

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



January 12, 1993

ALL-COUNTY LETTER NO. 93-05

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: WELFARE RIGHTS ORGANIZATION (WRO) V. MCMAHON CLAIMS CASE MANAGEMENT, INFORMATION AND PAYROLLING SYSTEM (CMIPS) INSTRUCTIONS

The purpose of this letter is to transmit to Counties the CMIPS instructions for the management and processing of claims resulting from the WRO v. McMahon court case. You have already received the final court judgment, proposed draft regulations and other pertinent information in a separate All-County Letter.

Instructions are attached hereto for the completion of the SOC 293, SOC 311 and the applicable judgment screens to be used for the processing of WRO claims. Field-by-field descriptions for these forms have been modified to accommodate the unique nature of the claim process.

Contained in the instruction package is a facsimile of a new Notice of Action form NA 690M (02/93). A supply of these forms will be provided each County in quantities sufficient to process expected claims. Additional copies can be obtained from the following:

State Department of Social Services  
Adult Services Branch  
744 P Street, MS 6-500  
Sacramento, CA 95814  
ATTN: Wayman Hindsman

Any questions regarding the management and processing of WRO v. McMahon claims should be directed to Mr. Wayman Hindsman at (916) 657-2134.

  
JAMES W. BROWN  
Acting Deputy Director  
Adult and Family Services

Attachments

cc: CWDA

WRO v. MCMAHON  
 IN-HOME SUPPORTIVE SERVICES  
 CASE MANAGEMENT, INFORMATION AND  
 PAYROLLING SYSTEM INSTRUCTIONS  
 TABLE OF CONTENTS

TABLE OF CONTENTS	PAGE - 1
INSTRUCTIONS	PAGE - 2
INTRODUCTION	PAGE - 2
WRO CLAIMS	PAGE - 2
CMIPS SOC 293 AND SOC 311	PAGE - 3
INTERCOUNTY TRANSFERS	PAGE - 4
CLAIM PERIODS	PAGE - 4
ELIGIBILITY DETERMINATION WORKSHEET	PAGE - 5
WARRANT(S)	PAGE - 6
VOID/STOP PAYMENTS	PAGE - 8
REPLACEMENT WARRANTS	PAGE - 8
DUPLICATE WARRANTS	PAGE - 9
FORGERIES	PAGE - 10
CROSS REFERENCE SCREEN	PAGE - 10
EDITS	PAGE - 11
NOTICE OF ACTION	PAGE - 12
 FORMS, SCREENS AND FIELD-BY-FIELD DESCRIPTIONS	
IN-HOME SUPPORTIVE SERVICES ASSESSMENT FORM (SOC 293 FORM)	PAGE - 16
FIELD-BY-FIELD DESCRIPTION	PAGE - 18
 IN-HOME SUPPORTIVE SERVICES PROVIDER ELIGIBILITY UPDATE (SOC 311 FORM)	PAGE - 25
FIELD-BY-FIELD DESCRIPTION	PAGE - 26
 WRO v. MCMAHON RECIPIENT RETROPAYMENT CLAIM SCREEN (WROR)	PAGE - 31
FIELD-BY-FIELD DESCRIPTION	PAGE - 32
 WRO v. MCMAHON PROVIDER RETROPAYMENT CLAIM SCREEN (WROP)	PAGE - 40
FIELD-BY-FIELD DESCRIPTION	PAGE - 41
 WRO v. MCMAHON WAGE AND INTEREST WORKSHEET SCREEN (WROW)	PAGE - 47
FIELD-BY-FIELD DESCRIPTION	PAGE - 48
 WRO v. MCMAHON UNDERPAYMENT WAGE WORKSHEET SCREEN (WROU)	PAGE - 53
FIELD-BY-FIELD DESCRIPTION	PAGE - 54
 NOTICE OF ACTION FORM, MESSAGES AND REASON CODES	PAGE - 58

WRO v. MCMAHON  
IN-HOME SUPPORTIVE SERVICES (IHSS)  
CASE MANAGEMENT, INFORMATION AND  
PAYROLLING SYSTEM (CMIPS) INSTRUCTIONS

INTRODUCTION

The following information is provided to facilitate the use of CMIPS in processing WRO v. McMahon claims. Those parts of the process which are automated include:

- o Eligibility Determination Worksheet printouts;
- o Notice of Action (NOA) with "boilerplate" messages including blanks which workers will fill in;
- o Generation of payments to claimants including:
  - withholding of employee/employer taxes when appropriate,
  - notifications of monies paid to the claimants at the end of the year through a W2 (Wage and Tax Statement) and/or a 1099-INT (Statement for Recipients of Interest Income);
- o County (CWD) and State (SDSS) reports.

All WRO claims must be processed through an IHSS recipient name and case number. If there is no open or discontinued case record file, a new case record number and file must be established. All documents, including CMIPS documents, must be kept in one case record file.

WRO CLAIMS

SDSS will have individual notices mailed 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. It is anticipated that some of these notices will be returned as undeliverable. As undeliverables are received at the Franchise Tax Board they will prepare two tapes each week listing the name, address and social security number of the potential WRO claimant. The tapes will be sent to TRW Credit, Inc. who will match the names against their data base and prepare a mailing label for each address that is different from the address on the tape. TRW Credit, Inc. will mail an explanatory flyer and a WRO Standard Claim Form to each claimant for whom a different address label is generated.

SDSS will send both notices, those that are returned as undeliverable from the remailing and those for which a different address was not found, for confidential destruction.

### CMIPS SOC 293 AND SOC 311

Some fields on the CMIPS forms, SOC 293 and SOC 311, will have different definitions and/or codes than what is currently used. The field-by-field descriptions (attached) and the CMIPS instructions below will assist CWD staff in processing the claim forms. If the claim form is complete, the CWD will continue to process it. Complete only the SOC 293 for recipient/applicant claimants and complete both the SOC 293 and SOC 311 if the claimant is a provider.

After completing the SOC 293 and/or 311, key enter this information on the CMIPS judgment screen(s), Recipient Retropayment Claim Screen (WROR) and/or the Provider Retropayment Claim Screen (WROP) - see the attached field-by-field description and facsimiles of the screens.

Facsimiles of the forms are marked to indicate which fields to complete:

The SOC 293 In-Home Supportive Services Assessment form will be used to collect all the data on the recipient/applicant and guardian if one is involved. This information is to be entered on the WROR screen. This screen can generate a Notice of Action (NOA) and payment address as well as the Standard and Supplemental Claim Form dates.

The SOC 311 In-Home Supportive Services Provider Eligibility Update form shall be used to collect all the data on the provider. This information is to be entered on the WROP screen which can generate NOAs and payment address, tax indicator, Standard and Supplemental Claim form dates and the relationship of the provider to the recipient/applicant.

When submitting a WRO claim, some people may be applying for IHSS. If there is no active case except for processing a WRO claim, you can process the usual SOC 293 but you must change the status to do so.

- o on the WROR screen, in a change (C) mode (using the second line in the top left hand corner - NEXT) enter one of the following status codes E, I or R in status field (F1)

- o status W will not change to E, I or R on the WROR screen but you can move to the RELA screen
- o while in the RELA, RELB and RELC, enter the usual additional applicant information; you will now have an active IHSS case as well as a Wro claim.

#### INTERCOUNTY TRANSFERS

When transferring a claim the first CWD will:

- o send a photocopy of the claim to each CWD affected;
- o generate and send a photocopy of the NOA to each CWD affected; and
- o send a "County Claims Transfer" NOA to the claimant, within 10 calendar days, to advise the claimant which CWD will contact him/her.

The Standard Claim Form filing date (field M2 on the SOC 293 and field F2 on the SOC 311) will be the date postmarked on the envelope. If the claim is filed in person at the CWD, the date of filing will be the date received in the CWD office, and the date stamped on the claim. If, however, the filing date cannot be determined as detailed above, the filing date will be the date the claim was signed. When a claim must be forwarded to another CWD for processing the first CWD's filing date will apply (see MPP 50-061.32(a), (b), (c), (d) and (e)).

When the first CWD must forward a claim, in total, to a second CWD, use Reason Code W005 for provider claimants or W105 for recipient/applicant claimants if transferring to one CWD. If more than one CWD is identified, use Reason Codes W006 and W007 for provider claimants or W106 and W107 for recipient/applicant claimants. These four reason codes (W006, W007, W106 and W107) tells CMIPS that the claim being transferred to a second CWD will also remain in a pending application status in the first CWD.

Add the two digit CWD code to the end of the Reason Code when transferring a claim, partially or in total. The two digit CWD code will tell CMIPS which CWD contact person and telephone number to print in the NOA message and advises the claimant which CWD will contact him/her.

#### CLAIM PERIODS

The retroactive claim period is from July 1, 1983 through September 30, 1984. The underpayment claim period is from October 1, 1984 through September 30, 1985. The final filing date for WRO claims is September 30, 1993.

ANY CLAIM WITH A FILING DATE AFTER 09-30-93 WILL BE DENIED.

Claim dates beyond the retroactive claim period will be processed as an underpayment claim. Claims eligible for underpayment consideration are only those claims where the eligibility for retroactive/interest payment extends through the end of the retroactive claim period, September 30, 1984.

The CWD will determine eligibility/ineligibility and compute payment due within 45 days of the filing date or promptly after all necessary forms have been completed and received by the CWD. The CWD will input this information into CMIPS so that interest can be computed on approved cases and the computation returned to the CWD within five working days from the date of CWD input.

Nonspouse recipients/applicants and providers are not eligible to receive payment under the WRO judgment. Nonspouse recipients/applicants and providers making a claim for payment under the WRO judgment will have their claim denied, Reason Code W045 or W145. These nonspouse recipients/applicants and providers may be eligible for retroactive payments and/or underpayments under the Miller v. Woods court case, and will receive a Miller Standard Claim Form with their WRO denial notice.

#### ELIGIBILITY DETERMINATION WORKSHEET

The CWD will reviewed the Standard and/or Supplemental Claim Forms and determine eligibility/ineligibility by following the manual instructions on the Eligibility Determination Worksheet, Part I and Part II, Section A; Part II, Section B of the worksheet will be entered into CMIPS on the Judgment Worksheet Screen(s). There is a Wage and Interest Worksheet Screen (WROW) and an Underpayment Wage Worksheet Screen (WROU). After the information is key entered on the worksheet screen(s), CMIPS will do the calculation to determine the amount of retroactive/interest payment, the amount of underpayment, if applicable and generate a printout that will print at CWDs' print sites. The printout will include:

- o a month by month breakdown of hours claimed for protective supervision services
- o a month by month breakdown of hours claimed for medical accompaniment
- o amount claimed for protective supervision services
- o amount claimed for medical accompaniment

- o the difference between the amount of hours claimed and the amount of hours originally authorized
- o amount of past due wages for protective supervision services
- o amount of past due wages for medical accompaniment
- o total amount of interest to be paid

An example of Part II of the Eligibility Determination Worksheet is attached. CWD staff will be required to complete and enter into CMIPS:

- o Column 1 - Month/Year Claimed: Enter MM YY;
- o Column 2 - Class Eligible: Yes/No: Enter Y or N;
- o Column 3 - Separately identify Protective Supervision Services (P) and Medical Accompaniment (M) Total Adjusted Hours Claimed (Part II, Section A): Enter the hours claimed to the nearest tenth;
- o Column 5 - Amount Originally Authorized: Enter the total dollar amount originally authorized, for the period claimed (from the case record); and,
- o Column 7 - NSI/SI: Enter the code that indicates whether the recipient/applicant was or would have been classified as non-severely impaired (N) or severely impaired (S).

CWD staff will review the Worksheet printout for accuracy, then enter a CWD authorization number and NOA code(s) on the bottom of the Worksheet. That information can also then be entered on the WROW and/or WROU CMIPS screens which will then generate three copies of the Worksheet, a NOA and warrant(s), when applicable.

The original printout and a copy of the second printout shall be filed in the Recipient/Applicant Case Record file and two copies attached to the appropriate NOA when it is mailed to the claimant.

#### WARRANT(S)

Two warrants will be issued for each approved retroactive claim and one warrant will be issued for each approved underpayment claim:

Retro- One warrant will include retroactive wages and the second will include any prejudgment interest due. The warrant stub will reflect the employee taxes withheld, if any; and,

Under- One warrant will include underpayment wages due which are not subject to interest. The warrant stub will reflect the employee taxes withheld, if any.

A statement on the bottom of the NOA will advise the claimant:

"The amount of money you receive as a result of this claim may affect your tax liability and/or continuing eligibility for certain programs including, but not limited to: In-Home Supportive Services (IHSS), Aid to Families with Dependent Children (AFDC), Medi-Cal, Food Stamps (FS), Supplemental Security Income and State Supplementary Program (SSI/SSP) and Veterans Benefits."

This statement is made because some claimants may receive lump sums great enough to exceed the exempt resource levels of a program for which they currently qualify. The WRO regulations states that lump sums will be disregarded as income/ resources for the month received and for the month after received as applied to State programs.

To avoid causing ineligibility because claimants do not have adequate time to dispose of those lump sums, WRO warrants will be mailed to be received by the claimants before the tenth day of the month.

- o Authorizations for warrants entered by the fifth of the month will meet the mailing criteria.
- o Otherwise, authorizations for warrants will be held on a special CMIPS tape until the fifth of the following month.
- o The intent is to provide at least six to seven weeks for the claimants to make a reasonable decision how they wish to dispose of the funds they received.

THE IHSS WORKERS DO NOT HAVE THE RESPONSIBILITY TO EXPLAIN HOW LUMP SUMS MAY IMPACT ELIGIBILITY FOR OTHER PROGRAMS. ADVISE THE CLAIMANT TO CONTACT THE PROPER PROGRAM REPRESENTATIVE FOR CORRECT PROGRAM INFORMATION.

## VOID/STOP PAYMENTS

A void/stop payment on a WRO warrant is initiated by CWDs at the request of the payee. All requests for void/stop payments must be sent from the CWD to the:

State Department of Social Services  
Adult Services Branch  
744 P Street, MS 6-500  
Sacramento, CA 95814  
ATTN: Wayman Hindsman

The CWD's request for a void/stop payment must be in writing, have the warrant(s) attached to the request, identify the reason(s) for the stop payment, include the payees name, address, case number, warrant number(s) and state whether a replacement warrant is required. Reasons for placing a void/stop payment on warrant(s) are incorrect amount, incorrect payee and payee ineligible. A void/stop payment request will only be processed if the warrant(s) is attached to the CWD's request. If the warrant(s) is not attached to the request, the request will be returned to the CWD unprocessed. The CWD should also draw a line through the warrant(s) and write "VOID" across it.

CWD's will not have the ability to place a stop payment on any WRO warrants, except as mentioned above. The V/R and WAR NUM fields on the WROW and WROU screens are accessible to Electronic Data Systems (EDS) staff only. CWD's request for a void/stop payment will be forwarded from SDSS to EDS who will enter the transaction in CMIPS; the WROW screen for either retroactive or prejudgment interest warrants and on the WROU screen for underpayment warrants.

Approximately two days later the State Treasurer's Office will place a stop payment on the warrant. The day after EDS enters the transaction for the void/stop payment they will enter the transaction that will generate a replacement warrant (only one warrant request a day).

## REPLACEMENT WARRANTS

SDSS will contact the appropriate CWD if any WRO warrants are returned as undeliverable and after the money is redeposited into the IHSS account. To issue a replacement warrant for a warrant that was redeposited into the IHSS account, CWDs will have to correct the address on the WROR or WROP screen and submit a written request to the address above. The written request must identify the reason for the replacement warrant(s), the payee's name, address, case number, warrant number(s) and the remaining

address. Once SDSS is assured that the funds are available and have received a request for a replacement warrant from the CWD, they will submit a request to EDS to issue a replacement warrant for the redeposited warrant. Redeposited warrants will only be replaced if the above procedures are closely followed.

- o Authorizations for replacement warrants entered by the fifth of the month will meet the mailing criteria, to be received by the claimants before the tenth day of the month.
- o Otherwise, authorizations for replacement warrants will be held on a special CMIPS tape until the fifth of the following month.

CWDs will not have the ability to replace any WRO warrants, except as mentioned above. The V/R and WAR NUM fields on the WROW and WROU screens are accessible to EDS staff only. CWD's request for a replacement warrant will be forwarded from SDSS to EDS who will enter the transaction in CMIPS.

#### DUPLICATE WARRANTS

A duplicate warrant is a warrant issued for a warrant that has been lost, stolen or never received by the payee. Any WRO warrants that meet this criteria will be handled in the same way as a replacement warrant. That is, a CWD's request for a duplicate warrant must be in writing, sent to SDSS at the address above, identify the reason for the duplicate warrant, payee's name, address, case number, the original warrant number(s) and the amount of each warrant to be duplicated.

