise Tax Board (FTB), Health and Welfare Agency, and

1 others as required), discuss any problems with plaintiffs' counsel
2 and supply all documentation and contracts with him before
3 execution.

4 2. By CMIPS Contractor, make a list with provider name,
5 sequential CMIPS number, address and Social Security Account Number
6 (SSAN).

7 3. By FTB, update CMIPS Contractor list from C.2.

8 4. By FTB, code each updated address by FTB or IRS source.

9 5. By FTB, sort returned mail by CMIPS Contractor, FTB or
10 IRS Code returned as undeliverable within the first three months
11 following the completion of mailing.

12 6. By FTB, develop a list of returned mail with name and
13 CMIPS number and either the FTB updated or CMIPS Contractor updated
14 address (none for IRS updated address), and send weekly to CMIPS
15 Contractor.

16 7. By DSS or other organization to be determined, develop
17 a list with name, address and SSAN, and send weekly to contracted
18 private credit reporting agency.

19 8. DSS will arrange to remail all updated addresses from
20 private credit reporting agency and give a minimum of two months
21 from the date of the last remailings for persons to file claims.

22 9. Take no further action to update or mail all returned
23 notices from second mailing, which will be destroyed.

24 V. WRIT OF MANDATE FOR PROCESSING

25 CLAIMS FOR RETROACTIVE BENEFITS

26 Let the writ of mandate issue pursuant to C.C.P. § 1085 on
27 behalf of the named petitioners and the class commanding
28

1 respondents to promulgate and implement regulations about the
2 following:

3 A. Claiming Period

4 1. Claims for retroactive benefits shall be accepted at
5 all county welfare department ("CWD") offices for a period of eight
6 (8) months beginning with the effective date of the beginning of
7 the claim period. contain in the regulations described in paragraph
8 V.

9 2. The date of filing for retroactive benefits claims
10 shall be determined as follows:

11 a. If the claim is mailed to the CWD, the date of
12 filing shall be the date postmarked on the envelope.

13 b. If the claim is filed in person at the CWD, the
14 date of filing shall be the date stamped on the claim.

15 c. If the date cannot be determined by subparagraph
16 V.A.2.a or b above; the date of filing shall be the date the claim
17 was signed.

18 B. Eligibility Conditions For Retroactive Benefits - The
19 eligibility conditions for receipt of retroactive benefits are:

20 1. The IHSS recipient or applicant met (a) the general
21 IHSS eligibility conditions, and (b) the specific conditions for
22 having a need for protective supervision and/or medical
23 transportation, in effect during each month for which retroactive
24 benefits are claimed. "Medical transportation" means "medical
25 travel accompaniment."

26 2. The provider was a spouse who left or was prevented from
27 obtaining full time employment because there was no other suitable
28

1 provider available to care for the IHSS spouse and whose care might
2 have prevented an inappropriate placement or inadequate care.

3 3. The recipient or applicant received less than the
4 applicable statutory grant maximum during the month claimed,
5 including any share of costs.

6 4. Claimants whose claim forms establish that they do not
7 meet the eligibility conditions in subparagraphs V.B.1-3 shall be
8 denied retroactive benefits.

9 C. Retroactive Claims Processing Procedures - The procedures
10 for processing claims for retroactive benefits will substantially
11 conform to the following steps:

12 1. Standard Claim Form

13 a. All initial claims for retroactive benefits must be
14 filed on the claim form described in subparagraph IV.B.3 above. A
15 class member who files a claim form shall be referred to as a
16 claimant in this judgment.

17 b. The claim form must be filled out, signed and dated
18 by the claimant and a witness under penalty of perjury.

19 c. If the claim form has not been completely filled
20 out, or if the claimant or a witness has not signed and dated the
21 claim form, the claim shall be denied for insufficient information.
22 The claimant shall be sent a notice of action denying the claim
23 with an explanation of the information needed to complete the claim
24 form. The claimant shall be allowed forty-five (45) days from the
25 date of the notice to submit the additional information. If the
26 information is not received within forty-five (45) days from the
27 date of the notice, the denial will stand.

1 2. Place of filing claims - Claims for retroactive
2 benefits shall be filed with the welfare department in the county
3 in which the claimant currently resides. If the covered services
4 were provided or received in a different county, the local CWD
5 shall forward the claim to the county where the service occurred.

6 3. Retroactive payment period - Retroactive benefits shall
7 be paid to claimants who paid for or who provided the covered
8 services within the period specified in subparagraph II.B, but were
9 not compensated under the IHSS program solely because the
10 respondents failed to ensure that the 1983 spouse provider
11 legislation was implemented retroactively to July 1, 1983.

12 4. General proof requirements - Information and
13 verification supplied by or on behalf of the claimant shall be
14 limited to that required by the Standard Claim Form or the
15 Supplemental Claim Form.

16 5. Recipient status and income eligibility - The existing
17 case files and information supplied according to subparagraph V.C.4
18 above, will be used to establish all eligibility conditions to the
19 maximum extent without further proof by the claimant.

20 6. Recipient's need for protective supervision and/or
21 medical transportation ("covered services")

22 a. An applicant or a recipient is presumed to have
23 needed the covered services:

24 (1) if a need was assessed at any time (in which
25 case the need shall be from that time forward) or;

26 (2) if an applicant's or recipient's need is
27 established by a sworn statement from the claimant and verified by
28 a witness.

1 b. The CWD shall review the case file and may obtain
2 other information to support or to rebut the eligibility
3 determination made in subparagraphs V.C. but must advise the
4 claimant of any adverse contradictory information regarding the
5 recipient's need for the covered services, and give an opportunity
6 to submit further information supporting the claim. The claim
7 shall be denied if the claimant is found to be ineligible.

8 7. Covered services provided

9 a. If a claimant shows that the covered services were
10 rendered, the CWD must presume that the provider did not render
11 them voluntarily.

12 b. The provision of services may be established by the
13 claimant's sworn statement verified by a witness concerning the
14 approximate number of hours per day, and by any other readily
15 available information in the claimant's possession, taking into
16 account the abilities of the claimant.

17 c. The CWD may obtain additional information to verify
18 the claimant's statement, but must advise the claimant of any
19 adverse contradictory information and give forty-five (45) days
20 from the date of the notice to submit further information
21 supporting the claim.

22 8. Computation of the amount of retroactive benefits -
23 The CWD shall determine the amount of retroactive benefits due for
24 each month based upon the following:

25 a. For claimants who were authorized IHSS, the amount
26 of retroactive benefits due for each month claimed shall be the
27 lesser of either (1) the difference between the applicable IHSS
28 statutory maximum for each month for which benefits are claimed and

1 the amount of IHSS benefits the recipient was authorized to
2 receive, or (2) the amount of covered services claimed. The amount
3 of benefits due shall not exceed the statutory maximum for the
4 months claimed.

5 b. For claimants who were not authorized IHSS, the
6 amount of retroactive benefits due shall be the number of hours of
7 covered services provided and claimed, multiplied by the county's
8 applicable individual provider hourly wage during each month for
9 which benefits are claimed. The statutory benefits shall not
10 exceed the statutory maximum for the periods claimed.

11 c. Any recipient share of cost shall not be considered
12 when computing the amount of retroactive benefits due to the
13 claimant in subparagraph V.C.8.b.

14 d. The amount of prejudgment interest shall be
15 calculated thereon from the date originally due through the last
16 day of the month following the month in which payment is
17 authorized.

18 9. CMIPS Contractor reporting - The CWD shall submit all
19 necessary documents to the CMIPS Contractor so that payment of
20 retroactive benefits may be issued within thirty (30) days from the
21 date the Notice of Action is mailed. DSS shall mail out the
22 payments on or before the 10th of the month, and otherwise shall
23 hold the payments for issuance until on or before the 10th of the
24 following month.

25 10. Standard Eligibility Determination Worksheet - DSS
26 shall design a Standard Eligibility Determination Worksheet for use
27 by CWDs to facilitate the eligibility determinations required to
28 process a claim for retroactive benefits.

1 11. Notice of Action - CWDs shall issue and mail a Notice
2 of Action on each claim within sixty (60) days from the date of
3 receipt of the claim form containing the following information:

4 a. For every month for which retroactive benefits are
5 claimed:

6 (1) the computation for the amount due, with and
7 without prejudgment interest, or

8 (2) the reasons and facts explaining why no amount
9 is due, or why less than the amount claimed is due, including a
10 statement of what additional information is needed (if the reason
11 is insufficient information) and that the claimant must provide it
12 within forty-five (45) days from the date of the notice;

13 b. The total amount of retroactive benefits determined
14 due each year and the amount of prejudgment interest thereon;

15 c. The allocation of any amount due the provider
16 and/or the recipient;

17 d. A statement regarding withholding taxes; and

18 e. Advice about the right to a state hearing and the
19 procedures for obtaining one.

20 12. State hearing - Grant each claimant or authorized
21 representative a state hearing which conforms to the procedures set
22 forth in Welfare and Institutions Code § 10950 and
23 MPP § 22-000 et seq. to contest any adverse action regarding the
24 retroactive benefits.

25 D. Regulations

26 1. DSS shall provide petitioners' counsel with the text of
27 the proposed regulations thirty (30) days before filing them with
28 the Office of Administrative Law.

1 2. Respondents shall use their best efforts to issue
2 emergency regulations to implement this judgment.

3 E. Underpayment Claim Processing - DSS will take the following
4 steps to process underpayment claims WRO:

5 1. Set the WRO underpayment period from October, 1984
6 through September, 1985.

7 2. Revise the claim forms to specify underpayments for the
8 periods in subparagraph V.E.1 and to allow for claiming by month
9 for hours of each service.

10 3. Revise county worksheet to include documentation for
11 underpayment claims and calculations.

12 4. Issue Notice of Actions for underpayment claims
13 decisions.

14 5. Include all underpayment forms used in case file.

15 6. Develop a monthly reporting system for county and state
16 totals for underpayment applications, pending, approved, and
17 denied, and total underpayments.

18

19 VI. WRIT OF MANDATE FOR INDIVIDUAL PETITIONERS

20 Issue a peremptory writ of mandate pursuant to C.C.P. § 1085 on
21 behalf of Lorraine and Paul Jackson commanding respondent McMahon
22 and her successors in office to:

23 A. Take the necessary steps to obtain and process a claim for
24 retroactive benefits according to the procedures set forth in the
25 judgment. The CWD shall take steps to secure the relevant
26 information to process their claim, including contacting them.

27 B. Make a return to this writ within sixty (60) days from the
28 date the CWD has rendered a final decision on their claim.

1 VII. WRIT OF MANDATE FOR MONITORING COMPLIANCE WITH THE JUDGMENT

2 Let the writ of mandate issue pursuant to C.C.P. § 1085 on
3 behalf of the named petitioners and the class commanding
4 respondents to:

5 A. County Statistical Reports - Beginning with the third month
6 following the beginning of the claim period as contained in the
7 retroactive regulations and continuing for one (1) year, DSS shall
8 produce monthly statistical reports. These reports shall contain
9 the following information:

- 10 1. Number of claims received;
- 11 2. Number of claims denied;
- 12 3. Number of claims approved;
- 13 4. Number of claims pending;
- 14 5. Amount of benefits approved.

15 B. CMIPS Contractor Reports.

16 Respondents shall obtain from CMIPS Contractor a final report
17 by county that includes:

- 18 1. Number of claimants paid;
- 19 2. Total amount of retroactive benefits paid;
- 20 3. Number of underpayments paid;
- 21 4. Total amount of underpayments paid.

22 C. Case Reviews

23 1. Respondents shall provide petitioners' counsel with a
24 copy of the monitoring plan for case reviews at least 60 days
25 before it is implemented. The plan shall include:

26 a. The 15 counties to be reviewed. Based on the
27 monthly reports described above, the 15 counties shall be those
28

1 having the largest number of claims over the six month claiming
2 period;

3 b. The number of cases to be reviewed in each county
4 and the method used to select them;

5 c. The personnel who shall conduct the case reviews
6 and the training they shall receive;

7 d. The format for the results.

8 2. Respondents shall provide petitioners' counsel with
9 copies of all monitoring documents and all findings and make
10 available all documents generated as a result of any monitoring
11 activity.

12
13 VIII. RETENTION OF JURISDICTION

14 This court retains jurisdiction over this case for the
15 following:

16 A. Ensure Compliance

17 1. Ensure compliance with the judgment and make such
18 further orders as may be necessary therefor until DSS demonstrates
19 that it has complied with the judgment.

20 2. Require DSS to send class counsel a bimonthly status
21 report about all actions taken on the Judgment and include any
22 basic implementation records. The first report is due thirty (30)
23 days from the date of this Judgment.

24 3. Require DSS to include in contracts with other agencies
25 an accurate account of all transactions.

26 B. Attorney's Fees And Costs - Rule on any motion for
27 attorney's fees and any request for costs filed by petitioners or
28 their counsel for work after November 23, 1988. This Judgment

1 modifies any and all statutory or other time limits, including
2 C.C.P. § 1033.5 and California Rules of Court, Rule 870, for making
3 a claim for costs and/or attorney's fees.

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Dated: JUL 19 1991

MICHAEL I. GREER

JUDGE OF THE SUPERIOR COURT

jud2

WELFARE RIGHTS ORGANIZATION V. McMAHON CLAIM FORM

INSTRUCTIONS: Please print. Fill in as much information as you can. If you need help, call or go in to your county welfare department. Sign your name in Section ___ and have someone who knows you provided the services sign in Section ___.

REMEMBER: YOU MUST GET THIS CLAIM FORM TO THE COUNTY WELFARE DEPARTMENT BY _____ TO GET ANY MONEY.

1. Your name _____ Soc.Sec.No. _____ Telephone number _____

Current Address: (Number, Street) _____ Apt/Space No. _____

City _____ County _____ State _____ ZIP Code _____

2. Answer these questions by checking the box. These questions cover anytime from July 1, 1983 through September 10, 1984:

(a) Was your spouse 65 or older, blind or disabled and did he/she live in California? Yes No Unknown

(b) Did you go with your spouse to medical appointments ("medical transportation")? Or did you have to watch out that your mentally ill or confused spouse was not injured or harmed doing the normal daily activities ("protective supervision")? Yes No Unknown

(c) If you had not provided the services, might your spouse have received inadequate services or have been inappropriately placed somewhere other than his/her own home? Yes No Unknown

(d) Did you have to give up a job or could not get one because there was no other suitable person to provide the services? Yes No Unknown

(e) Did your spouse apply for or receive In Home Supportive Services (IHSS)? Yes No Unknown

If you answered yes to questions (a) through (d), and either "yes" or "unknown" to question (e), complete the rest of this form.

Address at time you provided protective supervision or medical transportation if different from your current address:

Number, Street: _____ Apt. or Space Number _____

City: _____ County: _____ State: _____ ZIP Code: _____

spouse you provided medical transportation and/or protective supervision to:

Name Social Security Number Telephone

Spouse's address if different from your current address:

Number, Street: Apt. or Space Number

City: County: State: ZIP Code:

. On the back of this form, list the months and hours you provided medical transportation and/or protective supervision for which you were not paid.

. I understand that the information provided above is subject to verification and that my signature on this form is an authorization for such investigation.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

Your signature: Date:

I, the undersigned, declare under penalty of perjury that the person in "3" above provided medical transportation and/or protective supervision (as described on this claim form) to the person named in "4" above.

Signature: Date:

Relationship to person named in "1": in "4":

Number, Street: Apt. or Space Number

City: County: State: ZIP Code:

INSTRUCTIONS:

Complete columns for the period July 1983 through September 1984.
 Fill in the information in the columns as follows:

Column 1 - Write the number of hours, if any, that you went with your spouse to his/her medical appointments (medical transportation), and were not paid.

Column 2 - Write the number of hours, if any, that you watched your spouse to prevent harm or injury (protective supervision), and were not paid?

Remember for protective supervision in column 2: The number of hours each month is the length of time you were home and your spouse, who was mentally ill or confused, and aged, blind or disabled, needing your care could be doing something that might get him/her hurt if left alone.

