

NOTICE OF FORM CHANGE NO. 04-259

DATE

9/3/2004

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

Community Care Licensing District Offices
 Private and Public Adoption Agencies

District Attorney
 Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE **SOC 432 (8/04) Claim For Reimbursement, In-Home Supportive Services Program
Contract Expenditures**

ORDER UNIT MASTER ONLY	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input checked="" type="checkbox"/> Revised	DATE OF FORM 8/04	REPLACES 7/04	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input checked="" type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: Department of Social Services Warehouse P.O. Box 980788 West Sacramento, CA 95798-0788		<input type="checkbox"/> Other:	

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY

Use until exhausted Destroy

USE NEW FORM

When supply available in DSS Warehouse Use new form effective immediately.

USE FORM IN ACCORDANCE WITH

All County Letter No.
 Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

8-1/2" x 11", 2 page form.

Check on the internet to see if forms are available at www.dss.cahwnet.gov

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

CLAIM FOR REIMBURSEMENT IN-HOME SUPPORTIVE SERVICES PROGRAM CONTRACT EXPENDITURES

To: Adult Programs Branch
California Department of Social Services
744 P Street, MS 19-96
Sacramento, CA 95814

FROM:
COUNTY:
ADDRESS:
CONTACT PERSON:
PHONE NUMBER: ()

CONTRACT NUMBER	CONTRACTOR NAME	SERVICE MONTH/YEAR
-----------------	-----------------	--------------------

CONTRACT SERVICE DELIVERY TOTALS FOR MONTH BY FUNDING SOURCE: WARRANT DATE _____
FISCAL YEAR/QTR. _____

FUNDING SOURCE	TOTAL CASES	TOTAL HOURS	GROSS EXP.	*ADJUSTMENTS	TOTAL NET EXP.
PCSP	_____	_____	_____	_____	_____
IPW	_____	_____	_____	_____	_____
IHSS	_____	_____	_____	_____	_____
Totals	_____	_____	_____	_____	_____

* If the actual PCSP, IPW, and IHSS adjustment amounts are not known, please estimate the PCSP, IPW, and IHSS amounts based on the PCSP, IPW, and IHSS hours to total hours ratio.

COST REIMBURSEMENT DETAIL BY FUNDING SOURCE:

FUNDING SOURCE	FEDERAL	STATE/COUNTY	STATE	COUNTY	TOTAL NET EXPENDITURE
PCSP	(50%) _____	(50%) _____	(65%) _____	(35%) _____	_____
IPW	(50%) _____	(50%) _____	(65%) _____	(35%) _____	_____
IHSS	_____	_____	(65%) _____	(35%) _____	_____
Totals	_____	_____	_____	_____	_____

I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the Personal Care Services Program; that I have not violated any of the provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 & .951 Welfare and Institutions Code personal care services as a benefit for the medically needy and categorically eligible; and the provisions of Section 1090 to 1096, inclusive of the Government Codes; that the amounts claimed herein are properly claimable as expenditures for the administration of the project as specified in accordance with all provisions of the Welfare and Institutions Codes, the rules and regulations of the State Benefits and Services Advisory Board.

I hereby certify under penalty of perjury, that I am the official responsible for the examination and settlement of accounts, that I have not violated any provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 & .951 Welfare and Institutions Code personal care services as a benefit for the medically needy and categorically eligible; and the provisions of Sections 1070 to 1096, inclusive, of the Government Code; that the expenditures claimed herein have been authorized, that a clearly delineated audit trail is in place to substantiate said expenditures, and that payments therefore have been made or expenditures otherwise incurred according to law.

SIGNATURE OF COUNTY WELFARE DIRECTOR OR CONTRACT ADMINISTRATOR	DATE	SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE
--	------	---	------

Approved by: _____ Date: _____
(State IHSS Program Manager)

SECTION I OVERPAYMENTS/UNDERPAYMENTS

	PCSP CASES	IPW CASES	IHSS CASES	PCSP HOURS	IPW HOURS	IHSS HOURS	PCSP GROSS	IPW GROSS	IHSS GROSS
A PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
B CONNECTED PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
C ADJUSTMENT +/-	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

SECTION II OTHER _____ (COUNTY SPECIFIC)

	PCSP CASES	IPW CASES	IHSS CASES	PCSP HOURS	IPW HOURS	IHSS HOURS	PCSP GROSS	IPW GROSS	IHSS GROSS
D BILLED	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
E ADJUSTMENT +/-	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
F NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

SECTION III LIQUIDATED DAMAGES

	PCSP CASES	IPW CASES	IHSS CASES	PCSP HOURS	IPW HOURS	IHSS HOURS	PCSP GROSS	IPW GROSS	IHSS GROSS
G BILLED	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
H ADJUSTMENT +/-	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
I NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

SECTION IV PCSP / IHSS ADJUSTMENTS

	PCSP CASES	IPW CASES	IHSS CASES	PCSP HOURS	IPW HOURS	IHSS HOURS	PCSP GROSS	IPW GROSS	IHSS GROSS
J NET ADJUSTMENT C + E + H (+/=)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
K ADJUSTMENT +/-	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
L TOTAL NET ADJUSTMENT +/-	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

SECTION V CONTRACTOR BILLING

	PCSP CASES	IPW CASES	IHSS CASES	PCSP HOURS	IPW HOURS	IHSS HOURS	PCSP GROSS	IPW GROSS	IHSS GROSS
M SERVICE MONTH (1)									
N INVOICE BILLED	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
O NET ADJUSTMENT +/- C + E + H or L	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
P TOTAL NET ADJUSTMENT +/-	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)