If the written request is not complete SDSS will return the request to the CWD for completion. Duplicate warrants will be issued and mailed, to be received by the claimants, before the tenth day of the month.

- o Authorizations for duplicate warrants entered by the fifth of the month will meet the mailing criteria.
- o Otherwise, authorizations for warrants will be held on a special CMIPS tape until the fifth of the following month.

CWDs will not have the ability to request a duplicate WRO warrant, except as mentioned above. The V/R and WAR NUM fields on the WROW and WROU screens are accessible to EDS staff only. CWD's request for a duplicate warrant will be forwarded from SDSS to EDS who will enter the transaction in CMIPS.

**CWDs WILL NOT USE THE SOC 312 TRANSACTION TO VOID/STOP PAYMENT, REPLACE OR DUPLICATE ANY WRO WARRANT.**

If the original warrant is cashed before a stop payment can be placed on the warrant, the duplicate warrant process will be stopped and the warrant will not be duplicated. If the claimant denies cashing the warrant, request a photocopy of the warrant and have him/her review the signature on the photocopy. If the claimant still denies cashing the warrant, begin the forgery process.

#### FORGERIES

Warrants alleged to be forged will follow the forgery procedures currently in the CMIPS User's Manual. CWDs will submit a completed forgery affidavit package to:

Electronic Data Systems  
Attention: IHSS Payroll Clerk  
P. O. Box 700  
Rancho Cordova, CA 95741-0700

A complete forgery affidavit package (one for each warrant) will include: a photocopy of the forged warrant (front and back); a statement in the payee's own handwriting, after reviewing the signature on the warrant photocopy; and, three completed Forged Endorsement Affidavit forms. A completed Forged Endorsement Affidavit must include the payee's and two witness' signatures (or notarized - first page only) in ink on all three pages of the affidavit.

If the Forgery Endorsement Affidavit or the affidavit package is not complete, EDS will return the package to the CWD to complete. It is recommended that the payee be cautioned that it can take from 90 to 120 days to complete the processing of the forgery affidavit.

Use the PAY 963 form to request photocopies of WRO warrants. To request certified photocopies or original warrants, a type-written request stating why and when you need them must be attached to a completed PAY 963 and sent to EDS at the address above.

#### CROSS REFERENCE SCREEN

The Judgment Cross Reference Screen (JXRF), accessible through either a name or social security number, will identify:

The claimant's name, social security number, address, telephone number, recipient and/or provider name(s), social security number(s), case number, whether the claimant submitted a claim in Miller I, Miller II, WRO or any future court case and whether the claimant received an underpayment (code 09) from Miller I.

Every CWD will have access to the JXRF information statewide without having to enter a special password. The JXRF information will help CWDs to avoid double case numbers, double payments and/or over payments. You will receive the field-by-field description and a copy of the screen during training.

Any claimant who received payment under the Miller I judgment will only receive an eligibility determination for underpayments. CWDs must access the JXRF screen to identify these claimants and to use that information to determine eligibility for additional payment.

Prior to entering the SOC 293/311 information on the WROR/WROP screens the CWD should check the JXRF information for a name or social security number match. If the claimant and the recipient is listed the CWD will use the recipient name and case number from the JXRF screen. If the claimant is not listed or there is no opened or discontinued case record file the CWD must establish a new case number and case record file.

#### EDITS

On-line edits for all four judgment screens (WROR, WROP, WROW and WROU) will be distributed during the Miller v. Woods and WRO v. McMahon training sessions. On-line edits, or error messages, will be listed alphabetically and as they appear on the judgment screens followed by a brief explanation.

On the WROP screen, SOC 311 Field E2 'Rel of Prov' is a required field. When attempting to enter that data on the WROP screen you may receive an edit message that reads:

"Required field; enter on PELG"

If you are entering WRO data on a currently active case, information has "copied over" from the Provider Eligibility File where Field E2 is an optional field. To key the relationship of the provider, it is necessary to exit the WROP screen, enter the PELG screen and key the relationship of the provider in Field E2, exit the PELG screen and return to the WROP screen to continue to enter the WRO data.

The final filing date for the WRO claim period is 09-30-93. An on-line edit will become effective 10-01-93 that will prohibit payments on late claims.

- o WROR - "Claim DT > 09-30-93, enter NOA W175"
- o WROP - "Claim DT > 09-30-93, enter NOA W075"

REGARDLESS OF THE CLAIM DATE, PROPERLY PROCESS ALL CLAIMS AND DO NOT DESTROY ANY CLAIM FILED AFTER THE FINAL FILING DATE.

Please carefully review the entire ACL package, including the field-by-field descriptions for additional edits.

#### NOTICE OF ACTION (NOA)

A NOA (see the attached messages and Reason Codes) must be sent to each claimant whenever:

- o a claim is approved
- o a claim is denied
- o a document is returned to the claimant requesting that the document be completed and returned
- o a document is returned identifying contradictions with the information submitted by the claimant.

Provider NOA Reason Codes are numbered W001 through W077, W090 and W091. Specific NOA messages have been designed for claimant action. The purpose of each message is identified.

- o NOA message W008 is to be used in tandem with any adverse action NOA message (W009 through W036) when a CWD has contradictory information in its possession.
- o NOA message W037 is to be used in tandem with any final NOA message (W038 through W077).

All provider NOA Reason Codes are to be written on the SOC 311 in Field F8, G8 and H8. Enter more than one code for each field, if necessary. To generate a NOA, the Reason Code must be key entered on either the WROP, WROW or WROU screens. If a NOA Reason Code has been key entered on the WROP screen an on-line edit will not allow a NOA Reason Code to be key entered on either the WROW or WROU screens in the same day.

Recipient/Applicant NOA Reason Codes are numbered W101 through W177, W190 and W191. The purpose of each message is identified.

- o NOA message W108 is to be used in tandem with any adverse action NOA message (W109 through W136) when a CWD has contradictory information in its possession.
- o NOA message W137 is to be used in tandem with any final NOA message (W138 through W177).

All recipient/applicant NOA Reason Codes are to be written on the SOC 293 in feild ZZ2. To generate a NOA, the Reason Code must be entered on either the WROR, WROW or WROU screens. If a NOA Reason Code has been key entered on the WROR screen an on-line edit will not allow a NOA Reason Code to be key entered on either the WROW or WROU screens in the same day.

NOAs will be automated and some claim dates will be "plugged" in message blanks. CWD staff will be responsible for filling in other information and, when necessary, adding information to the NOA message (Reason Codes W034, W035, W072, W073, W076, W077 and W091 for providers; W134, W135, W172, W173, W176, W177 and W191 for recipients/applicants).

- o Remember to fill in the NOA Date when mailing the form NA 690W (2/93) to the claimant.
- o Remember to attach two copies of the worksheet printout to the appropriate NOA before mailing.

While attempting to key enter NOA Reason Codes on any of the judgment screens you may get the message:

"Invalid manual NOA code."

This means you have tried to enter the NOA Reason Code on the wrong screen.

The following are listings of all the codes and their applicable screen(s):

WROP: W001 - W077

WROR: W101 - W177

If separate Retroactive payment and Underpayment claims are submitted, then depending on the code (R or U) key entered in the "RETRO/UNDER" field will determine which Reason Code is valid.

IF "R" IS KEY ENTERED

WROP

W001 - W009  
W011  
W013  
W015  
W017  
W019  
W021  
W023  
W025  
W027  
W029  
W031 - W045  
W047  
W049  
W051  
W053  
W055  
W057  
W059  
W061  
W063  
W065  
W067  
W069 - W077

WROR

W101 - W109  
W111  
W113  
W115  
W117  
W119  
W121  
W123  
W125  
W127  
W129  
W131 - W145  
W147  
W149  
W151  
W153  
W155  
W157  
W159  
W161  
W163  
W165  
W167  
W169 - W177

IF "U" IS KEY ENTERED

WROP

W001 - W008  
W010  
W012  
W014  
W016  
W018  
W020  
W022  
W024  
W026  
W028  
W030 - W043

WROR

W101 - W108  
W110  
W112  
W114  
W116  
W118  
W120  
W122  
W124  
W126  
W128  
W130 - W143

WROP

W045  
W046  
W048  
W050  
W052  
W054  
W056  
W058  
W060  
W062  
W064  
W066  
W068 - W077

WROR

W145  
W146  
W148  
W150  
W152  
W154  
W156  
W158  
W160  
W162  
W164  
W166  
W168 - W177

## PAYMENT SCREENS

WROW:

Prov.	Recip.
W044	W144
W045	W145
W047	W147
W049	W149
W051	W151
W053	W153
W055	W155
W057	W157
W059	W159
W061	W161
W063	W163
W065	W165
W067	W167
W069 - W077	W169 - W177
W090	W190
W091	W191

WROU:

Prov.	Recip.
W045	W145
W046	W146
W048	W148
W050	W150
W052	W152
W054	W154
W056	W156
W058	W158
W060	W160
W062	W162
W064	W164
W066	W166
W068 - W077	W168 - W177
W090	W190
W091	W191

- o NOA message W091 is to be entered on the WROW or WROU judgment screen in tandem with any final NOA message as shown above.
- o NOA message W191 is to be entered on the WROW or WROU judgment screen in tandem with any final NOA message as shown above.

IN-HOME SUPPORTIVE SERVICES ASSESSMENT

										BIRTHDATE			
A	CNTY (1) ✓	RECIPIENT # ✓	CD. ✓	SEQ. # (2)	AID CODE (3) ✓	SOCIAL SECURITY NO. (4) ✓				SEX (5) M ✓ F	MONTH (6) ✓	DAY ✓	YEAR ✓
B	LAST NAME (1) ✓				FIRST NAME (2) ✓								MI (3) ✓
C	STREET (1) ✓				CITY (2) ✓				STATE (3) ✓	ZIP CODE / CT (4) ✓			
D	TELEPHONE # (1) ✓		(2)		(3)		GUARDIAN/CONSERVATOR (4) ✓						
E	STREET (1) ✓				CITY (2) ✓				STATE (3) ✓	ZIP CODE / CT (4) ✓			
F	STATUS (1) ✓	PRIM. DIAG. (2) ✓	CITIZEN (3)	ETHNIC (4)	LANG. (5) ✓	OTH. / COV. (6)	SSNV (7)	HIC. / RR. # (8)	FBI. # (9)				
G	SPOUSE / PARENT (1)		# HH (2)	# RCP (3)	RES (4)	L/A (5)	# ROOMS (6)	YARD (7) Y N	WASHER (8) Y N	DRYER Y N	STOVE Y N	REFRIG. Y N	
H	(1) HOUSEWORK LAUNDRY SHOPPING & ERRANDS MEAL PREP & CLEANUP MOBILITY INSIDE BATHING & GROOMING DRESSING BOWEL, BLADDER & MENSTRUAL TRANSFER EATING RESPIRATION MEMORY ORIENTATION JUDGEMENT FUNCTIONAL INDEX (2) FUNCTIONAL INDEX HOURS (3) H/D #ISS (4) NEED PROVIDER												
I	SHARE OF COST DATE (1)		LINK (2)	DEP (3)	SOURCE (4)	INCOME		DEDUCT	COUNTABLE INCOME (5)				
J	SOURCE (1)		INCOME		DEDUCT	SOURCE (2)		BENEFIT CODE / LEVEL (3)					
K	SOURCE (1)		INCOME		DEDUCT	SOURCE (2)		SHARE OF COST (3)					
L	MODE (1)	RATE	HOURS	MODE (2)	RATE	HOURS	RECOVERY (3)						
M	ACT	BEGINNING DATE (2) ✓	ENDING DATE (3) ✓	GROSS AMOUNT (4)	MODE (5)	RATE	HOURS	SHARE OF COST (6)	TYPE (7)	PAY OPT (8)			
N	D	✓	✓										
O	D	✓											
P	APPLICATION DATE (1)		REF (2)	FACE TO FACE DATE (3) ✓		COUNTY USE (4) ✓							
Q	D/O (1) ✓	(2)	SERVICE WORKER NAME (3) ✓				SW. # (4) ✓	SERVICE WORKER PHONE # (5) ✓					
R	ALERT MESSAGE												
S	NOA MESSAGE												
T	AUTHORIZATION::												
	VALIDATION:				DATE:				REMARKS:				
	VALIDATION:				DATE:				REMARKS:				

State of California - Health & Welfare Agency - Department of Social Services

LAST NAME & #	SEQ. #	TOTAL NEED	ADJUSTMENTS	INDIVIDUAL ASSESSED NEED	ALTERNATIVE RESOURCES	AUTH TO BE PURCH	UNMET NEED	COUNTY USE
AA								
	Domestic Services							
BB								
	• Preparation of Meals							
CC								
	** Meal Clean Up							
DD								
	Routine Laundry, Etc							
EE								
	Shopping for Food							
FF								
	Other Shopping & Errands							
GG								
	Heavy Cleaning							
HH								
	• Respiration							
II								
	• Bowel and Bladder Care							
JJ								
	• Feeding							
KK								
	• Routine Bed Baths							
LL								
	• Dressing							
MM								
	• Menstrual Care							
NN								
	• Ambulation							
OO								
	• Moving In/Out of Bed							
PP								
	• Bathing, Oral Hygiene, Grooming							
QQ								
	• Rubbing Skin, Repositioning, Etc.							
RR								
	• Care and Assistance with Prosthesis							
SS								
	Accompaniment To Medical Appointment							
TT								
	Accompaniment To Alternate Resources							
UU								
	Remove Grass, Weeds, Rubbish							
VV								
	Remove ice, Snow							
WW								
	Protective Supervision							
XX								
	Teaching & Demonstration							
YY								
	• Paramedical Services							

NOA. ✓	RSN. CD. ✓	RSN. CD. ✓	RSN. CD. ✓	RSN. CD. ✓	BEGINNING DATE	ENDING DATE	ADVANCE (5) Y N	MEAL ALLOW (6) Y N
(1) M C N	(2) ✓	✓	✓	✓	(3)	(4)	(5) Y N	(6) Y N
ZZ								
MONTHLY HRS. AUTHORIZED.	WKLY. HRS (1)	MEAL HRS. (BB+CC+EE) (2)	MO. HRS. (3)	TOTAL (4)	PURCHASE (5)	UNMET NEED (7)		
	=	x4.33 =	=	=	=	=		

IN-HOME SUPPORTIVE SERVICES  
WRO v. MCMAHON  
SERVICES ASSESSMENT FORM (SOC 293)  
FIELD-BY-FIELD DESCRIPTION

The SOC 293 must be used whether the claimant is an recipient/applicant or a provider. The SOC 293 is to be used to capture all of the recipient/applicant information and guardian information if applicable. If the claimant is a recipient/applicant, enter all required fields with the correct information. If the claimant is a provider, enter only those fields that are applicable.

Description:

Field A1           CNTY/RECIPIENT #/CD - Required

Enter the 2 digit county number, 7 digit recipient number and 1 digit check digit, if known. CMIPS will generate a check digit if the number is unknown.

Field A2           SEQ # - Automatically Generated

Each WRO v. McMahon case will have its own sequence number series.

Field A3           AID CODE - Required

Enter the correct aid code, if known. If unknown, enter aid code 60.

10 - Aged, general SSI/SSP  
18 - Aged, IHSS income eligible  
20 - Blind, general SSI/SSP  
28 - Blind, IHSS income eligible  
60 - Disabled, general SSI/SSP  
68 - Disabled, IHSS income eligible

Field A4           SOCIAL SECURITY NO. - Required

Enter the correct 9 digit Social Security Number (SSN). If the claimant is an recipient/applicant, you must enter a valid SSN. If the claimant is a provider and the recipient/applicant SSN is unknown, enter 000-00-0000.

Field A5           SEX - Required

Circle M or F if known; if unknown circle F.

Field A6        BIRTHDATE - Required  
Enter the birthdate in a MM DD YY format, if known.  
If the birthdate is unknown, enter 00 00 00.

Field B1        LAST NAME - Required  
Enter the last name of the recipient/applicant.

Field B2        FIRST NAME - Required  
Enter the first name of the recipient/applicant.

Field B3        MI - Optional  
Enter the middle initial of the recipient/  
applicant.

Field C1        STREET - Required  
Enter the current street address/P.O. Box, if  
known; if unknown, enter 0.

Field C2        CITY - Required  
Enter the current city if known; if unknown, enter  
0.

Field C3        ST - Required  
Enter the current state if known; if unknown, enter  
0.

Field C4        ZIP CODE/CT - Required  
Enter the current zip code if known; if unknown,  
enter 00000.

Field D1        TELEPHONE - Optional  
Enter the 10 digit telephone number, including the  
area code if known.