(Col. 1)

(Col. 2)

Year/Month	Number of hours each month you provided and were not paid for <u>medical transportation</u>	Number of hours each month you provided and were not paid for <u>protective supervision</u>
<u>1983</u>		
July		
August		
Sept.		
Oct.		
Nov.		
Dec.		
<u>1984</u>		
Jan.		
Feb.		
Mar.		
Apr.		
May		
June		
July		
Aug.		
Sept. 1-10		

READ THIS NOTICE: WE MAY OWE YOU MONEY FOR BACK WAGES
FROM JULY 1, 1983 THROUGH SEPTEMBER 10, 1984

WHY ARE YOU GETTING THIS NOTICE?

We did not pay all spouses for providing medical transportation or protective supervision to their aged, blind or disabled spouses from July 1, 1983 through September 10, 1984: In a lawsuit called Welfare Rights Organization v. McMahon, the court has told us to pay back wages for those services.

ARE YOU ELIGIBLE FOR BACK WAGES?

You may be eligible for back wages if you answer "yes" to these questions for anytime from July 1, 1983 through September 10, 1984:

1. Was your spouse 65 or older, blind or disabled and did he/she live in California?
2. Did you go with your spouse to medical appointments ("medical transportation")? Or did you have to watch out that your mentally ill or confused spouse was not injured or harmed doing the normal daily activities ("protective supervision")?
3. If you had not provided the services, might your spouse have received inadequate services or have been inappropriately placed somewhere other than his/her own home?
4. Did you have to give up a job or could not get one because there was no other suitable person to provide the services?

WHAT SHOULD YOU DO?

DO YOU THINK WE OWE YOU MONEY? Fill out the enclosed Welfare Rights Organization v. McMahon Claim Form as best you can. Take or mail the form to your local county welfare department office by _____.

ARE YOU UNSURE WHETHER WE OWE YOU MONEY? Fill out the claim form anyway. The county welfare department will help you with it.

DO YOU WANT MORE HELP OR HAVE ANY QUESTIONS? Call your local county welfare department or legal aid office. Ask about the WRO v. McMahon case.

YOU MAY HAVE ALREADY FILED A CLAIM IN MILLER V. WOODS. YOU MUST ALSO FILE THE WRO V. MCMAHON CLAIM FORM TO GET ANY MONEY FOR THE PERIOD FROM JULY 1, 1983 THROUGH SEPTEMBER 1, 1984.

REMEMBER: YOU MUST GET YOUR CLAIM FORM TO THE COUNTY WELFARE DEPARTMENT BY _____

ARE YOU IN A NURSING OR BOARD AND CARE HOME
BECAUSE YOU MIGHT GET HURT OR INJURED IF LEFT ALONE?

We did not pay all spouses for providing medical transportation or protective supervision to their aged, blind or disabled spouses from July 1, 1983 through September 10, 1984. You may have moved to a nursing or board and care home because you did not get these services.

In a lawsuit called Welfare Rights Organization v. McMahon, the court has told us to pay back wages to any spouse who provided these services.

IS YOUR SPOUSE ELIGIBLE TO BE PAID?

Your spouse may be eligible to be paid for providing you medical transportation or protective supervision if you answer "yes" to these questions for anytime from July 1, 1983 through September 10, 1984:

1. Were you 65 or older, blind or disabled, and did you live in California?
2. Did your spouse go with you to your medical appointments ("medical transportation")? Or did your spouse have to watch out that you did not injure or hurt yourself doing the normal daily activities because you were mentally ill or confused ("protective supervision")?
3. If your spouse had not provided the services, might you have received inadequate services or have been inappropriately placed somewhere other than your own home?
4. Did your spouse have to give up a job or could not get one because there was no other suitable person to provide you the services?

WHAT SHOULD YOU DO?

Call your local county welfare department or Legal Aid Office. Ask for more information about protective supervision and medical transportation under the IHSS program and the Welfare Rights Organization v. McMahon lawsuit.

If your spouse provided medical transportation or protective supervision between July 1, 1983 and November 10, 1984, ask the spouse to get the Welfare Rights Organization v. McMahon Claim Form from the county welfare department.

Will you be leaving the nursing or board and care home soon, or would you be able to do so if your spouse could provide medical transportation or protective supervision? Call your county welfare department.

REMEMBER: YOUR SPOUSE MUST GET THE CLAIM FORM TO THE COUNTY WELFARE DEPARTMENT BY _____.

INDEPENDENT LIVING CENTERS

Adult Independence Development
Center of Santa Clara County, Inc.
1190 Benton Street
Santa Clara, CA 95050
Santa Clara County
(408) 985-1243
Cheryl Cairns, Executive Director

C.A.P.H. ILC
1617 East Saginaw Way, Suite 109
Fresno, CA 93704
Fresno County
(209) 222-2274 (Voice)
(209) 222-2396 (TDD)
~~Doug Spates~~, Executive Director

Center for Independence of the
Disabled, Inc.
875 O'Neill Avenue
Belmont, CA 94002
San Mateo County
(415) 595-0783
Lucy Muir, Executive Director

Center for Independent Living
2539 Telegraph Avenue
Berkeley, CA 94704
Alameda County
(415) 841-4776
Michael Winter, Executive Director

Center for Independent Living
San Gabriel/Pomona Valley
2231 East Garvey Avenue
West Covina, CA 91790
Los Angeles County
(818) 339-1278
Denny Meehan, Executive Director

Community Rehabilitation Services
4716 Brooklyn Ave., Bldg. B, Rm. 75
Los Angeles, CA 90022
Los Angeles County
(213) 256-0453
Elsa Quezada, Executive Director

Community Resources for
Independence
915 Piner Road, Suite 5
Santa Rosa, CA 95401
Sonoma County
(707) 528-2745
Randy Kitch, Executive Director

Community Resources for Independent
Living, Inc.
25533 Jane Avenue
Hayward, CA 94544
Alameda County
(415) 881-5743
Ms. Johnnie Lacy, Executive Director

Community Service Center for the
Disabled
1295 University Avenue
San Diego, CA 92103
San Diego County
Bill Tainter, Executive Director
(619) 293-3500

Darrell McDaniel Independent Living
Center
14354 Haynes
Van Nuys, CA 91401
Los Angeles County
(818) 988-9525
Norma Vescovo, Executive Director

Dayle McIntosh Center for the
Disabled
8100 Garden Grove Blvd.
Garden Grove, CA 92644
Orange County
(714) 898-9571
(714) 532-1646 (Orange Office)
Brenda Premo, Executive Director

Disabled Resources Center, Inc.
1045 Pine Avenue
Long Beach, CA 90813
Los Angeles County
(213) 437-3543
Helene Pizzini, Executive Director

INDEPENDENT LIVING CENTERS

Disabilities Unlimited, Inc.
12458 Rives Avenue, Room 202
Downey, CA 90242
Los Angeles County
(213) 862-6531
Barbara Morrione, Executive Director

Good Shepherd Center for
Independent Living
4323 Laimert Blvd.
Los Angeles, CA 90008
Los Angeles County
(213) 295-8366
Gilbert Fernandez, Executive Director

Humboldt Access Project
712 Fourth Street
Eureka, CA 95501
Humboldt County
(707) 445-8404
Donna Janke, Interim Exec. Director

Independent Living Resource
Center
423 W. Victoria
Santa Barbara, CA 93101
Santa Barbara County
(805) 963-1359
Annette Rubino, Executive Director

Marin Center for Independent
Living
710 Fourth Street
San Rafael, CA 94901
Marin County
(415) 459-4011 (6245) X 320
Barbara Benson, Executive Director

Northern California Independent
Living Center
555 Pio Lindo Ave., Ste. B
Chico, CA 95926
Butte County
(916) 893-8527
Jorganne Cook, Int. Exec. Director

Resources for Independent Living
1230 H Street
Sacramento, CA 95814
Sacramento County
(916) 446-3074
Frances Gracechild, Executive Director

Rolling Start, Inc.
443 West Fourth Street
San Bernardino, CA 92401
San Bernardino County
(714) 884-2129
Don Vigil, Executive Director

Independent Living Resource Center-
San Francisco
4429 Cabrillo Street
San Francisco, CA 94121
San Francisco County
(415) 751-8765
Katherine Uhl, Executive Director

Westside Center for Independent
Living
12901 Venice Blvd.
Los Angeles, CA 90066
Los Angeles County
(213) 390-3611 Voice
(213) 398-9204 TDD
June Kailes, Executive Director

APPENDIX A-3

MULTIPURPOSE SENIOR SERVICES PROGRAM
SITE LOCATIONS

Multipurpose Senior Services Program
City of Oakland
659 14th Street
Oakland, CA 94612
(415) 273-3762

Multipurpose Senior Services Program
County of Santa Cruz
1777-A Capitola Road
Santa Cruz, CA 95062
(408) 425-2540

Multipurpose Senior Services Program
AltaMed
512 South Indiana Street
Los Angeles, CA 90063
(213) 263-2114

Multipurpose Senior Services Program
Jewish Family Service
330 North Fairfax Avenue
Los Angeles, CA 90036
(213) 937-5930

Multipurpose Senior Services Program
S.C.A.N. (Senior Care Action Network)
521 East Fourth Street
Long Beach, CA 90802-2502
(213) 437-6547 or (213) 436-0424

Multipurpose Senior Services Program
Mount Zion Pavilion
2356 Sutter Pavilion, 2nd Floor
San Francisco, CA 94115
(415) 885-7590

Multipurpose Senior Services Program
County of San Diego Area Agency on Aging
4165 Marlborough Avenue
San Diego, CA 92105
(619) 236-4330

Multipurpose Senior Services Program
Community Care Management Corporation
487 North State Street
Ukiah, CA 95482
(707) 468-9347

Multipurpose Senior Services Program
Humboldt Senior Citizens Council
1910 California Street
Eureka, CA 95501
(707) 443-9747

Multipurpose Senior Services Program
Area Agency on Aging
2nd and Normal Streets
California State University
Chico, CA 95929
(916) 895-5082

Multipurpose Senior Services Program
(Sonoma County Area Agency on Aging)
940 Hopper Lane
Santa Rosa, CA 95401
(707) 527-1147

Multipurpose Senior Services Program
(University of California, Davis)
1700 Alhambra Boulevard, Suite 203
Sacramento, CA 95816
(916) 453-5432

Multipurpose Senior Services Program
(County of San Mateo Department of
Health Services)
1860 El Camino Real, Suite 222
Burlingame, CA 94010
(415) 692-4500

Multipurpose Senior Services Program
Stanislaus County Department of Social Services
2125 Wylie Drive, Suite 1
Modesto, CA 95353
(209) 571-5792

Multipurpose Senior Services Program
(County of Santa Barbara)
505 West Morrison
Santa Maria, CA 93454
(805) 925-0990

Multipurpose Senior Services Program
Senior Care Network
Huntington Memorial Hospital
837 South Fair Oaks Avenue
Pasadena, CA 91105
(818) 356-3110

Multipurpose Senior Services Program
Senior Home and Health Care
County of San Bernardino
626 East Mill Street
San Bernardino, CA 92415
(714) 387-2434

Multipurpose Senior Services Program
County of Orange Community Services Agency
1300 South Grand, Building B
Santa Ana, CA 92705
(714) 834-8845

Multipurpose Senior Services Program
Watts Health Foundation, Inc.
2520 Industry Way, Suite D
Lynwood, CA 90262
(213) 632-0834

Multipurpose Senior Services Program
Council on Aging, Santa Clara County, Inc.
2131 The Alameda
San Jose, CA 95125
(408) 296-8290

Multipurpose Senior Services Program
Fresno County Department of Health
1221 Fulton Mall
Fresno, CA 93775
(209) 445-3339

Multipurpose Senior Services Program
San Joaquin County
511 East Magnolia, 3rd Floor
Stockton, CA 95202
(209) 468-3780

* Note: Site names enclosed in parenthesis () are not a part of the site's mailing address.

CALIFORNIA DEPARTMENT OF AGING
1600 K Street
Sacramento, CA 95814

(916) 323-6681

DIRECTORY OF CALIFORNIA LAW PROJECTS FOR THE ELDERLYPSA 1 - HUMBOLDT AND DEL NORTE COUNTIES

ROY SCHOENBERG
Senior Citizens Legal Services
1910 California Street
Eureka, CA 95501
(707) 443-9747

PSA 2 - SHASTA, TRINITY, MODOC, LASSEN
AND SISKIYOU COUNTIES

THOMAS M. WELSH
Senior Legal Center
P. O. Box 506
3015 South Market Street
Redding, CA 96099
(916) 243-3209

PSA 3 - BUTTE, PLUMAS, TEHAMA, GLENN
AND COLUSA COUNTIES

BARRIE ROBERTS
Legal Services of Northern California
P. O. Box 3728
Chico, CA 95927
(916) 345-9491

PSA 4 - PLACER COUNTY

RON ROGERS
Legal Services of No. California, Inc.
Motherlode Branch
190 Reamer
Auburn, CA 95603
(916) 823-7560 - (800) 822-6107

PSA 4 - SACRAMENTO COUNTY

JONATHAN ELLISON
Legal Center for the Elderly and Disabled
530 Bercut Drive, Suite G
Sacramento, CA 95814
(916) 446-4851

PSA 4 - YOLO COUNTY

CAROL GROSSMAN
Legal Center for the Elderly
933 Court Street
Woodland, CA 95695
(916) 662-1065

PSA 4 - YUBA AND SUTTER COUNTIES

SUSAN TOWNSEND
Yuba-Sutter Legal Center
725 "D" Street
Marysville, CA 95901
(916) 742-8289

PSA 5 - MARIN COUNTY

Senior Citizens Legal Project
710 "C" Street
San Rafael, CA 94901
(415) 454-0808

PSA 6 - SAN FRANCISCO COUNTY

ORAH YOUNG
Legal Assistance to the Elderly,
Inc.
333 Valencia Street
San Francisco, CA 94103
(415) 861-4444

WILLIAM TAMAYO
Asian Law Caucus
36 Waverly Place, Suite 2
San Francisco, CA 94108
(415) 391-1655

Mailing Address:
WILLIAM TAMAYO
Asian Law Caucus
1322 Webster, Suite 210
Oakland, CA 94612
(415) 835-1474

ILENE GUSFELD
Mission Community Legal Defense
2940 - 16th Street, Suite 3011
San Francisco, CA 94103
(415) 552-7208

PSA 7 - CONTRA COSTA COUNTY

MARCELINO VASQUEZ
 United Council of Spanish Speaking
 Organizations, Inc.
 516 Main Street
 Martinez, CA 94553
 (415) 229-2210

PSA 8 - SAN MATEO COUNTY

STEVE ZIEFF
 Senior Advocates
 298 Fuller Street
 Redwood City, CA 94063
 (415) 365-8411

PSA 9 - ALAMEDA COUNTY

DUNCAN FALLS
 Legal Assistance for Seniors
 1440 Broadway, Suite 206
 Oakland, CA 94612
 (415) 832-3040

PSA 10 - SANTA CLARA COUNTY

GEORGIA BACIL
 Senior Adults Legal Assistance
 160 E. Virginia Street, #250
 San Jose, CA 95112
 (408) 295-5991

PSA 11 - SAN JOAQUIN COUNTY

JOSE RAMIREZ
 Paralegal Services
 c/o Council for the Spanish Speaking
 142 South Aurora Street
 Stockton, CA 95202
 (209) 464-4576

PSA 12 - AMADOR COUNTY

JANETH HAGEN
 Senior Services, Inc.
 229 New York Ranch Road
 Jackson, CA 95642
 (209) 223-0442

PSA 12 - CALAVERAS COUNTY

FRANK MEYER
 California Human Development Corporation
 Box 1180
 San Andreas, CA 95249
 (209) 754-3987

PSA 13 - SANTA CRUZ COUNTY

TERRY HANCOCK
 Senior Citizens Legal Services
 343 Church Street
 Santa Cruz, CA 95060
 (408) 426-8824

PSA 14 - FRESNO COUNTY

MICHAEL J. KANZ
 Legal Aid for Seniors
 906 N Street
 Fresno, CA 93721
 (209) 441-1611

PSA 15 - TULARE AND KINGS COUNTIES

RANDALL LYONS
 Tulare-Kings Counties Legal
 Services
 900 W. Oak Street
 Visalia, CA 93277
 (209) 733-8770

PSA 16 - INYO AND MONO COUNTIES

LARRY STIDHAM
 Senior Citizens Legal Program
 See Vee Lane, P. O. Box 993
 Bishop, CA 93514
 (619) 873-3581

PSA 17 - SAN LUIS OBISPO COUNTY

JOEL DIRINGER
 JEANNIE BARRETT
 California Rural Legal Assistance
 1160 Marsh Street, Suite 204
 San Luis Obispo, CA 93401
 (805) 544-7994

PSA 17 - SANTA BARBARA COUNTY

DON KUHN
 Senior Citizens Law Center
 1032 Santa Barbara Street
 Santa Barbara, CA 93101
 (805) 966-4892

PSA 18 - VENTURA COUNTY

MICHAEL WILLIAMS
 Grey Law
 40 N. Fir Street
 Ventura, CA 93001
 (805) 653-0694

DRAFT

HANDBOOK BEGINS HERE

.1 Background

These regulations cover the retroactive payment and underpayment relief under an amended judgment in Welfare Rights Organization v. McMahon (WRO). Below is an overview of the case.

