

SHD Paraphrased Regulations - Social Services
620 IHSS Need Evaluation

620-1

County services staff shall conduct a needs assessment of applicants and recipients of IHSS. In making this assessment, the services staff shall determine the total amount of hours per week needed for the various services set forth in the program content. (§30-763.2) No need exists for services which the applicant/recipient is able to perform safely, without an unreasonable amount of physical or emotional stress. (§30-761.25)

620-2

The program content of the IHSS Program includes, but is not limited to, housecleaning, laundry, meal preparation and cleanup, bathing, food shopping and errands, bowel and bladder care, dressing, ambulation, feeding, transportation to and from medical providers, and paramedical services. (§30-757)

620-3 ADDED 6/08

There is no minimum number of hours required to authorize a case for IHSS.

(All County Letter 08-18, April 23, 2008, answer to question 2)

620-5 REVISED 12/06

When assessing the need for domestic services, the guideline time shall not exceed 6 hours per household unless the recipient's needs require an exception. (§30-758.11 renumbered to 30-757.11(k)(1) effective September 1, 2006)

620-6

Paramedical services are covered under the IHSS Program when the activities involved are those which persons would normally perform for themselves but for their functional limitations and are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health. The services must be ordered and performed under the direction of a licensed health care professional. The health care professional shall indicate to social services staff the time necessary to perform the ordered services. The services shall be provided by persons who ordinarily provide IHSS. (§30-757.19)

620-7 REVISED 12/06

State law provides that a time-per-task guideline may be used only if appropriate in meeting the individual's particular circumstances. (Welfare and Institutions Code (W&IC) §12301.2) Counties may establish such guidelines for services other than personal care services, meal preparation and cleanup, and paramedical services. (§30-758.2 repealed effective September 1, 2006)

620-7A ADDED 12/04

Welfare and Institutions Code (W&IC) §12301.2 requires the CDSS to develop and implement statewide hourly IHSS/PCSP task guidelines and instructions to provide counties with a standard tool for assessing service needs and authorizing service hours. It requires counties to use statewide guidelines when conducting an individual assessment or reassessment of an individual's need for services. The guidelines are to include criteria to assist county social workers to determine when an individual's service need falls outside an established normal range of time.

Subject to the existing 195 and 283 hour service limits, this statute requires counties to authorize services in amounts outside of a range of time provided in the guidelines when warranted based on an individual assessment. Counties must document in the case file the need for services outside the guidelines.

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This statute replaces the previous W&IC §12301.2 on time per task guidelines and there must be implementing regulations by 6/30/06.

(All County Information Notice I-69-04, September 30, 2004, addressing Senate Bill 1104 including W&IC §12301.2)

620-8 REVISED 12/06

Where laundry services are available in the home, the guideline time shall not exceed 1 hour total per week per household unless the recipient's needs require an exception to exceed this limit. (§30-758.121 renumbered to 30-757.134(c))

Laundry services are available in the home if, at a minimum, there exists a washing machine and a capability to dry clothes on the premises. (§30-757.134(a)) Where laundry facilities are not available in the home, the guideline time shall not exceed 1.5 hours total per week per household, unless the recipient's needs require an exception to exceed this limit. (§§30-757.135(b) and §30-758.122 renumbered to §30-757.134(d) effective September 1, 2006)

620-9 REVISED 12/06

The guideline time for "food shopping" shall not exceed 1 hour per week per household. unless the recipient's needs require an exception to exceed this limit. (§30-758.13 renumbered to §30-757.135(b)(1) effective September 1, 2006) The time for shopping is limited to the nearest available stores or facilities which meet the client's economy and needs; no time is allowable for the recipient to accompany the provider. (§30-757.136 renumbered to §30-757.135 effective September 1, 2006)

620-10 REVISED 12/06

The guideline time for "other shopping and errands" shall not exceed .5 hours per week per household unless the recipient's needs require an exception to exceed this limit. (§30-758.14 renumbered to (§§30-757.135(c)(1) effective September 1, 2006.)