THE FOLLOWING FIELDS (D and E) ARE OPTIONAL, EXCEPT WHEN A CLAIM  
IS MADE BY A GUARDIAN/CONSERVATOR, AUTHORIZED REPRESENTATIVE OR  
EXECUTOR OF THE ESTATE OF A RECIPIENT; THEN THE FOLLOWING FIELDS  
(D and E) ARE REQUIRED.

Field D4        GUARDIAN/CONSERVATOR - Optional  
Enter the guardian/conservator's name in last name,  
first name and middle initial format.

Field E1      STREET - Optional  
 Enter the guardian/conservator's current street address or P.O. Box.

Field E2      CITY - Optional  
 Enter the guardian/conservator's current city.

Field E3      ST - Optional  
 Enter the guardian/conservator's current state.

Field E4      ZIP CODE/CT - Optional  
 Enter the guardian/conservator's current zip code.

Field F1      STATUS - Required  
 Add code W to the form and circle it. Enter the same code on the WROR screen.

Field F2      PRIM DIAG - Required (Claimant)  
 Enter one of the following codes:  
                 P = Provider Claimant  
                 R = Recipient Claimant  
                 B = Both Provider and Recipient Claimant

Field F5      LANG. - Required  
 Enter one of the following codes:  
                 E = English NOA  
                 S = Spanish NOA

Field M2      BEGINNING DATE - Optional (Original Standard Claim Form File Date)  
 This field will be used to record the file date of the recipient/applicant WRO v. McMahon Standard Claim Form only. This date will print with the recipient/applicant boilerplate message. THIS FIELD WILL BECOME A REQUIRED FIELD IF A "R" OR "B" IS ENTERED IN THE CLAIM FIELD (F2) ON THE WROR SCREEN. IF THE CLAIMANT IS A PROVIDER, THIS FIELD WILL BE LEFT BLANK.  
 Enter the original Standard Claim Form file date as determined by MPP 50-061.32(a), (b), (c) and (d).

This date begins the first 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

The only two exceptions to the 45/60 day claim process are InterCounty transfers and where the completion of the specified tasks 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 claimant's case file.

CWDs receiving claims forwarded from another CWD shall process the claim, determine eligibility, enter the retroactive/interest payment, underpayment information, issue the necessary Notice of Action and forward the necessary documents to the CMIPS within 45 days of receipt from the original CWD or promptly after all necessary forms/documents are completed/submitted.

THE FILING DATE RECORDED IN THIS FIELD BY THE FIRST CWD WILL ALSO BE THE FILING DATE RECORDED IN THIS FIELD BY THE SECOND CWD.

Field M3

ENDING DATE - Optional (Resubmitted Standard Claim Form File Date)

This field will be used to record the date the recipient/applicant resubmitted his/her WRO v. McMahon Standard Claim Form only. THIS FIELD WILL BECOME A REQUIRED FIELD IF THE REASON CODE W138 IS ENTERED. IF THE CLAIMANT IS A PROVIDER, THIS FIELD WILL BE LEFT BLANK.

This date begins the second 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

Enter the resubmitted Standard Claim Form file date as determined by MPP 50-061.315.

Field N2

BEGINNING DATE - Optional (Original Supplemental Claim Form File Date)

This field will be used to record the date the recipient/applicant filed the original WRO v. McMahon Supplemental Claim Form only, if applicable. THIS FIELD WILL BECOME A REQUIRED FIELD IF THE REASON CODE W102 IS ENTERED. IF THE CLAIMANT IS A PROVIDER, THIS FIELD WILL BE LEFT BLANK.

This date begins the third 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

Enter the original Supplemental Claim Form file date as determined by MPP 50-061.32(a), (b), (c) and (d).

Field N3

ENDING DATE - Optional (Resubmitted Supplemental Claim Form File Date)

This field will be used to record the date the recipient/applicant resubmitted his/her WRO v. McMahon Supplemental Claim Form only, if applicable. THIS FIELD WILL BECOME A REQUIRED FIELD IF THE REASON CODE W140 IS ENTERED. IF THE CLAIMANT IS A PROVIDER, THIS FIELD WILL BE LEFT BLANK.

This date begins the fourth 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

Enter the resubmitted Supplemental Claim Form file date as determined by MPP 50-061.315.

Field 02

BEGINNING DATE - Optional (Adverse Action Rebuttal File Date)

This field will be used to record the date when the recipient/applicant submitted his/her WRO v. McMahon adverse action rebuttal information or documentation. IF THE CLAIMANT IS A PROVIDER, THIS FIELD WILL BE LEFT BLANK.

This date begins the fifth 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

Enter the rebuttal date as determined by MPP  
50-061.315

Field P4 COUNTY USE - Optional (County Transfer Date)

This field will be used to record the date the WRO v. McMahon Standard Claim Form and, if applicable, the Supplemental Claim Form are sent from the first CWD and received by the second CWD. IF THE CLAIMANT IS A PROVIDER, THIS FIELD WILL BE LEFT BLANK.

First CWD: Enter the date the first CWD transferred (mailed) the Standard Claim Form to the second CWD.

Second CWD: Enter the date the second CWD accepted (received) the transferred Standard Claim Form as determined by MPP 50-061.32(a), (b), (c), (d) and (e).

The second CWD's acceptance date begins the first 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

THE FILING DATE RECORDED BY THE FIRST CWD (FIELD M2) WILL ALSO BE THE FILING DATE RECORDED (FIELD M2) BY THE SECOND CWD.

Field Q1 D/O - Optional

Enter a digit number if there is more than one district office in your county (ie. 01, 02, etc.,).

Field Q2 SERVICE WORKER NAME - Required

Enter the Social Service Worker name in first name or initial and last name format.

Field Q3 SW# - Required

Enter the assigned Social Service Worker number.

Field Q4 SERVICE WORKER PHONE # - Required

Enter the 10 digit telephone number, including the area code, of the Social Service Worker named in Field Q2.

Field ZZ1 NOA - Display Only

All Notices of Action will be returned to the CWD for completion of the NOA message(s) - and to attach the computation of wages and interest (or other documents), if applicable - and mailing.

Field ZZ2 RSN CD - Optional

Enter the appropriate reason code(s) when ready to issue a Notice of Action. Unless the NOA message does not so specify, each Notice of Action begins a 45 day period that must be monitored as part of the WRO v. McMahon claim process.

Enter reason code W106 when initiating an Inter-County Transfer but the first CWD will keep partial responsibility for validation of part of the claim period(s). Refer to Notices of Action InterCounty Transfer procedures for additional instructions.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY  
 DEPARTMENT OF SOCIAL SERVICES  
 IN - HOME SUPPORTIVE SERVICES

PROVIDER ELIGIBILITY UPDATE

A	COUNTY (1) ✓	RECIPIENT # (1) ✓	CD. (1) ✓	PROVIDER NUMBER (2) ✓	SEQ # (3)	(4) ✓	RECIPIENT NAME			
B	LAST NAME (1) ✓			FIRST NAME (2) ✓		MI (3) ✓	STATUS (4) E L D X ✓		ETHNIC (5)	LANG. (6) ✓
C	STREET (1) ✓			CITY (2) ✓		STATE (3) ✓	ZIP CODE/CT (4) ✓			
D	SOCIAL SECURITY # (1) ✓	DED/EXEMPT (2) P S C B O ✓		TELEPHONE # (3) ✓	SEX (4) M F ✓	BIRTHDATE (5) MONTH DAY YEAR		W-5 (6)	W-4 (7) ✓	
E	COUNTY USE (1)					REL. OF PROV. (2) ✓	# OF PROV. (3)	RECOVERY (4)		
F	ACTION (1) DEL	BEGINNING DATE (2) ✓	ENDING DATE (3) ✓	HOURS (4)	SHARE/COSTS (5)	RATE (6)	SPLIT SHIFT (7)	(8) ✓		
G	(1) DEL	(2) ✓	(3) ✓	(4)	(5)	(6)	(7)	(8) ✓		
H	(1) DEL	(2) ✓	(3) ✓	(4)	(5)	(6)	(7)	(8) ✓		

A	PROVIDER NUMBER (2)									
B	LAST NAME (1)			FIRST NAME (2)		MI (3)	STATUS (4) E L D X		ETHNIC (5)	LANG. (6)
C	STREET (1)			CITY (2)		STATE (3)	ZIP CODE/CT (4)			
D	SOCIAL SECURITY # (1)	DED/EXEMPT (2) P S C B O		TELEPHONE # (3)	SEX (4) M F	BIRTHDATE (5) MONTH DAY YEAR		W-5 (6)	W-4 (7)	
E	COUNTY USE (1)					REL. OF PROV. (2)	# OF PROV. (3)	RECOVERY (4)		
F	ACTION (1) DEL	BEGINNING DATE (2)	ENDING DATE (3)	HOURS (4)	SHARE/COSTS (5)	RATE (6)	SPLIT SHIFT (7)	(8)		
G	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)		
H	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)		

COUNTY VALIDATION		
AUTHORIZATION	DATE	REMARKS
VALIDATION	DATE	REMARKS

SOC 311 (10/85)

IN-HOME SUPPORTIVE SERVICES  
WRO v. MCMAHON  
PROVIDER ELIGIBILITY UPDATE FORM (SOC 311)  
FIELD-BY-FIELD DESCRIPTION

The SOC 311 In-Home Supportive Services Provider Eligibility Update form shall be used to collect all the data on the provider/claimant. This information is to be entered on the WROP screen. The SOC 311 is to be used in tandem with the SOC 293 for provider claimants.

Field A1           CNTY/RECIPIENT #/CD - Required

Enter the 2 digit county number, 7 digit recipient number and 1 digit check digit.

Field A2           PROVIDER NUMBER - Required

Enter the last 6 digits of the provider's Social Security Number.

Field A3           SEQ # - Automatically Generated

Each WRO v. McMahon case will have its own sequence number series.

Field A4           RECIPIENT NAME - Display only

On the initial document enter the recipient name for identification purposes; afterwards, the recipient name will be displayed on the turnaround document.

Field B1           LAST NAME - Required

Enter the last name of the provider.

Field B2           FIRST NAME - Required

Enter the first name of the provider.

Field B3           MI - Optional

Enter the middle initial of the provider.

Field B4           STATUS - Required

Add code W to the form and circle it. Enter the same code on the WROP screen.

Field B6            LANG. - Required  
                    Enter one of the following codes:  
                    E = English NOA  
                    S = Spanish NOA

Field C1            STREET - Required  
                    Enter the provider's current street address/P.O.  
                    Box.

Field C2            CITY - Required  
                    Enter the provider's current city.

Field C3            STATE - Required  
                    Enter the provider's current state.

Field C4            ZIP CODE/CT - Required  
                    Enter the provider's current zip code.

Field D1            SOCIAL SECURITY # - Required  
                    Enter the correct 9 digit Social Security Number  
                    (SSN). Only valid SSN's will be acceptable.

Field D2            DED/EXEMPT - Required  
                    Circle S which signifies the provider's tax status.

Field D3            TELEPHONE # - Optional  
                    Enter the 10 digit telephone number, including the  
                    area code if known.

Field D4            SEX - Required  
                    Circle M or F if known; if unknown circle F.

Field D7            W-4 - Display only  
                    This field will display a W4 if there is an  
                    Employer's Withholding Allowance Certificate (W-4)  
                    on file to withhold Federal and State Income Taxes.

Field E2

REL. OF PROV. - Required

Enter the correct code:

01 = spouse  
02 = parent of minor child  
03 = parent of adult child  
04 = minor child  
05 = adult child  
06 = other relative  
07 = friend  
10 = housemate  
11 = live-in provider  
14 = other

Field F2

BEGINNING DATE - Optional (Original Standard Claim Form File Date)

This field will be used to record the file date of the provider's WRO v. McMahon Standard Claim Form only. This date will print with the provider's boilerplate message. THIS FIELD WILL BECOME A REQUIRED FIELD IF A "P" OR "B" IS ENTERED IN THE CLAIM FIELD (F2) ON THE WROR SCREEN.

Enter the original Standard Claim Form file date as determined by MPP 50-061.32 (a), (b), (c) and (d).

This date begins the first 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

The only two exceptions to the 45/60 day claim process are InterCounty transfers and where the completion of the specified tasks 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 claimant's case file.

CWDs receiving claims forwarded from another CWD shall process the claim, determine eligibility, compute retroactive/interest payment, underpayment, issue the necessary Notice of Action and forward the necessary documents to the CMIPS within 45 days of receipt from the original CWD or promptly after all necessary forms/documents are completed/submitted.

THE FILING DATE RECORDED IN THIS FIELD IN THE FIRST CWD WILL ALSO BE THE FILING DATE RECORDED IN THIS FIELD BY THE SECOND CWD.

Field F3

ENDING DATE - Optional (Resubmitted Standard Claim Form File Date)

This field will be used to record the date the provider resubmitted his/her WRO v. McMahon Standard Claim Form. THIS FIELD WILL BECOME A REQUIRED FIELD IF THE REASON CODE W038 IS ENTERED.

This date begins the second 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

Enter the resubmitted Standard Claim Form file date as determined by MPP 50-061.315.

Field G2

BEGINNING DATE - Optional (Original Supplemental Claim Form File Date)

This field will be used to record the date the provider filed the original WRO v. McMahon Supplemental Claim Form only. THIS FIELD WILL BECOME A REQUIRED FIELD IF THE REASON CODE W002 IS ENTERED.

This date begins the third 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

Enter the original Supplemental Claim Form file date as determined by MPP 50-061.32(a), (b), (c) and (d).

Field G3

ENDING DATE - Optional (Resubmitted Supplemental Claim Form File Date)

This field will be used to record the date the provider resubmitted his/her WRO v. McMahon Supplemental Claim Form only. THIS FIELD WILL BECOME A REQUIRED FIELD IF THE REASON CODE W040 IS ENTERED.

This date begins the fourth 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

Enter the resubmitted Supplemental Claim Form file date as determined by MPP 50-061.315.

Field H2

BEGINNING DATE - Optional (Adverse Action Rebuttal File Date)

This field will be used to record the date when the provider submitted his/her WRO v. McMahon adverse action rebuttal documents.

This date begins the fifth 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

Enter the rebuttal date as determined by MPP 50-061.32.

Field H3

COUNTY USE - Optional (InterCounty Transfer Date)

This field will be used to record the date the WRO v. McMahon Standard Claim Form and, if applicable, the Supplemental Claim Form are sent from the first CWD and received by the second CWD.

First CWD: Enter the date the first CWD transferred (mailed) the Standard Claim Form to the second CWD.

Second CWD: Enter the date the second CWD accepted (received) the transferred Standard Claim Form as determined by MPP 50-061.32(a), (b), (c) and (d).

The second CWD's acceptance date begins the first 45/60 day claim process: 45 days to determine eligibility for WRO v. McMahon retroactive/interest payment, underpayment and 15 days to process through CMIPS and mail a Notice of Action.

THE FILING DATE RECORDED BY THE FIRST CWD (FIELD F2) WILL ALSO BE THE FILING DATE RECORDED (FIELD F2) BY THE SECOND CWD.

Field F8, G8, H8 (RSN. CD.) - Optional

Enter the appropriate reason code(s) when ready to issue a Notice of Action. Enter 2 NOA codes per field, if necessary. Unless the NOA message does not so specify, each Notice of Action begins a 45 day period that must be monitored as part of the WRO v. McMahon claim process.

Enter reason code W006 when initiating an Inter-County transfer but the first CWD will keep partial responsibility for validation of part of the claim period(s). Refer to Notices of Action InterCounty Transfer procedures for additional instructions.

=====
THIS WROR I 1234567890
NEXT WROR I 1234567890

WRO RECIPIENT RETROPAYMENT CLAIM

RETRO/UNDER: R
SEQ# 001 AID 60 SSN 999 - 99 - 9999 SEX M BIRTHDATE: MM 99 DD 99 YY 1999
LAST NAME JONES FIRST CHARLES MI D
STR 123 STREET NAME CTY CHULA VISTA ST CA Z 12345 9999
PHONE # ( 999 ) 999 - 9999 GUARDIAN
STR CTY ST Z
STAT M CLAIM P LANG S

ORIGINAL CLAIM (M2): MM DD YY RESUB STD CLAIM (M3): MM DD YY
ORIG SUP CLAIM (N2): MM DD YY RESUB SUP CLAIM (N3): MM DD YY
ADV ACT REBUTAL (O2): MM DD YY COUNTY TRANSFER (P4): MM DD YY

OFFICE 99 SRV WKR NAME XXXXXXXXXXXXXXXXXXXXXXXX # XXXX PHONE # ( 999 ) 999 - 9999

NOA X REASON CODES : (1) XXXX (2) XXXX (3) XXXX (4) XXXX
CNTY TRANSFER NUMBER: 99 99 99 99

RETRO & UNDERPAYMENT REASON CODE HISTORY (CODE/CNTY TRANSFER NBR/PROCESS DATE)
XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY
XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY
=====

IN-HOME SUPPORTIVE SERVICES  
WRO v. MCMAHON  
RECIPIENT RETROPAYMENT CLAIM SCREEN  
FIELD-BY-FIELD DESCRIPTION

The IHSS WRO v. McMahon Recipient Retropayment Claim Screen (WROR) is used to collect all data if the claimant is an applicant/recipient and to collect some data if the claimant is a service provider. If the claimant is a current recipient, the Recipient and Guardian/Conservator information will be copied automatically from the CMIPS Recipient Eligibility (RELA) screen and will not require County staff input of the same information once a recipient number has been key entered on the "NEXT" line.