- .11 The case: The suit claimed that DSS did not promptly implement 1983 legislation authorizing spouse providers to be paid for protective supervision and travel to health related appointments, termed medical accompaniment. From July 1, 1981 to June 30, 1983, IHSS statutes prohibited paying spouse providers for these services. The legislation (Stats. 1983, ch. 232, section 116.7) required these services be paid from July 1, 1983 on.
- .12 Original judgment: The Superior Court (San Diego Co.) entered judgment in this case on November 23, 1988. Its implementation was delayed because of problems in implementing the original judgment in Miller I. No implementing regulations were issued for the original judgment.
- .13 Amended judgment: The Superior Court approved an amended judgment in this case on July 19, 1991. The modifications were based on the amended judgment in Miller II, approved by the court on July 19, 1991. The judgments contain consistent provisions insofar as practical. SDSS plans to implement the WRO and Miller II cases concurrently.
- .14 The class covered: The amended judgment applies to spouse providers as defined in Section 50-061.411 and spouse applicants/recipients as defined in Section 50-061.412.
- .15 Retroactive payments: Claimants may be eligible for retroactive payments from July 1, 1983 through September 30, 1984, plus prejudgment interest.
- .16 Underpayments: Claimants may be eligible for underpayments from October 1, 1984 through September 30, 1985. There is no prejudgment interest for underpayments.
- .17 Statutory maximums: Retroactive payments and underpayments are limited to the severely impaired (SI) or nonseverely impaired (NSI) maximum levels in effect at the time. In addition, such payments must also be reduced by any IHSS amounts authorized to the claimed recipient for any month in which WRO retroactive payments and/or underpayments are claimed.

The following provisions describe the procedures by which potential class members will be notified, claims for retroactive payments and underpayments will be processed, and payments due will be determined and paid.

HANDBOOK ENDS HERE

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. Mahon dated July 19, 1991, Case No. 531015.

Adopt New Section 50-061.2 to read:

.2 Notification of Potential Claimants

.21 In order to notify potential claimants, the Department shall:

.211 Send an Explanatory Flyer in English and Spanish, and a Provider Standard Claim Form in English, with instructions of how to obtain the Spanish version, to all past and present IHSS spouse providers contained on the IHSS Payroll System, from July 1, 1983 through November 30, 1988, who at any time during this period lived at the same address as the recipient. The Department will utilize the services of the Franchise Tax Board and Department of General Services to determine and mail to the most current mailing address available for providers identified in this manner.

.212 Provide each CWD with sufficient quantities of Standard Claim Forms, Supplemental Claim Forms, Explanatory Flyers, and 17" x 22" posters modeled after the Explanatory Flyers. Each of the above documents and posters will be in both English and Spanish.

(a) For WRO, there shall be a Provider Standard Claim Form, and a Provider Supplemental Claim Form.

(b) Provider claimants and recipient claimants shall use the same version of these forms.

.213 Provide those interested organizations and groups listed in Appendix A-1 through A-9 of the final judgment referred to in Section 50-061.11 with copies of the Standard Claim Forms, Explanatory Flyers, and the posters, with a request to display the posters in a prominent location and distribute the Explanatory Flyers and Standard Claim Forms on request throughout the claim period.

.214 Provide the Federal Social Security Administration offices in California with copies of the posters, in English and Spanish, and request that agency to display the posters throughout the claim period in prominent locations where there is public access.

.22 The claim period identified in this section shall be the eight month period from February 1, 1993 through September 30, 1993.

.23 In order to notify potential claimants, the CWDs shall:

.231 Place the posters described above in a prominent location in each local office having contact with the public throughout the claim period.

.232 Provide the Explanatory Flyer and Standard Claim Form to any person inquiring about eligibility for retroactive payments and/or underpayments for WRO v. McMahon.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

Adopt Section 50-061.3 to read:

.3 Application for Retroactive Payments and Underpayments

.31 Claimant Responsibilities

.311 The claimant shall cooperate in obtaining all information necessary to process the claim. Failure to provide the needed information shall result in the denial of the claim or of that portion of the claim for which the information is necessary.

.312 All claims for retroactive payments and underpayments shall be filed on a WRO v. McMahon claim form with the county welfare department in which the claimant currently resides.

.313 The claimant shall complete the claim form, sign the form under penalty of perjury, obtain the signature of a witness under penalty of perjury and mail or deliver the completed claim form to the CWD where she/he lives.

.314 The claim form shall be completed as stipulated in Sections 50-061.431 and .443, and hand-delivered by close of business or mailed and postmarked to the CWD by September 30, 1993. Claims hand-delivered or mailed and postmarked after this date shall be denied.

.315 If the claimant is sent a Notice of Action requesting the completion of either the Standard Claim Form or the Supplemental Claim Form, the claimant shall have forty-five (45) days from the date of the Notice of Action to complete and hand-deliver or mail the document to the CWD. Whenever the claimant must return a document or documents to the CWD within forty-five (45) days, the following shall apply:

(a) If mailed, the document(s) shall be postmarked by the last day of the forty-five (45) day period.

(b) If hand-delivered, the document(s) shall be delivered to the CWD no later than the close of business on the last day of the forty-five (45) day period.

(c) If required document(s) are not hand-delivered/mailed and postmarked within the time limits stated in this section, denial of the claim, or that portion of the claim for which the information is needed, shall result.

.316 Unless otherwise specified, all references to "days" in regard to time limits shall be construed to mean "calendar" days.

.32 County Welfare Department Responsibilities - Filing Date

- (a) The CWD shall date stamp the claim form when received. The CWD shall retain all claim forms and envelopes of any claims received for the WRO v. McMahon lawsuit.
- (b) The date of filing shall be the date postmarked on the envelope.
- (c) If the claim is filed in person at the CWD, the date of filing shall be the date received in the CWD office, e.g., the date stamped on the claim.
- (d) If the filing date cannot be determined as detailed above, the filing date shall be the date the claim was signed.
- (e) If the claim must be forwarded to another county for processing because the services were either provided or received in the second county, the first county's filing date shall apply.
- (f) If the date of filing on the Standard Claim Form is after September 30, 1993, the claim shall be denied.
- (g) If a Supplemental Claim Form, as described in Section 50-061.441, must be sent to the claimant, the filing date shall not change. The filing date shall remain that determined in accordance with Sections 50-061.32(a), (b), (c) and (d).
- (h) If the CWD receiving the claim determines that services were received or provided while the recipient/applicant lived in another county, for all or part of the claim period, the CWD shall:
 - (1) Send a copy of the claim to each affected county. The CWD shall also send a Notice of Action to the claimant within 10 calendar days of the filing date explaining that the correct CWD will process the claim for the period of time in which the services were provided/received in the other county.
 - (2) As noted in Section 50-061.32 (e) the filing date for the claim will be that determined by the first CWD receiving the claim.
- (i) The CWD shall determine eligibility/ineligibility and compute the retroactive payments and underpayments due within 45 days of the filing date or promptly after all necessary forms have been completed and received by the CWD. The CWD shall input this information into the Case Management Information and Payrolling System (CMIPS) so interest can be computed on approved cases and the computation returned to the CWD.
 - (1) The CMIPS shall compute the total retroactive payment and/or underpayment amount due, with and without interest and return the computation on a form developed by SDSS to the appropriate CWD within five working days from the date of CWD input.

- (j) Within 10 working days of receiving the computation from CMIPS, the CWD shall issue a Notice of Action to the claimant which contains the information specified in Section 50-061.631, and, if applicable, Sections 50-061.634 and .635. Once the CWD has issued the notice to the claimant, the CWD shall then send the necessary documents through the CMIPS so payment may be issued.
- (k) CWDs receiving claims forwarded from another county shall process the claim, determine eligibility, compute retroactive payments and/or underpayments, compute interest, issue the necessary Notice of Action and forward the necessary documents to the CMIPS within 45 days of receipt from the original county or promptly after all necessary forms are completed.
- (l) Time limits for CWDs specified in Section 50-061.32 may be exceeded in situations where completion of the determination of eligibility for retroactive payments and/or underpayments is delayed due to circumstances beyond control of the CWD. In these instances, the reason(s) for the delay(s) shall be documented in the affected claimant's case file.
- (m) Unless otherwise specified, all references to "days" for these time limits shall be construed as "calendar" days.

.33 Retroactive Payment and Underpayment Time Periods

.331 Eligibility for retroactive payments under WRO shall be limited to the following periods:

(a) July 1, 1983 through September 30, 1984 for claims in which the housemate was a spouse provider.

.332 Claims in which the period claimed is beyond the retroactive time period specified in Section 50-061.331(a) shall be processed as underpayments for the period October 1, 1984 through September 30, 1985.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

Adopt Sections 50-019.41, .42, .43, and .44 to read:

.4 Claim Processing

.41 Conditions for Class Membership

.411 IHSS spouse provider claimants may be eligible to receive retroactive payments and/or underpayments in WRO. Spouse provider claimants who are potentially eligible to receive these payments are persons who:

- (a) Were legally married to an individual meeting all applicable conditions stated in Section 50-061.412, and provided protective supervision and/or medical accompaniment services to that individual during the applicable retroactive payment and/or underpayment period specified in Section 50-061.33; or
- (b) Were considered to be a member of a married couple as defined for the purposes of SSI/SSP eligibility in 20 CFR 416.1806, lived with an individual meeting all applicable conditions stated in Section 50-061.412, and provided protective supervision and/or medical accompaniment services during the applicable retroactive payment and/or underpayment period specified in Section 50-061.33; and
- (c) Left full-time employment or was prevented from obtaining full-time employment because no other suitable provider was available, and
- (d) Needed to provide these services to their spouse, or inappropriate placement or inadequate care may have resulted, and
- (e) Were not compensated for providing protective supervision and/or medical accompaniment services for the month(s) claimed.

.412 IHSS recipient/applicant claimants potentially eligible to receive retroactive payments and/or underpayments are persons who:

- (a) Were California residents, aged, blind, or disabled during the applicable retroactive and/or underpayment period specified in Section 50-061.33 and met the eligibility conditions of MPP 30-755; and,
- (b) Required assistance during transportation to and from appointments with physicians, dentists and other health practitioners, where the recipient's presence was required at the destination, and/or

WELFARE RIGHTS ORGANIZATION V. MCMAHON
SUPPLEMENTAL CLAIM FORM

INSTRUCTIONS: Please print. Fill in as much information as you can. If you need help, call or go in to your county welfare department.

REMEMBER: You must complete this supplemental claim form and get it to the county welfare department before _____ to get any money.

1. Name of spouse providing protective supervision/medical transportation

Current Address: (Number, Street) Apt/Space No.

City County State ZIP Code

2. Name of spouse receiving protective supervision/med. transportation

Current Address: (Number, Street) Apt/Space No.

City County State ZIP Code

3. Did the person listed in #2 receive Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits (Gold Check) in any of the following years? Place an "X" below for each year in which SSI/SSP was received: _____ 1983 _____ 1984.

For each year(s) checked above, you may skip that same year(s) in questions 4 and 5 below.

4. List the average month income for yourself and your spouse for the following years: \$ _____ 1983 \$ _____ 1984.

5. Did you and your spouse have average liquid resources (cash, check or savings account, trust funds, checks or case safety deposit box, stocks or bonds, notes,) that were in excess of \$2250 during 1983 or 1984?

If yes, place an "X" below the year(s) in which the average monthly liquid resources of yourself and your spouse were more than \$2250? _____ 1983
_____ 1984

APPLICANT'S STATEMENT:

BE SURE YOU HAVE READ AND ANSWERED ALL THE QUESTIONS ABOVE.
READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING.

I understand that the information I put on this form may be verified and that my signature on this form is an authorization for such an investigation.

I, the undersigned, declare under penalty of perjury that the answers I have given are correct and true to the best of my knowledge.

Signature of applicant:

Date:

7. WITNESS' STATEMENT

Please have the person who can verify that the information you have provided is true and correct sign below.

I, the undersigned, declare under penalty of perjury that, to the best of my knowledge, the statements of the applicable made above are true and correct.

Signature of Witness:

Date:

Address:

City:

County:

State:

ZIP:

Relationship to applicant:

Relationship to person who received protective supervision or medical transportation:

- (c) Were nonself-directing, confused, mentally impaired, or mentally ill, and may have been hurt or injured if left alone, thus meeting the general conditions or requiring the service of protective supervision; and,
- (d) Received IHSS benefits, but were denied protective supervision services during the applicable retroactive payment and/or underpayment period solely because the provider was a spouse, and the amount of benefits was less than the severely impaired or nonseverely impaired maximum, as applicable at the time; and/or
- (e) Received IHSS benefits, but were denied medical accompaniment services during the applicable retroactive payment and/or underpayment period solely because the provider was a spouse, and the amount of benefits was less than the severely impaired or nonseverely impaired maximum, as applicable at the time; or
- (f) Applied for IHSS services during the applicable retroactive payment and/or underpayment period and were denied protective supervision services solely because the provider was a spouse; and/or
- (g) Applied for IHSS services during the applicable retroactive payment and/or underpayment period and were denied medical accompaniment services solely because the provider was a spouse; and,
- (h) Paid the spouse provider during the applicable retroactive payment and/or underpayment period for the provision of protective supervision and/or medical accompaniment services.

.42 Review of Class Membership Questions

.421 The CWD shall review the responses to the class membership qualifying questions in Part I, Section 2 of the Standard Claim Form.

- (a) The CWD shall issue a denial Notice of Action explaining that the claimant is not a WRO v. McMahon class member if the claimant did any of the following:
 - (1) The claimant answered "no" to 2A, or 2B, or 2E, or 2F;
 - (2) The claimant answered "no" to both 2C and 2D;
 - (3) The claimant answered "no" to both parts of 2G.

- (b) If the claimant answered "yes" to 2A, or 2B, or 2C, or 2D, or 2E, or 2F, or 2G, and the CWD has information available which contradicts the claimant's contention of class membership, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of this information. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.
- (c) If the claimant answered "unknown" to either questions in 2G, the CWD shall issue a Notice of Action and a WRO v. McMahon Supplemental Claim Form to the claimant. The claimant shall have 45 days from the date of the Notice of Action to complete the Supplemental Claim Form and return it to the CWD.

.43 Review of Information Contained on the Standard Claim Form

.431 The CWD shall review each Standard Claim Form submitted to determine if the claimant has provided the information necessary to further process the claim. For the purposes of this determination, a claim shall be considered complete when all the following requirements are met:

- (a) The following information requested in Part I, Section 1 is provided: claimant's name, social security number, and current address.
- (b) All qualifying questions in Part I, Section 2 are answered.
- (c) If Part I, Section 3 is applicable, the claimant's address at the time they claim to have provided/received protective supervision and/or medical accompaniment services.
- (d) The following information requested in Part I, Section 4 is provided: name of person whom it is claimed needed protective supervision and/or medical accompaniment; his/her current or last known address; and his/her relationship to the provider.
- (e) Part I, Section 5, is completed with date of marriage of claimant and spouse.
- (f) Part I, Section 6, is signed by the claimant and dated.
- (g) In Part I, Section 7, the Standard Claim Form is signed, dated, and the verifying witness' relationship to the claimant and the recipient is identified and this person's address is listed.
- (h) The information requested in Part II and Part III is provided, as applicable.

(i) The following information requested in Part IV is provided to support the application only if more than eight hours per month of medical accompaniment hours are claimed: the name of the health professional/health facility visited by the claimed recipient; location of origin and destination; type of transportation used; number of months/years visits took place; number of visits per month/year; and approximate duration of round-trip.