620-11 REVISED 12/06

Exceptions to the guideline times for domestic services, laundry, food shopping, and other shopping and errands can be made when necessary to enable the recipient to establish and maintain an independent living arrangement and/or remain safely in his/her home or abode of choice. (§30-758.4 repealed and renumbered in various sections of 30-757)

620-12

Assistance by the provider is available for transportation when the recipient's presence is required at the destination and such assistance is necessary to accomplish the travel which is limited to transportation to and from appointments with physicians, dentists and other health practitioners or dispensers of medical equipment. Transportation is not available if Medi-Cal will provide the transportation service or if such services are available through alternative resources. (§30-757.15)

620-12A ADDED 6/08

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

A: If the appointment is medically necessary and the health care professional is not local, the time to drive the recipient to the appointment and home would be allowed. Providers may only

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claim this time when the services are actually performed. (All County Letter 08-18, April 23, 2008, question and answer 22)

620-13

Social services staff shall explore alternative IHSS which may be available from other agencies and programs to meet the needs of the recipient. (§30-763.61)

Pursuant to San Mateo County Superior Court, Stipulation and Order No. 352667, 11/30/90, VA Aid and Attendance payments shall no longer be counted as income or treated as an alternative resource. (Clift v. McMahan)

620-13A

Following the Arp v. Anderson court case, counties were instructed that services provided by regional centers can no longer be considered an alternative resource under W&IC §12301(a) and MPP §30-763.61. PCSP and IHSS must be granted as though no services are being provided through a Regional Center. Determination of services to be provided must be based strictly on an assessment of the developmentally disabled applicant. (All-County Letter No. 98-53, July 9, 1998; Arp v. Anderson, San Diego County Superior Court, No. 711204, Stipulation for Final Judgment, February 18, 1998)

620-13B

State law gives the CDSS the authority, to the extent permitted by federal law, to waive regulations and general policies and make resources available which are necessary for the administration of Welfare & Institutions Code (W&IC) §9560 and following. (W&IC §9562(b))

Pursuant to this authority, the CDSS has authorized the MSSP to supplement their clients' IHSS awards as follows:

(a) For cases authorized to receive the statutory maxima, there will be no reduction in the authorization of services when the MSSP grants an additional level of services above the IHSS maxima.

(b) For cases assessed at a level less than the maxima, additional hours authorized by the MSSP will not be considered an alternative resource, and IHSS will be authorized at the previously determined need level.

(All-County Letter No. 00-34, May 19, 2000)

620-14

Social services staff shall explore with the recipient the willingness of relatives, housemates, friends, or other appropriate persons to provide voluntarily some or all of the services required by the recipient. Social services staff shall not compel any such volunteer to provide services. The social services staff shall document on the needs assessment form the total need for a specific service, which shall then be reduced by any service available from an alternative resource. (§30-763.62)

620-14A

If a provider of IHSS or PCSP voluntarily agrees to provide a service or services, the county social services staff shall obtain a statement from the provider that he/she knows of the right to compensation for the provision of the services, but voluntarily chooses to accept no payment or

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reduced payment. (§§30-575.176 and 30-763.64, effective November 14, 1998, based on Miller v. Woods/Community Services for the Disabled v. Woods, San Diego County Superior Court, Nos. 468192 and 472068)

620-14B

The voluntary service agreement for IHSS shall contain the following information:

- (1) Services to be performed.
- (2) Recipient's name.
- (3) Case number.
- (4) Day(s) and hour(s) per month service will be performed.
- (5) Provider of services.
- (6) Provider's address and telephone number.
- (7) Provider's signature, and date signed.
- (8) Name and signature of Social Service worker.

(§§30-757.176(a), referenced in §30-763.64, both sections effective November 14, 1998)

620-14C

When a need for services is assessed and authorized, then unless certain specified exceptions exist, an individual can legally be paid to perform those services. An individual who could be paid to provide the services can volunteer, and not be paid. But any individual willing to perform authorized services without compensation must complete and sign the Certification form, currently SOC 450. All voluntary service homes are shown as Alternative Resource hours, on form SOC 293.

No Certification form is required when services are provided by an organization, or by an individual willing to provide services that are not compensable.

(All-County Letter No. 00-28, April 25, 2000)

620-15

State law mandates that CDSS develop a uniform needs assessment tool.

The county shall use information as to the recipient's living environment, alternative resources, and the recipient's functional abilities in making its evaluation. (Welfare and Institutions Code (W&IC) §12309)

Under Subsection (d), the recipient's functioning rank shall be based on the following scale:

Rank One: The recipient's functioning is independent, and the recipient does not need human assistance. The recipient may have difficulty in performing the function but there is no substantial safety risk.

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Rank Two: The recipient is able to perform the function, but needs verbal assistance.

Rank Three: The recipient can perform the function with some human assistance, such as direct physical assistance from a provider.

Rank Four: The recipient can perform a function but only with substantial human assistance.

Rank Five: The recipient cannot perform the function.