Be sure, however to validate the claim information with the current recipient information.

DESCRIPTION:

Field: RECIPIENT/PROVIDER # (NEXT WROR)

Length: 10

Description: Recipient # - Enter the 2 digit County number, 7 digit recipient number and 1 digit check digit.

Field: RETRO/UNDER:

Length: 1

Description: Retroactive/Underpayment - If separate Retroactive and Underpayment claims are submitted this field will be used to identify which claim information will be displayed on the WROR and WROP screens.

R = Retroactive claimant information

U = Underpayment claimant information

IF A CODE IS NOT ENTERED CMIPS WILL DEFAULT TO "R"

Field: SEQ # - System Generated, Numeric

Length: 3

Description: Sequence Number - a computer generated chronological number that indicates the most recent turnaround document.

Field: AID - Required, Numeric  
Length: 2  
Description: Aid Code - State aid codes define the applicant/  
recipient's benefit categories for budget, Medical  
and accounting purposes. Enter the correct aid  
code, if known; if unknown, enter aid code 60

10 - Aged, general SSI/SSP  
18 - Aged, IHSS income eligible  
20 - Blind, general SSI/SSP  
28 - Blind, IHSS income eligible  
60 - Disabled, general SSI/SSP  
68 - Disabled, IHSS income eligible

Field: SSN - Required, Numeric  
Length: 9  
Description: Social Security Number - A 9 digit number assigned  
to the applicant/recipient by the Federal  
government. If the claimant is an applicant/  
recipient, you must enter a valid SSN. If the  
claimant is a provider and the applicant/recipient  
SSN is unknown, enter 000-00-0000

Field: SEX - Required, Alpha  
Length: 1  
Description: Sex - Identification of the applicant/recipient's  
gender. Enter the correct code, if known; if  
unknown, enter F:  
M = Male  
F = Female

Field: BIRTHDATE - Required, Numeric  
Length: 8 Format: MM = Month, DD = Day, YYYY = Year  
Description: Date of Birth - Denotes the birthday of the  
applicant/recipient. If the birthdate is unknown,  
enter 00-00-00.

Field: LAST NAME - Required, Alphanumeric  
Length: 17  
Description: Last Name - Alpha/special characters (.,/-) used to  
identify a specific applicant/recipient's family.

Field: FIRST - Required, Alphanumeric  
Length: 12  
Description: First Name - Alpha/special characters (.,/-) preceding the last name to identify individual applicant/recipients.

Field: MI - Optional, Alphanumeric  
Length: 1  
Description: MI - Alpha character representing the middle initial.

Field: STR - Required, Alphanumeric  
Length: 28  
Description: Street - Applicant/recipient's place of residence within a designated city - used as mailing address. If the street address is unknown, enter 0; but only if the claimant is a guardian/conservator or a provider.

Field: CTY - Required, Alpha  
Length: 17  
Description: City - Applicant/recipient's city of residence. If the city is unknown, enter 0; but only if the claimant is a guardian/conservator or a provider.

Field: ST - Required, Alpha  
Length: 2  
Description: State - Applicant/recipient's state of residence. Defaults to "CA" if not entered.

Field: Z - Required, Numeric  
Length: 9  
Description: Zip Code - A nine digit numeric code that identifies areas within the United States for purposes of simplifying the distribution of mail. If the zip code is unknown, enter 00000.

Field: PHONE # - Optional, Numeric  
Length: 10  
Description: Telephone Number - A unique numeric sequence used for identification of the area code and telephone number of an applicant/recipient.

Field: GUARDIAN - Optional, Alphanumeric  
Length: 30  
Description: Guardian/Conservator - Alpha/special characters (./-) designating an individual legally responsible for a specific applicant/recipient.

Field: STR - Optional, Alphanumeric  
Length: 28  
Description: Street - Guardian/Conservator's place of residence within a designated city. Used as address on any warrant or Notice of Action issued to an applicant/recipient.

Field: CTY - Optional, Alpha  
Length: 17  
Description: City - Guardian/Conservator's city of residence.

Field: ST - Optional, Alpha  
Length: 2  
Description: State - Guardian/Conservator's state of residence. Defaults to "CA" if not entered.

Field: Z - Optional, Numeric  
Length: 9  
Description: Zip Code - A nine digit numeric code that identifies areas within the United States for purposes of simplifying the distribution of mail.

Field: STAT - Required, Alpha  
Length: 1  
Description: Status - Code which distinguishes Miller v. Woods I from Miller v. Woods II or WRO v. McMahon. Enter the code "W" (WRO v. McMahon).

Field: CLAIM - Required, Alpha  
Length: 1  
Description: Claimant - Code which identifies whether the claimant is a Provider, Recipient or Both. Enter one of the following codes:  
P = Provider Claimant  
R = Recipient Claimant  
B = Both a Provider and Recipient Claimant

Field: LANG - Required, Numeric  
Length: 1  
Description: Language - A number designating whether an English or Spanish Notice of Action should be printed. Enter one of the following codes:  
E = English  
S = Spanish

Field: ORIGINAL CLAIM (M2) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Original Claim Date - The file date of the applicant/ recipient's WRO v. McMahon Standard Claim Form. If the claimant is a provider, this field will be left blank.

Field: RESUB STD CLAIM (M3) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Resubmit Original Claim Date - The file date the applicant/ recipient resubmits the WRO v. McMahon Standard Claim Form. If the claimant is a provider, this field will be left blank.

Field: ORIG SUP CLAIM (N2) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Original Supplemental Claim Date - The file date of the applicant/ recipient's WRO v. McMahon Supplemental Claim Form. If the claimant is a provider, this field will be left blank.

Field: RESUB SUP CLAIM (N3) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Resubmit Supplemental Claim Date - The file date the applicant/ recipient resubmits the WRO v. McMahon Supplemental Claim Form. If the claimant is a provider, this field will be left blank.

Field: ADV ACT REBUTAL (O2) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Adverse Action Rebuttal File Date - The file date the applicant/ recipient submits his/her adverse action rebuttal documents for reconsidering his/her eligibility for payment under the WRO v. McMahon judgment. If the claimant is a provider, this field will be left blank.

Field: COUNTY TRANSFER (P4) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: County Transfer Date - The date the WRO v. McMahon applicant/recipient's Standard Claim Form and, if applicable, the Supplemental Claim Form are sent from the first County and received by the second County.

First County: Enter the date the first County transferred (mailed) the Standard Claim Form as determined by MPP 50-061.32.

Second County: Enter the date the second County accepted (received) the transferred Standard Claim Form as determined by MPP 50-061.32(h)(2).

THE FILING DATE RECORDED BY THE FIRST COUNTY (FIELD M2) WILL ALSO BE THE FILING DATE RECORDED IN FIELD M2 BY THE SECOND COUNTY. IF THE CLAIMANT IS A PROVIDER, THIS FIELD WILL BE LEFT BLANK.

Field: OFFICE - Optional, Alphanumeric  
Length: 2  
Description: District Office - Two digit number identifying a specific office within the county. If not entered, system will default to 01.

Field: SRV WKR NAME - Required, Alphanumeric  
Length: 20  
Description: Service Worker Name - First name or initial and last name of the service worker identified in Q3.

Field: # - Required, Alphanumeric  
Length: 4  
Description: Service Worker Number - Number assigned by county to a service worker.

Field: PHONE # - Required, Numeric  
Length: 10  
Description: Service Worker Telephone Number - Telephone number of the service worker identified in Field Q2.

Field: NOA - Display only, Alpha  
Length: 1  
Description: Notice of Action - Denotes where the Notice of Action is to be sent. All Notices of Action will be returned to the County for completion of the NOA message(s) - and to attach the computation of wages and interest (or other documents), if applicable, and mailing.

Field: REASON CODES - Optional, Numeric  
Length: 4  
Description: Reason Code(s) - Four digit codes for actions described in Notice of Action messages.

Field: CNTY TRANSFER NUMBER - Optional, Numeric  
Length: 2  
Description: County Transfer Number - A two digit number which identifies the County Welfare Office to be sent a county transfer claim. This number will also identify, in CMIPS, the County Contact Name and Telephone Number to be included in the Notice of Action message. The following codes are valid:

01 ALAMEDA	02 ALPINE	03 AMADOR
04 BUTTE	05 CALAVERAS	06 COLUSA
07 CONTRA COSTA	08 DEL NORTE	09 EL DORADO
10 FRESNO	11 GLENN	12 HUMBOLDT
13 IMPERIAL	14 INYO	15 KERN
16 KINGS	17 LAKE	18 LASSEN
19 LOS ANGELES	20 MADERA	21 MARIN
22 MARIPOSA	23 MENDOCINO	24 MERCED
25 MODOC	26 MONO	27 MONTEREY
28 NAPA	29 NEVADA	30 ORANGE
31 PLACER	32 PLUMAS	33 RIVERSIDE
34 SACRAMENTO	35 SAN BENITO	36 SAN BERNARDINO
37 SAN DIEGO	38 SAN FRANCISCO	
39 SAN JOAQUIN	40 SAN LUIS OBISPO	
41 SAN MATEO	42 SANTA BARBARA	
43 SANTA CLARA	44 SANTA CRUZ	45 SHASTA
46 SIERRA	47 SISKIYOU	48 SOLANO
49 SONOMA	50 STANISLAUS	51 SUTTER
52 TEHAMA	53 TRINITY	54 TULARE
55 TUOLUMNE	56 VENTURA	57 YOLO
58 YUBA		

Field: REASON CODE HISTORY - Display Only

Length:

Description: Reason Code History - Displays the last 12 Reason Codes (NOA's) issued, from the most current to the first one issued, in the following format:

four digit Reason Code  
two digit County Transfer Number  
the date (MM-DD-YY) the notice was processed

THIS WROP I 123456789012345601  
NEXT WROP I 123456789012345601

WRO PROVIDER ~~UNDER~~<sup>RETRO</sup>PAYMENT CLAIM

RETRO/UNDER: U

SEQ# 001  
LAST NAME BILLY FIRST MARIE MI A STAT M LANG S  
STR 1234 STREET NAME CTY CITY NAME ST CA Z 12345 9999  
SSN 999 99 9999 TAX 0 PH# 999 999 9999 SEX M W4 9 99  
REL 99

ORIGINAL CLAIM (F2): MM DD YY RESUB STD CLAIM (F3): MM DD YY  
ORIG SUP CLAIM (G2): MM DD YY RESUB SUP CLAIM (G3): MM DD YY  
ADV ACT REBUTAL (H2): MM DD YY COUNTY TRANSFER (H3): MM DD YY

NOA X REASON CODES : (1) XXXX (2) XXXX (3) XXXX (4) XXXX  
CNTY TRANSFER NUMBER: 99 99 99 99

RETRO & UNDERPAYMENT REASON CODE HISTORY (CODE/CNTY TRANSFER NBR/PROCESS DATE)  
XXXX 99 MMDDYY  
XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY XXXX 99 MMDDYY

IN-HOME SUPPORTIVE SERVICES  
WRO v. MCMAHON  
PROVIDER RETROPAYMENT CLAIM SCREEN  
FIELD-BY-FIELD DESCRIPTION

The IHSS WRO v. McMahon Provider Retropayment Claim Screen (WROP) is used to collect provider information necessary for the correct Notice of Action and payment address, tax indicator, claim and supplemental form dates, relationship of the provider to the applicant/recipient and provider NOA codes. If the provider is currently in CMIPS, the Provider information will be copied automatically from the CMIPS Provider Eligibility (PELG) screen and will not require County staff input this information.

DESCRIPTION:

Field: RECIPIENT/PROVIDER # (NEXT WROP)

Length: 16

Description: Recipient/Provider # - Enter the 2 digit County number, 7 digit recipient number, 1 digit check digit and the 6 digit provider number.

Field: RETRO/UNDER:

Length: 1

Description: Retroactive/Underpayment - If separate Retroactive and Underpayment claims are submitted this field will be used to identify which claim information will be displayed on the WROR and WROP screens.

R = Retroactive claimant information

U = Underpayment claimant information

IF A CODE IS NOT ENTERED CMIPS WILL DEFAULT TO "R"

Field: SEQ # - System Generated, Numeric

Length: 3

Description: Sequence Number - a computer generated chronological number that indicates the most recent turnaround document.

Field: LAST NAME - Required, Alphanumeric  
Length: 17  
Description: Last Name - Alpha/special characters (.,/-) used to identify a specific provider.

Field: FIRST - Required, Alphanumeric  
Length: 12  
Description: First Name - Alpha/special characters (.,/-) preceding the last name to identify individual provider.

Field: MI - Optional, Alphanumeric  
Length: 1  
Description: MI - Alpha character representing the middle initial.

Field: STAT - Required, Alpha  
Length: 1  
Description: Status - Code which distinguishes Miller v. Woods I from Miller v. Woods II or WRO v. McMahon. Enter the code "W" (WRO v. McMahon).

Field: LANG - Required, Numeric  
Length: 1  
Description: Language - A number designating whether an English or Spanish Notice of Action should be printed. Enter one of the following codes:  
E = English  
S = Spanish

Field: STR - Required, Alphanumeric  
Length: 28  
Description: Street - provider's place of residence within a designated city - used as mailing address.

Field: CTY - Required, Alpha  
Length: 17  
Description: City - provider's city of residence.

Field: ST - Required, Alpha  
Length: 2  
Description: State - Provider's state of residence. Defaults to "CA" if not entered.

Field: Z - Required, Numeric  
Length: 9  
Description: Zip Code - A nine digit numeric code that identifies areas within the United States for purposes of simplifying the distribution of mail.

Field: SSN - Required, Numeric  
Length: 9  
Description: Social Security Number - A 9 digit number assigned to the provider by the Federal government. A valid SSN must be used here; invalid SSN's will not be accepted.

Field: TAX - Required, Alpha  
Length: 1  
Description: Tax Deduction/Exempt Status - Signifies the provider's tax status. Enter one of the following:  
P = Provider is parent  
S = Provider is spouse  
C = Provider is recipient's child and under 21  
O = Other

Field: PH # - Optional, Numeric  
Length: 10  
Description: Telephone Number - A unique numeric sequence used for identification of the area code and telephone number of a provider.

Field: SEX - Required, Alpha  
Length: 1 Format: M/F  
Description: Sex - Identification of the applicant/recipient's gender. Enter the correct code, if known; if unknown, enter F:  
M = Male  
F = Female

Field: W4 - Optional, Alphanumeric  
Length: 2  
Description: W-4 - Is an employee's withholding allowance form that is sent in by the provider to the County. Once EDS has received and entered a W-4 (Federal Income Tax), the withholding information designated by the provider will appear for inquiry purposes only.

Field: REL - Required, Numeric  
Length: 2  
Description: Relationship of Provider - Signifies the association of the provider to the applicant/recipient. Enter one of the following:  
01 = spouse  
02 = parent of minor child  
03 = parent of adult child  
04 = minor child  
05 = adult child  
06 = other relative  
07 = friend  
10 = housemate  
11 = live-in provider  
14 = other

Field: ORIGINAL CLAIM (F2) - Required, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Original Claim Date - The file date of the provider's WRO v. McMahon Standard Claim Form.

Field: RESUB STD CLAIM (F3) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Resubmit Original Claim Date - The file date the provider resubmits the WRO v. McMahon Standard Claim Form.

Field: ORIG SUP CLAIM (G2) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Original Supplemental Claim Date - The file date of the provider's WRO v. McMahon Supplemental Claim Form.

Field: RESUB SUP CLAIM (G3) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Resubmit Supplemental Claim Date - The file date the provider resubmits the WRO v. McMahon Supplemental Claim Form.

Field: ADV ACT REBUTAL (H2) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: Adverse Action Rebuttal File Date - The file date the provider submits his/her adverse action rebuttal documents for reconsidering his/her eligibility for payment under the WRO v. McMahon judgment.

Field: COUNTY TRANSFER (E1) - Optional, Numeric  
Length: 6 Format: MM = Month, DD = Day, YY = Year  
Description: County Transfer Date - The date the WRO v. McMahon provider's Standard Claim Form and, if applicable, the Supplemental Claim Form are sent from the first County and received by the second County.