.432 If the CWD determines that Part I, or Part IV if applicable, of the Standard Claim Form has not been completely filled out in accordance with the criteria in Section 50-061.431, or if the claimant and a verifying witness have not signed and dated the form, the CWD shall send the claimant a Notice of Action specifying that portion of the form which is in need of completion. The Notice of Action shall also state that the claimant has 45 days from the date of the Notice of Action to submit the completed form to the CWD. If the completed form is not returned to the CWD within the 45 days, the claim shall be denied, and a denial Notice of Action shall be mailed to the claimant.

.433 Upon receipt of the information requested in Section 50-061.432, the CWD shall review the resubmitted information to determine if the claim is now complete in accordance with the criteria in Section 50-061.431. If complete, the CWD shall continue processing the claim.

(a) If the claim is still not complete because the claimant did not provide all the requested information, the CWD shall deny the claim.

.434 Failure on the part of the claimant to respond within the 45-day period shall result in denial of the claim.

.435 The CWD shall review Parts II, III, and IV of the Standard Claim Form to determine if claimed medical accompaniment hours for any month during the retroactive payment and underpayment claim periods exceed eight hours and if information submitted on Part IV of the form supports the hours claimed. The CWD shall use the medical accompaniment regulations to determine entitlement to medical accompaniment services.

HANDBOOK BEGINS HERE

Medical accompaniment regulations are contained in MPP Section 30-757.15.

HANDBOOK ENDS HERE

- (a) If the CWD determines that Part IV is incomplete or does not support the claim for more than eight hours of medical accompaniment for any month during the retroactive payment or underpayment claim periods, according to the standards set forth in Section 50-061.435, the CWD shall issue a Notice of Action for Adverse Information specifying that Part IV is in need of completion or requesting that the claimant support the hours claimed. The Notice of Action shall also state that the claimant has 45 days from the date of the Notice of Action to submit the completed section or provide the additional information, if available, to the CWD.
- (b) Failure on the part of the claimant to respond within the 45 day period shall result in denial of the unsupported portion of the claim.
- (c) If the CWD determines that the medical accompaniment hours claimed during the retroactive payment and underpayment period do not exceed eight hours, or if more than eight hours per month are adequately supported by information submitted on Part IV of the Standard Claim Form, the CWD shall continue processing the claim.

.44 Supplemental Claim Form

.441 The CWD shall issue a Supplemental Claim Form to the claimant whenever the CWD is unable to locate either a previously approved IHSS case record or a record of denial of IHSS eligibility. The purpose of the Supplemental Claim Form shall be to: (1) request information from the claimant regarding the claimed recipient's applying for and being denied IHSS during the retroactive payment period; and (2) determine whether the person claiming to have received protective supervision and/or medical accompaniment services met and would have met the income/resource eligibility requirements for IHSS services during the period claimed. The CWD shall include a Notice of Action with the Supplemental Claim Form stating that completion of the form is necessary in order to further determine eligibility for retroactive payments and underpayments and that the claimant must return the completed form to the CWD within 45 days.

- (a) If the CWD has no case record of an IHSS application and/or denial for the claimed recipient during the retroactive payment periods being claimed, the Notice of Action accompanying the Supplemental Claim Form shall request the claimant to complete all parts of the Supplemental Claim Form in accordance with the criteria in Section 50-061.443.
- (b) If the CWD has a case record showing the claimed recipient had applied for and was denied IHSS for the retroactive payment periods being claimed, but the CWD cannot determine from the case record whether the claimed recipient met IHSS income/resource eligibility criteria, the Notice of Action

accompanying the Supplemental Claim Form shall request the claimant to complete Parts I, III, IV of the Supplemental Claim Form, relating to income/resource eligibility for IHSS, in accordance with the criteria in Section 50-061.443.

(c) If the CWD has lost or destroyed its records or did not maintain adequate records during the claimed period, the CWD shall send the Supplemental Claim Form requesting completion of applicable parts of the form, in accordance with the criteria in Section 50-061.443.

.442 Upon receipt the CWD shall date stamp the submitted Supplemental Claim Form following the provisions of Section 50-061.32(a).

.443 The CWD shall review the submitted Supplemental Claim Form to ensure that all required questions are answered, all required information is provided, and that the form is signed and dated by both the claimant and a verifying witness. For the purposes of this determination, the Supplemental Claim Form shall be considered complete when the required sections are completed as specified in Section 50-061.441 and:

(a) The following information requested in Part I, Section 1 is provided: name and current or last known address of the spouse who claims to have provided protective supervision and/or medical accompaniment services during the months claimed.

(b) Part I, Section 2, the name and current or last known address of the spouse who claims to have received protective supervision and/or medical accompaniment services during the months claimed, is completed.

(c) If Part II is applicable, Sections 1 and 2 requesting information and documentation related to an IHSS application and/or denial for the person for whom it is claimed received protective supervision and/or medical accompaniment services during the months claimed, is completed.

(d) Part III, Sections 1, 2, and 3 relating to the (1) receipt of Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits by spouse named in Part I, Section 2; (2) combined monthly income for claimant and spouse; and (3) the amount of combined average monthly liquid resources in excess of \$2250 for claimant and spouse; during the years for which hours are claimed.

(e) Part IV of the Supplemental Claim Form is signed and dated by the claimant.

(f) Part IV, Section 2 is signed by a verifying witness, dated, with his/her address and relationship to the claimant completed.

.444 If the CWD determines that the Supplemental Claim Form is incomplete based on the criteria in Section 50-061.443, the CWD shall send a Notice of Action requesting the missing information and attach to the Notice a copy of the original Supplemental Claim Form submitted. The Notice of Action shall specify the section number of the form which is in need of completion and shall state that the claimant has 45 days from the date of the Notice of Action to submit the completed form or the claim will be denied.

(a) Upon receipt of the information requested in Section 50-061.444, the CWD shall review the submitted information to determine whether the Supplemental Claim Form is now complete in accordance with Section 50-061.443. If complete, the CWD shall continue with processing the claim. If the Supplemental Claim Form is still not complete, the CWD shall deny the claim.

.445 If the completed Supplemental Claim Form is not received from the claimant within the 45-day limit, the CWD shall deny the claim in accordance with Section 50-061.314.

.446 Information submitted by the claimant on the Supplemental Claim Form shall be presumed to be true as long as the form has been signed and dated by both the claimant and a witness, unless the CWD has information available which contradicts information supplied by the claimant. If the CWD has such information available and the CWD determines that information indicates the claimed recipient of protective supervision/medical accompaniment services would not have been eligible for IHSS, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the contradictory information. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015; and 20 CFR 416.1806.

Add Section 50-061.45 to read:

.45 Existing Case File and Information Requirement

- .451 The CWD shall determine if there is an existing case file with which to match claim information for determining eligibility.
- .452 In accordance with Section 50-061.44, if the CWD cannot locate a case file for the IHSS recipient/applicant for whom it is claimed protective supervision and/or medical accompaniment services were provided without IHSS compensation, or if the CWD cannot determine eligibility from the existing case file for the months claimed, the CWD shall send the Supplemental Claim Form to the claimant.
- .453 All information received and/or obtained in relation to the WRO v. McMahon court case, and all forms generated as a result of the court case, shall be retained by the CWD in a WRO case file for each claimant. These documents shall include, but not be limited to:
- (a) Completed Standard Claim Form and any subsequent resubmittals;
 - (b) Completed Supplemental Claim Form, if applicable, and any subsequent resubmittals and any documents submitted by the claimant in responding to the Supplemental Claim Form;
 - (c) Completed Eligibility Determination Worksheets, including documentation of retroactive payment and prejudgment interest calculations as well as underpayment calculations;
 - (d) A copy of any Notices of Action sent to the claimant;
 - (e) A copy of any correspondence with other CWDs in relation to the claim;
 - (f) All CMIPS documents; and,
 - (g) A copy of all other documents used in the determination of eligibility and computation of payments.
- .454 The CWD shall not require the claimant to provide information other than that requested on the Standard Claim Form and, if needed, the Supplemental Claim Form. However, the claimant shall be offered an opportunity, in the form of a Notice of Action for Adverse Information, to submit additional information that might rebut a possible denial based on CWD records. The CWD shall consider any additional information submitted by the claimant to support his/her claim.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

Adopt Section 50-061.46 to read:

.46 Presumptive Need For and Provision of Protective Supervision

- .461 If other information available to the CWD, including, but not limited to, previous or current IHSS casefiles, does not rebut the presumption of need for protective supervision, the person claiming to have needed protective supervision is presumed to have needed protective supervision for the months claimed during the applicable retroactive payment and/or underpayment period if:
- (a) A need for protective supervision was assessed at any time, in which case the need shall be from that time forward; or,
 - (b) The need for protective supervision is attested to by a sworn statement on the Standard Claim Form from the claimant and verified by a sworn statement of a witness. The CWD shall consider any other documentation submitted by the claimant to support the presumption of need for protective supervision.
- .462 The person claiming to have needed protective supervision is presumed to have received protective supervision services for the months claimed during the applicable retroactive payment and underpayment periods if the delivery of such services is attested to by a sworn statement from the claimant and verified by a sworn statement of a witness, contained on the Standard Claim Form, and other information available to the CWD, including, but not limited to, previous or current IHSS casefiles, does not rebut the presumption of delivery of protective supervision services.
- (a) The CWD shall presume that any protective supervision services provided and claimed were not provided voluntarily.
- .463 If information available to the CWD rebuts the presumption of either the need for or the delivery of protective supervision services during any of the months claimed during the applicable retroactive payment and underpayment period, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the contradictory information. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.
- .464 If the CWD's IHSS recordkeeping system shows no record of the claimed recipient ever applying for or being denied IHSS for the period being claimed, the CWD shall issue a Notice of Action requesting the claimant to complete an attached Supplemental Claim Form in accordance with Section 50-061.44. The claimant shall have 45 days from the date of the Notice of Action to submit the completed Supplemental Claim Form.

¡LEA ESTE AVISO!**ES POSIBLE QUE EL PROGRAMA DE SERVICIOS DE CASA Y CUIDADO
PERSONAL (IHSS) LE DEBA DINERO****¿POR QUE ESTAMOS PAGANDO SALARIOS RETROACTIVOS?**

Una corte nos ordenó pagar salarios retroactivos a ciertas personas en una demanda colectiva conocida como Welfare Rights Organization (WRO) vs. McMahon porque no pagamos "supervisión con fines de protección" o "acompañamiento médico" que se le dió a ciertas personas de edad avanzada, ciegas o incapacitadas en el Programa de IHSS, de julio de 1983 a septiembre de 1985. A este esfuerzo se le llama WRO.

¿REUNE USTED LOS REQUISITOS PARA RECIBIR SALARIOS RETROACTIVOS?

Es posible que usted reúna los requisitos si contesta "sí" a ambas preguntas #1 y #2, así como a la #3 o #4, con relación a cualquier tiempo de julio de 1983 a septiembre de 1985.

1. ¿Estuvo usted legalmente casado(a) o se consideraba casado(a) con una persona de edad avanzada, ciega o incapacitada en California, con la cual vivió y a la cual usted proporcionó cuidado?
2. ¿Recibió esa persona o solicitó IHSS?
3. ¿Cuidó usted de la persona en el hogar suyo para evitar lesiones porque la persona no tenía control de sí misma, estaba confundida, tenía impedimentos mentales, o enfermedades mentales, y pudo haberse lastimado a sí misma si se le hubiera dejado sola? (A esto le llamamos proporcionar "supervisión con fines de protección.")
4. ¿Acompañó a esa persona para ir y venir a las citas con el médico porque se necesitaba la ayuda suya? (A esto le llamamos "acompañamiento médico.")

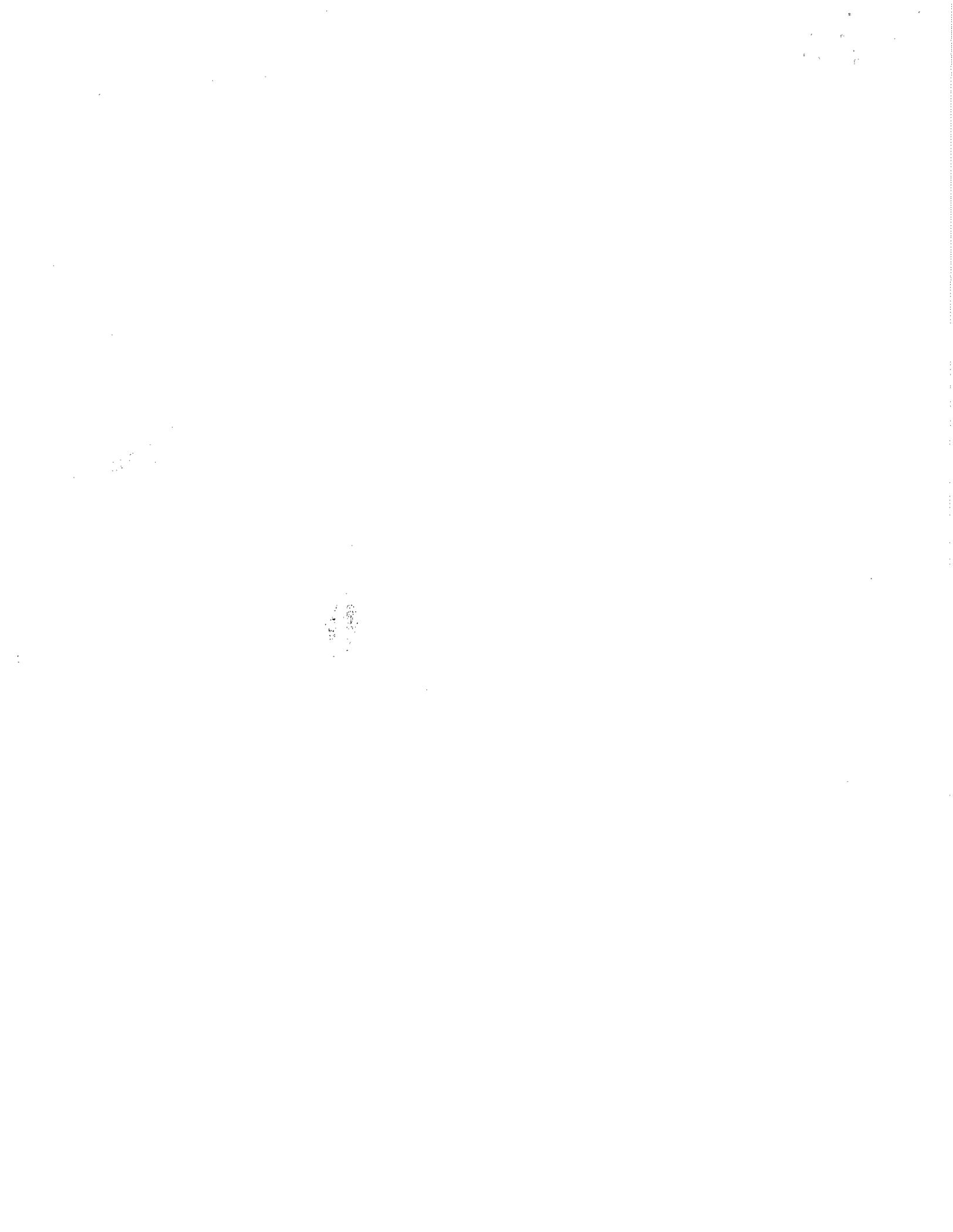
¿QUE DEBE HACER USTED?

Si contestó sí a ambas preguntas #1 y #2, así como a la #3 o a la #4, o no está seguro(a):

1. Llene la forma de reclamo WRO. Usted recibió una con esta notificación en el correo, o puede conseguir una en su departamento de bienestar del condado. Si necesita una forma de reclamo de WRO en español, por favor comuníquese con la Sección de IHSS en su departamento de bienestar del condado.
2. Presente la forma de reclamo WRO a más tardar el 30 de septiembre de 1993 a su departamento de bienestar del condado. Envíela o llévela ahora. Si la presenta tarde, usted no recibirá ningún dinero.

¿Necesita ayuda? Llame a su departamento de bienestar del condado u oficina de asesoramiento legal (*Legal Aid*) y pídale información con respecto al reclamo WRO.