(All-County Letter (ACL) No. 88-118, September 6, 1988, gives further explanations of uniformity assessments. This ACL adds a Rank Six to those listed above, which is used when the recipient needs paramedical services. Regulations implementing and clarifying the statute are contained in §30-756)

620-15A ADDED 6/08

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

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

(All County Letter 08-18, April 23, 2008, question and answer 25)

620-16

Social services staff shall determine need for services based on the recipient's physical/mental condition, or living/social situation; the recipient's statement of need; the available medical information; and other information social service staff considers necessary and appropriate. (§30-761.26)

Services staff shall determine the need for only those tasks in which the recipient has functional impairments. Recipients must cooperate, within their ability, to secure medical verification of their present condition, their ability to remain in their own homes, and their need for and level of out-of-home care. (§30-763.1)

620-18

When the IHSS recipient lives with the live-in provider, the need assessment is conducted as follows:

Domestic and heavy cleaning services shall not be provided in areas used solely by the provider. The need for related services may be prorated if the provider and recipient agree. All other services shall be assessed based on the recipient's individual need, as long as there is only one recipient in the home. (§30-763.47)

620-19

The county shall use a needs assessment and authorization form developed by the CDSS.

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(§30-761.27) Using the needs assessment form, services staff shall calculate the number of hours per week needed for each of the services that the claimant requires. The form developed by CDSS indicates that the monthly amount of IHSS hours needed is found by multiplying the weekly amount by 4.33 (§30-763.2)

620-20 ADDED 8/05

The department shall adopt regulations establishing a uniform range of services available to all eligible recipients base upon individual needs. The availability of services under these regulations is subject to the provisions of Section 12301 and county plans developed pursuant to Section 12302.

The department shall adopt emergency regulations implementing this section no later than September 30, 2005, unless notification of delay is made to the Chair of the Joint legislative Budget Committee prior to that date. Under no circumstances shall the adoption of emergency regulations or similar instructions be extended, beyond June 30, 2006

(W&IC §12301.1(a) and (e))

620-21 ADDED 8/05

Notwithstanding subdivision (b), at the county's option, assessments may be extended, on a case-by-case basis, for up to six months beyond the regular 12-month period, provided that the county documents that all of the following conditions exist:

- (A) The recipient has had at least one reassessment since the initial program intake assessment.
- (B) The recipient's living arrangement has not changed since the last annual reassessment and the recipient lives with others, or has regular meaningful contact with persons other than his or her service provider.
- (C) The recipient or, if the recipient is a minor, his or her parent or legal guardian, or if incompetent, his or her conservator, is able to satisfactorily direct the recipient's care.
- (D) There has been no known change in the recipient's supportive service needs within the previous 24 months.
- (E) No reports have been made to, and there has been no involvement of, an adult protective services agency or agencies since the county last assessed the recipient.
- (F) The recipient has not had a change in provider or providers for at least six months.
- (G) The recipient has not reported a change in his or her need for supportive services that requires a reassessment.
- (H) The recipient has not been hospitalized within the last three months.

(2) If some, but not all, of the conditions specified in paragraph (1) of subdivision (c) are met, the county may consider other factors in determining whether an extended assessment interval is appropriate, including, but not limited to, involvement in the recipient's care of a social worker, case manager, or other similar representative from another human services agency,

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such as a regional center or county mental health program, or communications, or other instructions from a physician or other licensed health care professional that the recipient's medical condition is unlikely to change.

(W&IC §12301.1(b) and (c))

620-22 ADDED 8/05

State law provides as follows:

(3) A county may reassess a recipient's need for services at a time interval of less than 12 months from a recipient's initial intake or last assessment if the county social worker has information indicating that the recipient's need for services is expected to decrease in less than 12 months.

(d) A county shall assess a recipient's need for supportive services any time that the recipient notifies the county of a need to adjust the supportive services hours authorized, or when there are other indications or expectations of a change in circumstances affecting the recipient's need for supportive services.

(W&IC §12301.1(c)(3) and (d))

620-23 ADDED 8/05

State law provides as follows:

(a) (1) The department, in consultation and coordination with county welfare departments and in accordance with Section 12305.72, shall establish and implement statewide hourly task guidelines and instructions to provide counties with a standard tool for consistently and accurately assessing service needs and authorizing service hours to meet those needs.

(2) The guidelines shall specify a range of time normally required for each supportive service task necessary to ensure the health, safety, and independence of the recipient. The guidelines shall also provide criteria to assist county workers to determine when an individual's service need falls outside the range of time provided in the guidelines.

(3) In establishing the guidelines the department shall consider, among other factors, adherence to universal precautions, existing utilization patterns and outcomes associated with different levels of utilization, and the need to avoid cost shifting to other government program services. During the development of the guidelines the department may seek advice from health professionals such as public health nurses or physical or occupational therapists.