First County: Enter the date the first County transferred (mailed) the Standard Claim Form as determined by MPP 50-061.32.

Second County: Enter the date the second County accepted (received) the transferred Standard Claim Form as determined by MPP 50-061.32(h)(2).

THE FILING DATE RECORDED BY THE FIRST COUNTY (FIELD F2) WILL ALSO BE THE FILING DATE RECORDED IN FIELD F2 BY THE SECOND COUNTY.

Field: NOA - Display only, Alpha  
Length: 1  
Description: Notice of Action - Denotes where the Notice of Action is to be sent. All Notices of Action will be returned to the County for completion of the NOA message(s) - and to attach the computation of wages and interest (or other documents), if applicable, and mailing.

Field: REASON CODES - Optional, Numeric  
Length: 4  
Description: Reason Code(s) - Four digit codes for actions described in Notice of Action messages.

Field: CNTY TRANSFER NUMBER - Optional, Numeric  
Length: 2

Description: County Transfer Number - A two digit number which identifies the County Welfare Office to be sent a county transfer claim. This number will also identify, in CMIPS, the County Contact Name and Telephone Number to be included in the Notice of Action message. The following codes are valid:

01 ALAMEDA	02 ALPINE	03 AMADOR
04 BUTTE	05 CALAVERAS	06 COLUSA
07 CONTRA COSTA	08 DEL NORTE	09 EL DORADO
10 FRESNO	11 GLENN	12 HUMBOLDT
13 IMPERIAL	14 INYO	15 KERN
16 KINGS	17 LAKE	18 LASSEN
19 LOS ANGELES	20 MADERA	21 MARIN
22 MARIPOSA	23 MENDOCINO	24 MERCED
25 MODOC	26 MONO	27 MONTEREY
28 NAPA	29 NEVADA	30 ORANGE
31 PLACER	32 PLUMAS	33 RIVERSIDE
34 SACRAMENTO	35 SAN BENITO	36 SAN BERNARDINO
37 SAN DIEGO	38 SAN FRANCISCO	
39 SAN JOAQUIN	40 SAN LUIS OBISPO	
41 SAN MATEO	42 SANTA BARBARA	
43 SANTA CLARA	44 SANTA CRUZ	45 SHASTA
46 SIERRA	47 SISKIYOU	48 SOLANO
49 SONOMA	50 STANISLAUS	51 SUTTER
52 TEHAMA	53 TRINITY	54 TULARE
55 TUOLUMNE	56 VENTURA	57 YOLO
58 YUBA		

Field: REASON CODE HISTORY - Display Only

Length:

Description: Reason Code History - Displays the last 12 Reason Codes (NOA's) issued, from the most current to the first one issued, in the following format:

four digit Reason Code  
two digit County Transfer Number  
the date (MM-DD-YY) the notice was processed



IN-HOME SUPPORTIVE SERVICES  
WRO v. MCMAHON  
WAGE AND INTEREST WORKSHEET SCREEN  
FIELD-BY-FIELD DESCRIPTION

The IHSS WRO v. McMahon Wage and Interest Worksheet Screen (WROW) is used to identify and calculate, by month and year, the amount of service hours claimed and the dollar amount paid as retroactive wages and/or interest. This information will come from the Provider Retroactive Payment Eligibility Determination Worksheet - Part II, Section B. County staff are required to complete the Worksheet Selection, Authorization and Notice of Action fields as well as Columns 1, 2, 3, 5 and 6. The Case Management, Information and Payrolling System (CMIPS) will automatically transfer the recipient/applicant and/or provider names, the claimant's Social Security number and compute the data for Columns 4, 7, 8, 9 and 10, determine the Grand Totals and print this information on a turnaround document at County print sites.

DESCRIPTION:

Field: RECIPIENT # (NEXT WROW)

Length: 10/16

Description: Recipient/Provider # - Enter the 2 digit County number, 7 digit recipient number and 1 digit check digit and if applicable the 6 digit provider number.

Field: WORKSHEET SEL - Required, Numeric

Length: 2

Description: Worksheet Selection - A two digit number that identifies the most recent turnaround document worksheet.

Field: SSN - System Generated

Length: 9

Description: Social Security Number - A 9 digit number assigned to the provider by the Federal government. A valid SSN must be used here; invalid SSN's will not be accepted.

Field: RECIP - System Generated  
Length: 30  
Description: Recipient/Applicant's Name - Alpha/special characters (.,/-) used to identify a specific recipient/applicant; the last name first, first name next and then the middle initial.

Field: PROV - System Generated  
Length: 30  
Description: Provider's Name - Alpha/special characters (.,/-) used to identify a specific provider of service; the last name first, first name next and then the middle initial.

Field: GRAND TOTALS \$ - System Generated  
Length: 12  
Description: Grand Totals - The dollar amount paid as retroactive wages and/or interest and the sum total of the two.

Field: V/R - Optional, Alpha  
Length: 1  
Description: Void/Replacement - Enter one of the following codes to issue a void/stop payment or a void/stop pay and replace of a WRO warrant (EDS staff only):  
  
V = Void/Stop Payment  
R = Void/Stop Payment and Replace

Field: WAR NUM - Optional, Numeric  
Length: 8  
Description: Warrant Number - Enter the warrant number to either be replaced or a void/stop payment issued (EDS staff only).

Field: AUTH - Optional, Alphanumeric  
Length: 5  
Description: Authorized By - The official County assigned authorization number that must be entered with every Notice of Action issuing retroactive and/or interest payments.

Field: NOAS - Required, Alpha

Length: 4

Description: Notice of Actions (Reason Codes) - Four digit codes for actions described in Notice of Action messages.

Field: COL 1: MO/YR CLAIM - Required, Numeric

Length: 4

Description: Column 1: Month and Year Claimed - The month and year protective supervision services and/or medical accompaniment were claimed either received or provided. Enter as identified on the WRO v. McMahon Standard Claim Form (Part III).

Field: COL 2: CLASS ELIG - Required, Numeric

Length: 1

Description: Column 2: Class Eligibility - Identifies, for each month/year claimed, if the recipient/applicant applied for or was denied IHSS. Enter either Y for yes or N for no.

Field: COLUMN 3: P/M, HOURS CLAIM - Required, Alphanumeric

Length: 1 and 7

Description: Column 3: P/M and Hours Claimed - Identifies, for each month/year claimed, the number of hours protective supervision services and/or medical accompaniment were received or provided. Enter one of the following in the P/M column:

P = Protective Supervision Services  
M = Medical Accompaniment

Also enter the corresponding number of hours, by month/year, as identified on the WRO v. McMahon Standard Claim Form (Part III).

Field: COLUMN 4: AMT CLAIM (HRS X RATE) - System Generated

Length: 10

Description: Column 4: Amount Claimed - Identifies the number of hours claimed in a dollar amount (hours multiplied by the hourly rate). CMIPS will calculate and display the dollar amount on the screen and print the amount on the turnaround document.

Field: COLUMN 5: AMT AUTH - Required, Numeric  
 Length: 7  
 Description: Column 5: Amount Originally Authorized - Identifies the amount of In-Home Supportive Services originally authorized during a specific month/year. Enter the total number of hours authorized for each month/ year protective supervision services and/or medical accompaniment is claimed.

Field: COLUMN 6: ST MAX (N/S) - Required, Alpha  
 Length: 1  
 Description: Column 6: Statutory Maximum - Identifies whether the recipient/applicant was or would have been classified as non-severely impaired or severely impaired and the payment rate CMIPS will use to calculate retroactive payment. CMIPS will also display one of the following dollar amounts on the screen and the turnaround document:

Effective Date:	NSI:	SI:
07/01/83 --- 06/30/84	\$604	\$872
07/01/84 --- 06/30/85	\$638	\$921
07/01/85 --- 09/30/85	\$674	\$974

Field: COLUMN 7: ST MAX LESS AMT AUTH - System Generated  
 Length: 7  
 Description: Column 7: Statutory Maximum Amount Less The Amount Originally Authorized - Identifies the difference between the statutory maximum and the amount originally authorized. Calculated, displayed and printed on the turnaround document by CMIPS.

Field: COLUMN 8: AMT DUE LESS OF COL 4/7 - Computed by CMIPS  
 Length: 7  
 Description: Column 8: Dollar Amount Due - Identifies the dollar amount, by month/year, to be paid as retroactive wages. The amount to be paid will be the smallest amount between Column 4 and 7 and will be displayed on the screen and printed on the turnaround document by CMIPS.

Field: COLUMN 9: INTEREST DUE (10%) - System Generated

Length: 8

Description: Column 9: Interest Due (10%) - Identifies the dollar amount to be paid as prejudgment interest, by month/year. The amount will be calculated and displayed on the screen and printed on the turnaround document by CMIPS. CMIPS will calculate the prejudgment interest at the following rate:

10% for the period July 1, 1983 through September 30, 1985.

The prejudgment interest will 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.

Field: COLUMN 10: TOTAL AMT DUE - Displayed by CMIPS

Length: 9

Description: Column 10: Total Amount Due - Identifies the total dollar amount due as retroactive wages and prejudgment interest, by month/year. The amount will be calculated and displayed on the screen and printed on the turnaround document by CMIPS. CMIPS will also print a total by year for Columns 8, 9 and 10 and as well as a grand total on the turnaround document.



IN-HOME SUPPORTIVE SERVICES  
WRO v. MCMAHON  
UNDERPAYMENT WAGE WORKSHEET SCREEN  
FIELD-BY-FIELD DESCRIPTION

The IHSS WRO v. McMahon Underpayment Wage Worksheet Screen (WROU) is used to identify and calculate, by month and year, the amount of service hours claimed and the dollar amount paid as underpayment wages. This information will come from the Provider Underpayment Eligibility Determination Worksheet - Part II, Section B. County staff are required to complete the Worksheet Selection, Authorization and Notice of Action fields as well as Columns 1, 2, 3, 5 and 6. The Case Management, Information and Payrolling System (CMIPS) will automatically transfer the recipient/applicant and/or provider names, the claimant's Social Security number and compute the data for Columns 4, 7, 8, and 10, determine the Grand Totals and print this information on a turnaround document at County print sites.

DESCRIPTION:

Field: RECIPIENT # (NEXT WROU)

Length: 10/16

Description: Recipient/Provider # - Enter the 2 digit County number, 7 digit recipient number and 1 digit check digit and if applicable the 6 digit provider number.

Field: WORKSHEET SEL - Required, Numeric

Length: 2

Description: Worksheet Selection - A two digit number that identifies the most recent turnaround document worksheet.

Field: SSN - System Generated

Length: 9

Description: Social Security Number - A 9 digit number assigned to the provider by the Federal government. A valid SSN must be used here; invalid SSN's will not be accepted.

Field: RECIP - System Generated

Length: 30

Description: Recipient/Applicant's Name - Alpha/special characters (./-) used to identify a specific recipient/applicant; the last name first, first name next and then the middle initial.

Field: PROV - System Generated

Length: 30

Description: Provider's Name - Alpha/special characters (./-) used to identify a specific provider of service; the last name first, first name next and then the middle initial.

Field: GRAND TOTALS \$ - System Generated

Length: 12

Description: Grand Totals - The dollar amount paid as underpayment wages.

Field: V/R - Optional, Alpha

Length: 1

Description: Void/Replacement - Enter one of the following codes to issue a void/stop payment or a void/stop pay and replace of a WRO warrant (EDS staff only):

V = Void/Stop Payment

R = Void/Stop Payment and Replace

Field: WAR NUM - Optional, Numeric

Length: 8

Description: Warrant Number - Enter the warrant number to either be replaced or a void/stop payment issued (EDS staff only).

Field: AUTH - Optional, Alphanumeric

Length: 5

Description: Authorized By - The official County assigned authorization number that must be entered with every Notice of Action issuing underpayment.

Field: NOAS - Required, Alpha  
Length: 4  
Description: Notice of Actions (Reason Codes) - Four digit codes for actions described in Notice of Action messages.

Field: COL 1: MO/YR CLAIM - Required, Numeric  
Length: 4  
Description: Column 1: Month and Year Claimed - The month and year protective supervision services and/or medical accompaniment were claimed either received or provided. Enter as identified on the WRO v. McMahon Provider Standard Claim Form (Part III only).

Field: COL 2: CLASS ELIG - Required, Numeric  
Length: 1  
Description: Column 2: Class Eligibility - Identifies, for each month/year claimed, if the recipient/applicant applied for or was denied IHSS. Enter either Y for yes or N for no.

Field: COLUMN 3: P/M, HOURS CLAIM - Required, Alphanumeric  
Length: 1 and 7  
Description: Column 3: P/M and Hours Claimed - Identifies, for each month/year claimed, the number of hours protective supervision services and/or medical accompaniment were received or provided. Enter one of the following in the P/M column:  
  
P = Protective Supervision Services  
M = Medical Accompaniment  
  
Also enter the corresponding number of hours, by month/year, as identified on the WRO v. McMahon Standard Claim Form (Part III).

Field: COLUMN 4: AMT CLAIM (HRS X RATE) - System Generated  
Length: 10  
Description: Column 4: Amount Claimed - Identifies the number of hours claimed in a dollar amount (hours multiplied by the hourly rate). CMIPS will calculate and display the dollar amount on the screen and print the amount on the turnaround document.

Field: COLUMN 5: AMT AUTH - Required, Numeric  
Length: 7  
Description: Column 5: Amount Originally Authorized - Identifies the amount of In-Home Supportive Services originally authorized during a specific month/year. Enter the total number of hours authorized for each month/ year protective supervision services and/or medical accompaniment is claimed.

Field: COLUMN 6: ST MAX (N/S) - Required, Alpha  
Length: 1  
Description: Column 6: Statutory Maximum - Identifies whether the recipient/applicant was or would have been classified as non-severely impaired or severely impaired and the payment rate CMIPS will use to calculate underpayments. CMIPS will also display one of the following dollar amounts on the screen and the turnaround document:

Effective Date:	NSI:	SI:
10/01/85 --- 08/31/86	\$674	\$974

Field: COLUMN 7: ST MAX LESS AMT AUTH - System Generated  
Length: 7  
Description: Column 7: Statutory Maximum Amount Less The Amount Originally Authorized - Identifies the difference between the statutory maximum and the amount originally authorized. Calculated, displayed and printed on the turnaround document by CMIPS.

Field: COLUMN 8: TOTAL DUE LESS OF COL 4/7 - System Generated  
Length: 7  
Description: Column 8: Total Dollar Amount Due - Identifies the total dollar amount, by month/year, to be paid as underpayment wages. The amount to be paid will be the smallest amount between Column 4 and 7 and will be displayed on the screen and printed on the turnaround document by CMIPS.

NOTICE OF ACTION MESSAGES  
WRO v. MCMAHON  
TABLE OF CONTENTS

TABLE OF CONTENTS	PAGE 58
PROVIDER CLAIMS	
INITIAL MESSAGES	PAGE 59 - 60
ADVERSE INFORMATION MESSAGES	PAGE 61 - 65
FINAL MESSAGES	PAGE 66 - 72
APPROVAL	PAGE 73
PARTIAL APPROVAL/DENIAL	PAGE 73
RECIPIENT CLAIMS	
INITIAL MESSAGES	PAGE 74 - 75
ADVERSE INFORMATION MESSAGES	PAGE 76 - 80
FINAL MESSAGES	PAGE 81 - 87
APPROVAL	PAGE 88
PARTIAL APPROVAL/DENIAL	PAGE 88
NOTICE OF ACTION FORM NA 690M (02/93)	PAGE 89

NOTICE OF ACTION MESSAGES  
WRO v. MCMAHON

THESE NOA MESSAGES ARE FOR PROVIDER CLAIMS SUBMITTED UNDER THE  
WRO v MCMAHON JUDGMENT.

INITIAL MESSAGES:

BOILERPLATE:

MPP 50-061.32

(Date system generated) we received a WRO v. McMahon claim that you provided protective supervision services and/or medical accompaniment to In-Home Supportive Services recipient/applicant (Name system generated) for the period(s) of \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_.

INCOMPLETE STANDARD CLAIM FORM RECEIVED:

W001 MPP 50-061.315, .431, .432 and .632

We cannot process your claim because it is incomplete. Your Standard Claim Form is being returned to you with Sections \_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_ checked which you need to complete. If other information is needed, you will find specific requests listed below. You must return this form to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_ or your claim will be denied.

INCOMPLETE SUPPLEMENTAL CLAIM FORM RECEIVED:

W002 MPP 50-061.315, .444, .464(c), .474(c) and .632

Your WRO v. McMahon Supplemental Claim Form was received \_\_\_-\_\_\_-\_\_\_ but we cannot process your claim because it is incomplete. The Supplemental Claim Form is being returned to you with Sections \_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_ checked which you need to complete. You must return this form to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_ or your claim will be denied.