LA FECHA TOPE PARA PRESENTAR EL RECLAMO ES EL 30 DE SEPTIEMBRE DE 1993. EL DEPARTAMENTO DE BIENESTAR DEL CONDADO TIENE QUE RECIBIR SU FORMA DE RECLAMO A MAS TARDAR EN ESTA FECHA O EL MATASELLOS DEL CORREO TIENE QUE MOSTRAR ESTA FECHA FINAL.



READ THIS NOTICE!
THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
MAY OWE YOU MONEY

WHY ARE WE PAYING BACK WAGES?

A court ordered us to pay back wages to certain persons in a lawsuit called Welfare Rights Organization (WRO) v. McMahon because we did not pay for "protective supervision" or "medical accompaniment" given to some aged, blind or disabled people in the IHSS Program from July 1983 through September 1985. This effort is called WRO.

ARE YOU ELIGIBLE FOR BACK WAGES?

You may be eligible if you answer "yes" to both questions #1 and #2, as well as #3 or #4, for any time from July 1983 through September 1985.

1. Were you legally married to, or did you consider yourself married to an aged, blind or disabled person in California with whom you lived and to whom you provided care?
2. Did that person receive or apply for IHSS?
3. Did you watch the person in your home to prevent injuries because that person was nonself-directing, confused, mentally impaired, or mentally ill, and may have hurt themselves if left alone? (We call this providing "protective supervision.")
4. Did you go with that person to and from medical appointments because your help was needed? (We call this "medical accompaniment").

WHAT SHOULD YOU DO?

If you answered yes to both #1 and #2, as well as #3 or #4, or are unsure:

1. Fill out the WRO claim form. You received one with this notice in the mail. Or, you can get one from your county welfare department. If you need a spanish WRO claim form, please contact the IHSS Section of your county welfare department.
2. File the WRO claim form by September 30, 1993 with your county welfare department. Mail or take it in now. If you file late, you will not get any money.

Need help? Call your county welfare department or legal aid office and ask about the WRO claim.

THE DEADLINE FOR FILING A CLAIM IS SEPTEMBER 30, 1993. YOUR CLAIM FORM MUST BE POSTMARKED OR RECEIVED BY THE COUNTY WELFARE DEPARTMENT BY THIS DATE.

LEA ESTA NOTIFICACION
ES POSIBLE QUE EL PROGRAMA DE SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS)
LE DEBA DINERO
¿POR QUE ESTAMOS PAGANDO SALARIOS RETROACTIVOS?

Una orden de la corte nos ordenó pagar salarios retroactivos a ciertas personas en una demanda colectiva llamada Welfare Rights Organization (WRO) vs. McMahon porque no pagamos "supervisión con fines de protección" o "acompañamiento médico" que se les dió a algunas personas de edad avanzada, ciegas o incapacitadas en el Programa de IHSS de julio de 1983 a septiembre de 1985. A este esfuerzo se le llama Miller II.

¿REUNE USTED LOS REQUISITOS PARA SALARIOS RETROACTIVOS?

Es posible que usted reúna los requisitos si contesta "sí" a ambas preguntas #1 y #2, así como ya sea a la #3 o a la #4, con respecto a cualquier tiempo entre julio de 1983 y septiembre de 1985.

1. ¿Estuvo legalmente casado(a) o se consideró casado(a) con una persona de edad avanzada, ciega o incapacitada en California con la cual vivió, y a la que le proporcionó cuidado?
2. ¿Recibió esa persona o solicitó IHSS?
3. ¿Cuidó usted de esa persona en el hogar suyo para evitar lesiones porque esa persona no tenía control de sí misma, estaba confundida, tenía impedimentos mentales o enfermedades mentales, y pudiera haberse lastimado si se le hubiera dejado sola (A esto le llamamos proporcionar "supervisión con fines de protección").
4. ¿Fue usted con esa persona a citas médicas porque se necesitaba la ayuda de usted? (A esto le llamamos "acompañamiento médico").

¿QUE DEBE HACER USTED?

Si usted contestó "sí" a ambas preguntas #1 y #2 y ya sea a la #3 o a la #4 o no está seguro(a):

1. Obtenga la forma de reclamo WRO de su departamento de bienestar del condado.
2. Entregue la forma de reclamo WRO a más tardar el 30 de septiembre de 1993 a su departamento de bienestar del condado. Envíela o llévela ahora. Si presenta la forma tarde, usted no recibirá ningún dinero.

¿Necesita ayuda? Llame a su departamento de bienestar del condado u oficina de asistencia legal (Legal Aid) y pregunte acerca del reclamo Miller II.

El plazo final para presentar la forma de reclamo es el 30 de septiembre de 1993. Su forma de reclamo tiene que mostrar esa fecha en el matasellos del correo, o que la reciba el departamento de bienestar del condado a más tardar en esa fecha.

READ THIS NOTICE THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MAY OWE YOU MONEY WHY ARE WE PAYING BACK WAGES?

A COURT ORDERED US TO PAY BACK WAGES TO CERTAIN PERSONS IN A LAWSUIT CALLED WELFARE RIGHTS ORGANIZATION (WRO) V. MCMAHON BECAUSE WE DID NOT PAY FOR "PROTECTIVE SUPERVISION" OR "MEDICAL ACCOMPANIMENT" GIVEN TO SOME AGED, BLIND OR DISABLED PEOPLE IN THE IHSS PROGRAM FROM JULY 1983 THROUGH SEPTEMBER 1985. THIS EFFORT IS CALLED WRO.

ARE YOU ELIGIBLE FOR BACK WAGES?

YOU MAY BE ELIGIBLE IF YOU ANSWER "YES" TO BOTH QUESTIONS #1 AND #2, AS WELL AS EITHER #3 OR #4, FOR ANY TIME FROM JULY 1983 THROUGH SEPTEMBER 1985.

1. WERE YOU LEGALLY MARRIED TO, OR DID YOU CONSIDER YOURSELF MARRIED TO AN AGED, BLIND OR DISABLED PERSON IN CALIFORNIA WITH WHOM YOU LIVED AND TO WHOM YOU PROVIDED CARE?
2. DID THAT PERSON RECEIVE OR APPLY FOR IHSS?
3. DID YOU WATCH THAT PERSON IN YOUR HOME TO PREVENT INJURIES BECAUSE THAT PERSON WAS NONSELF-DIRECTING, CONFUSED, MENTALLY IMPAIRED OR MENTALLY ILL AND MAY HAVE HURT THEMSELF IF LEFT ALONE? (WE CALL THIS PROVIDING "PROTECTIVE SUPERVISION")
4. DID YOU GO WITH THAT PERSON TO AND FROM MEDICAL APPOINTMENTS BECAUSE YOUR HELP WAS NEEDED? (WE CALL THIS "MEDICAL ACCOMPANIMENT").

WHAT SHOULD YOU DO?

IF YOU ANSWERED "YES" TO BOTH QUESTIONS #1 AND #2 AND EITHER #3 OR #4, OR ARE UNSURE:

1. GET THE WRO CLAIM FORM FROM YOUR COUNTY WELFARE DEPARTMENT.
2. FILE THE WRO CLAIM FORM BY SEPTEMBER 30, 1993 WITH YOUR COUNTY WELFARE DEPARTMENT. MAIL OR TAKE IT IN NOW. IF YOU FILE LATE, YOU WILL NOT GET ANY MONEY.

NEED HELP? CALL YOUR COUNTY WELFARE DEPARTMENT OR LEGAL AID OFFICE AND ASK ABOUT THE WRO CLAIM.

THE DEADLINE FOR FILING A CLAIM IS SEPTEMBER 30, 1993. YOUR CLAIM FORM MUST BE POSTMARKED OR RECEIVED BY THE COUNTY WELFARE DEPARTMENT BY THIS DATE.

Adopt Section 50-061.64 to read:

.64 State Hearings

.641 The right to a state hearing on any WRO v. McMahon claim shall be granted only to WRO v. McMahon claimants or their authorized representatives.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

Adopt Section 50-061.65 to read:

.65 Treatment of Lump Sum Payments in the IHSS Program

.651 It shall be the responsibility of the CWD to determine if the lump sum WRO v. McMahon retroactive payments and underpayments affect or does not affect the continued eligibility of all WRO v. McMahon claimants who are currently IHSS recipients.

.652 WRO v. McMahon payments shall be disregarded for IHSS financial eligibility determinations for the month of receipt and the following month. Any remaining balance from the WRO v. McMahon payments shall be counted as a resource in the second month following the month of receipt.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

.8 Appendix - WRO Forms

.81 The following forms are to be used to process WRO claims:

- (1) Poster - 2041 (Eng/Sp) (11/92)
- (2) Explanatory Flyer - 2040 (Eng/Sp) (11/92)
- (3) Standard Claim Form - 2007 (Eng/Sp) (11/92)
- (4) Supplemental Claim Form - 2006 (Eng/Sp) (11/92)
- (5) Underpayment Worksheet - 2008 (11/92)
- (6) Retroactive Worksheet - 2009 (11/92)

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

Adopt Sections 50-061.7 and .8 to read:

.7 Monitoring CWD Compliance

.71 County Statistical Reports

.711 Beginning February 1, 1993 and continuing until an eligibility determination has been made on each claim received, the SDSS shall compile a monthly report on retroactive payment claims and a separate monthly report on underpayment claims. The reports shall contain the following information:

- (a) The number of claims received;
- (b) The number of claims denied;
- (c) The number of claims approved;
- (d) The number of claims pending; and,
- (e) The amount of payments approved.

.72 Final Report

.721 SDSS shall obtain from the CMIPS a final report, by county, that includes the following:

- (a) The number of claimants paid;
- (b) The total amount of retroactive payments;
- (c) The number of underpayments paid; and,
- (d) The total amount of underpayments paid.

.73 Case Reviews

.731 Based on the quarterly reports, SDSS shall determine the fifteen (15) counties having the largest number of claims over the eight-month period.

.74 County Cooperation

.741 Each CWD shall cooperate with SDSS in providing information deemed necessary to monitor county compliance with the provisions of these regulations and the WRO v. McMahon final judgment.

(a) If the claimant does not respond within the 45 days and provide information to rebut the CWD's contradictory information, the CWD shall issue a Final Notice of Action denying the claim for the months of ineligibility.

.634 For each claim denied, the Notice of Action shall clearly state the reason(s) for each period claimed and denied.

.635 For each approved claim in which the claimant is currently an IHSS recipient, the Notice of Action shall advise the claimant that the payment received as a result of his/her WRO v. McMahon claim may adversely affect his/her IHSS, SSI eligibility or other aid program eligibility and tax liability.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

.63 Notices of Action

.631 For each claim received for retroactive payments and underpayments, the CWD shall issue a final Notice of Action. The Notice of Action shall contain the following information:

- (a) The month(s) determined eligible and/or ineligible for retroactive payments and/or underpayments. The reason(s) for any months determined ineligible shall be clearly stated;
- (b) The amount of retroactive payments due for each month, which shall be shown with and without interest;
- (c) The amount of retroactive payments and interest due for each year, if payments are claimed for more than one year;
- (d) The total retroactive payments due and the total amount of interest due;
- (e) The combined amount of retroactive payments and interest due;
- (f) The amount of underpayments due for each month, for each year if payments are claimed for more than one year, and the total underpayments due;
- (g) A statement regarding withholding taxes;
- (h) A statement regarding the claimant's right to a State Hearing on WRO v. McMahon determinations made by the CWD and information on how to request such hearings;
- (i) The final Notice of Action approving or denying WRO claims for medical accompaniment shall specify the exact amount of and reason for adjusted hours, if any, for the service of medical accompaniment.

.632 Each Notice of Action issued due to the claimant's failure to complete either the Standard Claim Form or Supplemental Claim Form in its entirety shall specify those sections of the form in need of completion.

.633 Each Notice of Action as a result of the CWD having contradictory information shall include a copy of the information and shall advise the claimant that he/she has 45 days from the date of the Notice of Action to provide additional information, if available, or the claim shall be denied.

Adopt Section 50-061.62 to read:

.62 Prejudgment Interest

.621 Prejudgment interest for retroactive payments only shall be calculated at the following rate:

(a) Ten percent for the period July 1, 1983 through September 30, 1985.

.622 The interest shall be computed on the amount of the monthly payment up through the last day of the month following the month in which payment is authorized.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

Adopt Section 50-061.61 to read:

.6 General Provisions

.61 Share of Cost

.611 The CWD shall not consider any recipient share of cost when computing the amount of retroactive payments and/or underpayments due.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

Adopt Section 50-061.58 to read:

.58 IHSS Statutory Maximum During Retroactive Payment and Underpayment shall be:

<u>Effective Date</u>	<u>NSI</u>	<u>SI</u>
<u>7/1/83 --- 6/30/84</u>	<u>\$604</u>	<u>\$872</u>
<u>7/1/84 --- 6/30/85</u>	<u>\$638</u>	<u>\$921</u>
<u>7/1/85 --- 8/31/86</u>	<u>\$674</u>	<u>\$974</u>

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015; and Sections 12300, 12303.5, 12304, Welfare and Institutions Code.

.57 Calculating the Actual Underpayments - Claims With and Without IHSS Case Records

.571 The CWD shall use Section 50-061.54 for the calculation of underpayments for claims with an IHSS case record, and are otherwise eligible to receive underpayments.

.572 The CWD shall use Section 50-061.55 to calculate underpayments for claims with no IHSS case record, and are otherwise eligible to receive underpayments.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015; and Sections 12300, 12303.5, 12304, 12304.5, Welfare and Institutions Code.

(3) Underpayments due shall not be subject to prejudgment interest.

.554 After completion of calculations for retroactive payments and/or underpayments, the CWD claim processor and his/her immediate supervisor shall sign and date the appropriate worksheet at the space provided.

.56 The CWD shall use the WRO v. McMahon Underpayment Eligibility Determination Worksheet to document all determinations for underpayment claims which were determined eligible for retroactive payments. Information from the Standard Claim Form, Retroactive Payment Eligibility Determination Worksheet, and Supplemental Claim Form and case record, where available, shall be used to complete the worksheet.

.561 The CWD shall record the claimed provider's and recipient's names, social security numbers, and case number, at the top of Part I.

.562 The CWD shall determine the claimant's eligibility for retroactive payments by reviewing the Retroactive Payment Eligibility Determination Worksheet, and shall document these findings on Part I, step #1 and #2, of the worksheet.

(a) If the claimant is not eligible for retroactive payments under WRO, the CWD shall deny the claim for underpayments.

(b) If the claimant is eligible for retroactive payments under WRO, the CWD shall determine if the claimant is eligible for retroactive payments through the end of the retroactive period, September 30, 1984.

(1) If the claimant is not eligible for retroactive payments through the end of the retroactive period, September 30, 1984, the CWD shall deny the claim for underpayments.

(2) If the claimant is eligible for retroactive payments through the end of the retroactive payment period of September 30, 1984, the CWD shall proceed to step #3 of the worksheet.

.563 The CWD shall determine if there is an IHSS case record for the claim.

(a) If there is no case record, CMIPS shall calculate underpayments using nonseverely impaired maximums.

(b) If there is a case record, CMIPS shall calculate underpayments at the appropriate maximums, subtracting payment amounts for previously authorized IHSS services.

.552 Part II, Section A of the appropriate worksheet shall be utilized to record hours of protective supervision and/or medical accompaniment hours claimed, adjusted medical accompaniment hours as determined by the CWD, and total adjusted hours claimed, as described in Section 50-061.542(a) through (e).

.553 For each claim in which the CWD has either located a record of IHSS denial or the CWD has been unable to locate a case record and eligibility for IHSS has been established by the responses on the Supplemental Claim Form, the CWD shall use Part II, Section B of the appropriate worksheet to calculate and document the payments due for each month as follows:

(a) A determination of whether the claimant is "class eligible," as indicated on Part I, step #2, shall be entered for each eligible month in Column 2.

(b) The number of hours claimed as entered in the first and fourth columns of Part II, Section A, shall be entered in the appropriate space in Column 3.

(c) The dollar amount claimed, which shall be determined by multiplying the number of hours claimed by the CWD's lowest individual provider hourly wage rate during the period claimed, shall be calculated by CMIPS in Column 4.

(d) The applicable nonseverely impaired statutory maximum, as specified in Section 50-061.58 shall be calculated by CMIPS in Column 6.