(b) A county shall use the statewide hourly task guidelines when conducting an individual assessment or reassessment of an individual's need for supportive services.

(d) The department shall adopt regulations to implement this section by June 30, 2006.

(W&IC §12301.2)

620-24 ADDED 8/05

Subject to the (195 and 283 hour) limits imposed by Section 12303.4, counties shall approve an amount of time different from the guideline amount whenever the individual assessment

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indicates that the recipient's needs require an amount of time that is outside the range provided for in the guidelines. Whenever task times outside the range provided in the guidelines are authorized the county shall document the need for the authorized service level.

The department shall adopt regulations to implement this section by June 30, 2006.

W&IC §12301.2(c) and (d))

620-25 ADDED 6/08

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

A: Yes, provided the service has been authorized, the provider is in the accompaniment of the recipient, and/or the absence is not precluded by the out-of-state absence requirements at MPP Sections 30-770.444 and .461. (All County Letter 08-18, April 23, 2008, question and answer 30)

622-1

Net nonexempt income in excess of the applicable SSI/SSP benefit level shall be applied to the cost of IHSS. (§30-755.233)

622-2

Unearned income includes any payments received as an annuity, pension, retirement, disability, Old Age, Survivors and Disability Insurance, unemployment, veterans' or workers' compensation benefits. (§30-775.332)

622-3

There is a disregard for the first \$20 of earned or unearned income per month. (§30-775.433)

622-4

The monthly benefit level for ___ aged or disabled person(s) is \$___. (§46-120.1)

622-5

Where the correct share of cost was more than the recipient paid, the resulting overpayment is determined by subtracting the amount paid from the correct amount. (§30-768.23)

622-6

Unearned income includes those amounts of countable earned income deemed to be available to the individual from the income of his or her ineligible spouse or parents. The deeming procedures shall conform to those specified in 20 CFR §§416.1165-1166 and as set forth on a form approved by the Department. (§30-775.337)

622-6A ADDED 3/09

The SOC 294-A form is the form used to determine IHSS Adult Income Eligibility and share of cost. The form is consistent with *Hodson v Woods* that held that Welfare and Institutions Code (W&IC) §12051 requires the use of the deeming methodology used for SSI/SSP.

The form includes additional steps for calculating the deemed income of an ineligible spouse contained in 20 CFR 416.1763c.

(All County Letter 85-110, October 29, 1985)

622-6B ADDED 6/07

How we deem income to you from your ineligible spouse. If you have an ineligible spouse who lives in the same household, we apply the deeming rules to your ineligible spouse's income in the following order.

(a) Determining your ineligible spouse's income. We first determine how much earned and unearned income your ineligible spouse has, using the appropriate exclusions in Sec. 416.1161(a).

(b) Allocations for ineligible children. We then deduct an allocation for ineligible children in the household to help meet their needs. Exception: We do not allocate for ineligible children who are receiving public income-maintenance payments (see Sec. 416.1142(a)).

(1) The allocation for each ineligible child is the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual. The amount of the allocation automatically increases whenever the Federal benefit rate increases. The amount of the allocation that we use to determine the amount of a benefit for a current month is based on the Federal benefit rate that applied in the second prior month unless one of the exceptions in Sec. 416.1160(b)(2) applies.

(2) Each ineligible child's allocation is reduced by the amount of his or her own income as described in Sec. 416.1161(c).

(3) We first deduct the allocations from your ineligible spouse's unearned income. If your ineligible spouse does not have enough unearned income to cover the allocations we deduct the balance from your ineligible spouse's earned income.

(c) Allocations for aliens sponsored by your ineligible spouse. We also deduct an allocation for eligible aliens who have been sponsored by and who have income deemed from your ineligible spouse.

(1) The allocation for each alien who is sponsored by and who has income deemed from your ineligible spouse is the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual. The amount of the allocation automatically increases whenever the Federal benefit rate increases. The amount of the allocation that we use to compute your benefit for a current month is based on the Federal benefit rate that applied in the second prior month (unless the current month is the first or second month of eligibility or re-eligibility as explained in Sec. 416.420(a) and (b) (2) and (3)).

(2) Each alien's allocation is reduced by the amount of his or her own income as described in Sec. 416.1161(d).

(3) We first deduct the allocations from your ineligible spouse's unearned income. If your ineligible spouse does not have enough unearned income to cover the allocations, we deduct the balance from your ineligible spouse's earned income.