SEND SUPPLEMENTAL CLAIM FORM/COMPLETE PARTS I, III AND IV:

W003 MPP 50-061.421(c), .441, .452, .464, .474, .513(c) and .531

We cannot process your claim without additional information. Enclosed is a WRO v. McMahon Supplemental Claim Form. Completion of this form is necessary to determine your eligibility for retroactive payments and/or underpayments. Please complete Parts I, III and IV of this form. You must return this form to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_ or your claim will be denied.

SEND SUPPLEMENTAL CLAIM FORM (COMPLETE ENTIRE FORM):

W004 MPP 50-061.421(c), .441, .452, .464, .474, .513(c) and .531  
We cannot process your claim without additional information. Enclosed is a WRO v. McMahon Supplemental Claim Form. Completion of this form is necessary to determine your eligibility for retroactive payments and/or underpayments. You must complete this entire form and return it to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_ or your claim will be denied.

COUNTY TRANSFER (TRANSFER IN TOTAL):

W005 MPP 50-061.32(h)  
Your WRO v. McMahon Standard Claim Form must be processed by the County Welfare Department where you and your spouse lived during the period you claim you provided protective supervision services and/or medical accompaniment.

Your claim form has been forwarded to \_\_\_\_\_ County for processing. County staff will contact you within 45 days. The County contact person is \_\_\_\_\_, telephone number ( ) \_\_\_-\_\_\_\_.

COUNTY TRANSFER (PARTIAL TRANSFER):

W006 MPP 50-061.32(h)  
Your WRO v. McMahon Standard Claim Form must be processed by the County Welfare Department where you and your spouse lived during the period you claim you provided protective supervision services and/or medical accompaniment.

Your claim for the period \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_ has been forwarded to \_\_\_\_\_ County which will process that portion of your claim and contact you within 45 days. The County contact person is \_\_\_\_\_, telephone number ( ) \_\_\_-\_\_\_\_.

COUNTY TRANSFER (MULTIPLE TRANSFERS):

W007 MPP 50-061.32(h)  
Your claim for the period \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_ has been forwarded to \_\_\_\_\_ County which will process that portion of your claim and contact you within 45 days. The County contact person is \_\_\_\_\_, telephone number ( ) \_\_\_-\_\_\_\_.

ADVERSE INFORMATION MESSAGES:

FOR ALL ADVERSE MESSAGES:

W008 MPP 50-061.463 and .473  
We have information that contradicts your claim (see attached). Your WRO v. McMahon claim is denied. If you do not agree with our decision you have until \_\_\_-\_\_\_-\_\_\_ to get us a written explanation and/or any records about why you disagree with our decision. If you get us the information by that date, we will review your claim again and send you a new decision.

You do not qualify as a WRO v. McMahon class member because:

NOT A CALIFORNIA RESIDENT (RETROACTIVE PERIOD):

W009 MPP 50-061.411(a) and .421(a)(1)  
The person you claim you provided protective supervision services and/or medical accompaniment for did not live in California at any time from July 1983 through September 1984.

NOT A CALIFORNIA RESIDENT (UNDERPAYMENT PERIOD):

W010 MPP 50-061.411(a) and .421(a)(1)  
The person you claim you provided protective supervision services and/or medical accompaniment for did not live in California at any time from October 1984 through September 1985.

NOT LEGALLY MARRIED (RETROACTIVE PERIOD):

W011 MPP 50-061.411(a)  
You were not legally married to an IHSS recipient/applicant at any time from July 1983 through September 1984.

NOT LEGALLY MARRIED-UNDERPAYMENT PERIOD:

W012 MPP 50-061.411(a)  
You were not legally married to an IHSS recipient/applicant at any time from October 1984 through September 1985.

NOT A SPOUSE (SSI/SSP ELIG)-RETROACTIVE PERIOD:

W013 MPP 50-061.411(b)  
You were not considered to be a member of a married couple with an IHSS recipient/applicant, as defined for the purposes of SSI/SSP eligibility in 20 CR 416.1806 at any time from July 1983 through September 1984.

NOT A SPOUSE (SSI/SSP ELIG)-UNDERPAYMENT PERIOD:

W014 MPP 50-061.411(b)

You were not considered to be a member of a married couple with an IHSS recipient/applicant, as defined for the purposes of SSI/SSP eligibility in 20 CR 416.1806 at any time from October 1984 through September 1985.

DID NOT PROVIDE PROTECTIVE SUPVR/MED ACCOMP-RETRO PERIOD:

W015 MPP 50-061.411(a) and .421(a)(2)

You did not stay and watch your spouse to make sure he/she did not harm or injure himself/herself nor did you take him/her to medical appointments at any time from July 1983 through September 1984.

DID NOT PROVIDE PROTECTIVE SUPVR/MED ACCOMP-UNDERPYT PERIOD:

W016 MPP 50-061.411(a) and .421(a)(2)

You did not stay and watch your spouse to make sure he/she did not harm or injure himself/herself nor did you take him/her to medical appointments at any time from October 1984 through September 1985.

LEAVE OR PREVENTED FULL-TIME EMPLOYMT (RETRO PERIOD):

W017 MPP 50-061.411(c) and .421(a)(1)

You did not leave nor were prevented from seeking full-time employment to stay and watch your spouse to make sure he/she did not harm or injure himself/herself nor did you take him/her to medical appointments at any time from July 1983 through September 1984.

LEAVE OR PREVENTED FULL-TIME EMPLOYMT (UNDERPYMT PERIOD):

W018 MPP 50-061.411(c) and .421(a)(1)

You did not leave nor were prevented from seeking full-time employment to stay and watch your spouse to make sure he/she did not harm or injure himself/herself nor did you take him/her to medical appointments at any time from October 1984 through September 1985.

INAPPROPRIATELY PLACED (RETRO PERIOD):

W019 MPP 50-061.411(d) and .421(a)(1)

You did not need to provide protective supervision services and/or medical accompaniment to prevent your spouse from receiving inadequate services or from being inappropriately placed somewhere other than his/her own home at any time from July 1983 through September 1984.

INAPPROPRIATELY PLACED (UNDERPAYMENT PERIOD):

W020 MPP 50-061.411(d) and .421(a)(1)  
You did not need to provide protective supervision services and/or medical accompaniment to prevent your spouse from receiving inadequate services or from being inappropriately placed somewhere other than his/her own home at any time from October 1984 through September 1985.

NO REQUIRE MEDICAL ACCOMPANIMENT (RETROACTIVE PERIOD):

W021 MPP 50-061.411(a) and .421(a)(2)  
Your spouse did not require assistance during transportation to and from medical appointments at any time from July 1983 through September 1984.

NO REQUIRE MEDICAL ACCOMPANIMENT (UNDERPAYMENT PERIOD):

W022 MPP 50-061.411(a) and .421(a)(2)  
Your spouse did not require assistance during transportation to and from medical appointments at any time from October 1984 through September 1985.

NO REQUIRE PROTECTIVE SUPERVISION SVS (RETROACTIVE PERIOD):

W023 MPP 50-061.411(a) and .421(a)(2)  
Your spouse did not require protective supervision services at any time from July 1983 through September 1984.

NO REQUIRE PROTECTIVE SUPERVISION SVS (UNDERPAYMENT PERIOD):

W024 MPP 50-061.411(a) and .421(a)(2)  
Your spouse did not require protective supervision services at any time from October 1984 through September 1985.

NOT 65 YRS, BLIND OR DISABLED (RETROACTIVE PERIOD):

W025 MPP 50-061.411(a) and .421(a)(1)  
Your spouse was not age 65 or older, blind or disabled at any time from July 1983 through September 1984.

NOT 65 YRS, BLIND OR DISABLED (UNDERPAYMENT PERIOD):

W026 MPP 50-061.411(a) and .421(a)(1)  
Your spouse was not age 65 or older, blind or disabled at any time from October 1984 through September 1985.

SELF-DIRECTING (RETROACTIVE PERIOD):

W027 MPP 50-061.411(a) and .421(a)(2)  
Your spouse was self-directing, not confused, mentally impaired nor mentally ill at any time from July 1983 through September 1984.

SELF-DIRECTING (UNDERPAYMENT PERIOD):

W028 MPP 50-061.411(a) and .421(a)(2)  
Your spouse was self-directing, not confused, mentally impaired nor mentally ill at any time from October 1984 through September 1985.

NEITHER RECEIVED NOR DENIED SVS (RETROACTIVE PERIOD):

W029 MPP 50-061.421(a)(3)  
Your spouse did not receive nor was denied In-Home Supportive Service benefits at any time from July 1983 through September 1984.

NEITHER RECEIVED NOR DENIED SVS (UNDERPAYMENT PERIOD):

W030 MPP 50-061.421(a)(3)  
Your spouse did not receive nor was denied In-Home Supportive Service benefits at any time from October 1984 through September 1985.

PAID AS AUTHORIZED SERVICES:

W031 MPP 50-061.411(a)  
Protective supervision services and/or medical accompaniment have already been paid by the County as part of the authorized In-Home Supportive Services. The attached computation of hours and payment will tell you how these services and their cost were figured.

COMPENSATED:

W032 MPP 50-061.411(e)  
You have already been paid by your spouse for providing protective supervision services and/or medical accompaniment.

STATUTORY MAXIMUM HOURS OF SERVICE RECEIVED BY RECIPIENT:

W033 MPP 50-061.523(a) and .58  
Your spouse received In-Home Supportive Services paid at the statutory maximum payment. The attached computation of hours and payment will tell you how these services and their cost were figured.

SSI/SSP PERSONAL AND REAL PROPERTY:

W034 MPP 50-061.411(a)  
You and your spouse had monthly income and/or monthly liquid resources in excess of SSI/SSP standards which are listed below:

Income/Resources

SSI/SSP Standards

REASON FOR DENIAL OTHER THAN SPOUSE:

W035 MPP 50-061.411(a), .521(a) and .522(a)  
Your spouse was denied protective supervision services and/or medical accompaniment because:

EXCESSIVE MEDICAL HOURS CLAIMED:

W036 MPP 50-061.435(a)  
The information submitted in Part IV of the Standard Claim Form does not support the excessive medical accompaniment hours for the claim period \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_. Please provide additional information or documentation that will support your claim for medical accompaniment hours that are more than twice the state average, or more than eight hours a month.

FINAL MESSAGES:

FOR ALL FINAL MESSAGES:

W037 MPP 50-061.63  
You do not qualify as a WRO v. McMahon class member. Your  
WRO v. McMahon claim is denied because:

INCOMPLETE STANDARD CLAIM FORM RETURNED:

W038 MPP 50-061.311 and .433(a)  
A Standard Claim Form was returned to you with Sections  
\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_ checked which needed to be  
completed. We received your Standard Claim Form \_\_\_\_-\_\_\_\_-\_\_\_\_;  
however the claim form is still not complete.

INCOMPLETE STANDARD CLAIM FORM NOT RETURNED:

W039 MPP 50-061.315 and .434  
A Standard Claim Form was returned to you with Sections  
\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_ checked which needed to be  
completed. We did not receive the Standard Claim Form we  
returned to you for completion by \_\_\_\_-\_\_\_\_-\_\_\_\_.

INCOMPLETE SUPPLEMENTAL CLAIM FORM RETURNED:

W040 MPP 50-061.311 and .444(a)  
A Supplemental Claim Form was returned to you with Sections  
\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_ checked which needed to be  
completed. We recieved the Supplemental Claim Form  
\_\_\_\_-\_\_\_\_-\_\_\_\_; however the claim form is still not complete.

INCOMPLETE SUPPLEMENTAL CLAIM FORM NOT RETURNED:

W041 MPP 50-061.315 and .445  
A Supplemental Claim Form was returned to you with Sections  
\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_ checked which needed to be  
completed. We did not receive your Supplemental Claim Form  
we returned to you for completion by \_\_\_\_-\_\_\_\_-\_\_\_\_.

SUPPLEMENTAL CLAIM FORM NOT RETURNED (PART I, III AND IV):

W042 MPP 50-061.315 and .445  
We did not receive your Supplemental Claim Form we mailed  
you to complete Parts I, III and IV by \_\_\_\_-\_\_\_\_-\_\_\_\_.

SUPPLEMENTAL CLAIM FORM NOT RETURNED (THE ENTIRE FORM):

W043 MPP 50-061.315 and .445  
We did not receive your Supplemental Claim Form we mailed  
you to complete by \_\_\_\_-\_\_\_\_-\_\_\_\_.

OUTSIDE RETROACTIVE PAYMENT PERIOD:

W044 MPP 50-061.331

You are claiming you provided protective supervision services and/or medical accompaniment for periods other than July 1, 1983 through September 30, 1984.

REFER MILLER v WOODS:

W045 MPP 50-061.411(a)

Non-spouse claimants do not qualify for payments under the WRO v. McMahon judgment. However, you may qualify for payments under the Miller v. Woods judgment. Please complete the Miller v. Woods Standard Claim Form enclosed and return the form to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_.

UNDERPAYMENT PERIOD:

W046 MPP 50-061.332 and .481(a)

Your eligibility for retroactive payments does extend through the end of the retroactive payment claim period, September 30, 1984.

NOT A CALIFORNIA RESIDENT (RETROACTIVE PERIOD):

W047 MPP 50-061.411(a) and .421(a)(1)

Your spouse did not live in California at any time from July 1983 through September 1984.

NOT A CALIFORNIA RESIDENT (UNDERPAYMENT PERIOD):

W048 MPP 50-621.411(a) and .421(a)(1)

Your spouse did not live in California at any time from October 1984 through September 1985.

NOT LEGALLY MARRIED (RETROACTIVE PERIOD):

W049 MPP 50-061.411(a)

You were not legally married to an IHSS recipient/applicant at any time from July 1983 through September 1984.

NOT LEGALLY MARRIED-UNDERPAYMENT PERIOD:

W050 MPP 50-061.411(a)

You were not legally married to an IHSS recipient/applicant at any time from October 1984 through September 1985.

NOT A SPOUSE (SSI/SSP ELIG)-RETROACTIVE PERIOD:

W051 MPP 50-061.411(b)  
You were not considered to be a member of a married couple,  
as defined for the purposes of SSI/SSP eligibility in 20 CR  
416.1806 at any time from July 1983 through September 1984.

NOT A SPOUSE (SSI/SSP ELIG)-UNDERPAYMENT PERIOD:

W052 MPP 50-061.411(b)  
You were not considered to be a member of a married couple,  
as defined for the purposes of SSI/SSP eligibility in 20 CR  
416.1806 at any time from October 1984 through September  
1985.

DID NOT PROVIDE PROTECTIVE SUPVR/MED ACCOMP--RETRO PERIOD:

W053 MPP 50-061.411(a) and .421(a)(2)  
You did not stay and watch your spouse to make sure he/she  
did not harm or injure himself/herself nor did you take  
him/her to medical appointments at any time from July 1983  
through September 1984.

DID NOT PROVIDE PROTECTIVE SUPVR/MED ACCOMP--UNDERPYT PERIOD:

W054 MPP 50-061.411(a) and .421(a)(2)  
You did not stay and watch your spouse to make sure he/she  
did not harm or injure himself/herself nor did you take  
him/her to medical appointments at any time from October  
1984 through September 1985.

LEAVE OR PREVENTED FULL-TIME EMPLOYMT (RETROACTIVE PERIOD):

W055 MPP 50-061.411(c) and .421(a)(1)  
You did not leave nor were prevented from seeking full-time  
employment to stay and watch your spouse to make sure  
he/she did not harm or injure himself/herself nor did you  
take him/her to medical appointments at any time from July  
1983 through September 1984.

LEAVE OR PREVENTED FULL-TIME EMPLOYMENT (UNDERPYMT PERIOD):

W056 MPP 50-061.411(c) and .421(a)(1)  
You did not leave nor were prevented from seeking full-time  
employment to stay and watch your spouse to make sure  
he/she did not harm or injure himself/herself nor did you  
take him/her to medical appointments at any time from  
October 1984 through September 1985.

INAPPROPRIATELY PLACED (RETROACTIVE PERIOD):

W057 MPP 50-061.411(d) and .421(a)(1)  
You did not need to provide protective supervision services and/or medical accompaniment to prevent your spouse from receiving inadequate services or from being inappropriately placed somewhere other than his/her own home at any time from July 1983 through September 1984.

INAPPROPRIATELY PLACED (UNDERPAYMENT PERIOD):

W058 MPP 50-061.411(d) and .421(a)(1)  
You did not need to provide protective supervision services and/or medical accompaniment to prevent your spouse from receiving inadequate services or from being inappropriately placed somewhere other than his/her own home at any time from October 1984 through September 1985.