(1) The CWD shall use the applicable nonseverely impaired statutory maximum to calculate payments for all eligible cases in which: the CWD has no record of denial or the case record could not be located; eligibility has been established through the Supplemental Claim Form; and available evidence does not clearly show recipient need at the severely-impaired level. The CWD shall enter the appropriate impairment level in Column 7.

(e) The total retroactive payment and/or underpayments due, which shall be the amount claimed, as specified in Section 50-061.543(c) and entered in Column 4, provided the amount claimed for any month does not exceed the applicable nonseverely impaired statutory maximum during the month claimed, shall be calculated by CMIPS in Column 9.

(1) The total payments due shall be limited to the applicable nonseverely impaired statutory maximum amount during the month claimed.

(2) Claimants entitled to retroactive payments shall also be entitled to prejudgment interest.

- (1) If the case record indicates that the IHSS recipient was severely impaired, CMIPS shall calculate payments using the applicable severely impaired maximums. If the case record indicates that the IHSS recipient was nonseverely impaired, CMIPS shall calculate payments using the applicable nonseverely impaired maximums. The CWD shall enter the appropriate impairment level in Column 7.
- (f) The applicable statutory maximum, as specified in Section 50-061.58 minus the amount originally authorized, as entered in Column 5, shall be calculated by CMIPS in Column 8.
- (g) Total retroactive payments and/or underpayments due shall be calculated by CMIPS in Column 9.
- (1) For those claims in which it has been established from the case record that the person who is claimed to have received protective supervision services was an IHSS recipient, the total retroactive payments and/or underpayments due shall be the lesser of the following:
- (A) The difference between the applicable statutory maximum, as specified in Section 50-061.58 and the amount originally authorized, as entered in Column 5, or
- (B) The amount claimed, as entered in Column 4.
- (2) Claimants entitled to retroactive payments shall also be entitled to prejudgment interest.
- (A) CMIPS shall calculate the amount of prejudgment interest due based on the amount of retroactive payments present in Column 9.
- (3) Underpayments due shall not be subject to prejudgment interest.

.544 After completion of calculations for retroactive payments and/or underpayments, the CWD claim processor and his/her immediate supervisor shall sign and date the appropriate worksheet at the space provided.

.55 Calculating the Actual Retroactive Payments and/or Underpayments -Denied and No Record Cases

.551 Parts II, III, and IV of the Standard Claim Form, and the case record and the Supplemental Claim Form, if used, shall be utilized to calculate retroactive payments and underpayments due on the Retroactive Payment Eligibility Determination Worksheet and the Underpayment Eligibility Determination Worksheet. The CWD shall use the appropriate worksheet to calculate retroactive payments and underpayments if the claimant is found eligible.

(c) Medical accompaniment hours claimed shall be adjusted by the CWD when the monthly amount of medical accompaniment hours claimed are more than eight hours per month, and are not supported by information submitted on Part IV of the Standard Claim Form or other information submitted by the claimant.

(d) The CWD shall review all information submitted by the claimant in response to the Notice of Action for Adverse Information regarding claims for medical accompaniment hours which exceed eight hours per month. The CWD may use the medical accompaniment regulations contained in MPP Section 30-757.15, to determine the correct assessment for this service if the claimant is determined eligible for retroactive payments for this service. The CWD shall enter the adjusted figure for medical accompaniment hours claimed in the third column of Part II, Section A, of the appropriate worksheet.

(e) The CWD shall enter total medical accompaniment hours, after adjustment if applicable, for each month claimed, in the fourth column of Part II, Section A, of the appropriate worksheet.

.543 For each claim in which IHSS eligibility during the applicable retroactive payment and/or underpayment periods has been established by the findings in the case record, the CWD shall use Part II, Section B of the appropriate worksheet to calculate and document the payments due for each month as follows:

(a) A determination of whether the claimant is "class eligible," as provided on Part I, step #2, shall be entered for each eligible month in Column 2.

(b) The number of hours claimed as entered in the first and fourth columns of Part II, Section A, shall be entered in the appropriate space in Column 3.

(c) The dollar amount claimed, which shall be determined by multiplying the number of hours claimed by the CWD's lowest individual provider hourly wage rate during the period claimed, shall be calculated by CMIPS in Column 4.

(d) The amount of payment the IHSS recipient was originally authorized during the applicable retroactive payment and/or underpayment period shall be entered by the CWD, from the case record, in Column 5.

(e) The applicable statutory maximum as specified in Section 50-061.58 shall be entered by CMIPS in Column 6.

(b) If the claimant's response on Part III, Sections 2 and 3, of the Form indicate that the IHSS income/resource eligibility requirements would not have been met during the period claimed, the CWD shall deny the claim for those period(s) of ineligibility, document the reason for denial, and then proceed to Section 50-061.55 for any remaining period(s) of eligibility.

(c) If the claimant's responses on Part III, Sections 2 and 3, of the Form indicate that the IHSS income/resource eligibility requirements would have been met during the period claimed, but the CWD obtains information which contradicts that supplied by the claimant, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the contradictory information. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.

.533 If the claimant fails to return the completed Supplemental Claim Form to the CWD within 45 days from the date of the Notice of Action, the CWD shall deny those months in which the IHSS eligibility could not be established. If there are any remaining months of potential eligibility, the CWD shall determine eligibility and shall proceed, as applicable, to Section 50-061.55.

.54 Calculating the Actual Retroactive Payments and Underpayments - IHSS Case Record For Period Being Claimed

.541 Parts II, III, and IV of the Standard Claim Form and information from the case record, if available, shall be utilized to calculate retroactive payments and underpayments due on the Retroactive Payment Eligibility Determination Worksheet and the Underpayment Eligibility Determination Worksheet. The CWD shall use the appropriate worksheet to calculate retroactive payments and underpayments if the claimant is found eligible.

.542 Part II, Section A of the appropriate worksheet shall be utilized to record hours of protective supervision and/or medical accompaniment hours claimed, adjusted medical accompaniment hours as determined by the CWD, and total adjusted hours claimed.

(a) Total protective supervision hours, if claimed, shall be entered in the first column of Part II, Section A, of the appropriate worksheet, for each month claimed.

(b) Medical accompaniment hours claimed, if the claimant is determined eligible to be paid for medical accompaniment upon review of Part IV of the Standard Claim Form by the CWD, shall be entered in the second column of Part II, Section A, of the appropriate worksheet, for each month claimed.

days from the date of the Notice of Action to provide additional information if available. The CWD shall process the claim for any remaining month(s) of eligibility, pending the receipt of a response from the claimant.

.523 Determine from the case record whether the IHSS recipient was receiving the statutory maximum payment, as described in Section 50-061.58, during any eligible month(s) claimed. Check the appropriate response on step #6 of the worksheet.

(a) For any eligible month(s) claimed in which the IHSS recipient was receiving the statutory maximum payment, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the relevant information from the case record. The claimant shall have 45 days from the date of the Notice of Action to provide additional information regarding their level of authorized hours, if available.

(b) The CWD shall proceed to Section 50-061.54 and determine if there are any remaining month(s) in which the case was not authorized the statutory maximum.

.524 Determine from the case record whether the claimed IHSS recipient was severely impaired (SI) or nonseverely impaired (NSI) and check the appropriate response on step #7 of the worksheet.

.53 In determining eligibility for those claims in which the claimed recipient of protective supervision and/or medical accompaniment was denied IHSS during the month(s) claimed, the CWD shall complete step #8 of the Retroactive Payment Eligibility Determination Worksheet, locate the record of denial, and follow the procedures in Sections 50-061.521 and .522. The CWD shall proceed to Section 50-061.55 for instructions to complete the calculation of net payments on WRO claims in which an IHSS case had been denied and the WRO claimant is determined eligible for payments.

.531 If the CWD is unable to determine from the record the reason for denial of IHSS during either the entire or partial period claimed, the CWD shall issue a Notice of Action and a Supplemental Claim Form to the claimant to establish whether the claimed recipient of protective supervision and/or medical accompaniment would have met the income/resource eligibility requirements for IHSS. The claimant shall have 45 days from the date of the Notice of Action to complete the Supplemental Claim Form and return it to the CWD, or the claim shall be denied.

.532 Upon the CWD's receipt of the completed Supplemental Claim Form, for denied IHSS cases, the CWD shall check the appropriate responses on Part I, steps #9 through #11 of the worksheet. The CWD shall proceed to Section 50-061.55 if:

(a) The claimant's responses on Part III, Sections 2 and 3 of the form indicate that the IHSS income/resource eligibility requirements would have been met during the period claimed.

- (a) If there is a record of approval or denial the CWD shall:
 - (1) proceed to step #4 of the worksheet if there is a record of approval for IHSS.
 - (2) proceed to step #8 of the worksheet if there is a record of denial for IHSS.
- (b) If there is no IHSS case record, the CWD shall send the claimant a Supplemental Claim Form.

.52 In determining eligibility for those claims in which the CWD has verified by case record that the claimed recipient of protective supervision and/or medical accompaniment services was authorized IHSS during the month(s) claimed, the CWD shall do the following, using the Retroactive Payment Eligibility Determination Worksheet, Part I, steps #4 through #7:

.521 Determine whether the case record indicates that protective supervision and/or medical accompaniment services were denied during the month(s) claimed for a reason other than because a spouse was providing the service, and check the appropriate response on step #4 of the worksheet.

- (a) If, for any month(s) claimed, the case record indicates that the denial was based on a reason other than the provision of protective supervision and/or medical accompaniment by the spouse, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the information which indicates the reason for denial of protective supervision. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available. The CWD shall process the claim for any remaining month(s) of eligibility, pending receipt of a response from the claimant.

.522 Determine whether any information exists outside the case record which indicates that protective supervision and/or medical accompaniment services were denied during the month(s) claimed for any reason other than those services were provided by the spouse, and check the appropriate response on step #5 of the worksheet. Information outside the case record may consist of, but not be limited to, the CWD's knowledge of the IHSS recipient's placement in a state hospital or other type of out-of-home care during the month(s) claimed.

- (a) If, for any month(s) claimed, information exists outside the case record, as described in Section 50-061.522, the CWD shall document the reason on the provided space on the worksheet, issue a Notice of Action for Adverse Information, and attach a copy of the information which indicates the reason for denial of protective supervision and/or medical accompaniment. The claimant shall have 45

Adopt Sections 50-061.51, .52, .53, .54, .55, .56, and .57 to read:

.5 Use of County Worksheets to Document Findings and Calculate Payments Due.

.51 The CWD shall use the WRO v. McMahon Retroactive Payment Eligibility Determination Worksheet to document all determinations made on each claim submitted. Information from the Standard Claim Form, and the Supplemental Claim Form and case record, where available, shall be used to complete the worksheet.

.511 The CWD shall record the claimed provider's and recipient's names, social security numbers, and case number, at the top of Part I of the worksheet.

.512 The CWD shall determine the claimed recipient's eligibility for class membership by reviewing the claimant's response on Part I, Section 2 of the Standard Claim Form, and shall document these findings on step #1 of the worksheet

(a) If the claimant answered "yes" to questions 2A, and 2B, and 2E, and 2F, and either 2C or 2D of the Standard Claim Form, the CWD shall proceed to step #2 of the worksheet.

(b) If the claimant answered "no" to questions 2A, or 2B, or 2E, or 2F, or both 2C and 2D the CWD shall issue a denial Notice of Action explaining that the claimed recipient is not a WRO class member.

.513 The CWD shall determine if the claimed recipient applied for or was denied IHSS during the retroactive claim period by reviewing the claimant's response on Part I, Section 2, question 2G, of the Standard Claim Form, and shall document this finding on step #2 of the worksheet.

(a) If the claimant answered "yes" to either part of question 2G of the Standard Claim Form, the CWD shall proceed to step #3 of the worksheet.

(b) If the claimant answered "no" to both parts of question 2G of the Standard Claim Form, the CWD shall issue a denial Notice of Action.

(c) If the claimant answered "unknown" to either part of question 2G, the CWD shall attempt to locate the case record, or record of denial. If neither can be located, the CWD shall send a Supplemental Claim Form to the claimant.

.514 The CWD shall determine if there is any record of an IHSS approval or denial, and shall document this finding on step #3 of the worksheet.

Adopt Section 50-061.48 to read:

.48 Eligibility for Underpayments

.481 WRO claims shall be eligible for underpayment consideration only if their eligibility for WRO retroactive payments extended through the end of the retroactive payment claim period, September 30, 1984.

(a) Claimants shall have their WRO claim for underpayments denied if their eligibility for retroactive payments does not extend through the end of the WRO retroactive payment claim period, September 30, 1984. Their WRO claim for underpayments shall be denied with a Notice of Action stating the reason for the denial.

HANDBOOK BEGINS HERE

(b) Eligibility for underpayments in WRO results from IHSS cases or WRO cases carried through the effective date of the corrected spouse provider regulations, MPP 30-763.214(f), September 1984. Potentially eligible cases are those that were not corrected as of the effective date of the revised regulations. Claims or underpayments in which there was not an active case requiring updating to reflect the housemate regulations shall be denied, with the expectation of approved WRO claimants whose eligibility extends through the end of the retroactive claim period.

HANDBOOK ENDS HERE

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgement regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

- (a) If the claimant does not submit the Supplemental Claim Form within the 45-day period, the claim shall be denied.
- (b) If the claimant submits the Supplemental Claim Form, and it is complete based on criteria contained in Section .443, the CWD shall continue processing the claim.
- (c) If the submitted Supplemental Claim Form is incomplete based on criteria contained in Section 50-061.443, the CWD shall follow instructions in Section 50-061.444.
- (d) If the CWD determines that information supplied by the claimant verifies that the claimed recipient did in fact apply for and was denied IHSS during the retroactive payment period being claimed, the CWD shall continue processing the claim to determine eligibility for payments.
- (e) If the CWD determines that the information supplied by the claimant does not verify the claimed recipient applied for and was denied IHSS during the retroactive payment period being claimed, the CWD shall issue a denial Notice of Action stating the specific reason(s) for the denial.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Arended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

.47 Presumptive Need For and Provision of Medical Accompaniment

.471 If other information available to the CWD, including, but not limited to, previous or current IHSS casefiles, does not rebut the presumption of need for medical accompaniment, the person claiming to have needed medical accompaniment is presumed to have needed medical accompaniment for the months claimed during the applicable retroactive payment and/or underpayment period if:

(a) A need for medical accompaniment was assessed at any time, in which case the need shall be from that time forward; or,

(b) The need for medical accompaniment is attested to by a sworn statement on the Standard Claim Form from the claimant and verified by a sworn statement of a witness. The CWD shall consider any other documentation submitted by the claimant to support the presumption of need for medical accompaniment.

.472 The person claiming to have needed medical accompaniment is presumed to have received medical accompaniment services for the months claimed during the applicable retroactive payment and underpayment periods if the delivery of such services is attested to by a sworn statement from the claimant and verified by a sworn statement of a witness, contained on the Standard Claim Form, and other information available to the CWD, including, but not limited to, previous or current IHSS casefiles, does not rebut the presumption of delivery of medical accompaniment services.

(a) The CWD shall presume that any medical accompaniment services provided and claimed were not provided voluntarily.

.473 If information available to the CWD rebuts the presumption of either the need for or the delivery of medical accompaniment services during any of the months claimed during the applicable retroactive payment and underpayment period, the CWD shall issue a Notice of Action for Adverse Information and attach a copy of the contradictory information. The claimant shall have 45 days from the date of the Notice of Action to provide additional information if available.

.474 If the CWD IHSS recordkeeping system shows no record of the claimed recipient ever applying for or being denied IHSS for the period being claimed, the CWD shall issue a Notice of Action requesting the claimant to complete an attached Supplemental Claim Form in accordance with Section 50-061.44. The claimant shall have 45 days from the date of the Notice of Action to submit the completed Supplemental Claim Form.