(d) Determining your eligibility for SSI. (1) If the amount of your ineligible spouse's income that remains after appropriate allocations is not more than the difference between the Federal

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benefit rate for an eligible couple and the Federal benefit rate for an eligible individual, there is no income to deem to you from your spouse. In this situation, we subtract only your own countable income from the Federal benefit rate for an individual to determine whether you are eligible for SSI benefits.

(2) If the amount of your ineligible spouse's income that remains after appropriate allocations is more than the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual, we treat you and your ineligible spouse as an eligible couple. We do this by:

- (i) Combining the remainder of your spouse's unearned income with your own unearned income and the remainder of your spouse's earned income with your earned income;
 - (ii) Applying all appropriate income exclusions in Sec. Sec. 416.1112 and 416.1124; and
 - (iii) Subtracting the couple's countable income from the Federal benefit rate for an eligible couple. (See Sec. 416.2025(b) for determination of the State supplementary payment amount.)
- (e) Determining your SSI benefit.

(1) In determining your SSI benefit amount, we follow the procedure in paragraphs (a) through (d) of this section. However, we use your ineligible spouse's income in the second month prior to the current month. We vary this rule if any of the exceptions in Sec. 416.1160(b)(2) applies (for example, if this is the first month you are eligible for payment of an SSI benefit or if you are again eligible after at least a month of being ineligible). In the first month of your eligibility for payment (or re-eligibility), we deem your ineligible spouse's income in the current month to determine both whether you are eligible for a benefit and the amount of your benefit.

In the second month, we deem your ineligible spouse's income in that month to determine whether you are eligible for a benefit but we deem your ineligible spouse's income in the first month to determine the amount of your benefit.

(2) Your SSI benefit under the deeming rules cannot be higher than it would be if deeming did not apply.

(20 CFR 416.1163)

622-7 REVISED 9/08

The IHSS payment shall be determined by multiplying the monthly adjusted need for IHSS hours by the payment rate used by the county. (§30-764.12)

The base rate of compensation used by the county shall not be less than the legal minimum wage in effect at the time the work is performed. (The minimum wage is \$8.00 per hour as of January 1, 2008.) (§30-764.21; ACIN I-100-06)

622-8

Under Assembly Bill (AB) No. 2779, PCSP eligibility was extended to individuals who were not receiving categorical aid payments.

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When the individual who is now PCSP eligible has both a Medi-Cal and an IHSS share of cost (SOC), the individual shall not be financially disadvantaged under the state law. If the IHSS SOC is higher, the recipient must meet the lower Medi-Cal SOC. If the Medi-Cal SOC is higher, the recipient must meet the lower IHSS SOC, and the state will pay the amount between the Medi-Cal and the IHSS SOC.

(All County Welfare Directors Letter No. 99-13, March 29, 1999)

622-9 ADDED 5/05

All Medi-Cal eligibility determinations are to be completed following Medi-Cal rules. This includes Medi-Cal eligibility determinations for IHSS and PCSP recipients. (All County Welfare Director's Letter 04-27, August 30, 2004)

625-1

A person who is eligible for a personal care service through PCSP shall not be eligible for that service through IHSS. A service provided by IHSS shall be equal to the level of the same service provided by PCSP. (§30-757.1)

625-1A ADDED 7/06

Recipients who remain in the IHSS-R program are those who have been determined eligible for IHSS-R services, but who are not eligible for federally funded full-scope Medi-Cal, such as non-citizens under the five year ban (ACIN I-28-06, April 11, 2006, answer to question 2)

625-2

By September 1, 1993, the California Department of Social Services shall notify Pickle eligible persons, and persons eligible for services under 42 United States Code §1383c(c), they may receive PCSP without an SOC rather than IHSS if they meet other PCSP requirements and agree to accept payment for services in arrears rather than on an advanced basis. (W&IC §14132.95(k))

626-1

The IHSS Program content includes protective supervision. Protective supervision consists of monitoring the behavior of nonself-directing, confused, mentally impaired or mentally ill recipients in order to safeguard the recipient against injury, hazard or accident. Protective supervision is not available when the need is due to a medical condition and the form of supervision required is medical. It is not available in anticipation of a medical emergency. It is not available to prevent or control antisocial or aggressive recipient behavior. (§30-757.171)

Protective supervision is available when social services staff determines that a 24-hour need exists for protective supervision and that the recipient can remain at home safely if protective supervision is provided. Services staff shall determine that the entire 24-hour need for protective supervision can be met through any of the following, or combination of the following: IHSS; alternative resources; or a reassurance phone service when reasonable and appropriate. (§30-757.172)

626-1A REVISED 3/07

Protective supervision regulations were modified effective June 26, 2006.

Protective Supervision consists of observing recipient behavior and intervening as appropriate in order to safeguard the recipient against injury, hazard, or accident.

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Protective Supervision is available for observing the behavior of nonself-directing, confused, mentally impaired, or mentally ill persons only.

(a) Protective Supervision may be provided through the following, or combination of the following arrangements.

- (1) In-Home Supportive Services program;
- (2) Alternative resources such as adult or child day care centers, community resource centers, Senior Centers; respite centers;
- (3) Voluntary resources;

(§30-757.17 and .171 effective June 26, 2006 and revised effective February 5, 2007)

626-1B REVISED 3/07

Protective Supervision shall not be authorized:

- (a) For friendly visiting or other social activities;
- (b) When the need is caused by a medical condition and the form of the supervision required is medical.
- (c) In anticipation of a medical emergency;
- (d) To prevent or control anti-social or aggressive recipient behavior.
- (e) To guard against deliberate self-destructive behavior, such as suicide, or when an individual knowingly intends to harm himself/herself.

(§30-757.172 effective June 26, 2006 and revised effective February 5, 2007)

626-1C ADDED 12/06

Protective Supervision is only available under the following conditions as determined by social service staff:

(a) At the time of the initial assessment or reassessment, a need exists for twenty four-hours-a-day of supervision in order for the recipient to remain at home safely.

(1) For a person identified by county staff to potentially need Protective Supervision, the county social services staff shall request that the form SOC 821 (11/05), "Assessment of Need for Protective Supervision for In-Home Supportive Services Program," be completed by a physician or other appropriate medical professional to certify the need for Protective Supervision and returned to the county.

(A) For purposes of this regulation, appropriate medical professional shall be limited to those with a medical specialty or scope of practice in the areas of memory, orientation, and/or judgment.

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(2) The form SOC 821 (11/05) shall be used in conjunction with other pertinent information, such as an interview or report by the social service staff or a Public Health Nurse, to assess the person's need for Protective Supervision.

(3) The completed form SOC 821 (11/05) shall not be determinative, but considered as one indicator of the need for Protective Supervision.

(4) In the event that the form SOC 821 (11/05) is not returned to the county, or is returned incomplete, the county social services staff shall make its determination of need based upon other available information.

HANDBOOK BEGINS HERE

(5) Other available information can include, but is not limited to, the following:

(A) A Public Health Nurse interview;

(B) A licensed health care professional reports;

(C) Police reports;

(D) Collaboration with Adult Protective Services, Linkages, and/or other social service agencies;

(E) The social service staff's own observations.

HANDBOOK ENDS HERE.

(b) At the time of reassessment of a person receiving authorized Protective Supervision, the county social service staff shall determine the need to renew the form SOC 821 (11/05).

(1) A newly completed form SOC 821 (11/05) shall be requested if determined necessary, and the basis for the determination shall be documented in the recipient's case file by the county social service staff.

(c) Recipients may request protective supervision. Recipients may obtain documentation (such as the SOC 821) from their physicians or other appropriate health care professionals for submission to the county social service staff to substantiate the need for protective supervision.

(§30-757.173 effective June 26, 2006)

626-1D ADDED 6/08

Q: Can (a county) accept mental health diagnoses from other medical professionals or should it be diagnoses provided by mental health professionals only?

A mental health diagnosis can only be made by a mental health professional.

(All County Letter 08-18, April 23, 2008, question and answer 36)

626-2

The California Court of Appeals ruled that protective supervision for IHSS recipients could be limited to those recipients who were nonself-directing or mentally infirm. (Marshall v. McMahon (1993) 22 Cal.Rptr. 2d 220)

626-3

For service authorization purposes, no need for protective supervision exists during periods when a provider is in the home to provide other services. (§30-763.332)

626-4

In the case of Calderon v Anderson, Calderon, was 35 years old and suffered from severe mental retardation, physical deformities, and cerebral palsy, which rendered him completely bedridden. Calderon functioned at the cognitive level of a one-year old child. He had no use of his extremities, which remained in a fixed position, could not move his head, was nonverbal, and was unable to care for himself.

In holding that Calderon was not eligible for protective supervision services, the Court of Appeals stated the following:

“Calderon is "non-self-directing"; however, his physical condition makes it impossible for him to engage in any activities that would require observation or preventive intervention. While Calderon's medical condition is severe and his situation unfortunate, protective supervision is not available merely to provide constant oversight in anticipation of environmental or medical emergencies, or exigent circumstances.”

(Calderon v. Anderson 45 Cal.App.4th 607, 616, 52 Cal.Rptr.2d 846, at 851)

626-5

The following procedures should be followed when assessing a minor's need for protective supervision in the IHSS program.

A county social worker should always assess an IHSS eligible minor for mental functioning. (§§30-756.1, 756.2, 761.261; Welfare & Institutions Code (W&IC) §§12300(d)(4), 12301.1, 12309, (b)(1)(2)(c)) The following shall be used to assess a minor's mental functioning:

The county social worker must review a minor's mental functioning on an individualized basis and must not presume a minor of any age has a mental functioning score of "1". (§30-756.372; W&IC §§12301(a), 12301.1)

A county social worker must assess all eligible minors for a mental impairment. In doing so, the worker must request the parent or guardian to obtain available information and documentation about the existence of a minor's mental impairment. A county social worker is not required to independently obtain such information and documentation, but must review any information provided. (§§30-756.31, 756.32, 761.26). For example, is the minor SSI eligible based on mental impairments, or is the minor eligible for regional center services based on mental retardation, autism, or a condition like mental retardation or does the minor need services like someone with mental retardation?

A county social worker must evaluate a mentally impaired minor in the functions of memory, orientation, and judgment. (§30-756.372)

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A county social worker must advise parents or guardians of a minor with a mental impairment of the conditions for receiving protective supervision, and the availability of that service. (§§30-760.21, 760.23, 760.24; W&IC §§10061, 12301.1, 12309(c)(1))

A county social worker is not to presume that services, which are otherwise compensable, will be provided voluntarily by a parent or guardian or anyone else in accordance with §30-763.622.

A county social worker must assess the minor's need for protective supervision under §30-757.17 based on the minor's individual need, if the minor has a mental impairment. (§§30-756.1, 756.2, 761.261; W&IC §§12300(d)(4), 12301.1, 12309(b)(1)(b)(2)(C))

A county social worker must determine whether a minor needs more supervision because of his/her mental impairments than a minor of the same age without such impairment. (W&IC §12300(d)(4))

A minor must not be denied protective supervision based solely on age, or solely because the minor has had no injuries at home due to the mental impairment, as long as the minor has the potential for injury by having the physical ability to move about the house (not bedridden). (§§30-761.26, 30-763.1; W&IC §§12300, 12301.1)

A minor must not be denied protective supervision solely because a parent leaves the child alone for some fixed period of time, like five minutes. (§§30-761.26, 30-760.24, 30-763.1; W&IC §12301.1)

A county social worker must consider factors such as age, lack of injuries and parental absence, together with the other facts, in determining whether or not a minor needs protective supervision. (W&IC §12301.1)

(These instructions are based on the above-cited state laws and regulations, and the court order in Lam v. Anderson and in Garrett v. Anderson, San Diego County Superior Court No. 712208, Stipulation for Entry of Final Judgment and Judgment, June 12, 1998 and implemented through All-County Letter (ACL) No. 98-87, October 30, 1998.)

626-5A

If a provider of IHSS or PCSP voluntarily agrees to provide a service or services, the county social services staff shall obtain a statement from the provider that he/she knows of the right to compensation for the provision of the services, but voluntarily chooses to accept no payment or reduced payment. (§§30-575.176 and 30-763.64, effective November 14, 1998, based on Miller v. Woods/Community Services for the Disabled v. Woods, San Diego County Superior Court, Nos. 468192 and 472068)

626-5B

The voluntary service agreement for IHSS shall contain the following information:

- (1) Services to be performed.
- (2) Recipient's name.
- (3) Case number.

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- (4) Day(s) and hour(s) per month service will be performed.
- (5) Provider of services.
- (6) Provider's address and telephone number.
- (7) Provider's signature, and date signed.
- (8) Name and signature of Social Service worker.

(§§30-757.176(a), referenced in §30-763.64, both sections effective November 14, 1998)

626-6 ADDED 8/05

The department shall, in consultation and coordination with the county welfare departments and in accordance with Section 12305.72, develop for statewide use a standard form on which to obtain certification by a physician or other appropriate medical professional as determined by the department of a person's need for protective supervision.

At the time of an initial assessment at which a recipient's potential need for protective supervision has been identified, the county shall request that a person requesting protective supervision submit the certification to the county. The county shall use the certification in conjunction with other pertinent information to assess the person's need for protective supervision. The certification submitted by the person shall be considered as one indicator of the need for protective supervision, but shall not be determinative. In the event that the person fails to submit the certification, the county shall make its determination of need based upon other available evidence.