NO REQUIRE MEDICAL ACCOMPANIMENT (RETROACTIVE PERIOD):

W059 MPP 50-061.411(a) and .421(a)(2)  
Your spouse did not require assistance during transportation to and from medical appointments at any time from July 1983 through September 1984.

NO REQUIRE MEDICAL ACCOMPANIMENT (UNDERPAYMENT PERIOD):

W060 MPP 50-061.411(a) and .421 (a)(2)  
Your spouse did not require assistance during transportation to and from medical appointments at any time from October 1984 through September 1985.

NO REQUIRE PROTECTIVE SUPERVISION SVS (RETROACTIVE PERIOD):

W061 MPP 50-061.411(a) and .421(a)(2)  
Your spouse did not require protective supervision services at any time from July 1983 through September 1984.

NO REQUIRE PROTECTIVE SUPERVISION SVS (UNDERPAYMENT PERIOD):

W062 MPP 50-061.411(a) and .421(a)(2)  
Your spouse did not require protective supervision services at any time from October 1984 through September 1985.

NOT 65 YRS, BLIND OR DISABLED (RETROACTIVE PERIOD):

W063 MPP 50-061.411(a) and .421(a)(1)  
Your spouse was not age 65 or older, blind or disabled at any time from July 1983 through September 1984.

NOT 65 YRS, BLIND OR DISABLED (UNDERPAYMENT PERIOD):

W064 MPP 50-061.411(a) and .421(a)(1)  
Your spouse was not age 65 or older, blind or disabled at any time from October 1984 through September 1985.

SELF-DIRECTING (RETROACTIVE PERIOD):

W065 MPP 50-061.411(a) and .421(a)(2)  
Your spouse was self-directing, not confused, mentally impaired nor mentally ill at any time from July 1983 through September 1984.

SELF-DIRECTING (UNDERPAYMENT PERIOD):

W066 MPP 50-061.411(a) and .421(a)(2)  
Your spouse was self-directing, not confused, mentally impaired nor mentally ill at any time from October 1984 through September 1985.

NEITHER RECEIVED NOR DENIED SVS (RETROACTIVE PERIOD):

W067 MPP 50-061.421(a)(3)  
Your spouse did not receive nor was denied In-Home Supportive Service benefits at any time from July 1983 through September 1984.

NEITHER RECEIVED NOR DENIED SVS (UNDERPAYMENT PERIOD):

W068 MPP 50-061.421(a)(3)  
Your spouse did not receive nor was denied In-Home Supportive Service benefits at any time from October 1984 through September 1985.

PAID AS AUTHORIZED SERVICES:

W069 MPP 50-061.411(a)  
Protective supervision services and/or medical accompaniment have already been paid by the County as part of the authorized In-Home Supportive Services. The attached computation of hours and payment will tell you how these services and their cost were figured.

COMPENSATED:

W070 MPP 50-061.411(e)  
You have already been paid by your spouse for providing protective supervision services and/or medical accompaniment.

STATUTORY MAXIMUM HOURS OF SERVICE RECEIVED BY RECIPIENT:

W071 MPP 50-061.58

Your spouse received In-Home Supportive Services paid at the statutory maximum payment. The attached computation of hours and payment will tell you how these services and their cost were figured.

SSI/SSP PERSONAL AND REAL PROPERTY

W072 MPP 50-061.411(a)

You and your spouse had monthly income and/or monthly liquid resources in excess of SSI/SSP standards which are listed below:

Income/Resources

SSI/SSP Standards

REASON FOR DENIAL OTHER THAN SPOUSE:

W073 MPP 50-061.411(a)

Your spouse was denied protective supervision services and/or medical accompaniment because:

EXCESSIVE MEDICAL HOURS CLAIMED:

W074 MPP 50-061.435

On \_\_\_-\_\_\_-\_\_\_ we mailed you a Notice of Action message which required that you to submit additional information or documentation to support your claim of excessive medical accompaniment hours. Excessive medical accompaniment hours are any hours claimed that is twice the state average or more than eight hours a month.

We did not receive any additional information or documentation required by \_\_\_-\_\_\_-\_\_\_.

LATE FILING

W075 MPP 50-061.22, .314 and .32(f)

Your claim was received after the final filing date of September 30, 1993.

FINAL DENIAL OF A REBUTTAL

W076 MPP 50-061.464(e) and .474(e)

We have reviewed the WRO v. McMahon Claim Form and have considered the additional information you have submitted since your denial Notice of Action dated \_\_\_-\_\_\_-\_\_\_. The denial of your claim is final because:

INFO DOES NOT SUBSTANTIATE CLAIM:

W077 MPP 50-061.464(e)

We have reviewed your WRO v. McMahon Claim Form and have considered the additional information you have submitted. The information you submitted does not substantiate your claim. Your claim is denied because:

APPROVAL AND  
PARTIAL APPROVAL/DENIAL NOTICES:

APPROVAL:

W090 MPP 50-061.63

Your claim is approved in the amount of \$\_\_\_\_\_ past due wages and \$\_\_\_\_\_ interest (see attached computation).

Your past due wages and interest are taxable income and we will report the amount to the Internal Revenue Service (IRS) and the Franchise Tax Board. Your check may not have enough taxes withheld, you must figure out how much you owe. You may wish to contact the IRS or a tax consultant for assistance. The check(s) you receive will tell you what deductions, if any, have been made.

Your check(s) will be mailed to you within the next 30 days.

PARTIAL APPROVAL:

W091 MPP 50-061.63

Your claim is approved in part and denied in part. The part of your claim that is approved equals the amount of \$\_\_\_\_\_ past due wages and \$\_\_\_\_\_ interest (see attached computation).

Your past due wages and interest are taxable income and we will report the amount to the Internal Revenue Service (IRS) and the Franchise Tax Board. Your check may not have enough taxes withheld, you must figure out how much you owe. You may wish to contact the IRS or a tax consultant for assistance. The check(s) you receive will tell you what deductions, if any, have been made.

Your check(s) will be mailed to you within the next 30 days. That part of your claim for the period(s) \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_ is denied is based on the following information:

THESE NOA MESSAGES ARE FOR RECIPIENT CLAIMS SUBMITTED UNDER THE  
WRO v MCMAHON JUDGMENT:

INITIAL MESSAGES:

BOILERPLATE:

MPP 50-061.32

(Date system generated) we received a WRO v. McMahon claim that you paid your spouse for providing you with protective supervision services and/or medical accompaniment for the period(s) of \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_.

INCOMPLETE STANDARD CLAIM FORM RECEIVED:

W101 MPP 50-061.315, .431, .432 and .632

We cannot process your claim because it is incomplete. Your Standard Claim Form is being returned to you with Sections \_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_ checked which you need to complete. If other information is needed, you will find specific requests listed below. You must return this form to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_ or your claim will be denied.

INCOMPLETE SUPPLEMENTAL CLAIM FORM RECEIVED:

W102 MPP 50-061.315, .444, .464(c), .474(c) and .632

Your WRO v. McMahon Supplemental Claim Form was recorded \_\_\_-\_\_\_-\_\_\_ but we cannot process your claim because it is incomplete. The Supplemental Claim Form is being returned to you with Sections \_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_ checked which you need to complete. You must return this form to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_ or your claim will be denied.

SEND SUPPLEMENTAL CLAIM FORM/COMPLETE PARTS I, III AND IV:

W103 MPP 50-061.421(c), .441, .452, .464, .474, .513(c) and .531

We cannot process your claim without additional information. Enclosed is a WRO v. McMahon Supplemental Claim Form. Completion of this form is necessary to determine your eligibility for retroactive payments and/or underpayments. Please complete Parts I, III and IV of this form. You must return this form to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_ or your claim will be denied.

SEND SUPPLEMENTAL CLAIM FORM/COMPLETE ALL OF THE FORM:

W104 MPP 50-061.421(c), .441, .452, .464, .474, .513(c) and .531  
We cannot process your claim without additional information. Enclosed is a WRO v. McMahon Supplemental Claim Form. Completion of this form is necessary to determine your eligibility for retroactive payments and/or underpayments. You must complete this entire form and return it to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_ or your claim will be denied.

COUNTY TRANSFER (TRANSFER IN TOTAL):

W105 MPP 50-061.32(h)  
Your WRO v. McMahon Standard Claim Form must be processed by the County Welfare Department where you and your spouse lived during the period you claim you provided protective supervision services and/or medical accompaniment.

Your claim form has been forwarded to \_\_\_\_\_ County for processing. County staff will contact you within 45 days. The County contact person is \_\_\_\_\_, telephone number ( ) \_\_\_-\_\_\_\_.

COUNTY TRANSFER (PARTIAL TRANSFER):

W106 MPP 50-061.32(h)  
Your WRO v. McMahon Standard Claim Form must be processed by the County Welfare Department where you and your spouse lived during the period you claim you provided protective supervision services and/or medical accompaniment.

Your claim for the period \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_ has been forwarded to \_\_\_\_\_ County which will process that portion of your claim and contact you within 45 days. The County contact person is \_\_\_\_\_, telephone number ( ) \_\_\_-\_\_\_\_.

COUNTY TRANSFER (MULTIPLE TRANSFERS):

W107 MPP 50-061.32(h)  
Your claim for the period \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_ has been forwarded to \_\_\_\_\_ County which will process that portion of your claim and contact you within 45 days. The County contact person is \_\_\_\_\_, telephone number ( ) \_\_\_-\_\_\_\_.

ADVERSE INFORMATION MESSAGES:

FOR ALL ADVERSE MESSAGES:

W108 MPP 50-061.463 and .473

We have information that contradicts your claim (see attached). Your WRO v. McMahon claim is denied. If you do not agree with our decision you have until \_\_\_-\_\_\_-\_\_\_ to get us a written explanation and/or any records about why you disagree with our decision. If you get us the information by that date, we will review your claim again and send you a new decision.

You do not qualify as a WRO v. McMahon class member because:

NOT A CALIFORNIA RESIDENT (RETROACTIVE PERIOD):

W109 MPP 50-061.412(a) and .421(a)(1)

You did not live in California at any time from July 1983 through September 1984.

NOT A CALIFORNIA RESIDENT (UNDERPAYMENT PERIOD):

W110 MPP 50-061.412(a) and .421(a)(1)

You did not live in California at any time from October 1984 through September 1985.

NOT LEGALLY MARRIED (RETROACTIVE PERIOD):

W111 MPP 50-061.412

You were not legally married to someone who may have provided protective supervision services and/or medical accompaniment at any time from July 1983 through September 1984.

NOT LEGALLY MARRIED-UNDERPAYMENT PERIOD:

W112 MPP 50-061.412

You were not legally married to someone who may have provided protective supervision services and/or medical accompaniment at any time from October 1984 through September 1985.

NOT A SPOUSE (SSI/SSP ELIG)-RETROACTIVE PERIOD:

W113 MPP 50-061.412

You were not considered to be a member of a married couple as defined for the purposes of SSI/SSP eligibility in 20 CR 416.1806 at any time from July 1983 through September 1984.

NOT A SPOUSE (SSI/SSP ELIG)-UNDERPAYMENT PERIOD:

W114 MPP 50-061.412

You were not considered to be a member of a married couple as defined for the purposes of SSI/SSP eligibility in 20 CR 416.1806 at any time from October 1984 through September 1985.

DID NOT PROVIDE PROTECTIVE SUPVR/MED ACCOMP-RETRO PERIOD:

W115 MPP 50-061.412 and .421(a)(2)

It was not necessary for someone to stay and watch that you did not harm or injure yourself or to assist you during transportation to and from medical appointments at any time from July 1983 through September 1984.

DID NOT PROVIDE PROTECTIVE SUPVR/MED ACCOMP-UNDERPYT PERIOD:

W116 MPP 50-061.412 and .421(a)(2)

It was not necessary for someone to stay and watch that you did not harm or injure yourself or to assist you during transportation to and from medical appointments at any time from October 1984 through September 1985.

LEAVE OR PREVENTED FULL-TIME EMPLOYMENT (RETRO PERIOD):

W117 MPP 50-061.421(a)(1)

Your spouse did not leave nor were prevented from seeking full-time employment to stay and watch you to make sure you did not harm or injure yourself or to assist you during transportation to and from medical appointments at any time from July 1983 through September 1984.

LEAVE OR PREVENTED FULL-TIME EMPLOYMENT (UNDERPYMT PERIOD):

W118 MPP 50-061.421(a)(1)

Your spouse did not leave nor were prevented from seeking full-time employment to stay and watch you to make sure you did not harm or injure yourself or to assist you during transportation to and from medical appointments at any time from October 1984 through September 1985.

INAPPROPRIATELY PLACED (RETRO PERIOD):

W119 MPP 50-061.421(a)(1)

Your spouse did not need to provide protective supervision services and/or medical accompaniment to prevent you from receiving inadequate services or from being inappropriately placed somewhere other than his/her own home at any time from July 1983 through September 1984.

INAPPROPRIATELY PLACED (UNDERPAYMENT PERIOD):

W120 MPP 50-061.412 and .421(a)(1)  
Your spouse did not need to provide protective supervision services and/or medical accompaniment to prevent you from receiving inadequate services or from being inappropriately placed somewhere other than his/her own home at any time from October 1984 through September 1985.

NO REQUIRE MEDICAL ACCOMPANIMENT (RETROACTIVE PERIOD):

W121 MPP 50-061.412(b) and .421(a)(2)  
You did not require assistance during transportation to and from medical appointments at any time from July 1983 through September 1984.

NO REQUIRE MEDICAL ACCOMPANIMENT (UNDERPAYMENT PERIOD):

W122 MPP 50-061.412(b) and .421(a)(2)  
You did not require assistance during transportation to and from medical appointments at any time from October 1984 through September 1985.

NO REQUIRE PROTECTIVE SUPERVISION SVS (RETROACTIVE PERIOD):

W123 MPP 50-061.412(c) and .421(a)(2)  
You did not require protective supervision services at any time from July 1983 through September 1984.

NO REQUIRE PROTECTIVE SUPERVISION SVS (UNDERPAYMENT PERIOD):

W124 MPP 50-061.412(c) and .421(a)(2)  
You did not require protective supervision services at any time from October 1984 through September 1985.

NOT 65 YRS, BLIND OR DISABLED (RETROACTIVE PERIOD):

W125 MPP 50-061.421(a)(1)  
You were not age 65 or older, blind or disabled at any time from July 1983 through September 1984.

NOT 65 YRS, BLIND OR DISABLED (UNDERPAYMENT PERIOD):

W126 MPP 50-061.421(a)(1)  
You were not age 65 or older, blind or disabled at any time from October 1984 through September 1985.

SELF-DIRECTING (RETROACTIVE PERIOD):

W127 MPP 50-061.412(c) and .421(a)(2)  
You were self-directing, not confused, mentally impaired  
nor mentally ill at any time from July 1983 through  
September 1984.

SELF-DIRECTING (UNDERPAYMENT PERIOD):

W128 MPP 50-061.412(c) and .421(a)(2)  
You were self-directing, not confused, mentally impaired  
nor mentally ill at any time from October 1984 through  
September 1985.

NEITHER RECEIVED NOR DENIED SVS (RETROACTIVE PERIOD):

W129 MPP 50-061.421(a)(3)  
You did not receive nor were you denied In-Home Supportive  
Service benefits at any time from July 1983 through  
September 1984.

NEITHER RECEIVED NOR DENIED SVS (UNDERPAYMENT PERIOD):

W130 MPP 50-061.421(a)(3)  
You did not receive nor were you denied In-Home Supportive  
Service benefits any time from October 1984 through  
September 1985.

PAID AS AUTHORIZED SERVICES:

W131 MPP 50-061.412  
Protective supervision services and/or medical  
accompaniment have already been paid by the County as part  
of the authorized In-Home Supportive Services. The  
attached computation of hours and payment will tell you how  
these services and their cost were figured.

YOU DID NOT PAY FOR SERVICES:

W132 MPP 50-061.412(h)  
You did not pay your spouse for providing protective  
supervision services and/or medical accompaniment.

STATUTORY MAXIMUM HOURS OF SERVICE RECEIVED BY RECIPIENT:

W133 MPP 50-061.412(d), .412(e), .523(a) and .58  
You received In-Home Supportive Services paid at the  
statutory maximum payment. The attached computation of  
hours and payment will tell you how these services and  
their cost were figured.

SSI/SSP PERSONAL AND REAL PROPERTY

W134 MPP 50-061.412(a) and .446  
You and your spouse had monthly income and/or monthly liquid resources in excess of SSI/SSP standards which are listed below:

Income/Resources

SSI/SSP Standards

REASON FOR DENIAL OTHER THAN SPOUSE

W135 MPP 50-061.412  
You were denied protective supervision services and/or medical accompaniment because:

EXCESSIVE MEDICAL HOURS CLAIMED:

W136 MPP 50-061.435(a)  
The information submitted in Part IV of the Standard Claim Form does not support the excessive medical accompaniment hours for the claim period \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_. Please provide additional information or documentation that will support your claim for medical accompaniment hours more than twice the state average, or more than eight hours a month.

FINAL MESSAGES:

FOR ALL FINAL MESSAGES:

W137 MPP 50-061.63

You do not qualify as a WRO v. McMahon class member. Your WRO v. McMahon claim is denied because:

INCOMPLETE STANDARD CLAIM FORM RETURNED:

W138 MPP 50-061.311 and .433(a)

A Standard Claim Form was returned to you with Sections \_\_\_'\_\_\_'\_\_\_'\_\_\_'\_\_\_' checked which needed to be completed. We received your Standard Claim Form \_\_\_-\_\_\_-\_\_\_; however, the claim form is still not complete.

INCOMPLETE STANDARD CLAIM FORM NOT RETURNED:

W139 MPP 50-061.315 and .434

A Standard Claim Form was returned to you with Sections \_\_\_'\_\_\_'\_\_\_'\_\_\_'\_\_\_' checked which needed to be completed. We did not receive your Standard Claim Form we returned to you for completion by \_\_\_-\_\_\_-\_\_\_.

INCOMPLETE SUPPLEMENTAL CLAIM FORM RETURNED:

W140 MPP 50-061.311 and .444(a)

A Supplemental Claim Form was returned to you with Sections \_\_\_'\_\_\_'\_\_\_'\_\_\_'\_\_\_' checked which needed to be completed. We received your Supplemental Claim Form \_\_\_-\_\_\_-\_\_\_; however, the claim form is still not complete.

INCOMPLETE SUPPLEMENTAL CLAIM FORM NOT RETURNED:

W141 MPP 50-061.315 and .445

A Supplemental Claim Form was returned to you with Sections \_\_\_'\_\_\_'\_\_\_'\_\_\_'\_\_\_' checked which needed to be completed. We did not receive your Supplemental Claim Form we returned to you for completion by \_\_\_-\_\_\_-\_\_\_.

SUPPLEMENTAL CLAIM FORM NOT RETURNED (PART I, II AND IV):

W142 MPP 50-061.315 and .445

We did not receive your Supplemental Claim Form we mailed you to complete Parts I, III and IV by \_\_\_-\_\_\_-\_\_\_.

SUPPLEMENTAL CLAIM FORM NOT RETURNED (THE ENTIRE FORM):

W143 MPP 50-061.315 and .445

We did not receive your Supplemental Claim Form we mailed you to complete by \_\_\_-\_\_\_-\_\_\_.

OUTSIDE RETROACTIVE PAYMENT PERIOD:

W144 MPP 50-061.331  
You are claiming you received protective supervision services and/or medical accompaniment for periods other than July 1, 1983 through September 30, 1984.

REFER MILLER v WOODS:

W145 MPP 50-061.412(a)  
Non-spouse claimants do not qualify for payments under the WRO v. McMahon judgment. However, you may qualify for payments under the Miller v. Woods judgment. Please complete the Miller v. Woods Standard Claim Form enclosed and return the form to the IHSS County office listed above (top lefthand corner) by \_\_\_-\_\_\_-\_\_\_.

UNDERPAYMENT PERIOD:

W146 MPP 50-061.332 and .481(a)  
Your eligibility for retroactive payments does extend through the end of the retroactive payment claim period, September 30, 1984.

NOT A CALIFORNIA RESIDENT (RETROACTIVE PERIOD):

W147 MPP 50-061.412(a) and .421(a)(1)  
You did not live in California at any time from July 1983 through September 1984.

NOT A CALIFORNIA RESIDENT (UNDERPAYMENT PERIOD):

W148 MPP 50-061.412(a) and .421(a)(1)  
You did not live in California at any time from October 1984 through September 1985.

NOT LEGALLY MARRIED (RETROACTIVE PERIOD):

W149 MPP 50-061.412(a)  
You were not legally married to someone who may have provided protective supervision services and/or medical accompaniment at any time from July 1983 through September 1984.

NOT LEGALLY MARRIED-UNDERPAYMENT PERIOD:

W150 MPP 50-061.412(a)  
You were not legally married to someone who may have provided protective supervision services and/or medical accompaniment at any time from October 1984 through September 1985.

NOT A SPOUSE (SSI/SSP ELIG)-RETROACTIVE PERIOD:

W151 MPP 50-061.412(a)  
You were not considered to be a member of a married couple as defined for the purposes of SSI/SSP eligibility in 20 CR 416.1806 at any time from July 1983 through September 1984.

NOT A SPOUSE (SSI/SSP ELIG)-UNDERPAYMENT PERIOD:

W152 MPP 50-061.412(a)  
You were not considered to be a member of a married couple as defined for the purposes of SSI/SSP eligibility in 20 CR 416.1806 at any time from October 1984 through September 1985.

DID NOT PROVIDE PROTECTIVE SUPVR/MED ACCOMP-RETRO PERIOD:

W153 MPP 50-061.412(c) and .421(a)(2)  
It was not necessary for someone to stay and watch that you did not harm or injure yourself or to assist you during transportation to and from medical appointments at any time from July 1983 through September 1984.

DID NOT PROVIDE PROTECTIVE SUPVR/MED ACCMP-UNDERPYT PERIOD:

W154 MPP 50-061.412(c) and .421(a)(2)  
It was not necessary for someone to stay and watch that you did not harm or injure yourself or to assist you during transportation to and from medical appointments at any time from October 1984 through September 1985.

LEAVE OR PREVENTED FULL-TIME EMPLOYMT (RETRO PERIOD):

W155 MPP 50-061.412 and .421(a)(1)  
Your spouse did not leave nor were prevented from seeking full-time employment to stay and watch you to make sure you did not harm or injure yourself or to assist you during transportation to and from medical appointments at any time from July 1983 through September 1984.

LEAVE OR PREVENTED FULL-TIME EMPLOYMT (UNDERPYMT PERIOD):

W156 MPP 50-061.412 and .421(a)(1)  
Your spouse did not leave nor were prevented from seeking full-time employment to stay and watch you to make sure you did not harm or injure yourself or to assist you during transportation to and from medical appointments at any time from October 1984 through September 1985.

INAPPROPRIATELY PLACED (RETRO PERIOD):

W157 MPP 50-061.412 and .421(a)  
Your spouse did not need to provide protective supervision services and/or medical accompaniment to prevent you from receiving inadequate services or from being inappropriately placed somewhere other than his/her own home at any time from July 1983 through September 1984.

INAPPROPRIATELY PLACED (UNDERPAYMENT PERIOD):

W158 MPP 50-061.412(a) and .421(a)(1)  
Your spouse did not need to provide protective supervision services and/or medical accompaniment to prevent you from receiving inadequate services or from being inappropriately placed somewhere other than his/her own home at any time from October 1984 through September 1985.

NO REQUIRE MEDICAL ACCOMPANIMENT (RETROACTIVE PERIOD):

W159 MPP 50-061.412(b)  
You did not require assistance during transportation to and from medical appointments at any time from July 1983 through September 1984.

NO REQUIRE MEDICAL ACCOMPANIMENT (UNDERPAYMENT PERIOD):

W160 MPP 50-061.412(b)  
You did not require assistance during transportation to and from medical appointments at any time from October 1984 through September 1985.

NO REQUIRE PROTECTIVE SUPERVISION SVS (RETROACTIVE PERIOD):

W161 MPP 50-061.412(c) and .421(a)(2)  
You did not require protective supervision services at any time from July 1983 through September 1984.

NO REQUIRE PROTECTIVE SUPERVISION SVS (UNDERPAYMENT PERIOD):

W162 MPP 50-061.412(c) and .421(a)(2)  
You did not require protective supervision services at any time from October 1984 through September 1985.

NOT 65 YRS, BLIND OR DISABLED (RETROACTIVE PERIOD):

W163 MPP 50-061.412(a) and .421(a)(1)  
You were not age 65 or older, blind or disabled at any time from July 1983 through September 1984.

NOT 65 YRS, BLIND OR DISABLED (UNDERPAYMENT PERIOD):

W164 MPP 50-061.412(a) and .421(a)(1)  
You were not age 65 or older, blind or disabled at any time  
from October 1984 through September 1985.

SELF-DIRECTING (RETROACTIVE PERIOD):

W165 MPP 50-061.412(c) and .421(a)(2)  
You were self-directing, unconfused and not mentally  
impaired or mentally ill at any time from July 1983 through  
September 1984.

SELF-DIRECTING (UNDERPAYMENT PERIOD):

W166 MPP 50-061.412(c) and .421(a)(2)  
You were self-directing, unconfused and not mentally  
impaired or mentally ill at any time from October 1984  
through September 1985.

NEITHER RECEIVED NOR DENIED SVS (RETROACTIVE PERIOD):

W167 MPP 50-061.421(a)(3)  
You did not receive nor were you denied In-Home Supportive  
Service benefits at any time from July 1983 through  
September 1984.

NEITHER RECEIVED NOR DENIED SVS (UNDERPAYMENT PERIOD):

W168 MPP 50-061.421(a)(3)  
You did not receive nor were you denied In-Home Supportive  
Service benefits any time from October 1984 through  
September 1985.

PAID AS AUTHORIZED SERVICES:

W169 MPP 50-061.412(h)  
Protective supervision services and/or medical  
accompaniment have already been paid by the County as part  
of the authorized In-Home Supportive Services. The  
attached computation of hours and payment will tell you how  
these services and their cost were figured.

YOU DID NOT PAY FOR SERVICES:

W170 MPP 50-061.412(h)  
You did not pay your spouse for providing protective  
supervision services and/or medical accompaniment.

STATUTORY MAXIMUM HOURS OF SERVICE RECEIVED BY RECIPIENT:

W171 MPP 50-061.412(d) and .412(e)  
You received In-Home Supportive Services paid at the statutory maximum payment. The attached computation of hours and payment will tell you how these services and their cost were figured.

SSI/SSP PERSONAL AND REAL PROPERTY

W172 MPP 50-061.412(a)  
You and your spouse had monthly income and/or monthly liquid resources in excess of SSI/SSP standards which are listed below:

Income/Resources

SSI/SSP Standards

REASON FOR DENIAL OTHER THAN SPOUSE

W173 MPP 50-061.412  
You were denied protective supervision services and/or medical accompaniment because:

EXCESSIVE MEDICAL HOURS CLAIMED:

W174 MPP 50-061.435(a)  
On \_\_\_-\_\_\_-\_\_\_ we mailed you a Notice of Action message which required that you submit additional information or documentation to support your claim of excessive medical accompaniment hours. Excessive medical accompaniment hours are any hours claimed that is twice the state average or more than eight hours a month.

We did not receive any additional information or documentation required by \_\_\_-\_\_\_-\_\_\_.

LATE FILING:

W175 MPP 50-061.22, .314 and .32(f)  
Your claim was received after the final filing date of September 30, 1993.

FINAL DENIAL OF A REBUTTAL:

W176 MPP 50-061.464(e) and .474(e)  
We have reviewed the WRO v. McMahon Claim Form and have considered the additional information you have submitted since your denial Notice of Action dated \_\_\_-\_\_\_-\_\_\_. The denial of your claim is final because:

INFO DOES NOT SUBSTANTIATE CLAIM:

W177 MPP 50-061.464(e)

We have reviewed your WRO v. McMahon Claim Form and have considered the additional information you have submitted. Your claim is denied because:

APPROVAL AND  
PARTIAL APPROVAL/DENIAL NOTICES

APPROVAL:

W190 MPP 50-061.63

You claim is approved in the amount of \$\_\_\_\_\_ past due wages and \$\_\_\_\_\_ interest (see attached computation).

Your past due wages and interest are taxable income and we will report the amount to the Internal Revenue Service and the Franchise Tax Board. Your check may not have enough taxes withheld, you must figure out how much you owe. You may wish to contact the IRS or a tax consultant for assistance. The check(s) you receive will tell you what deductions, if any, have been made.

Your check(s) will be mailed to you within the next 30 days.

PARTIAL APPROVAL:

W191 MPP 50-061.63

Your claim is approved in part and denied in part.

The part of your claim that is approved equals the amount of \$\_\_\_\_\_ past due wages and \$\_\_\_\_\_ interest (see attached computation).

Your past due wages and interest are taxable income and we will report the amount to the Internal Revenue Service and the Franchise Tax Board. Your check may not have enough taxes withheld, you must figure out how much you owe. You may wish to contact the IRS or a tax consultant for assistance. The check(s) you receive will tell you what deductions, if any, have been made.

Your check(s) will be mailed to you within the next 30 days. That part of your claim for the period(s) \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_, \_\_\_-\_\_\_-\_\_\_ through \_\_\_-\_\_\_-\_\_\_ is denied is based on the following information:

Note: This notice relates ONLY to your Social Services. -  
KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

IF REQUESTING A STATE HEARING, PLEASE SEND TO:

YOUR  
IHSS  
OFFICE

Case Number

Date Mailed

The following action(s) is supported by Federal Law (Social Security Act), State Law (Welfare and Institutions Code), Federal Regulations (Code of Federal Regulations), State Regulations (California Administrative Code and State Department of Social Services Manual of Policies and Procedures) and Court Order:

Fold

4953

5866-4

3300 556

The amount of money you receive as a result of this claim may affect your tax liability and/or continuing eligibility for certain programs including, but not limited to: In-Home Supportive Services (IHSS), Aid to Families with Dependent Children (AFDC), Medi-Cal, Food Stamps (FS), Supplemental Security Income and State Supplementary Program (SSI/SSP) and Veterans Benefits.

If you need assistance with translation of this notice, or if you have any questions or think additional facts should be considered, please contact the worker shown below.

District Office: Service Worker:

SW #: Telephone:

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING. PLEASE SEND YOUR WRITTEN REQUEST TO THE COUNTY ADDRESS ON THE TOP RIGHT HAND CORNER OF THIS FORM.

# RIGHT TO REQUEST A STATE HEARING

1. You have the right to a conference with representatives of the County Welfare Department to talk about this intended action. At such a conference, you may speak for yourself or be represented by a lawyer, a friend or other spokesperson. If you want a conference, contact your county department.
2. Whether you request a conference or not, you also have the right to request a State Hearing and decision by the Director of the State Department of Social Services (see form below). Your request may be written or oral but it must state that you want a hearing and why you are dissatisfied. **YOUR REQUEST FOR A HEARING MUST BE MADE WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.**
3. **IF YOU REQUEST A STATE HEARING ANYTIME BEFORE THE EFFECTIVE DATE OF THE COUNTY'S PROPOSED ACTION, YOUR SERVICES MAY CONTINUE UNTIL THE HEARING.** You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request is made in good faith.
4. You may request a State Hearing on your own, or you may ask your county department for assistance. In either case, however, be sure to inform your county department worker as soon as possible.
5. At a State Hearing you have the right to be represented by an attorney or any other person (a friend, relative, or other spokesperson), of your choice. You may obtain free legal advice and the services of a lawyer. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response. You may also contact the nearest social service rights organization for assistance in presenting your claim.

6. State regulations governing State Hearings for social services are available at the office of the County Welfare Department.
7. Information Practices - The information you are requested to provide is mandatory in order to process your request for a State Hearing pursuant to W&IC 10950. A case file will be established by the Office of the Chief Referee. You have the right to examine the materials that constitute the record for decision. Any information you provide may be shared with the County Welfare Department or the United States Department of Health and Human Services.

*If you wish to make a written request for a State Hearing, please send this page to the County Welfare Department. The address is found on the front side of this notice on the top right hand corner.*

*To make an oral request for a State Hearing, or obtain further information about your State Hearing rights or files, you may contact:*

---

Public Inquiry and Response  
 State Department of Social Services  
 744 P Street, Mail Station 16-23  
 Sacramento, Ca. 95814  
 (800) 952-5253 (toll-free number)\*  
 TDD (800) 952-8349\* For Hearing and Speech Impaired

---

\*You may have to dial "1" first.

## REQUEST FOR STATE HEARING

Name (Last, First, Middle Initial)	Phone No.	Social Security No.
Address	City	State      Zip Code

I hereby request a State Hearing before the State Department of Social Services on the action taken by the County regarding my social services. The reasons for my request are as follows:

---



---



---



---



---



---

I have trouble understanding English, therefore I request an interpreter for my hearing in the following:	Language	Dialect
Signature	Date Signed	

### AUTHORIZED REPRESENTATIVE

I have authorized the following person to act on my behalf in my appeal. I authorize the Department to release any or all information about my case to that person.

Name of Authorized Representative	
Address of Authorized Representative	
Signature of State Hearing Coordinator	Date Signed