- (a) If the claimant does not submit the Supplemental Claim Form within the 45-day period, the claim shall be denied.
- (b) If the claimant submits the Supplemental Claim Form, and it is complete based on criteria in Section 50-061.443, the CWD shall continue processing the claim.
- (c) If the submitted Supplemental Claim Form is incomplete based on criteria in Section 50-061.443, the CWD shall follow instructions in Section 50-061.444.
- (d) If the CWD determines that information supplied by the claimant verifies that the claimed recipient did in fact apply for and was denied IHSS during the retroactive payment period being claimed, the CWD shall continue to process the claim to determine eligibility for payments.
- (e) If the CWD determines that the information supplied by the claimant does not verify the claimed recipient applied for and was denied IHSS during the retroactive payment period being claimed, the CWD shall issue a denial Notice of Action stating the specific reason(s) for the denial.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Amended judgment regarding WRO v. McMahon dated July 19, 1991, Case No. 531015.

**WELFARE RIGHTS ORGANIZATION (WRO) V. MCMAHON
PROVIDER STANDARD CLAIM FORM**

INSTRUCTIONS: Please print. This form must be completed to determine if we owe you any money. If you need help completing this form, contact the IHSS Section of your county welfare department. Be sure to sign your name in Part I, Section 6 and have someone who knows that you provided protective supervision and/or medical accompaniment to your spouse sign his/her name in Section 7 of Part I.

If you need a Spanish WRO claim form, please contact the IHSS section of your county welfare department.

REMEMBER: This form must be sent/delivered to the county welfare department by September 30, 1993. If mailed, the envelope must be postmarked by September 30, 1993. If not postmarked or received in the county welfare department by that date, your claim will be denied.

NOTE: Part I of this form asks questions about you and your spouse who needed protective supervision and/or medical accompaniment. Part II asks you for specific information about when protective supervision and/or medical accompaniment were actually provided. Part III asks for information about your providing protective supervision and/or medical accompaniment beyond the WRO retroactive payment period. Part IV asks for information about each medical source to which your spouse required medical accompaniment.

PART I:

1. YOUR NAME:		SOCIAL SECURITY NUMBER:	TELEPHONE NUMBER: ()
CURRENT ADDRESS (NUMBER, STREET):		APARTMENT/SPACE NUMBER:	
CITY:	COUNTY:	STATE:	ZIP CODE:

2. Check the appropriate box for each of the following questions. At any time between the period July 1983 through September 1984:

	YES	NO	UNKNOWN
A. Was your spouse 65 or older, blind, or disabled?	<input type="checkbox"/>	<input type="checkbox"/>	
B. Did he/she live in California?	<input type="checkbox"/>	<input type="checkbox"/>	
C. Did you go with your spouse to medical appointments because your assistance was required (medical accompaniment)?	<input type="checkbox"/>	<input type="checkbox"/>	
D. Did you have to watch out that your mentally ill or confused spouse was not injured or harmed doing normal, daily activities (protective supervision)?	<input type="checkbox"/>	<input type="checkbox"/>	
E. If you had not provided the services, might your spouse have received inadequate services or have been inappropriately placed somewhere other than his/her own home?	<input type="checkbox"/>	<input type="checkbox"/>	
F. Did you have to give up a job or could not get one because there was no other suitable person to provide the services?	<input type="checkbox"/>	<input type="checkbox"/>	
G. Did your spouse apply for and receive In-Home Supportive Services (IHSS)? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was your spouse denied IHSS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Your address at the time you provided protective supervision and/or medical accompaniment (if different from above)

NUMBER, STREET:		APARTMENT/SPACE NUMBER:	
CITY:	COUNTY:	STATE:	ZIP CODE:

4. NAME OF SPOUSE WHO NEEDED PROTECTIVE SUPERVISION AND/OR MEDICAL ACCOMPANIMENT:		HIS/HER SOCIAL SECURITY #	TELEPHONE NUMBER: ()
CURRENT ADDRESS (NUMBER, STREET):		APARTMENT/SPACE NUMBER:	
CITY:	COUNTY:	STATE:	ZIP CODE:

5. Date you and your spouse were married:

DATE OF MARRIAGE:

6. DECLARATION OF SPOUSE PROVIDER:

I understand that the information I have provided above and in Parts II, III and IV on the back of this form is subject to verification by a governmental agency and that my signature on this form is an authorization for such investigation. I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

NAME OF SPOUSE PROVIDER (PRINT):	SIGNATURE OF SPOUSE PROVIDER:	DATE:
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7. DECLARATION OF WITNESS:

I, the undersigned, declare under penalty of perjury that the person named in Section 1, above was the spouse of, lived with, and provided protective supervision and/or medical accompaniment to his/her spouse named in Section 4, above.

NAME OF WITNESS (PRINT):	SIGNATURE OF WITNESS:	DATE:
ADDRESS (NUMBER, STREET):		APARTMENT/SPACE NUMBER:
CITY:	COUNTY:	STATE:
RELATIONSHIP OF WITNESS TO PROVIDER:		RELATIONSHIP OF WITNESS TO CLAIMED RECIPIENT:
		TELEPHONE NO.: () ZIP CODE:

8. Turn to the back side of this form and read the instructions carefully. Once you have answered ALL the questions on both sides of this form, return it to the county welfare department.

**WELFARE RIGHTS ORGANIZATION (WRO) vs. MCMAHON
FORMA NORMAL DE RECLAMO PARA PROVEEDORES**

INSTRUCCIONES: Por favor escriba con letra de imprenta. Se tiene que completar esta forma para determinar si le debemos dinero. Si necesita asistencia para completarla, comuníquese con la Sección de IHSS del departamento de bienestar de su condado. Asegúrese de firmar en la Sección 6 de la parte I y pedirle a alguien que sepa que usted proporcionó supervisión con fines de protección y/o acompañamiento médico a su esposo(a), que firme la Sección 7 de la Parte I.

RECUERDE: Esta forma tiene que ser enviada/entregada al departamento de bienestar del condado a más tardar el 30 de septiembre de 1993. Si la envía por correo, el sobre tiene que mostrar el matasellos del correo a más tardar el 30 de septiembre de 1993. Se negará su reclamo si no muestra el matasellos del correo a más tardar en esa fecha, o no se recibe en el departamento de bienestar del condado a más tardar en esa fecha.

NOTA: La Parte I de esta forma hace preguntas sobre usted y su esposo(a) que necesitaba supervisión con fines de protección y/o acompañamiento médico. La Parte II le pide información específica acerca de cuándo se proveyeron, en realidad, la supervisión con fines de protección y/o el acompañamiento médico. La Parte III le pide información acerca de la supervisión con fines de protección y el acompañamiento médico que usted prestó después del período de pagos retroactivos WRO. La Parte IV le pide información acerca de cada establecimiento médico para el cual su cónyuge necesitó acompañamiento médico.

PARTE I:			
1. SU NOMBRE:		NUMERO DEL SEGURO SOCIAL:	NUMERO DE TELEFONO: ()
DIRECCION ACTUAL (NUMERO, CALLE):		NUMERO DE ESPACIO/APARTAMENTO:	
CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

2. Marque la casilla pertinente por cada una de las siguientes preguntas. En cualquier momento en el período de julio de 1983 a septiembre de 1984:

	SI	NO	NO SE
A. ¿Tenía su esposo(a) 65 años de edad o más, o estaba ciego o incapacitado?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. ¿Vivió él/ella en California?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. ¿Fue usted con su esposo(a) a citas médicas porque se necesitaba su asistencia (acompañamiento médico)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. ¿Tuvo usted que asegurarse que su esposo(a) que estaba enfermo mentalmente, o confundido no se lastimara o lesionara al llevar a cabo las actividades diarias normales (supervisión con fines de protección)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Si usted no hubiera proporcionado los servicios, ¿es posible que su esposo(a) haya recibido servicios inadecuados, o haya sido colocado inapropiadamente en algún lugar que no haya sido el hogar de él/ella?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. ¿Tuvo usted que renunciar a un empleo, o no pudo obtener uno porque no había otra persona apropiada para proporcionar los servicios?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. ¿Solicitó su esposo(a), y recibió Servicios de Casa y Cuidado Personal (IHSS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
¿Le negaron a su esposo(a) IHSS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Su dirección en la fecha en que usted proporcionó la supervisión con fines de protección y/o acompañamiento médico (si es diferente de la de arriba)

NUMERO, CALLE:			NUMERO DE ESPACIO/APARTAMENTO:
CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

4. NOMBRE DEL ESPOSO(A) QUE NECESITABA SUPERVISION CON FINES DE PROTEC. Y/O ACOMPAÑAMIENTO MEDICO: SU NO. DEL SEGURO SOCIAL:

DIRECCION ACTUAL (NUMERO, CALLE):			NUMERO DE TELEFONO: ()
NUMERO DE ESPACIO/APARTAMENTO:			
CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

5. Fecha en que se casaron usted y su cónyuge:

FECHA DEL MATRIMONIO:

6. DECLARACION DEL CONYUGE PROVEEDOR:
Entiendo que la Información que he proporcionado arriba y en las Partes II, III y IV en el reverso de esta forma, puede ser verificada por dependencias gubernamentales, y entiendo que mi firma en esta forma es una autorización para que se haga dicha investigación. Yo, el suscrito, declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas.

NOMBRE DEL ESPOSO PROV.(A) (LETRA DE IMPRENTA):	FIRMA DEL ESPOSO PROVEEDOR(A):	FECHA:
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7. DECLARACION DEL TESTIGO:
Yo, el suscrito, declaro bajo pena de perjurio que la persona mencionada en la Sección 1 de arriba era el esposo(a) de, vivió con, y proporcionó supervisión con fines de protección y/o acompañamiento médico a su esposo(a) mencionado en la Sección 4 de arriba.

NOMBRE DEL TESTIGO (LETRA DE IMPRENTA):	FIRMA DEL TESTIGO:	FECHA:
DIRECCION (NUMERO, CALLE):		NUMERO DE ESPACIO/APARTAMENTO:
NO. DE TELEFONO: ()		
CIUDAD:	CONDADO:	ESTADO:
ZONA POSTAL:		
PARENTESCO DEL TESTIGO CON EL PROVEEDOR:		PARENTESCO DEL TESTIGO CON EL BENEFICIARIO EN EL RECLAMO:

8. Pase al reverso de esta forma y lea cuidadosamente las instrucciones. Una vez que haya contestado TODAS las preguntas en ambos lados de esta forma, regrésela al departamento de bienestar del condado.

INSTRUCCIONES PARA LAS PARTES II Y III

1. Columna 1: Complete el número total de horas con respecto a cada mes en que usted proporcionó supervisión con fines de protección.

2. Columna 2: Complete el número total de horas con respecto a cada mes en que usted proporcionó acompañamiento médico.

RECUERDE: • El número total de horas por concepto de supervisión con fines de protección es la cantidad de tiempo, en cada mes, que usted tuvo que quedarse en casa y cuidar a su esposo(a) para evitar que resultara lastimado o lesionado porque estaba mentalmente enfermo o confundido.

• El número total de horas por concepto de acompañamiento médico es la cantidad de tiempo, en cada mes que usted tuvo que ir y venir a citas médicas con su esposo(a) porque se necesitaba su ayuda. Por favor vea el AVISO EXPLICATIVO WRO vs. MCMAHON para enterarse de los requisitos de elegibilidad.

PARTE II - RECLAMO CON RELACION A BENEFICIOS RETROACTIVOS

INSTRUCCIONES: Por favor complete las columnas 1 y 2 enseguida con relación al período del 1 de julio de 1983 al 30 de septiembre de 1984. Anote la información en las columnas de la manera siguiente:

AÑO/MES	COLUMNA 1: Número de horas reclamadas por proporcionar supervisión con fines de protección:	COLUMNA 2: Número de horas reclamadas por proporcionar acompañamiento médico:
1983		
Julio		
Agosto		
Septiembre		
Octubre		
Noviembre		
Diciembre		
1984		
Enero		
Febrero		
Marzo		
Abril		
Mayo		
Junio		
Julio		
Agosto		
Septiembre		

PARTE III - RECLAMO CON RELACION A PAGOS INSUFICIENTES

INSTRUCCIONES: Si usted continuó proporcionando supervisión con fines de protección y/o acompañamiento médico a su esposo(a) del 1 de octubre de 1984 al 30 de septiembre de 1985, de la manera en que se describe y bajo las condiciones de la manera en que se explican en el Aviso Explicativo WRO vs. MCMAHON, usted puede reclamar salario retroactivo (pago insuficiente) abajo. Por favor siga las instrucciones para las columnas 1 y 2 de la manera en que se explican en la Parte II de arriba.

AÑO/MES	COLUMNA 1: Número de horas reclamadas por proporcionar supervisión con fines de protección:	COLUMNA 2: Número de horas reclamadas por proporcionar acompañamiento médico:
1984		
Octubre		
Noviembre		
Diciembre		
1985		
Enero		
Febrero		
Marzo		
Abril		
Mayo		
Junio		
Julio		
Agosto		
Septiembre		

PARTE IV - ESTABLECIMIENTOS DE TRATAMIENTO MEDICO

INSTRUCCIONES: Por cada mes en que usted reclama haber proporcionado acompañamiento médico más de ocho (8) horas de la manera mencionada en las Partes II y III, columna 2, anote el nombre del profesional o establecimiento de salud, localidad (de la ciudad donde usted vivía a la ciudad donde se encontraba el profesional o establecimiento de salud), clase de transporte que se usó (automóvil, autobús, taxi, otro), mes/año de las visitas, número de visitas mensuales con/a ese profesional o establecimiento de salud y tiempo aproximado que se tomó para completar el viaje redondo.

	Nombre del profesional de la Salud/Establecimiento	Localidad		Clase de Transporte	Mes/Año de las visitas	Número de visitas por mes	Horas por viaje redondo
		De	A				
1.							
2.							
3.							
4.							
5.							

WELFARE RIGHTS ORGANIZATION (WRO) vs. MCMAHON
FORMA SUPLEMENTAL DE RECLAMO DEL PROVEEDOR

INSTRUCCIONES: Por favor escriba con letra de imprenta. Anote toda la información que se le pide. Si necesita asistencia, comuníquese con la Sección de IHSS del departamento de bienestar de su condado y pida que le ayuden.

PLAZO: Usted tiene que completar esta forma suplemental de reclamo y regresaría al departamento de bienestar del condado en un plazo de 45 días contados a partir de la fecha que aparece en la Notificación de Acción.

PARTE I.

1. NOMBRE DEL CONYUGE (ESPOSO/ESPOSA) QUE PROPORCIONO SUPERVISION CON FINES DE PROTECCION Y/O ACOMPAÑAMIENTO MEDICO DURANTE LOS MESES QUE SE RECLAMAN (LETRA DE IMPRENTA):

DIRECCION ACTUAL (NUMERO, CALLE):			NUMERO DE ESPACIO/APARTAMENTO:
CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

2. NOMBRE DEL CONYUGE (ESPOSO/ESPOSA) QUE RECIBIO SUPERVISION CON FINES DE PROTECCION Y/O ACOMPAÑAMIENTO MEDICO DURANTE LOS MESES QUE SE RECLAMAN (LETRA DE IMPRENTA):

DIRECCION ACTUAL (NUMERO, CALLE):			NUMERO DE ESPACIO/APARTAMENTO:
CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

PARTE II.

No tenemos información acerca de la persona a la que usted dice le proporcionó supervisión con fines de protección y/o acompañamiento médico, indicando que alguna vez haya solicitado y que se le hayan negado IHSS durante el período del reclamo de 7/83 - 9/85. Por favor complete lo siguiente:

1. ¿Tiene usted otra información relativa a la solicitud para IHSS y la negación durante los períodos de reclamo arriba mencionados para la persona a la que usted dice le proporcionó servicios de supervisión con fines de protección y/o acompañamiento médico?..... SI NO

Si no, pase al 2.

Si sí, por favor anote la información en los espacios en blanco que se proporcionan en seguida:

- A. ¿Quién fue la persona en particular que solicitó IHSS? _____
- B. ¿Se presentó la solicitud verbalmente o por escrito? _____
- C. ¿Cuándo se presentó la solicitud? _____
- D. ¿Qué servicios se solicitaron? _____

2. ¿Tiene usted cualesquier documentos relacionados a la solicitud de IHSS y a la negación de las mismas durante los períodos de reclamo mencionados arriba con respecto a los meses que usted dice le proporcionó supervisión con fines de protección y/o acompañamiento médico?..... SI NO

Si sí, por favor adjunte una copia de dichos documentos.

PARTE III.

1. ¿Recibió la persona anotada en la Parte I, #2 de arriba beneficios de Seguridad de Ingreso Suplemental/Programa Suplementario del Estado (SSI/SSP) (cheque dorado) en cualquiera de los años siguientes? Ponga una X enseguida por cada año en que se haya recibido SSI/SSP.