(W&IC §12301.21(a) and (b))

628-1 ADDED 6/07

Under Assembly Bill (AB) No. 2779, PCSP eligibility was extended to individuals who were not receiving categorical aid payments.

When the individual who is now PCSP eligible has both a Medi-Cal and an IHSS share of cost (SOC), the individual shall not be financially disadvantaged under the state law. If the IHSS SOC is higher, the recipient must meet the lower Medi-Cal SOC. If the Medi-Cal SOC is higher, the recipient must meet the lower IHSS SOC, and the state will pay the amount between the Medi-Cal and the IHSS SOC.

(All County Welfare Directors Letter No. 99-13, March 29, 1999)

628-1A ADDED 6/07

All IHSS Residual Program recipients who are eligible for federally funded full-scope Medi-Cal must move into either the IHSS Plus Waiver or PCSP. There will no longer be PCSP recipients who are eligible for the IHSS Residual Program. However, WIC Section 12305.1 (which limits the SOC of PCSP recipients, who would otherwise be eligible for the IHSS Residual Program, to the lesser of the Medi-Cal or IHSS SOC) will still apply to PCSP cases and is being expanded in legislation to include IHSS Plus Waiver cases. This will be accomplished through a payment of Medi-Cal recognized expenses made by DSS to DHS on the first day of each month.

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County Medi-Cal eligibility workers (EWs) must determine Medi-Cal eligibility and they will calculate the Medi-Cal SOC for the individual or family budget unit.. County social workers (SWs) or other designated county staff must continue to calculate the IHSS SOC for PCSP and Waiver recipients and report this IHSS SOC to CMIPS so that CMIPS can calculate the amount of the Medi-Cal recognized expense payment to be made to DHS and to prepare the SOC Spenddown File for DHS at the beginning of each month.

The balance of the Medi-Cal SOC to be paid by the recipient should be equal to the amount that the IHSS SOC would have been had the transition to Medi-Cal not taken place.

(All County Letter 05-05, June 2, 2005 and 05-05 errata July 20, 2005)

628-1B ADDED 6/07

In determining the applicable share of cost the following shall apply:

1. Medi-Cal rules regarding share of cost will be followed for purposes of determining Medi-Cal eligibility.
2. To the extent a recipient comes within the terms of the supplemental payment program described in Welfare and Institutions Code Section 12305.1, a share-of-cost comparison as described in that section shall be performed. The applicable share of cost for such recipients shall include the supplementary payment authorized in that section.

(§30-785(b)(5))

628-1C ADDED 6/07

Any aged, blind, or disabled individual who is receiving Medi-Cal personal care services pursuant to subdivision (p) of Section 14132.95, and who would otherwise be deemed a categorically needy recipient pursuant to Section 12305, is eligible to receive a supplementary payment under this article to be used towards the purchase of personal care services. Additionally, any aged, blind, or disabled individual who is receiving services pursuant to Section 14132.951, and who would otherwise be deemed a categorically needy recipient pursuant to Section 12305 is eligible to receive a supplementary payment under this article to be used towards the purchase of services under Section 14132.951.

A supplementary payment pursuant to this section shall be the difference between the following amounts:

- (1) A beneficiary's excess income as determined under Section 12304.5.
- (2) The beneficiary's nonexempt income as determined pursuant to Section 14005.7, in excess of the income levels for maintenance need pursuant to Section 14005.12.

(Welfare and Institutions Code (W&IC) §12305.1(a) and (b))

628-2 ADDED 12/07

In order to minimize the confusion related to the combination of Conlan II, share of cost (SOC) and Buy-Out claims, all beneficiaries/recipients who believe they have paid a SOC in excess of their obligation must submit their claims through the Department of Health Care Services

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(CDHCS) Beneficiary Services Center (BSC), unless it is a Buy-Out claim for reimbursement for the current month or one month prior. Those reimbursements may be made by the County using the Special Pre-Authorized Transaction (SPEC) created for this purpose. The BSC will then forward the claims to CDSS, Adult Programs Division. CDSS will review and process claims as required. (All County Letter 07-32, September 13, 2007)

628-3 ADDED 6/08

Share of cost means an individual's net non-exempt income in excess of the applicable SSI/SSP benefit level which must be paid toward the cost of IHSS authorized by the county (MPP §30-701(s)(3))

628-4 REVISED 3/09

Effective January 2008, the SSI/SSP payment standard for one person living independently is \$870. That standard increased to \$907 effective January 1, 2009. (All County Welfare Director's Letters 07-21, November 2007, 08-51E December 10, 2008)

628-4A ADDED 6/08

Effective _____, , the SSI/SSP payment standard for one person living independently is (_____)