1983 1984

2. Anote los ingresos mensuales promedio combinados suyos y de su cónyuge con relación a los siguientes años.

1983 _____ 1984 _____

3. ¿Tuvieron usted y su esposa(o) recursos mensuales promedio combinados convertibles en efectivo (dinero en efectivo, cuenta de cheques o de ahorros, fondos en fideicomiso, cheques o efectivo en una caja de seguridad, acciones o bonos, pagarés, hipotecas, escrituras) que excedían \$2,250 durante el período del 1 de julio de 1983 al 30 septiembre de 1984?

SI NO

Si sí, coloque una X enseguida con respecto a cada año en el cual los recursos mensuales promedio convertibles en efectivo suyos y de su cónyuge excedían \$2,250.

1983 _____ 1984 _____

PARTE IV.

1. **DECLARACION DEL PROVEEDOR:**
ASEGURESE DE HABER LEIDO Y CONTESTADO TODAS LAS PREGUNTAS ANTERIORES.
LEA LAS DECLARACIONES SIGUIENTES CUIDADOSAMENTE ANTES DE FIRMAR.

- Entiendo que la información que he incluido en esta forma puede ser verificada, y que mi firma en la misma es una autorización para que se haga dicha investigación.
- Yo, el suscrito(a), declaro bajo pena de perjurio que las respuestas que he dado son correctas y verdaderas.

NOMBRE DEL PROVEEDOR (ESCRIBA CON LETRA DE IMPRENTA):	FIRMA DEL PROVEEDOR:	FECHA:
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2. **DECLARACION DEL TESTIGO:**
Yo, el suscrito(a), declaro bajo pena de perjurio que las respuestas que el proveedor dió arriba son correctas y verdaderas según mi leal saber y entender.

NOMBRE DEL TESTIGO (ESCRIBA CON LETRA DE IMPRENTA):	FIRMA DEL TESTIGO:	FECHA:		
DIRECCION:	CIUDAD:	CONDADO:	ESTADO:	ZONA POSTAL:

PARENTESCO/RELACION CON EL PROVEEDOR

PARENTESCO/RELACION CON LA PERSONA QUE RECIBIO SUPERVISION CON FINES DE PROTECCION Y/O ACOMPAÑAMIENTO MEDICO:

WELFARE RIGHTS ORGANIZATION (WRO) V. MCMAHON

PROVIDER SUPPLEMENTAL CLAIM FORM

INSTRUCTIONS: Please print. Fill in all information requested. If you need help, contact the IHSS Section of your county welfare department office and ask for assistance.

DEADLINE: You must complete this supplemental claim form and return it to the county welfare department within 45 days of the date on the Notice of Action.

PART I.

1. NAME OF SPOUSE WHO PROVIDED PROTECTIVE SUPERVISION AND/OR MEDICAL ACCOMPANIMENT DURING THE MONTH(S) CLAIMED (PRINT):

CURRENT ADDRESS (NUMBER, STREET):			APARTMENT/SPACE NUMBER:
CITY:	COUNTY:	STATE:	ZIP CODE:

2. NAME OF SPOUSE WHO RECEIVED PROTECTIVE SUPERVISION AND/OR MEDICAL ACCOMPANIMENT DURING THE MONTH(S) CLAIMED (PRINT):

CURRENT ADDRESS (NUMBER, STREET):			APARTMENT/SPACE NUMBER:
CITY:	COUNTY:	STATE:	ZIP CODE:

PART II.

We have no record of the person you claim to have provided protective supervision and/or medical accompaniment ever having applied for and been denied IHSS during the claim periods of 7/83 - 9/85. Please complete the following:

1. Do you have other information relating to the IHSS application and denial during the above claim periods for the person you claim to have provided protective supervision and/or medical accompaniment? YES NO

If no, proceed to 2.

If yes, please provide that information in the blanks below:

A. Who actually applied for IHSS? _____

B. Was the application verbal or in writing? _____

C. When was the application made? _____

D. What services were requested? _____

2. Do you have any documentation relating to the IHSS application and denial during the above claim period(s) for the month(s) you claim to have provided protective supervision and/or medical accompaniment? YES NO

If yes, please attach a copy of all such documentation.

PART III.

1. Did the person listed in Part I, #2 above receive Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits (Gold Check) in any of the following years? Place an X below for each year in which SSI/SSP was received.

1983 1984

2. List the average combined monthly income for yourself and your spouse for the following years.

1983 _____ 1984 _____

3. Did you and your spouse have combined average monthly liquid resources (cash, checking or savings account, trust funds, checks or cash in safety deposit box, stocks or bonds, notes, mortgages, deeds) that were in excess of \$2250 during the period July 1, 1983 through September 30, 1984?

YES NO

If "yes", place an "x" below for each year in which the average monthly liquid resources of yourself and your spouse were more than \$2250.

1983 _____ 1984 _____

PART IV.**1. PROVIDER'S STATEMENT:**

**BE SURE YOU HAVE READ AND ANSWERED ALL THE QUESTIONS ABOVE.
READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING.**

• I understand that the information I put on this form may be verified and that my signature on this form is an authorization for such an investigation.

• I, the undersigned, declare under penalty of perjury that the answers I have given are correct and true.

NAME OF PROVIDER (PRINT):	SIGNATURE OF PROVIDER:	DATE:
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2. WITNESS' STATEMENT:

I, the undersigned, declare under penalty of perjury that the answers provided above by the provider are correct and true to the best of my knowledge.

NAME OF WITNESS (PRINT):	SIGNATURE OF WITNESS:	DATE:
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ADDRESS:	CITY:	COUNTY:	STATE:	ZIP CODE:
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RELATIONSHIP TO PROVIDER:

RELATIONSHIP TO PERSON WHO RECEIVED PROTECTIVE SUPERVISION AND/OR MEDICAL ACCOMPANIMENT:

WRO V. MCMAHON**PROVIDER RETROACTIVE PAYMENT ELIGIBILITY DETERMINATION WORKSHEET****PART I**

PROVIDER'S NAME:		SOCIAL SECURITY NUMBER:	
RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:	

- Did the claimant answer yes to questions 2A and 2B, and 2E and 2F and either 2C or 2D on the Provider Standard Claim Form? YES NO
If yes, proceed.
If no, to questions 2A or 2B or 2E or 2F, or both 2C and 2D, issue a denial notice.
- Did claimant answer yes to either part of question 2G on the Provider Standard Claim Form? YES NO
If yes, proceed. (Enter response here and Part II, Section B, Column 2)
If no, issue denial notice.
If unknown, try to locate either the case record or the record of denial.
If neither can be located, send a Supplemental Claim Form.
- Do you have any record of a denial or approval? YES NO
If yes, proceed to #4 if an approval, or to #8 if a denial.
If no, send Supplemental Claim Form.

INSTRUCTIONS: STEPS 4 - 7 ARE TO BE FOLLOWED WHEN IHSS WAS AUTHORIZED DURING THE PERIOD CLAIMED.

- Is there any information in the case record that shows the recipient was denied protective supervision and/or medical accompaniment for reason(s) other than provision by spouse? YES NO
If yes, send 45-day Adverse Information Notice for months determined ineligible and document the reason(s) for ineligibility in the space below, and then proceed to #6 for any remaining months of eligibility.
Reason(s) _____
If no or questionable, proceed to #5.
- Is there any other information (outside the case record) that shows recipient was denied protective supervision and/or medical accompaniment for reasons other than provision by spouse? YES NO
If yes, send 45-day Adverse Information Notice for months determined ineligible and document the reason(s) for ineligibility in the space below, and then proceed to #7 for the remaining months of eligibility.
Reason(s) _____
If no, proceed to #6.
- Was the case at statutory maximum (stat max) for any month claimed? YES NO
If yes, send 45-day Adverse Information Notice for months in which case was at stat max.
If no for any month, proceed with months not at stat max.
- Check (✓) one of the following: Recipient was severely impaired (SI) nonseverely impaired (NSI)
(Enter response here and Part II, Section B, Column 7)
If SI, CMIPS will compute each month using SI maximums not to exceed the allowable maximum for any given month, including costs of previously authorized services.
If nonseverely impaired (NSI), CMIPS will compute each month using NSI maximums not to exceed the allowable maximum for any given month, including costs of previously authorized services.

INSTRUCTIONS: STEP 8 IS TO BE FOLLOWED WHEN IHSS WAS NOT AUTHORIZED DURING THE PERIOD CLAIMED.

- Was the spouse the reason for denial of protective supervision and/or medical accompaniment? YES NO
If yes, proceed to Part II, Section A.
If no for any period claimed, document the reason(s) in the space below and send a 45-day Adverse Information Notice.
Reason(s) _____
If no for a partial period, document in the space below, the reason(s) for ineligibility during the period when the spouse was not the reason and proceed to Part II, Section A for the period in which the spouse was the sole reason for denying protective supervision and/or medical accompaniment.
Reason(s) _____

CMIPS will compute eligibility at the SI or NSI maximum for all eligible months claimed.
If unknown, send Supplemental Claim Form.

INSTRUCTIONS: STEPS 9-11 ARE TO BE FOLLOWED WHEN A COMPLETED PROVIDER SUPPLEMENTAL CLAIM FORM HAS BEEN RECEIVED BY THE CWD.

- Did the claimant provide information on the Provider Supplemental Claim Form and/or attach documentation that substantiates the claimed recipient of protective supervision and/or medical accompaniment applied for and was denied IHSS during the period July 1983 through September 1984? YES NO
If yes, proceed to #10.
If no, proceed to #11.
- Based on the information provided on the Provider Supplemental Claim Form, did the claimed recipient meet IHSS income/resource eligibility requirements for the months being claimed? YES NO
If yes for any or all months being claimed, CMIPS will calculate payments for all months of eligibility.
If no for any or all months being claimed, deny the claim for those months.
- Answer only if #9 is NO
Based on the information provided on the Provider Supplemental Claim Form, did the claimed recipient meet IHSS income/resource eligibility requirements for the months being claimed? YES NO
If yes, deny the claim for the reason that the claimed recipient never applied for and was denied IHSS during the months being claimed.
If no, deny the claim for two reasons:
(1) the claimed recipient never applied for and was denied IHSS during the months claimed; and
(2) The claimed recipient did not meet IHSS income/resource eligibility requirements for the months being claimed.

**WRO V. MCMAHON
PROVIDER RETROACTIVE PAYMENT ELIGIBILITY DETERMINATION WORKSHEET
PART II**

PROVIDER'S NAME:	SOCIAL SECURITY NUMBER:
RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:
	CASE NUMBER:

PART II, SECTION A SUMMARY OF SERVICE HOURS CLAIMED

Mo./Year Claimed	Total Protective Sup (PS) Hours (Enter here and in Part II, Sec. B, Col. 3)	Medical Accomp (MA) Hours Claimed	- Adjust. =	Total MA Hours (Enter here and in Part II, Sec. B, Col. 3)
1983				
July				
August				
September				
October				
November				
December				
1984				
January				
February				
March				
April				
May				
June				
July				
August				
September				

PART II, SECTION B RETROACTIVE PAYMENT CALCULATION WORKSHEET

INSTRUCTIONS:

- Column 1: Month and year claimed.
- Column 2: Enter yes/no response from Part I, step #2.
- Column 3: Fill-in the total number of hours claimed for protective supervision (PS) and/or medical accompaniment (MA) from Part II, Section A.
- Column 4: The amount claimed will be calculated by CMiPS and displayed on a turn-around document. No manual entry is required.
- Column 5: From the case record, enter the total number of hours authorized for protective supervision and/or medical accompaniment.
- Column 6: The statutory maximum for the month being claimed will be calculated by CMiPS and displayed on a turn-around document. No manual entry is required.
- Column 7: Enter SI/NSI response from Part I, step #7.
- Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMiPS and displayed on a turn-around document. No manual entry is required.
- Column 9: The total payment amount due will be calculated by CMiPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Total Adjusted Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed)	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 5 or Column 8 whichever is less)
1983									
July		PS: _____ MA: _____							
August		PS: _____ MA: _____							
September		PS: _____ MA: _____							
October		PS: _____ MA: _____							
November		PS: _____ MA: _____							
December		PS: _____ MA: _____							
1984									
January		PS: _____ MA: _____							
February		PS: _____ MA: _____							
March		PS: _____ MA: _____							
April		PS: _____ MA: _____							
May		PS: _____ MA: _____							
June		PS: _____ MA: _____							
July		PS: _____ MA: _____							
August		PS: _____ MA: _____							
September		PS: _____ MA: _____							

SIGNATURE OF CLAIM PROCESSOR:	DATE:
SIGNATURE OF SUPERVISOR OR DESIGNEE:	DATE:

WRO V. MCMAHON

PROVIDER UNDERPAYMENT ELIGIBILITY DETERMINATION WORKSHEET

PART I

PROVIDER'S NAME:		SOCIAL SECURITY NUMBER:	
RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:	

1. Is the claimant eligible for retroactive payments? YES NO

If no, deny underpayment claim.
If yes, proceed to #2.

2. Is the claimant eligible for retroactive payments through the end of the retroactive period (July 1, 1983 through September 30, 1984)? YES NO

If no, deny underpayment claim.
If yes, proceed to #3.

3. Was there an IHSS case record? YES NO

If no, CMIPS will calculate underpayments using nonseverely impaired maximums, not to exceed the allowable maximum for any given month, including previously authorized services. Proceed to Part II.
If yes, proceed to #4.

4. Check () one of the following: Recipient was severely impaired (SI) nonseverely impaired (NSI)
(Enter response here and Part II, Section B, Column 7)

If SI, CMIPS will calculate underpayments at the SI maximums.
If NSI, CMIPS will calculate underpayments at the NSI maximums.

PART II, SECTION A: SUMMARY OF SERVICE HOURS CLAIMED

Mo/Year Claimed	Total Protective Sup (PS) Hours (Enter here and in Part II, Sec. B, Col. 3)	Medical Accomp (MA) Hours Claimed	- Adjust. =	Total MA Hours (Enter here and in Part II, Sec. B, Col. 3)
1984				
October				
November				
December				
1985				
January				
February				
March				
April				
May				
June				
July				
August				
September				

PART II, SECTION B:

UNDERPAYMENT CALCULATION WORKSHEET

PROVIDER'S NAME:		SOCIAL SECURITY NUMBER:	
RECIPIENT'S NAME:	SOCIAL SECURITY NUMBER:	CASE NUMBER:	

INSTRUCTIONS:

- Column 1: Month and year claimed
- Column 2: Enter Yes/No response from Part I, question #2.
- Column 3: Fill-in the total number of hours claimed for protective supervision (PS) and/or medical accompaniment (MA) from Part II, Section A.
- Column 4: The amount claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.
- Column 5: From the case record, enter the total number of hours authorized for protective supervision and/or medical accompaniment.
- Column 6: The statutory maximum for the month being claimed will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.
- Column 7: Enter SI/NSI response from Part I, question #4.
- Column 8: The statutory maximum minus the amount originally authorized will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.
- Column 9: The total payment amount due will be calculated by CMIPS and displayed on a turn-around document. No manual entry is required.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7		COLUMN 8	COLUMN 9
Month/Year Claimed	Class Eligible? Yes/No	Total Adjusted Hours Claimed	Amount Claimed (Hours claimed x IP Rate During Month Claimed)	Amount Originally Authorized	Stat. Max. During Month Claimed	NSI	SI	Stat. Maximum Minus Amount Originally Authorized	Amount Due (Either Column 5 or Column 8 whichever is less)
1984									
October		PS: _____							
		MA: _____							
November		PS: _____							
		MA: _____							
December		PS: _____							
		MA: _____							
1985									
January		PS: _____							
		MA: _____							
February		PS: _____							
		MA: _____							
March		PS: _____							
		MA: _____							
April		PS: _____							
		MA: _____							
May		PS: _____							
		MA: _____							
June		PS: _____							
		MA: _____							
July		PS: _____							
		MA: _____							
August		PS: _____							
		MA: _____							
September		PS: _____							
		MA: _____							

SIGNATURE OF CLAIM PROCESSOR:	DATE:
SIGNATURE OF SUPERVISOR OR DESIGNEE:	DATE: