



In-Home Supportive Services (IHSS): A Guide for Advocates

JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

drc Disability
Rights
California

JUNE 2019

Written By

Claire Ramsey

Senior Staff Attorney, Justice in Aging

About this Guide

The In-Home Supportive Services (IHSS) Advocates Guide is designed for advocates and individuals who provide assistance to low-income older adults, as well as children and adults with disabilities. This Guide provides in-depth information about the IHSS program and is divided into eight chapters: (1) IHSS Program Overview; (2) Eligibility and Applying for IHSS; (3) Medi-Cal Programs and IHSS; (4) IHSS Services Overview; (5) Types of Services; (6) IHSS Providers; (7) Post-Eligibility Issues; and (8) Appeals and Hearings. Justice in Aging strives to make the information in this Guide as accurate as possible as of the publication date. To get more information on the IHSS program and to sign-up for alerts, Justice in Aging webinars, and other trainings, please visit our website at www.justiceinaging.org.

Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972 we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Acknowledgment

Justice in Aging would like to thank Disability Rights California for its tremendous support, without which this manual would not have been possible. We particularly want to highlight the contributions of Elizabeth Zirker, Elissa Gershon, Maria Fernanda Iriarte, Crystal Padilla, Anna Leach-Proffer, Marilyn Holle, Angelica Galang and Ali Nicolette. We'd also like to thank the Long Foundation, whose generous support made this guide possible.

Table of Contents

Chapter 1: IHSS: Program Overview	5
1. Introduction	5
2. Important Definitions	5
3. The Four Types of IHSS Programs	9
4. Important Agencies	11
5. Relevant Legal Authority	12
Chapter 2: Eligibility and Applying for IHSS	19
1. Eligibility Standards and Need for Services	19
2. Alternative Resources and Other HCBS Services	23
3. Application Process and Timelines	24
4. Presumptive Eligibility and Eligibility for Emergency Services	27
5. Home Visit and Assessment Preparation	27
6. Approval or Denial	28
Chapter 3: Medi-Cal Programs and IHSS	33
1. Overview of Specific Medi-Cal Programs	33
2. Spousal Impoverishment Protections	37
3. Effects of Medi-Cal Changes and Terminations on IHSS	38
4. Medi-Cal Waiver Programs	40
Chapter 4: IHSS Services Overview	47
1. Hours and Need	47
2. Monthly Limits	51
3. Unmet Need	52
4. Shared Living and Proration	53
5. In-Depth: Protective Supervision	55
Chapter 5: Types of Services	65

Chapter 6: IHSS Providers	79
1. IHSS Provider Eligibility Criteria	79
2. Selection, Hiring, and Termination	80
3. Payment Issues, including Share-Of-Cost	81
4. Timesheets and worksheets	84
5. Overtime, Exemptions, Wait Time, Travel Time and Violations	86
Chapter 7: Post-Eligibility Issues	97
1. Annual Reassessments	97
2. Change of Circumstance Reassessments	97
3. Inter-County Transfers	98
4. Overpayments	99
5. Institutional Placement and its Effect on IHSS	100
6. County Social Worker Issues	100
7. Third Party Liability	101
8. Estate Recovery	101
Chapter 8: Appeals and Hearings	104
1. Appeals Basics	104
2. Adequate Notice	105
3. Appeals Deadlines	106
4. Requesting A Hearing	107
5. Authorized Representatives	108
6. Before the Hearing	108
7. Preparing for the Hearing	110
8. At the Hearing	112
9. Decisions, Rehearings, And Administrative Writs	113
Appendix A	119
Appendix B	122
Appendix C	123

Chapter 1: IHSS: Program Overview

1. INTRODUCTION

The In-Home Supportive Services (IHSS) program is a Medi-Cal program in California that pays for in-home care for people with disabilities, including children, adults, and seniors.¹ The purpose of the IHSS program is to provide supportive services to Medi-Cal recipients “who are unable to perform the services themselves and who cannot safely remain in their homes... unless these services are provided.”² Services include domestic and related services, personal care services, paramedical services, and protective supervision.³ With roots in the 1970s disability rights movement, IHSS is the oldest and largest consumer self-directed program of personal care services.

IHSS is also the largest of California’s Home and Community-Based Services (HCBS) programs, and can be used in conjunction with other HCBS services.⁴ In Fiscal Year 2017-18, the IHSS program served more than 564,000 recipients.⁵ IHSS recipients are a diverse group—more than 60% are women, more than 50% speak a language other than English as their primary language, 41% are seniors age 65-84, 15% are 85 years of age or older, 37% are adults with disabilities, and 7% are children under the age of 18.⁶ This diversity of recipients reflects the diversity of California and speaks to the importance of the IHSS program for California residents of all backgrounds.

The IHSS Advocate Manual provides in-depth information about the IHSS program for advocates and consumers. It is divided into eight chapters: (1) IHSS Program Overview; (2) Eligibility and Applying for IHSS; (3) Medi-Cal Programs and IHSS; (4) IHSS Services Overview; (5) Types of Services; (6) IHSS Providers; (7) Post-Eligibility Issues; and (8) Appeals and Hearings.

2. IMPORTANT DEFINITIONS

Like many social services programs, IHSS has its own vocabulary. These terms have special meaning within the IHSS program. The following terms are used throughout the “IHSS Advocates Guide” and are defined here. Additional definitions related to the IHSS program can be found in the Welfare and Institutions Code section 12300 *et. seq.* and the California Department of Social Services’ Manual of Policies and Procedures section 30-700 *et. seq.*⁷

- **ACTIVITIES OF DAILY LIVING (ADL)** refer to basic tasks of everyday life, and includes any of the following: dressing, feeding, toileting, bathing, grooming, and mobility and associated tasks.⁸
- **ADVANCE PAY** means a payment to be used for the purchase of authorized IHSS services, which is sent directly to the recipient of the services being provided.⁹ To be eligible for advance pay, a recipient must be “severely impaired”, which means they

require in-home supportive care of at least 20 hours per week to assist with activities of daily living or paramedical services. Additionally, advance pay recipients must be capable of handling their own financial and legal affairs.¹⁰ For individuals who do not receive advance pay, payment is sent directly to the individual's provider for services rendered.

- **ASSESSMENT** means a written document that contains information relevant to the case situation and an assessment of case service needs.¹¹
- **AUTHORIZED REPRESENTATIVE** means a person authorized in writing by the recipient of services to act on their behalf.¹² An authorized representative can be a relative, a friend, or an attorney.¹³
- **CONSUMER** means an individual who is a current or past user of personal care services provided by an IHSS program.¹⁴
- **ELIGIBLE** means entitled to receive IHSS services.¹⁵
- **FEDERAL FINANCIAL PARTICIPATION (FFP)** is a formula used to determine the amount of money that the federal government contributes toward each state's Medicaid services. California currently receives a 50% federal match for the Personal Care Services Program and IHSS Plus Option Program. The federal match for the Community First Choice Option is 50% plus an additional 6% for an enhanced rate of 56%. The IHSS-Residual program does not receive federal monies.
- **FULL-SCOPE FEDERAL FINANCIAL PARTICIPATION (FFP)** means an individual is eligible for complete Medi-Cal services funded partially by the federal government. In order to be eligible for full-scope Medi-Cal, individuals must meet income and resource criteria. This group primarily includes people who are: aged 65 or older, blind, disabled, under 21, pregnant, in a skilled nursing or intermediate care home, a parent or caretaker relative of a child under age 21, and low-income adults.¹⁶ Services for an individual who is not eligible for full-scope FFP are funded entirely by the state and county.
- **HOME AND COMMUNITY-BASED SERVICES AND SUPPORTS (HCBS)** are long-term services and supports provided in home and community-based settings.¹⁷ Some other HCBS programs include the Multipurpose Senior Services Program (MSSP), Community Based Adult Services (CBAS), the Home and Community-Based Alternative Waiver (HCBA) (formerly the Nursing Facility/Acute Hospital), Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD), and the Assisted Living Waiver (ALW).¹⁸
- **INSTITUTIONAL DEEMING** means an individual is assessed for Medi-Cal eligibility as if they were living in a long-term care facility. The income, property, and assets of the individual's spouse or parents are treated differently when determining the individual's Medi-Cal eligibility.¹⁹ Without the application of institutional deeming, the spouse or

parent of the individual who requires services at an institutional level of care would have too much income or resources and the individual would not be eligible for Medi-Cal. Institutional deeming between spouses is also related to the spousal impoverishment provision and is discussed in more detail in Chapter 3.²⁰

- **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)** are related to independent living and include any of the following: housework, meals, laundry, taking of medication, money management, appropriate transportation, correspondence, telephoning, and related tasks.²¹ Some IADLS are covered by the IHSS programs.
- **LEGALLY RESPONSIBLE RELATIVE PROVIDER** is a relative who is responsible to contribute to the cost of health care services received by a Medi-Cal beneficiary.²² The responsibility of a relative to contribute to the cost of health care for a Medi-Cal applicant or beneficiary is limited to spouses and parents of children under 18.²³
- **LIVE-IN PROVIDER** means a provider who is not related to the recipient and who lives in the recipient's home expressly for the purpose of providing IHSS-funded services.²⁴
- **MEDI-CAL** is California's Medicaid program which provides health insurance for low-income Californians. It is a joint federal-state program. Medi-Cal can pay for a wide variety of health care services including IHSS and many other Home and Community-Based Services.
- **NOTICE OF ACTION** is a written document which provides applicants and beneficiaries with an explanation of their eligibility and their services, and is also used to notify a recipient of a denial, change, or termination of services.²⁵ A Notice of Action is commonly referred to as a "NOA." The county social services agency will issue NOAs when a change occurs in Medi-Cal or IHSS.
- **OWN HOME** means the place where an individual chooses to reside. An individual's own home does not include institutional facilities including acute care hospitals, skilled nursing facilities, intermediate care facilities, or board and care facilities.²⁶ A person receiving an enhanced Supplemental Security Income (SSI) or a State Supplemental Payment (SSP) because they live in a nonmedical out-of-home living arrangement, such as a board and care home or a residential care facility, is not considered to be living in his/her own home.²⁷
- **PAYMENT PERIOD** means the time period for which wages are paid. There are two IHSS payment periods per month corresponding to the first through the fifteenth of the month and the sixteenth through the end of the month.²⁸
- **PERSONAL ATTENDANT** means a provider who is employed by the recipient and who spends at least 80% of his/her time performing the following services for the recipient: meal preparation; meal clean-up; meal planning; consumption of food; routine bed baths; bathing, oral hygiene, and grooming; dressing; and protective supervision.²⁹

- **PERSONAL CARE SERVICES** includes all the following: assistance with ambulation; bathing, oral hygiene, and grooming; dressing; care and assistance with prosthetic devices; bowel, bladder, and menstrual care; repositioning, skin care, and range of motion exercises; transfers; feeding and assurance of adequate fluid intake; respiration; assistance with self-administration of medications.³⁰
- **PROTECTIVE SUPERVISION** is a specialized type of IHSS service that consists of observing recipient behavior and intervening as appropriate to safeguard the recipient against injury, hazard, or accident.³¹
- **PUBLIC AUTHORITY** is a public agency set up to assist IHSS recipients and providers. There are 56 public authorities statewide serving all 58 counties. The scope of services varies by public authority, but all offer a provider registry and act as the employer of record for IHSS providers.³²
- **REASSESSMENT** means a written document which reviews all past assessments and examines the current condition of the recipient.³³
- **RECIPIENT** means a child or adult receiving IHSS, including an applicant for such services when clearly implied by the context of the regulations.³⁴
- **REGIONAL CENTERS** provide and coordinate services and support for individuals with developmental disabilities. The California Department of Developmental Services contracts with 21 Regional Centers statewide.³⁵
- **RELATIVE PROVIDER** means a mother, father, grandfather, grandmother, son, daughter, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, niece, half-brother, half-sister, any such person of a preceding or succeeding generation denoted by a prefix of grand, great or great-great or the suffix in-law, who is providing care to the recipient.³⁶
- **RESTAURANT MEAL ALLOWANCE** is an alternative service for recipients who have adequate cooking facilities at home, but whose disabilities prevent them from cooking for themselves.³⁷
- **SEVERELY IMPAIRED** means a recipient with a total assessed need of 20 hours or more per week in one or more of the following types of services: any personal care services, preparation of meals, meal clean-up, and paramedical services.
- **SHARE OF COST** means the amount a person or family must pay toward the cost of their health care services each month in order to be eligible for Medi-Cal in the same month.³⁸
- **STATE PLAN** means a comprehensive written document created by the State of California that describes the nature and scope of the Medi-Cal program.³⁹

- **SUPPORTIVE SERVICES** include domestic and related services, heavy cleaning, personal care services, accompaniment by a provider to health-related appointments, yard hazard abatement, protective supervision, teaching and demonstration, and paramedical services.⁴⁰
- **WAIVER PERSONAL CARE SERVICES (WPCS)** are supportive and health-related services authorized by the Department of Health Care Services for participants in specific Medicaid waiver programs.⁴¹ WPCS is often used by participants to provide additional in-home care on top of a significant number of IHSS hours, however WPCS is a separate program.

3. THE FOUR TYPES OF IHSS PROGRAMS

The statewide IHSS program is comprised of four different programs. The different programs have slightly different eligibility criteria and funding sources. The programs are:

1. Community First Choice Option,
2. Personal Care Services Program,
3. IHSS Plus Option, and
4. IHSS-Residual Program.

The Community First Choice Option, the Personal Care Services Program, and the IHSS Plus Option are federally-funded Medicaid programs. The IHSS-Residual Program is not a Medicaid-funded program and only receives state and county funds. Typically, the applicant or recipient will not know which IHSS program they are enrolled in, although it should be noted on their notices of action. Except where noted, the IHSS rules described in this manual are the same for all four programs. Differences in eligibility, maximum hours, and services available are discussed in-depth in Chapter 2. This section provides an overview of each program.

Community First Choice Option (CFCO)

The CFCO program was established as a new State Plan Option by the Affordable Care Act (ACA).⁴² It allows the State to receive more federal money to pay for IHSS services.⁴³

The State began enrolling consumers in the CFCO program on December 1, 2011.⁴⁴ Beginning July 1, 2013, the eligibility requirements became more stringent.⁴⁵ Consumers who no longer meet the more stringent standards are now served in the Personal Care Services Program or the IHSS Plus Option. These three programs account for 99% of IHSS enrollment.⁴⁶

In order to be eligible for the CFCO program as of July 1, 2013, an applicant must be (1) eligible for full-scope, federal financial participation Medi-Cal and (2) meet CFCO Nursing Facility Level of Care eligibility.⁴⁷

Consumers enrolled in the CFCO program are eligible for four services:

1. Assistance with ADLs, IADLs, and health-related tasks;
2. Acquisition, maintenance, and enhancement of skills necessary to perform ADLs, IADLs, and health-related tasks;
3. Back-up systems to ensure continuity of services and supports; and
4. Voluntary recipient training.⁴⁸

Consumers enrolled in the CFCO program are eligible for the restaurant meal allowance and advance pay. Additionally, their services can be provided by their spouse or by their parent.⁴⁹ Effective September 1, 2014, consumers who are non-severely impaired are eligible to receive a maximum of 195 hours per month of protective supervision, plus hours for other services, and consumers who are severely impaired are eligible to receive a maximum of 283 hours per month, including protective supervision and hours for other services.⁵⁰

Personal Care Services Program (PCSP)

The PCSP was implemented in April 1993 for categorically needy Medi-Cal recipients.⁵¹ It is part of the Medicaid state plan.⁵² Consumers who are not eligible for the CFCO program, typically because they do not meet the Nursing Facility Level of Care eligibility criteria, are enrolled in the PCSP. In order to be eligible for PCSP, the applicant must be eligible for full-scope, federal financial participation Medi-Cal.⁵³

The PCSP began as a way to obtain Medi-Cal funding to support IHSS. In 1999, the program was expanded to include children under 18 years of age who were Medi-Cal eligible through institutional deeming.⁵⁴ Effective May 1, 2004, PCSP services were expanded to include ancillary services including domestic and related services and protective supervision as long as neither are provided by a parent or spouse.⁵⁵

The PCSP has some restrictions with regard to services offered and allowable providers. Specifically, PCSP recipients cannot be authorized for the restaurant meal allowance or for advance pay,⁵⁶ and are not allowed to have a spouse or parent provider.⁵⁷ Consumers enrolled in PCSP are eligible to receive a maximum of 283 hours per month regardless of whether they are designated non-severely or severely impaired.⁵⁸ Consumers who require any of these services, or who wish to hire a spouse or parent provider and who do not meet the CFCO level of care criteria, are enrolled in the IHSS Plus Option.

IHSS Plus Option (IPO)

The IPO program is part of the Medicaid state plan.⁵⁹ Enrollment into the IPO program began in 2009.⁶⁰ Consumers who are eligible for full-scope, federal financial participation Medi-Cal, do not require a nursing facility level of care, but who require either the restaurant meal allowance, advance pay, or a spouse or parent provider, are enrolled in the IPO program.⁶¹ These consumers are eligible for all IHSS services allowed by the PCSP program, except for teaching and demonstration.⁶² Consumers who are non-severely impaired are eligible to receive a maximum of 195 hours per month and consumers who are severely impaired are eligible to receive a maximum of 283 hours per month.⁶³

IHSS Residual (IHSS-R)

Consumers who do not qualify for full-scope, federal financial participation Medi-Cal are enrolled in IHSS-R.⁶⁴ The Counties must evaluate all applicants for Medi-Cal eligibility before evaluating eligibility for the IHSS-R program.⁶⁵ The State and counties have a strong financial incentive to ensure that all Medi-Cal eligible IHSS-applicants are enrolled in CFCO, PCSP, or IPO because the federal government will pay for at least 50% of the care provided, whereas the IHSS-R program is funded only through state and county funds.⁶⁶

Certain applicants who are pending a final disability eligibility determination may be presumptively eligible⁶⁷ for IHSS and enrolled in the IHSS-R program.⁶⁸ An applicant will be considered presumptively eligible if either (1) the applicant is disabled, not employed, and has no expectation of employment within the next 45 days; and if in the county's judgment the applicant appears to have mental or physical impairments that will last for more than one year or end in death, or (2) if the applicant is blind as defined by MPP § 30-771.2.⁶⁹

Additionally, in some counties individuals are temporarily transitioned onto IHSS-R when they are suspended or terminated from Medi-Cal. This transitional use of the IHSS-R program allows individuals to receive one month of IHSS services while Medi-Cal eligibility issues are addressed. It also allows the county to recover from the state any funds spent on IHSS services for these recipients.

Under IHSS-R, non-severely impaired recipients may receive up to a total of 195 hours, including any needed protective supervision.⁷⁰ The entire 195 hours can be for protective supervision if no other needed services are paid for by IHSS.⁷¹ Severely impaired recipients may receive up to a total of 283 hours, including any needed protective supervision.⁷²

As Medi-Cal enrollment has expanded, enrollment in IHSS-R has steeply declined. Currently only about 1% of all consumers are enrolled through the IHSS-R program.⁷³

4. IMPORTANT AGENCIES

The California Department of Health Care Services (DHCS) administers the Medi-Cal program.⁷⁴ DHCS is the single state agency responsible for administration of the Medicaid program in California.⁷⁵ Although DHCS retains ultimate authority over all Medicaid programs, it delegates the administration of the IHSS program to the California Department of Social Services (CDSS).

CDSS is the agency responsible for the state-level administration of the IHSS program. The county welfare departments in each of the 58 California counties handle the day-to-day administration of the program, including determining eligibility for Medi-Cal.⁷⁶ Separate units of the county welfare departments are responsible for Medi-Cal and IHSS eligibility. With regard to the IHSS program, the county welfare departments:

- Determine eligibility for the IHSS program;
- Evaluate applicant need;

- Determine which IHSS services each applicant will receive;
- Determine the number of hours for each service;
- Perform quality assurance tasks;
- Reassess consumer eligibility; and
- Deny or terminate applicants or recipients who are ineligible to receive services.⁷⁷

The public authority is a separate entity established by a county to manage enrollment of IHSS providers, provide trainings, maintain a registry of available providers, and act as the employer of record for collective bargaining purposes.⁷⁸

The California Department of Developmental Services is the agency through which the State of California provides services and supports to individuals with developmental disabilities. The Department of Developmental Services contracts with 21 Regional Centers⁷⁹ to serve as a local resource to help find and access the services and supports available to individuals with developmental disabilities. Although neither the Department of Developmental Services nor the Regional Centers are directly involved in administration of the IHSS program, the Regional Centers must ensure that individuals with developmental disabilities receive appropriate home and community-based services, which can include IHSS.⁸⁰

The California Department of Aging (CDA) “administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state.”⁸¹ CDA administers a number of home and community-based programs, including Community Based Adult Services (CBAS), (formerly known as Adult Day Health Care), and the Multipurpose Senior Services Program (MSSP).⁸²

5. RELEVANT LEGAL AUTHORITY

The IHSS Program is a California-specific program, but the laws and rules governing the program are a combination of federal and state statutes and regulations, and extensive state sub-regulatory guidance. The following are the sources of law on which the IHSS program is based. Specific legal authority is cited throughout this manual.

FEDERAL LAW: 42 U.S.C. § 1396 *et. seq.* (Medicaid Act).⁸³

FEDERAL REGULATIONS: 42 Code of Federal Regulations § 430 *et. seq.* (Medicaid Regulations).⁸⁴

CALIFORNIA LAW: Welfare and Institutions Code § 12300 *et. seq.* (In-Home Supportive Services); § 14132.95 (Personal Care Services); § 14132.951 (IHSS Plus Waiver); § 14132.952 (IHSS Plus Option); § 14132.955 (Personal Care Services, authorization limitations); § 14132.96 (Personal Care Services, provider rates); § 14132.97 (Waiver of Personal Care Services).⁸⁵

CALIFORNIA REGULATIONS: California Code of Regulations, Title 22, §§ 51181, 51183, 51350 (Relating to Personal Care Services).⁸⁶ Manual of Policies and Procedures, §§ 30-700 through 30-785 (IHSS Programs); §§ 30-000 through 30-600 (Social Services Standards Manual);⁸⁷ §§ 22-000 *et. seq.* (State Hearings).⁸⁸

CALIFORNIA SUB-REGULATORY GUIDANCE: All County Letters and All County Information Notices are guidance issued by the Department of Social Services to the counties. These letters and notices provide clarification about programs and policies and their implementation. They are found organized by year of release on the Department of Social Services website.⁸⁹

Chapter 1 Endnotes

- 1 Cal. Welf. & Inst. Code § 12300 *et. seq.*
- 2 Cal. Welf. & Inst. Code § 12300(a).
- 3 Cal. Welf. & Inst. Code § 12300(b).
- 4 Cal. Welf. & Inst. Code § 12300(g).
- 5 IHSS Overview, Assembly Budget-Sub 3 Committee, (March 2, 2017), available at http://www.cicaihss.org/sites/default/files/ihss_overview_for_senate_budget_sub_3_hearing_3-2-2017_v2.pdf.
- 6 All County Information Notice (“ACIN”) I-22-19 (April 4, 2019), available at http://www.cdss.ca.gov/Portals/9/ACIN/2019/I-22_19.pdf?ver=2019-04-08-132918-777.
- 7 California Dept. of Social Services Manual of Policies & Procedures (“MPP”) § 30-700 *et. seq.*, available at <http://www.cdss.ca.gov/ord/entres/getinfo/pdf/ssman2.pdf> (§§ 30-700 thru 30-764) and <http://www.cdss.ca.gov/ord/entres/getinfo/pdf/ssman3.pdf> (§§ 30-765 thru 30-785).
- 8 Cal. Health & Safety Code § 1569.2(l).
- 9 Cal. Welf. & Inst. Code § 12304(a); MPP § 30-701(d)(3).
- 10 Cal. Welf. & Inst. Code § 12304(a) and (d).
- 11 MPP § 30-002(a)(1). The Manual of Policies and Procedures 30-000 *et. seq.*, available at <http://www.cdss.ca.gov/ord/entres/getinfo/pdf/ssman1.pdf>.
- 12 Cal. Welf. & Inst. Code § 12300.3.
- 13 MPP § 30-002(r)(3). It is important to note that an authorized representative is distinct from an agent appointed by an advance health care directive, an attorney-in-fact appointed by a power of attorney, a guardian, or a conservator.
- 14 MPP § 30-701(c)(3).
- 15 MPP § 30-002(e)(1).
- 16 Department of Health Care Services, Do you Qualify for Medi-Cal Benefits? Available at <http://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx>.
- 17 42 U.S.C. § 1396n(d)(5)(C); 42 C.F.R. §440.182(c).
- 18 For a full list of HCBS waivers go to: https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx?utm_source=Resources&utm_medium=SideBar&utm_campaign=Waivers.
- 19 MPP § 30-701(d)(1) (deeming defined); ACL 00-83 (December 7, 2000), pg. 2, available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl00/pdf/00-83.PDF> (explains how institutional deeming relates to deeming as defined by the MPP).
- 20 All County Welfare Directors Letter (“ACWDL”) 17-25 (July 19, 2017), available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2017/17-25.pdf>.
- 21 Cal. Health & Safety Code § 1569.2(i).
- 22 Cal. Code Regs. tit. 22, § 50088.

- 23 Cal. Code Regs. tit. 22, § 50351.
- 24 MPP § 30-701(l)(3).
- 25 MPP §§ 10-116.1; 30-759.7, 30-763.8; 22 C.C.R. § 50179. California Dept. of Social Services Manual of Policies and Procedures 10-000 et. seq., available at <http://www.cdss.ca.gov/ord/entres/getinfo/pdf/opsman1.PDF>. See also Cal. Welf. & Inst. Code § 12300.2.
- 26 MPP § 30-701(o)(2).
- 27 Id.
- 28 MPP § 30-701(p)(2).
- 29 MPP § 30-701(p)(4).
- 30 Cal. Welf. & Inst. Code § 12300(c); MPP § 30-757.14.
- 31 MPP § 30-757.17.
- 32 Cal. Welf. & Inst. Code § 12301.6; MPP § 30-701(p)(8). See also <https://capaihss.org/> for more information about public authorities and to find links to each county's public authority.
- 33 MPP § 30-002(r)(1).
- 34 MPP § 30-002(r)(2).
- 35 The location and contact information of all 21 Regional Centers are available at: <http://www.dds.ca.gov/RC/RCList.cfm>.
- 36 Cal. Code Regs. tit. 22, § 50084.
- 37 MPP § 30-757.133.
- 38 Cal. Code Regs. tit. 22, § 50090.
- 39 Department of Health Care Services, California's Medicaid State Plan (Title XIX), available at <http://www.dhcs.ca.gov/formsandpubs/laws/pages/californiastateplan.aspx>.
- 40 Cal. Welf. & Inst. Code § 12300(b).
- 41 See Department of Health Care Services, Waiver Personal Care Services: Frequently Asked Questions, available at http://www.dhcs.ca.gov/services/ltc/Documents/WPC_Frequently_Asked_Questions.pdf.
- 42 The Patient Protection and Affordable Care Act of 2010 (Pub.L 111-148); 42 U.S.C. § 18001 et. seq.
- 43 All County Letter ("ACL") 14-60 (August 29, 2014), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>. The State receives an additional 6% for each CFCO enrolled recipient.
- 44 Id.
- 45 Id.
- 46 IHSS Overview, Assembly Budget-Sub 3 Committee, (April 28, 2016), pg. 5, available at <http://www.cdss.ca.gov/cdssweb/entres/pdf/legislature/IHSSOverview4-28-16.pdf>.
- 47 ACL 14-60 (August 29, 2014), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>.

- 48 Id.
- 49 Id.
- 50 Cal. Welf. & Inst. Code § 12303.4; ACL 14-60 (August 29, 2014), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>.
- 51 ACL 93-21 (March 16, 1993), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl93/93-21.PDF>; ACL 94-47 (June 10, 1994), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl94/94-47.PDF>. See also Cal. Welf. & Inst. Code § 51350.
- 52 42 U.S.C. § 1396n(i).
- 53 Cal. Welf. & Inst. Code § 14132.95; see also ACIN No. I-180-08 (March 12, 2008), available at http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin08/I-18_08.pdf. “In general, U.S. citizens, nationals, and individuals who are lawfully residing in the United States are eligible for full-scope Medi-Cal. Individuals who do not have lawful status (or who fail to provide verification of status) are eligible for restricted-scope Medi-Cal, which covers emergency services as well as certain other services...” Western Center on Law and Poverty, Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates, Chapter 1 (March 2016), available at https://wclp.org/wp-content/uploads/2016/04/WesternCenter_2016_HCGuide_Chapter1.pdf. For more information on immigrant eligibility for benefits programs, see National Immigrant Law Center’s helpful publication, available at <https://www.nilc.org/wp-content/uploads/2015/11/cal-benefits-table.pdf>. In addition, immigration requirements for IHSS eligibility are discussed in Chapter 2 of this manual.
- 54 All County Welfare Directors Letter (“ACWDL”) 00-59 (November 15, 2000), available at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-59.pdf>.
- 55 Cal. Welf. & Inst. Code § 14132.95(d)(2) (authorizing ancillary services); ACWDL 05-21 (June 13, 2005), available at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c05-21.pdf>.
- 56 Cal. Welf. & Inst. Code § 14132.95; Cal. Code Regs. tit. 22, § 51183.
- 57 Cal. Welf. & Inst. Code § 14132.95(f); Cal. Code Regs. tit. 22, § 51181.
- 58 ACL 93-21 (March 16, 1993), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl93/93-21.PDF>.
- 59 42 U.S.C. §1396n(j).
- 60 Cal. Welf. & Inst. Code § 14132.952; ACL 11-19 (February 23, 2011), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-19.pdf>.
- 61 Id.
- 62 See ACL 14-60 (August 29, 2014), implementing the CFCO program, available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>.
- 63 Cal. Welf. & Inst. Code § 14132.952; ACL 11-19 (February 23, 2011), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-19.pdf>.
- 64 Cal. Welf. & Inst. Code § 12305.6; ACIN I-28-06 (April 11, 2006), available at http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin06/pdf/I-28_06.pdf.
- 65 ACL 12-36 (July 24, 2012), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2012/12-36.pdf>.
- 66 ACL 14-60 (August 29, 2014), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>.

- 67 It is important to note that this paragraph only refers to presumptive eligibility for IHSS, which is distinct from presumptive eligibility for Medi-Cal. Beneficiaries who are presumptively eligible for Medi-Cal may be eligible for IHSS under the CFCO, PCPS, or IPO program if they have need and meet the other IHSS eligibility criteria.
- 68 MPP § 30-759.3; ACL 14-67 (November 4, 2014), pg. 2, available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-67.pdf>.
- 69 *Id.* MPP § 30-771.2 defines blindness as an individual who “has central visual acuity of 20/200 or less in the better eye with use of a correcting lens” or “is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.”
- 70 Cal. Welf. & Inst. Code § 12303.4(a); MPP § 30-765.12.
- 71 California Dept. of Social Services Para-Regs 612-5, available at <http://www.cdss.ca.gov/ParaRegs-Text/Social-Services>.
- 72 Cal. Welf. & Inst. Code § 12303.4(b); MPP § 30-765.11.
- 73 IHSS Overview, Assembly Budget-Sub 3 Committee, (April 28, 2016), pg. 5, available at <http://www.cdss.ca.gov/cdssweb/entres/pdf/legislature/IHSSOverview4-28-16.pdf>.
- 74 Cal. Code Reg. tit. 22, § 50004.
- 75 42 U.S.C. § 1396a(5); Welfare and Institutions Code § 10740.
- 76 *Id.*
- 77 MPP § 30-760.2.
- 78 MPP § 30-701(p)(8).
- 79 “Regional centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. They have offices throughout California to provide a local resource to help find and access the many services available to individuals and their families.” Department of Developmental Services, Information about Regional Centers, available at <http://www.dds.ca.gov/RC/index.cfm>.
- 80 For more information about the Department of Developmental Services and the Regional Centers go to: <http://www.dds.ca.gov/>.
- 81 California Department of Aging, available at <https://www.aging.ca.gov>.
- 82 California Department of Aging, Programs, available at <https://www.aging.ca.gov/Programs/>.
- 83 For the relevant statutes, see the Government Publishing Office, available at <https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap7-subchapXIX.htm>.
- 84 For the relevant regulations, see the Government Publishing Office, available at <https://www.gpo.gov/fdsys/pkg/CFR-2000-title42-vol3/xml/CFR-2000-title42-vol3-part430.xml>.
- 85 For California Welfare and Institutions Code statutes, see California Legislative Information, available at <http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC>.
- 86 For relevant regulations in the California Code of Regulations, Title 22, see Westlaw California Code of Regulations, available at <https://bit.ly/1b7Bgzc>.

- 87 For the Manual of Policies and Procedures, Chapter 30 (Social Services Standards), see Department of Social Services, available at <http://www.cdss.ca.gov/inforesources/Letters-Regulations/Legislation-and-Regulations/Adult-Services-Regulations>.
- 88 For the Manual of Policies and Procedures, Chapter 22 (State Hearings), see Department of Social Services, available at <http://www.cdss.ca.gov/ord/entres/getinfo/pdf/4cfcman.pdf>.
- 89 The link to the sub-regulatory guidance is available at <http://www.cdss.ca.gov/inforesources/Letters-Regulations/Letters-and-Notices/All-County-Letters>.

Chapter 2: Eligibility and Applying for IHSS

This chapter will provide an in-depth overview of eligibility requirements and the application process for IHSS. There are six sections: (1) Eligibility Standards and Need for Services; (2) Alternative Resources and Other HCBS Programs; (3) Application Process and Timelines; (4) Presumptive Eligibility and Eligibility for Emergency Services; (5) Home Visit and Assessment Preparation; and (6) Approval and Denial of Applications.

1. ELIGIBILITY STANDARDS AND NEED FOR SERVICES

Beyond an applicant's need for IHSS services, which is discussed below in section 1.7, there are five basic eligibility requirements for IHSS:

1. Medi-Cal eligible;⁹⁰
2. Qualified immigration status;⁹¹
3. California resident;⁹²
4. Live in own home;⁹³ AND
5. Aged, blind, or disabled.⁹⁴

Each requirement is discussed in detail below.

1.1 Medi-Cal Eligibility

In order to qualify for IHSS, an applicant must also qualify for and enroll in Medi-Cal.⁹⁵ Chapter 3 discusses a variety of Medi-Cal programs briefly, but an in-depth discussion of Medi-Cal eligibility criteria is beyond the scope of this manual. Extensive materials on Medi-Cal programs and eligibility rules are available online.⁹⁶

If an individual wants to apply for IHSS, but does not already have Medi-Cal, the individual can apply for both programs through the county welfare department in their county of residence. There are separate applications for each program, and different units in the county social services agency process the applications.

Almost all IHSS recipients receive Medi-Cal that is paid, in part, with federal dollars (also known as "federal financial participation" or FFP). A very small percentage of IHSS recipients receive IHSS services through the IHSS-Residual program, which is state and locally funded. These recipients may include non-citizens under the five-year ban who receive state-only Medi-Cal and those who are transitioning off FFP Medi-Cal.⁹⁷

1.2 Immigration Requirements

The federal government restricts receipt of FFP Medi-Cal to United States citizens or "qualified" immigrants.⁹⁸ Therefore, IHSS services provided through one of the federal Medi-Cal

linked IHSS programs are only available to U.S. citizens and qualified immigrants. Qualified immigrants are:

1. Lawful permanent residents;
2. Refugees, persons granted asylum, persons granted withholding of deportation, and conditional entrants;
3. Persons granted parole by the U.S. Department of Homeland Security for a period of at least one year;
4. Cuban/Haitian entrants;
5. Certain abused immigrants, their children, and/or their parents;
6. Certain survivors of trafficking.⁹⁹

Three categories of “not qualified” immigrants are also *potentially* eligible for receipt of IHSS through the state and locally funded IHSS-R program:

1. Certain immigrants permanently residing in the United States under color of law (PRUCOL);¹⁰⁰
2. T Visa applicants who are pending certification for federal benefits;
3. U Visa holders and applicants.¹⁰¹

T Visas are issued to victims of human trafficking and their immediate family, while U Visas are issued to victims of certain crimes who cooperate with law enforcement. For additional information on immigration and public benefit eligibility, visit the National Immigration Law Center’s website at www.nilc.org.¹⁰²

1.3 California Residency

In order to receive IHSS services, an applicant must live in California and apply in their county of residence.¹⁰³ If a recipient is physically absent from the State for 30 days or longer, the county must determine whether the absence is temporary or permanent.¹⁰⁴ Although the recipient is not required to affirmatively inform the county of their absence, they must respond to inquiries about residency from the county. The recipient must submit a written statement detailing the anticipated date of return to the state or their intention not to return, the reason for the absence from the state, and information about their current location and household arrangements.¹⁰⁵ The recipient must return this written statement to the county by the specified date or the county will terminate the recipient from the IHSS program.¹⁰⁶

If an IHSS recipient is absent from the state for more than 60 days, the state will presume that the recipient intends to establish residency outside of California, unless the recipient submits evidence that they are prevented from returning due to illness or for another good cause.¹⁰⁷ In all cases of an absence of 30 days or longer, the county will weigh the evidence and, if it determines the absence is permanent, it will discontinue IHSS.

1.4 Lives in Own Home

An IHSS recipient must live in their own home in order to be eligible for the program. “Own home” is defined as the place where an individual chooses to reside and can include a house, an apartment, a motel, or a hotel. An individual’s own home does not include certain facilities, including acute care hospitals, skilled nursing facilities, intermediate care facilities, or assisted living facilities. Any person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement, such as at a board and care, is not considered to be living in their own home.¹⁰⁸

An applicant currently living in an institutional setting, however, may still be assessed and found eligible for IHSS.¹⁰⁹ The institutionalized individual must wish to live in their own home and be capable of doing so safely if IHSS is provided.¹¹⁰ The county is obliged to perform a preliminary assessment before the applicant leaves the facility.¹¹¹ The vast majority of IHSS services can only begin once the recipient returns home.¹¹² However, the county may authorize heavy cleaning and yard abatement hours to prepare the home before the individual’s return.¹¹³

PRACTICE TIP: Advocates working with currently institutionalized individuals who would be eligible for IHSS upon discharge should work with the county and the facility to coordinate the preliminary assessment. It is important to give the county as much notice as possible of discharge so once a potentially eligible individual has a reasonably firm discharge date, the individual or their authorized representative should start the application process and ask for the pre-discharge assessment.

Currently, there is a lot of uncertainty among the counties regarding the definition of “own home” with regard to nontraditional housing arrangements like RVs, cars, and homeless shelters. Advocates have successfully argued that many nontraditional spaces can be considered an individual’s “own home” for IHSS purposes, however, these arguments are more challenging when the individual is moving around continually or does not have access to facilities where services can be provided. Additionally, there is explicit guidance stating that living in the open with no shelter would not be considered living in a “home” for IHSS purposes.¹¹⁴ Given the confusion, CDSS has agreed to release clarifying statewide guidance. It is anticipated that the guidance will be issued in 2019.

1.5 Aged, Blind, or Disabled

An applicant must be aged, blind, or disabled as defined by the Social Security Act in order to be eligible for IHSS.¹¹⁵ Aged means 65 years or older.¹¹⁶

The definition of disability differs for adults and children. Disability for adults is defined as “the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”¹¹⁷ This is the same definition used by the Social Security Administration to determine eligibility for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI).

A child under age 18 will be determined disabled if they have “a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.”¹¹⁸ These two definitions are just the starting point for a complicated area of law regarding disability determinations. For purposes of IHSS, however, it is simply important to know that if an applicant is determined “disabled” for SSI or Medi-Cal purposes, they are disabled for IHSS eligibility purposes as well.¹¹⁹

Blind is defined as “central visual acuity of 20/200 or less in the better eye with use of a correcting lens.”¹²⁰ An eye with a “limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.”¹²¹ As with the disability determination, if an applicant is determined blind for SSI or Medi-Cal purposes, they are blind for IHSS eligibility purposes as well.¹²²

Adults aged 19-64 who are approved for MAGI Medi-Cal do not need a formal disability determination, but still must be disabled to qualify for IHSS.¹²³ MAGI Medi-Cal is discussed in greater detail in Chapter 3.

It is important to note that being aged, blind, or disabled is necessary, but not sufficient, for receipt of IHSS services. As discussed in section 1.7 below, the applicant must also have a need for the services in order to qualify for the program.

1.6 Additional Eligibility Requirements for CFCO

Unlike the other IHSS programs, the CFCO program requires an applicant to meet its Nursing Facility Level of Care standard. There is no separate application for CFCO; all IHSS applicants are screened for CFCO eligibility.

There are three ways to meet the CFCO Nursing Facility Level of Care standard:¹²⁴

1

Have a total assessed need of 195 or more IHSS hours per month (excluding heavy cleaning and yard hazard abatement)

OR

2

Have a total assessed need of less than 195 IHSS hours per month (excluding heavy cleaning and yard hazard abatement) AND

- » Need three (3) or more from a list of specific services with a high functional ranking;¹²⁵ OR
- » Have a combined functional index rank of 6 or higher in mental functioning (memory, orientation, and judgment, which can each have FI Ranks for 1, 2 or 5).

OR

3

Have a combined “Individual Assessed Need” total of 20 hours or more per week from a specific list of services.¹²⁶

Because of the higher reimbursement rate provided by the federal government, the State has moved a significant number of IHSS recipients into the CFCO program.

One benefit of qualifying for the CFCO program is more favorable Medi-Cal eligibility rules for married couples, called the “spousal impoverishment” rule. This rule allows the spouse needing the IHSS services to qualify for Medi-Cal while the other spouse retains significantly more income and assets than allowed under other Medi-Cal eligibility rules.¹²⁷ For further discussion of the spousal impoverishment eligibility methodology, see Chapter 3.

1.7 Need

If an applicant meets the eligibility requirements outlined above, the county will then determine the applicant’s “level of ability and dependence upon verbal or physical assistance by another” for each of the services provided by IHSS.¹²⁸ The assessment will evaluate the applicant’s physical, cognitive, and emotional impairments and determine if the applicant has a functional limitation that can be supported by an IHSS covered service.

A diagnosis of a specific condition is generally not enough to show need. For example, the fact that an applicant has diabetes is not enough to show need. The county social worker will need to understand what functional limitations are present because of the diabetes. So the applicant will want to explain if and how the diabetes causes difficulty seeing, walking, eating, etc. Then the social worker will use the information gathered to determine the level of need and how much time should be allotted for the service. In-depth information about the needs assessment can be found in Chapter 4.

2. ALTERNATIVE RESOURCES AND OTHER HCBS SERVICES

2.1 Alternative Resources

As part of the needs assessment, the county will collect information about alternative resources available to the applicant.¹²⁹ The purpose is to determine if there are other available ways in which the applicant receives or could receive IHSS-type assistance.¹³⁰ Alternative resources include adult and child day care centers, community resource centers, senior centers, and respite centers.¹³¹ Regional centers are not alternative resources for IHSS purposes.¹³² The alternative resources must be actually available and cannot result in a cost to the IHSS program or to the applicant unless the applicant chooses to incur the cost or the applicant has share of cost.¹³³

Receipt of alternative resources will be documented and will reduce the number of hours allotted to the applicant for each specific service that is provided through the alternative resource, unless the applicant needs more than the maximum number of IHSS hours.¹³⁴

IHSS hours can be allotted for travel to and accompaniment at an alternative resource if needed by the consumer.¹³⁵ Generally, an alternative resource program provides similar or complementary services to those provided by the IHSS program. For example, if a consumer attends a Community-Based Adult Services center (formerly an adult day health center) in the

morning, IHSS cannot be approved for the hours while at the center, but could be approved if the consumer needs assistance in the afternoon or evening when the CBAS services aren't available.

2.2 Voluntary Services

Voluntary services provided to the applicant by a family member, housemate or friend are not considered alternative resources.¹³⁶ If the service is being provided voluntarily, even though compensation is available through the IHSS program, the county social services worker will obtain a signed statement from the provider.¹³⁷ The county cannot require a family member or friend to provide services on a voluntary basis.¹³⁸

2.3 Other HCBS Resources

IHSS is one of several home and community-based services (HCBS) available in California. The goal of HCBS is to allow recipients to receive services in a non-institutional setting. Over the last several years, Medicaid spending has shifted so that now, HCBS spending represents over 50% of total Medicaid spending on long-term services and supports.¹³⁹

A list of California HCBS program can be found in Appendix A. Disability Rights California also has separate publications about the Multipurpose Senior Services Program (MSSP), the AIDS Medi-Cal Waiver, and the Home and Community-Based Alternatives Waiver (formerly the Nursing Facility/Acute Hospital Waiver).¹⁴⁰ Individuals must apply separately for each HCBS program. It is important to note that many non-IHSS HCBS programs have enrollment caps and waiting lists.

3. APPLICATION PROCESS AND TIMELINES

3.1 Application Process

There are six basic steps to the IHSS application process.

- 1 To begin, individuals who need in-home services must contact the county welfare department's IHSS unit in their county of residence. Although a written application is available, most individuals apply for IHSS by phone.¹⁴¹ The CDSS website lists the contact information for each county's IHSS unit.¹⁴²
- 2 If an IHSS applicant has not already applied for Medi-Cal, the county will refer them to the Medi-Cal benefits eligibility division of the county welfare office. The county welfare office should process the applications separately, but concurrently. However, many counties wait for the Medi-Cal approval before they start processing the IHSS application.
- 3 The applicant will receive a home visit from a county social worker. The social worker will interview the applicant in the home to help determine the applicant's eligibility for services, functional impairment, living arrangement, and any alternative resources that are available. If the applicant is currently residing in a facility, the county must do a preliminary assessment. They will follow-up with an in-home assessment once the applicant has returned to the home.¹⁴³

- 4 As part of the assessment, the social worker is required to ask whether or not the applicant needs an accommodation due to blindness or visual impairment (this must happen at initial application and at annual reviews). The social worker should record that information as well as any communication needs related to it (e.g., use of a telephone timesheet system for approval of timesheets; requests for timesheets in 18 point font; requests for notices of action in 18 point font, in braille, in audio CD, or in accessible text CD.) If an individual needs a different type of accommodation, they should ask their social worker for it.¹⁴⁴
- 5 An applicant must return a completed IHSS Health Care Certification form (SOC 873)¹⁴⁵ or its functional equivalent to the county welfare office.¹⁴⁶ The county will assist an applicant with this process if the applicant requests assistance.¹⁴⁷ A Medi-Cal enrolled health care provider may not charge for the completion of the form.¹⁴⁸ The law is not as clear with respect to non-Medi-Cal enrolled providers, however, a broad list of health care providers may complete the form. So, if one doctor or nurse wants to charge for completing the form, the applicant may be able to ask a different provider.

If an applicant is requesting paramedical services or protective supervision, they are required to submit additional certification. For paramedical services, a health care professional must fill out and submit SOC 321.¹⁴⁹ For protective supervision, a health care professional must fill out and submit SOC 821.¹⁵⁰ These forms are not required as a part of the initial application.

An applicant has 45 days from the date of receipt of the blank form to return it completed and signed.¹⁵¹ The county cannot authorize IHSS without receipt of the Health Care Certification form, unless the applicant is being discharged from a hospital or nursing home or is at imminent risk of out-of-home placement.¹⁵² An applicant can request an additional 45 days to submit the Health Care Certification form if good cause exists for the delay.¹⁵³

- 6 The county must process the completed application within 30 days.¹⁵⁴ This includes the eligibility determination, needs assessment, and sending the notice of action. It is not uncommon for a county to exceed this 30-day timeline. If a disability determination is pending, the county may extend the 30-day period.¹⁵⁵
- 7 The county must send a Notice of Action (NOA) describing its determination.¹⁵⁶ If services are approved, the NOA will include information about the particular services and hours allotted to the recipient.¹⁵⁷ An applicant who has applied to Medi-Cal concurrently will receive a separate Notice of Action for that determination.¹⁵⁸

APPLICATION CHECKLISTS

APPLICANT:

- Apply for IHSS by phone, in-person, or by mail to your county's welfare department
- Submit the Health Care Certification form
- Allow the county to conduct the in-home and the needs assessment

COUNTY:

- Accept the application by phone, in-person, or by mail
- Help the applicant obtain the Health Care Certification form, if needed
- Complete the home visit and needs assessment
- Process the application within 30 days
- Send a Notice of Action approving or denying the application

3.2 Application Timeline

Although state law provides a timeline for processing IHSS applications, federal law requires states to comply with Medicaid timeliness standards when processing Medicaid applications.¹⁵⁹ Specifically, the states must complete processing within 90 days for applicants who apply on the basis of disability and 45 days for all other applicants.¹⁶⁰ The 45/90 day timeline runs from the date of initial application (or transfer from another insurance program) to the date the agency notifies the applicant of its decision.¹⁶¹

Because California regulations require that IHSS applications must be processed within 30 days, the protections afforded by the federal Medicaid Act may seem unnecessary.¹⁶² In practice, however, delays are common.¹⁶³ If there is a county pattern of delays, advocates can contact Justice in Aging to discuss advocacy options or go directly to the Department of Social Services, Adult Programs Division.

Although the health care certification form is required before services can be authorized, it is not part of the application itself. Delays in returning the Health Care Certification form (step 4 above) may result in a delay of a Medi-Cal or IHSS determination beyond the 45/90 day deadlines. IHSS eligibility determinations that extend beyond the 45/90 day deadline may violate the federal Medicaid timeliness standards.

4. PRESUMPTIVE ELIGIBILITY AND ELIGIBILITY FOR EMERGENCY SERVICES

4.1 IHSS Presumptive Eligibility

Generally, receipt of IHSS services is dependent upon completion and approval of the Medi-Cal application process. In limited circumstances, however, an applicant may be eligible for presumptive eligibility of IHSS services even without a Medi-Cal determination. If an applicant has applied for Medi-Cal and is complying with all Medi-Cal requirements, but the determination of their Medi-Cal eligibility is pending a disability evaluation determination, that applicant may be eligible for IHSS services through the IHSS-Residual (IHSS-R) program.¹⁶⁴ Although IHSS-R is often thought of as IHSS for those who are not Medi-Cal eligible, it often operates as a catch-all program, serving those on state-only Medi-Cal, those presumptively eligible, and those transitioning off Medi-Cal.

Receipt of IHSS through the IHSS-R program will continue until the disability determination is made and Medi-Cal is approved or denied. If Medi-Cal is approved, the consumer will continue with IHSS, but it will be provided through one of the federal Medi-Cal linked IHSS programs. If the Medi-Cal application is denied, the IHSS temporarily authorized through the IHSS-R program will also be terminated.¹⁶⁵ The county must notify the consumer of its intent to terminate IHSS and provide them with an opportunity to appeal the decision. A consumer seeking to challenge this decision should appeal both the denial of IHSS and the denial of Medi-Cal.

4.2 Presumptive Disability

Certain conditions do not require a disability determination. Instead, for purposes of Medi-Cal and IHSS eligibility, the individual will be considered presumptively disabled if they have one of the articulated conditions: Some examples include amputation of a leg at the hip, total deafness, and total blindness.¹⁶⁶ The county will still conduct a needs assessment of the presumptively disabled individual to establish hours of need.

4.3 Medi-Cal Presumptive Eligibility

Separately, there are also several Medi-Cal presumptive eligibility programs, including the Breast and Cervical Cancer Treatment Program, Child Health and Disability Prevention Program, Every Woman Counts, Presumptive Eligibility for Pregnant Women, and Hospital Presumptive Eligibility. These programs provide qualified individuals immediate temporary access to Medi-Cal coverage based on the individual's self-attested preliminary information.¹⁶⁷

5. HOME VISIT AND ASSESSMENT PREPARATION

5.1 Home Visit

In order to evaluate an applicant's need for IHSS, a county social worker will conduct a home visit.¹⁶⁸ The county will also conduct home visits for reassessments. The applicant must cooperate with the county to conduct these in-home assessments.¹⁶⁹ CDSS also has a protocol for unannounced home visits as part of its quality assurance efforts.¹⁷⁰

At the home visit, the county social worker will assess the applicant's physical and mental conditions, their living situation, and how long it takes the applicant to perform tasks.¹⁷¹ It is important to note, however, that the home visit is only a part of the overall needs assessment and the county social worker's determinations about the applicant's needs **should not** be based only on the home visit. Nonetheless, the home visit is a very important part of the needs assessment, so it is helpful for applicants to be prepared for the visit. Applicants can choose to have a family member, friend, advocate, or other representative with them at the visit.

The California Department of Social Services has created an instructional video that may be helpful for some applicants preparing for a home visit.¹⁷² Disability Rights California has also created a self-assessment guide which can be used by a consumer or a family member to help show what a consumer's monthly need is.¹⁷³

6. APPROVAL OR DENIAL

The county must send an IHSS Notice of Action (NOA) to the applicant explaining the eligibility determination. If the services are approved, the NOA will provide a detailed explanation of the hours assigned for each service.¹⁷⁴ Chapter 4 provides information about each service category and the time guidelines for each task. A sample NOA is attached to this guide as Appendix C. See attachment sent by Vanessa and add to the end of the document after Appendix B.

Applicants have a right to a written denial.¹⁷⁵ Verbal denials are not valid. Applicants have the right to appeal an IHSS denial or an award of hours, if they disagree with the number of hours assigned. Chapter 7 provides a more in-depth explanation of appeal rights and procedures.

Chapter 2 Endnotes

- 90 Cal. Welf. & Inst. Code § 12301.5.
- 91 Cal. Welf. & Inst. Code §§ 11104, 12305.6; California Dept. of Social Services Manual of Policies & Procedures (“MPP”) § 30-770.41.
- 92 MPP § 30-755.11 (Non-PCSP eligibility); MPP § 30-770.41 (PCSP eligibility).
- 93 MPP § 30-755.11; see also MPP § 30-700.1.
- 94 MPP § 30-755.11; MPP §§ 30-770.1, 30-770.2; see also 20 C.F.R. § 416.202.
- 95 Cal. Welf. & Inst. Code § 14132.95, MPP § 30-700.2 (PCSP); MPP § 30-755.31 (Non-PCSP Programs).
- 96 See Health Consumer Alliance at www.healthconsumer.org; Western Center on Law & Poverty, www.wclp.org, Health Care Eligibility Guide.
- 97 Cal. Welf. & Inst. Code §12300 et seq.
- 98 Cal. Welf. & Inst. Code § 14007.5; Cal. Code Regs., tit. 22, § 50301(b).
- 99 8 U.S.C. § 1641(b); Welfare and Institutions Code §§ 11104, 12305.6.
- 100 All County Information Notice (“ACIN”) I-18-08 (March 12, 2008), available at http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin08/I-18_08.pdf; immigrants who are eligible under the PRUCOL definition are described in POMS SI 00501.420, available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0500501420>.
- 101 MPP § 30-770.5; All County Letter (“ACL”) 08-15 (April 4, 2008), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl08/08-15.pdf>.
- 102 See also National Immigrant Legal Center, *Major Benefit Programs Available to Immigrants in California*, (May 2017), available at <https://www.nilc.org/wp-content/uploads/2015/11/cal-benefits-table.pdf>; It is also important to note that sponsor deeming may separately affect an immigrant’s ability to qualify for benefits. Page 6 of NILC’s attached chart provides additional information about sponsor deeming and IHSS eligibility.
- 103 MPP §30-770.41.
- 104 MPP § 30-770.42.
- 105 MPP § 30-770.421.
- 106 MPP § 30-770.422.
- 107 MPP § 30-770.441. Good cause includes but is not limited to: (1) outpatient medical treatment necessary to maintain the recipient’s health where the medical treatment is not available in California; (2) short-term schooling or training necessary for the recipient to obtain self-sufficiency where such training is not available in California; (3) court-issued subpoena or summons. Welfare & Institutions Code § 11100.1.
- 108 MPP § 30-701(o)(2).
- 109 MPP § 30-755.12.
- 110 *Id.*
- 111 MPP § 30-755.12.

- 112 MPP § 30-755.121.
- 113 MPP § 30-755.121; MPP § 30-757.12.
- 114 ACL 08-18 (April 23, 2008), Question 27, available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl08/08-18.pdf>.
- 115 20 C.F.R. § 416.202; Cal. Welf. & Inst. Code § 12300; MPP 30-700.1; 30-755.231.
- 116 20 C.F.R. § 416.202(1); Cal. Welf. & Inst. Code § 12050(b).
- 117 20 C.F.R. § 416.905(a); Cal. Welf. & Inst. Code § 12050(d); The Social Security Blue Book, which contains the disability listings, available at <https://www.ssa.gov/disability/professionals/bluebook/>.
- 118 20 C.F.R. § 416.906; Cal. Welf. & Inst. Code § 12050(d).
- 119 Cal. Welf. & Inst. Code § 12300; MPP § 30-755.11.
- 120 20 C.F.R. § 416.981.
- 121 Id.
- 122 Cal. Welf. & Inst. Code § 12050(c).
- 123 ACL 14-67 (November 4, 2017), pgs. 1-2, available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-67.pdf>.
- 124 ACL 14-60 (August 29, 2014), pgs. 2-4, available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>.
- 125 Here are the applicable services and functional ranks: Eating, FI Rank of 3-6; Bowel and Bladder/Menstrual Care, FI Rank of 3-6; Bathing/Grooming, FI Rank 4-5; Dressing, FI Rank of 4-5; Mobility Inside, FI Rank of 4-5; Transfer, FI Rank of 4-5; Respiration, FI Rank of 5-6; Paramedical, FI Rank not applicable.
- 126 Here are the applicable services: Preparation of Meals, Meal Clean-Up, Respiration, Bowel and Bladder Care, Feeding, Routine Bed Baths, Dressing, Menstrual Care, Ambulation, Transfer, Bathing, Oral Hygiene, Grooming, Repositioning and Rubbing Skin, Care and Assistance with Prosthesis, and Paramedical.
- 127 SMD #15-001 (May 7, 2015), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd050715.pdf>; 42 U.S.C. §1396r-5(a).
- 128 Cal. Welf. & Inst. Code § 12309; MPP § 30-756.1.
- 129 Cal. Welf. & Inst. Code § 12309(b)(2)(B).
- 130 MPP § 30-763.6.
- 131 MPP § 30-757.171(a)(2).
- 132 ACL 98-53 (July 9, 1998), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl98/98-53.PDF>.
- 133 MPP §§ 30-763.611; 30-763.613.
- 134 MPP § 30-763.63.
- 135 MPP § 30-757.154; ACL 14-82 (November 25, 2014), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-82corrected.pdf>.
- 136 MPP § 30-763.62.

- 137 MPP §§ 30-763.64, 30-757.176; All County Letter 00-28 (April 25, 2000), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl00/pdf/00-28.PDF>; See SOC 450 Voluntary Services Certification, available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC450.pdf>.
- 138 *Id.*
- 139 See Eiken, Steve, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, (April 15, 2016), available at <https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf>.
- 140 MSSP: <http://www.disabilityrightsca.org/pubs/539501.pdf>; AIDS Waiver: <http://www.disabilityrightsca.org/pubs/543501.pdf>; NF/AH Waiver: <http://www.disabilityrightsca.org/pubs/559101.pdf>.
- 141 The written application for IHSS is SOC 295 and it was updated in September 2018. The English application is available at <http://www.cdss.ca.gov/Portals/9/FMUForms/Q-T/SOC295.pdf?ver=2018-07-18-103154-373>. The large print English application is available at <http://www.cdss.ca.gov/Portals/9/FMUForms/Q-T/SOC295L.pdf?ver=2018-10-09-140506-307>. Applications in Spanish, Chinese and Armenian can be found here: <http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications>.
- 142 County IHSS Offices: <http://www.cdss.ca.gov/inforesources/County-IHSS-Offices>.
- 143 MPP § 30-755.12; ACIN I-43-06 (June 8, 2006), available at http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin06/pdf/I-43_06.pdf; ACL 02-68 (August 30, 2002), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-68.pdf>.
- 144 ACL 15-60 (July 22, 2015), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2015/15-60.pdf>.
- 145 California Dept. of Social Services Form SOC 873, available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC873.pdf>.
- 146 Cal. Welf. & Inst. Code § 12309.1, MPP § 30-754; ACL 16-78 (September 28, 2016). New regulations implementing the health care certification requirements became effective on October 1, 2016. MPP § 30-701(l)(2) defines a licensed health care provider for purposes of the health care certification. MPP § 30-754.2 mandates use of the department-approved form, but MPP § 30-754.21 also requires counties to accept alternative documentation that provides counties with the same needed information as the SOC 873 form.
- 147 SOC 874 states that the county can send the Health Care Certification form directly to the applicant's licensed health care provider, but the applicant must provide the LHCP's name and address. SOC 874 which provides notice to applicants of the requirement is available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC874.pdf>.
- 148 42 USC § 1396t(c)(2)(A).
- 149 California Dept. of Social Services Form SOC 321: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC321.pdf>.
- 150 California Dept. of Social Services Form SOC 821: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC821.PDF>.
- 151 MPP § 30-754.4; ACL 16-78 (September 29, 2016).
- 152 MPP § 30-754.6. Applicants who were granted an exception and received IHSS services before the county received the Health Care Certification form will still need to return the completed and signed form once the county requests it and will then have 45 days from that date to return it per MPP § 30-754.63. Those applicants may also be granted an additional 45 day extension for good cause per MPP § 30-754.64.

- 153 Cal. Welf. & Inst. Code § 12309.1(e)(2).
- 154 MPP § 30-759.2.
- 155 MPP §§ 30-759.2, 30-771.3.
- 156 Cal. Welf. & Inst. Code § 12300.2; MPP §§ 30-759.7, 30-763.8.
- 157 Id.
- 158 22 C.C.R. § 50179.
- 159 42 C.F.R. § 435.912.
- 160 42 C.F.R. § 435.912(c)(3).
- 161 Code of Federal Regulation, Title 42, section 435.912(e) contemplates the unusual circumstances where a state may legally not abide by the timeliness guidelines. Subsection (e)(1) creates an exception to the timeliness standards when “the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action.”
- 162 MPP § 30-759.2.
- 163 Per Cal. Welf. & Inst. Code § 12309.1, there are two exceptions to this requirement: (1) services may be authorized prior to receipt if an individual is being discharged from a hospital or nursing home and the services are needed to enable the individual to return home safely or (2) services may be authorized temporarily if the county determines there is a risk of an out of home placement.
- 164 MPP § 30-759.2; ACL 12-36 (July 24, 2012), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2012/12-36.pdf>.
- 165 ACL 12-36 (July 24, 2012).
- 166 MPP § 30-785(g); 22 C.C.R. § 50167(a)(1)(C); 20 C.F.R. § 416.934.
- 167 More information about these programs is available at: https://files.medi-cal.ca.gov/pubsdoco/presumptive_eligibility/PE_Programs_landing.asp.
- 168 MPP § 30-761.13.
- 169 MPP § 30-60.13.
- 170 See CDSS, IHSS Uniform Statewide Protocols, available at [http://www.cdss.ca.gov/agedblinddisabled/res/IHSSUniformStatewideProtocols-ProgramIntegrityActMAR2013\(bookmarked\).pdf](http://www.cdss.ca.gov/agedblinddisabled/res/IHSSUniformStatewideProtocols-ProgramIntegrityActMAR2013(bookmarked).pdf).
- 171 MPP § 30-761.261.
- 172 The video can be found at: <http://www.cdss.ca.gov/agedblinddisabled/PG3154.htm>. It is also available in Spanish, Chinese, and Armenian.
- 173 The full assessment guide is available at: <https://www.disabilityrightsca.org/publications/ihss-self-assessment-and-fair-hearing-guide#>.
- 174 Cal. Welf. & Inst. Code § 12300.2; MPP §§ 30-759.7, 30-763.8.
- 175 MPP § 22-001(a)(1).

Chapter 3: Medi-Cal Programs and IHSS

This chapter will provide an overview of the Medi-Cal program and its relationship to the IHSS program. There are four sections: (1) Overview of Specific Medi-Cal Programs; (2) Spousal Impoverishment Protections; (3) Effects of Changes and Terminations in Medi-Cal on IHSS; (4) IHSS and Medi-Cal Managed Care and (5) Medi-Cal HCBS Waivers.

1. OVERVIEW OF SPECIFIC MEDI-CAL PROGRAMS

Medi-Cal is California's Medicaid program. It currently serves more than 13.4 million Californians. Although Medi-Cal is presented as one large insurance program, Medi-Cal actually consists of dozens of different programs with different eligibility requirements. Enrollment in IHSS does not depend on being eligible for a particular Medi-Cal program. However, it is helpful to understand the basics of a few of the different Medi-Cal programs most closely associated with IHSS. This manual only provides a general overview of different Medi-Cal programs. For more in-depth information about Medi-Cal, Western Center on Law and Poverty¹⁷⁶, the Health Consumer Alliance¹⁷⁷, and Disability Rights California¹⁷⁸ have additional resources.

Medi-Cal programs fall broadly into two categories: those that determine income eligibility according to Modified Adjusted Gross Income (MAGI Medi-Cal) and those that use traditional Medicaid eligibility groups (non-MAGI Medi-Cal). There are numerous subcategories of non-MAGI Medi-Cal. It is important to note that not all Medi-Cal programs are free. Some programs require a small monthly premium and others require recipients to incur a monthly share of cost before Medi-Cal will cover any services. A share of cost is the amount a person or family must pay towards the cost of their health care services each month in order to be eligible for Medi-Cal in the same month.¹⁷⁹

Most Medi-Cal recipients are enrolled in managed care. This shift from fee-for-service to managed care has not significantly affected the administration of the IHSS program, which has remained with the county welfare departments even as other long-term services and supports have become managed care benefits.

1.1 MAGI Medi-Cal

There are four broad programs under the umbrella of MAGI Medi-Cal: expansion adults, parents and caretaker relatives, pregnant women, and children. MAGI stands for "Modified Adjusted Gross Income." It represents a new methodology for establishing income eligibility for Medi-Cal, based on the Internal Revenue Service (IRS) income rules.¹⁸⁰ Starting January 1, 2014, Medi-Cal began providing free health insurance to two groups of adults who were formerly ineligible for Medi-Cal: low-income single adults without children between the ages of 19-64 and former foster youth up to age 26.¹⁸¹ More than 3.6 million recipients, or 27% of the Medi-Cal population, qualify for Medi-Cal as a result of this expansion.¹⁸²

Prior to the passage of the Affordable Care Act, having low or no income was not a sufficient basis for Medi-Cal eligibility. Instead, a person had to fit into a specific eligibility group. Now, an adult who (1) has a modified gross adjusted income below 138% of the Federal Poverty Level (FPL)¹⁸³; (2) is **not eligible** for Medicare Part A or B¹⁸⁴; (3) is not pregnant; and (4) is a U.S. citizen or qualified immigrant, is eligible for MAGI Medi-Cal under the expansion adult population.¹⁸⁵ MAGI Medi-Cal uses yearly income to determine eligibility.¹⁸⁶ Income is limited to 138% FPL for adults. Generally, Medi-Cal will use household income reported to the Internal Revenue Service (IRS) on the 1040 form. MAGI Medi-Cal **does not** have an asset or resource test.¹⁸⁷

Parents and caretaker relatives are eligible for MAGI Medi-Cal if (1) they have a linkage to the child by blood, adoption, or marriage; (2) live with that child; (3) have primary responsibility for the child; (4) have income at or below 109% FPL.¹⁸⁸ Parents and caretakers with income between 109% and 138% can qualify through the expansion adult program if they meet the other criteria described above.

Pregnant women are eligible for MAGI Medi-Cal. There are multiple programs covering pregnant women and eligibility for each largely depends on income and immigration status. Free full-scope Medi-Cal is available to pregnant women with satisfactory immigration status up to 138% FPL and pregnancy-related Medi-Cal is available regardless of immigration status up to 213% FPL.¹⁸⁹ Practically speaking, all medically necessary services should be covered regardless of whether a woman is on full-scope Medi-Cal or pregnancy-related Medi-Cal.¹⁹⁰

Children aged 0-19 years old are also eligible for MAGI Medi-Cal as well as coverage under the Targeted Low-Income Children's Program (TLICP).¹⁹¹ These two Medi-Cal programs cover low-income children. The income eligibility limit for both programs varies depending on the age of the child.¹⁹² Generally, children are eligible for Medi-Cal with income up to 266% FPL, and some infants are eligible for Medi-Cal coverage up to 322% FPL.¹⁹³ Children between 1 and 19 with family incomes between 161% and 266% FPL will be required to pay a monthly premium of \$13 per child, which is capped at \$39 per family.¹⁹⁴

MAGI Medi-Cal recipients are eligible for IHSS services¹⁹⁵ Each county must separately determine IHSS eligibility for MAGI Medi-Cal recipients.¹⁹⁶ The county will determine whether the recipient has full-scope Federal Financial Participation Medi-Cal, whether the recipient is aged, blind, or disabled, and assess whether that recipient needs IHSS services. If the recipient meets all three criteria, they will be eligible to receive IHSS services through the Community First Choice Option (CFCO), the Personal Care Services Program (PCSP), or the IHSS Plus Option (IPO) programs.¹⁹⁷ All three programs are described in detail in Chapter 1.

1.2 Non-MAGI Medi-Cal

All Medi-Cal programs that do not use the modified adjusted gross income counting methodology are considered non-MAGI programs. Non-MAGI Medi-Cal programs are traditional Medi-Cal programs. Almost all seniors are enrolled in non-MAGI programs. A significant number of adults with disabilities are also in non-MAGI programs. The three largest programs are SSI-linked, Aged & Disabled Federal Poverty Level, and Medically Needy Medi-Cal.

A significant number are also served by the 250% Working Disabled Program. Each will be discussed briefly.¹⁹⁸

In general, traditional Medi-Cal programs have limits on how much income and how many resources individuals can have and still qualify for benefits. Additionally, traditional Medi-Cal determines eligibility based on monthly income, not yearly income. For more information about traditional Medi-Cal property limits see the DHCS Medi-Cal Information Notice 007.¹⁹⁹

SSI-Linked Medi-Cal

Seniors and adults with disabilities receiving Supplemental Security Income (SSI) are automatically eligible for free Medi-Cal. These recipients do not have to separately apply for Medi-Cal through the county. However, like all Medi-Cal recipients, they will have to apply for IHSS through the county.

Aged & Disabled Federal Poverty Level Medi-Cal

The Aged and Disabled (A&D) Federal Poverty Level (FPL) program serves low-income people with disabilities, including seniors.²⁰⁰ Seniors are defined as individuals aged 65 and over.²⁰¹ Disability can be established through a Social Security disability determination or by applying for Medi-Cal.²⁰² It is a free Medi-Cal program so eligible individuals do not have a share of cost.

The income limits change every year based on the Federal Poverty Level. The exact income limit is set each April. The income limits are 100% of FPL for a couple or individual, plus the \$230 standard disregard for an individual and the \$310 disregard for a couple. In 2019, seniors or people with disabilities must have net countable income below \$1,271 for an individual and \$1,720 for a couple.²⁰³ In addition to meeting this income limit, the senior or adult with disabilities must also have countable resources below the Medi-Cal resource limit of \$2,000 for an individual and \$3,000 for a couple. Resource determinations can be complicated and advocates should consult the manuals recommended above for more details.

There are ways for individuals to reduce their net countable income for Medi-Cal purposes, which may help them qualify for free Medi-Cal through the Aged and Disabled program. For more information, see Disability Rights California's publication, "Worksheets for Determining Eligibility under the Aged & Disabled Federal Poverty Level Medi-Cal Program."²⁰⁴

Aged, Blind & Disabled Medically Needy Medi-Cal/Share of Cost

Low-income seniors and adults with disabilities with higher incomes, who do not qualify for other Medi-Cal programs or who have a pending SSI application may be eligible for the Medically Needy Medi-Cal program.²⁰⁵ The Medically Needy program is free for some ultra-low income recipients, but most have a Share of Cost.

A share of cost, sometimes called "spend down," is an amount of money that a recipient must pay or incur each month for medical goods and services before the Medi-Cal program will begin to pay for health care services, including IHSS. The formula used to calculate Medi-Cal share of cost has not been updated in almost 30 years, so it often results in unaffordably high shares of cost for recipients.

To determine share of cost, the county will begin by determining total gross income. It then subtracts the standard \$20 deduction, and the earned income deduction, if applicable.²⁰⁶ Next, it will subtract any medical premiums paid by the applicant, including Medicare Part B premiums.²⁰⁷ After subtracting all allowable deductions from gross income, the county will have a net countable income for the individual or couple. If the income is below the eligibility limit for the Medi-Cal Aged and Disabled Federal Poverty Level program the person will receive free Medi-Cal; if it is above the limit the individual will be eligible for the Medically Needy program. The share of cost will be the net countable income minus the monthly maintenance need income level of \$600 for an individual and \$934 for a couple.²⁰⁸

Example 1—Share of Cost with no medical premium deductions

Juanita receives \$1,500 in monthly retirement income and pays no medical premiums. The county subtracts the standard \$20 deduction. Juanita's net countable income is \$1,480. Because this is higher than \$1,271 (the Medi-Cal Aged & Disabled limit in 2019) the county will need to determine her share of cost by subtracting \$600 from \$1,480. Juanita's share of cost will be \$880 per month.

Example 2—Share of Cost with medical premium deductions

James receives \$1,500 in gross monthly Social Security income and pays \$134 per month for Part B premiums. The county subtracts the standard \$20 deduction and the \$134 medical premium. James's net countable income is \$1,346. Because this is higher than \$1,271 (the Medi-Cal Aged & Disabled limit in 2019) the county will need to determine his share of cost by subtracting \$600 from \$1,346. James's share of cost will be \$746 per month.

Example 3—No Share of Cost with medical premium deductions

Miriam receives \$1,500 in gross monthly Social Security income and pays \$250 in monthly medical premiums. The county subtracts the standard \$20 deduction and the \$250 medical premium. Miriam's net countable income is \$1,230. Because this is lower than \$1,271 (the Medi-Cal Aged & Disabled limit in 2019), Miriam is eligible for free Medi-Cal and will not have a share of cost.

Note that in both Example 1 and 2 above, Juanita and James can also look into purchasing additional insurance in order to bring their income below the \$1271 threshold amount and thus avoid paying a share of cost.

IHSS and Share of Cost

Individuals who have a high share of cost may have difficulty accessing Medi-Cal services, including IHSS. In fact, the IHSS recipients are particularly negatively affected by having a monthly share of cost. This is because the share of cost is directly subtracted from a provider's wages each month that the recipient does not incur other medical bills. This means that the recipient will be responsible to pay the provider any wages not paid by the State.

Example 4—Effect of Share of Cost on IHSS

Tim has a monthly share of cost of \$880. He is eligible for 170 hours per month of IHSS at a rate of \$12 per hour. Based on this information, Tim’s provider will earn \$2,040 per month. However, if this is the only Medi-Cal covered expense Tim has each month, the state will deduct \$880 every month from Tim’s provider’s wages and Tim will be responsible for paying that share of cost amount directly to his provider each month. In other words, the provider is owed \$2,040 each month in wages, the state will pay \$1,160 (\$2,040 less the \$880 share of cost), and Tim owes his provider \$880 in wages. Because this accounts for more than half of Tim’s income, it is unlikely that he can afford to pay this amount, which will make it difficult for him to maintain a provider.

Reducing or Eliminating Share of Cost

It is possible to reduce or eliminate a share of cost, and individuals who need IHSS may have a strong financial incentive to do so. Individuals may purchase dental or vision insurance so they have an additional medical premium deduction.²⁰⁹ Individuals may also want to contact Disability Rights California or another legal services organization to discuss eligibility for Medi-Cal under a more favorable program like the 250% Working Disabled Program described below.

If individuals cannot eliminate their share of costs, they can try to use other medical expenses, including paying out-of-pocket for additional personal care services as a way to meet their share of cost.²¹⁰ It is important to note that as of 2015 out-of-pocket personal care services can no longer be used as an income deduction.²¹¹ For more information about this see Disability Rights California publication entitled “How Can I Use My Share of Cost to Get More Services I Need?”²¹²

250% Working Disabled Program

The 250% Working Disabled Program is a Medi-Cal program for adults with disabilities who receive disability-based income. This program requires payment of a monthly premium based on countable income.²¹³ Because these premiums can be significantly less than a Medi-Cal Share of Cost for the same income, it is worth determining whether an individual or couple is eligible under the 250% Working Disabled Program.

A qualified individual must meet the Social Security definition of disabled, have net family income less than 250% FPL, and be eligible for SSI benefits if it weren’t for their earnings. The individual must also have earnings from work (even a very small amount of work), and have resources below the \$2000/\$3000 threshold.²¹⁴ Any money earned for work performed is considered earnings for this program.²¹⁵ Individuals who received Social Security Disability Insurance benefits that converted to retirement benefits may also participate in this program.

For more information about this program, see Western Center on Law and Poverty’s “2016 Medi-Cal Eligibility Guide”.²¹⁶

2. SPOUSAL IMPOVERISHMENT PROTECTIONS

The spousal impoverishment protection is a specialized Medicaid eligibility rule that benefits married couples when one member of the couple needs long-term services and supports.

Spousal impoverishment rules can be used to assist married IHSS applicants to establish Medi-Cal eligibility because it provides an alternative method to allocate, or count, income and resources.

In general, this protection allows a Medi-Cal applicant's income and resources to be allocated to a community spouse so that the Medi-Cal applicant and/or recipient can meet income and resource limitations. Originally, the purpose of the rule was to allow a spouse in need of long-term care to become Medi-Cal eligible so he or she could reside in an institutionalized setting, while preventing the spouse still living at home from becoming destitute.²¹⁷ Although this rule helped married couples, it had the unintended consequence of forcing the institutionalization of a spouse who could have been cared for at home with the proper supports.²¹⁸

Beginning on January 1, 2014, the Patient Protection and Affordable Care Act of 2010 ("ACA") expanded the spousal impoverishment protections.²¹⁹ The purpose of the expansion, which sunset on December 31, 2018, and was extended until March 31, 2019, is to allow more seniors and adults with disabilities to access needed home and community-based services, including IHSS. By amending the definition of "institutionalized spouse" to include a spouse who is eligible for home and community-based services pursuant to a Medicaid state plan or waiver program at a nursing home level of care, the ACA allowed more couples to avail themselves of the Spousal Impoverishment Protections.

In July of 2017, Justice in Aging, Disability Rights California, Western Center on Law and Poverty, Bet Tzedek Legal Services, and pro bono firm, McDermott, Will, & Emery sued the Department of Health Care Services for failure to implement the expanded Spousal Impoverishment protections.²²⁰ After the filing of the lawsuit, *Kelley v. Kent*, the Department of Health Care Services released initial statewide guidance and in 2018 followed up with a second guidance letter. Applicants and recipients, however, are still not consistently being evaluated for eligibility based on the spousal impoverishment protection.²²¹ For additional information about the spousal impoverishment rule or the *Kelley* case, contact Justice in Aging or Disability Rights California.

3. EFFECTS OF MEDI-CAL CHANGES AND TERMINATIONS ON IHSS

Because IHSS eligibility is largely dependent upon Medi-Cal eligibility, changes to a recipient's Medi-Cal coverage can affect that recipient's ability to access IHSS²²². There are two major categories of Medi-Cal changes that can negatively affect an individual's IHSS: (1) changes that increase a recipient's out-of-pocket costs for IHSS (for example, going from a free Medi-Cal program to a Medi-Cal program which will cost a recipient money) and (2) Medi-Cal terminations.²²³

3.1 Share of Cost or Other Cost-Sharing Changes

Changes in income can affect Medi-Cal eligibility.²²⁴ Once a change in income is reported to the county, the county must process that change and determine whether the individual is still eligible for their current Medi-Cal program or if they must be moved into another program.

Counties evaluate Medi-Cal eligibility using an established hierarchy.²²⁵ A shift between Medi-Cal programs can result in enrollment into a premium-based Medi-Cal program, like the 250% Working Disabled Program or into the Medically Needy Share of Cost program.

Typically, Medi-Cal premiums are meant to be affordable and, in most circumstances, should not prevent an individual from retaining Medi-Cal. However, the individual will have the responsibility to ensure they pay each month or risk termination from the Medi-Cal program.

Share of Cost, however, may limit an individual's ability to access Medi-Cal services, including IHSS. As explained in more detail above, Medi-Cal recipients are required to pay or incur their Share of Cost amount before Medi-Cal will pay for those services. For most recipients, this change means that IHSS is no longer affordable.

If the county correctly assesses a Medi-Cal share of cost, a recipient or an advocate working with a recipient should explore alternatives including (1) determining whether the recipient is eligible or can become eligible for another free or lower cost Medi-Cal program, such as the ones mentioned above, or (2) determining whether the recipient wants to purchase services Medi-Cal does not pay for to meet their Share of Cost. For more information about how to meet a share of cost, see Disability Rights California's publication entitled "How Can I Use My Share of Cost to Get More Services I Need?"²²⁶

If an individual thinks the county has made an error, like incorrectly calculating the Share of Cost or placing the recipient in the wrong Medi-Cal program, the recipient or advocate has the right to appeal. In fact, any adverse actions to a recipient's Medi-Cal eligibility trigger due process rights for the individual.²²⁷ Changes to a recipient's Medi-Cal eligibility such as placing an individual in the Medically Needy Share of Cost program would be considered an adverse action.²²⁸ The recipient must be notified of all adverse actions through a county-issued Notice of Action, also referred to as a NOA.

To ensure that services continue pending a hearing (and that the changes proposed in the NOA are put on hold), a request for hearing should be made before the effective date of the change in the Medi-Cal Notice of Action. For more complete information on Medi-Cal due process rights and appeals, see Western Center on Law and Poverty's "2016 Health Care Eligibility Guide."²²⁹

Appeal rights in the IHSS program are the focus of Chapter 8 of this manual. If a client's Medi-Cal eligibility determination will negatively impact their ability to receive IHSS, a separate appeal to continue IHSS eligibility may need to be filed.

3.2 Medi-Cal Terminations

Termination from the Medi-Cal program can happen for a number of reasons. For the purposes of this manual, however, there are two categories of terminations—(1) the beneficiary no longer meets Medi-Cal eligibility criteria or (2) the beneficiary continues to meet eligibility criteria, but has been discontinued for some other reason. This is an important distinction because recipients in Category (1) who are unable to make themselves eligible for a different Medi-Cal program are no longer eligible for IHSS. Recipients in Category (2) may be able to keep

IHSS, if they can correct the problem that led to the Medi-Cal discontinuance. Because of this difference, we will look at each category separately.

Recipient No Longer Meets Medi-Cal Eligibility Criteria

If a Medi-Cal recipient no longer meets all eligibility criteria for the Medi-Cal program, the county will issue a NOA explaining why the recipient is no longer eligible.²³⁰

For example, if a recipient is over the resource limit, the recipient will remain ineligible for Medi-Cal unless and until they spend down to below the Medi-Cal resource limit. This underlying Medi-Cal ineligibility will also result in a termination from the IHSS program. A recipient should receive two NOAs—one for the Medi-Cal termination and one for the IHSS termination. The individual should appeal both NOAs. If the recipient appeals before the date on the notice indicating when the change takes place, the recipient can retain their Medi-Cal while awaiting the appeal determination—this is called aid paid pending.²³¹ For more complete information on Medi-Cal due process rights and appeals, see Western Center on Law and Poverty’s “2016 Health Care Eligibility Guide”.²³²

Generally, an IHSS recipient will receive one additional month of IHSS under the state-funded IHSS-Residual program after Medi-Cal is terminated. However, after that month, services and payment will end. The Medi-Cal termination must be appealed if a recipient wants to continue their IHSS coverage.

Recipient Meets Medi-Cal Eligibility Criteria

It is not uncommon for recipients to be terminated from the Medi-Cal program even though they still meet all the Medi-Cal eligibility criteria. If a recipient fails to complete redetermination paperwork, for example, they will receive a termination NOA even though their underlying eligibility has not changed. In these cases, the recipient should appeal the Medi-Cal termination within 90 days from the date the NOA is mailed.²³³ If possible the recipient should appeal before the date on the notice that the change takes place, to receive aid paid pending.²³⁴

A recipient who is actively appealing a Medi-Cal termination should also file an IHSS appeal to ensure IHSS is not erroneously terminated while the Medi-Cal appeal is pending. Chapter 8 of this manual discusses IHSS appeals in further detail.

4. MEDI-CAL WAIVER PROGRAMS

The IHSS program is one Medi-Cal program that can help individuals with disabilities live safely in their own homes. For individuals with more intensive care needs, there are a number of Medi-Cal waiver programs that can provide additional home and community-based services (HCBS). There are five HCBS Medi-Cal waivers currently available in California. It is important to note that there are generally restrictions on eligibility for the Medi-Cal waiver programs, including based on medical condition and/or geography, as well as enrollment caps. It is also important to note that individuals cannot be enrolled in more than one waiver.

4.1 Acquired Immune Deficiency Syndrome (AIDS) Waiver

The AIDS Waiver serves children and adults with HIV and AIDS who qualify for a nursing facility level of care and who are Medi-Cal eligible. Services provided include: case management, skilled nursing, attendant care, psychotherapy, home-delivered meals, nutritional counseling, nutritional supplements, medical equipment and supplies, minor physical adaptations to the home, non-emergency medical transportation, and financial supplements for foster care. AIDS Waiver agencies can provide additional information regarding eligibility, enrollment, and services.²³⁵

4.2 Assisted Living Waiver (ALW)

The Assisted Living Waiver serves adults 21 and older with disabilities who qualify for a nursing facility level of care and who are eligible for non-share of cost Medi-Cal. The Assisted Living Waiver pays for assisted living, care coordination, and other benefits for eligible recipients. It is available in Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma counties. There are currently 3,744 authorized slots available statewide.²³⁶ An additional 2,000 slots were funded through the 2018-19 California budget, however, the state still needs to seek approval from the federal government.

4.3 Home and Community-Based Alternatives Waiver (HCBA Waiver)

The Home and Community-Based Alternatives waiver, formerly the Nursing Facility/Acute Hospital Waiver, serves individuals with disabilities with long-term medical conditions who meet specified level of care needs and who are Medi-Cal eligible. The waiver provides a wide range of services, including: private duty nursing, waiver personal care services, case management/coordination, habilitation, home respite, community transition, continuous nursing and supportive services, environmental accessibility adaptations, facility respite, and many more. The waiver personal care services may be used to increase the amount of in-home care beyond what is allocated through IHSS. The waiver is available statewide, but there is a waiting list for most participants.²³⁷

4.4 Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD Waiver)

The HCBS-DD Waiver serves individuals with developmental disabilities who are eligible for Medi-Cal, are Regional Center consumers, and meet the level of care requirement. The HCBS-DD Waiver funds many of the home and community-based services available for people with developmental disabilities through the Regional Centers, including homemaker, home health aide services, respite care, habilitation, transportation, communication aides, nutritional consultation, and many others.²³⁸

4.5 Multipurpose Senior Services Program (MSSP)

The MSSP Waiver serves Medi-Cal eligible individuals 65 and older who qualify for a nursing home level of care. MSSP services include: case management, personal care services, respite care, transportation, meal services, money management, housing assistance/home repair, and many others. Enrollment is capped at 12,000 participants and is not available in every county.²³⁹

Chapter 3 Endnotes

- 176 See Western Center on Law and Poverty’s 2016 Health Care Eligibility Guide, available at <https://wclp.org/advocate-resources/manuals-2/2016-health-care-guide/>.
- 177 See the Health Consumer Alliance’s publication page, available at https://healthconsumer.org/your_rights/.
- 178 See Disability Rights California’s Health Benefits page, available at <http://www.disabilityrightsca.org/pubs/PublicationsHealthBenefits.htm>.
- 179 Cal. Code Regs., tit. 22, § 50090.
- 180 42 U.S.C. § 1396a(e)(14); Cal. Welf. & Inst. Code § 14005.64.
- 181 42 U.S.C. § 1396a(k); Cal. Welf. & Inst. Code § 14005.60.
- 182 http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Sept_16_ADA.pdf.
- 183 42 U.S.C. § 1396a(a)(10)(A)(i)(VII); 42 C.F.R. § 435.119(b)(5); Welf. & Inst. Code § 14005.60(a).
- 184 Medicare beneficiaries are potentially eligible for non-MAGI Medi-Cal programs.
- 185 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), (IX).
- 186 All County Welfare Directors Letter (“AWCDL”) 18-03E (March 23, 2018), available at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2018/18-03E.pdf> provides real dollar value of 138% FPL in 2018. The Department of Health Care Services updates these numbers yearly.
- 187 42 U.S.C. § 1396a(e)(14)(C).
- 188 42 C.F.R. § 435.110; see also ACWDL 14-28 (July 7, 2014), available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2014/14-28.pdf>.
- 189 Cal. Welf. & Inst. Code §§ 14005.22, 14005.225 ACWDL 15-35 (Nov. 12, 2015), available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2015/15-35.pdf>; MEDIL 15-25 (Aug. 19, 2015), available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL/2015/15-25.pdf>.
- 190 For additional information about Medi-Cal eligibility and pregnancy, see Dept. of Health Care Services, Pregnant Woman Fact Sheet, available at https://www.dhcs.ca.gov/services/medi-cal/Documents/Pregnancy_Fact_Sheet_Chart.pdf.
- 191 42 U.S.C. § 1396a(k)(3); Cal. Welf. & Inst. Code § 14005.27.
- 192 See Western Center on Law and Poverty, “2016 Health Care Eligibility Guide”, pg. 2.60.
- 193 Cal. Welf. & Inst. Code §§ 14005.26, 14005.64, 15832. For 2018 eligibility limits in real dollars, see ACWDL 18-03E (March 23, 2018).
- 194 Cal. Welf. & Inst. Code § 14005.26(d).
- 195 All County Letter (“ACL”) 14-67 (November 4, 2014), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-67.pdf>.
- 196 *Id.*
- 197 *Id.* Those enrolled in IHSS through the IHSS-Residual program are not affected by MAGI Medi-Cal rules.

- 198 For additional information about all the Medi-Cal programs see Western Center on Law and Poverty's 2016 Health Care Eligibility Guide, available at <https://wclp.org/advocate-resources/manuals-2/2016-health-care-guide/>.
- 199 Medi-Cal Information Notice 007 (11/2018), available at https://www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/Info_Note/MC_007_ENG_110118.pdf.
- 200 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(X), 1396a(a)m)(1)(authorizing establishment of an aged and disabled program); Cal. Welf. & Inst. Code § 14005.40.
- 201 Cal. Code Regs., tit. 22, § 50221.
- 202 Cal. Code Regs., tit. 22, § 50223.
- 203 ACWDL 19-10 (March 28, 2019), available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2019/19-10.pdf>.
- 204 <https://www.disabilityrightsca.org/system/files?file=file-attachments/545001.pdf>.
- 205 Cal. Code Regs., tit. 22, § 50203.
- 206 Cal. Code Regs., tit. 22, § 50653.
- 207 Cal. Code Regs., tit. 22, § 50555.2.
- 208 For additional information see Disability Rights California, *Worksheets for Determining Eligibility under the Aged & Disabled Federal Poverty Level (A&D FPL) Medi-Cal Program*, available at <https://www.disabilityrightsca.org/system/files?file=file-attachments/545001.pdf>.
- 209 Vision and dental insurance premiums are considered health care premiums and are therefore an allowable income deduction per 22 C.C.R. § 50555.2.
- 210 ACWDL 15-02 (January 12, 2015), available at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2015/15-02.pdf>.
- 211 *Id.*
- 212 <http://www.disabilityrightsca.org//pubs/559601.pdf>.
- 213 Cal. Welf. & Inst. Code § 14007.9(d). As of 2019, premiums range from between \$20-\$250 for an individual and \$30 to \$375 for a couple, depending on countable income.
- 214 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII); Cal. Welf. & Inst. Code § 14007.9(a)(1).
- 215 See ACWDL 00-51 (September 27, 2000), available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-51.pdf>.
- 216 Western Center on Law and Poverty, *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates* (March 2016), pgs. 83-89, available at <https://wclp.org/advocate-resources/manuals-2/2016-health-care-guide/>.
- 217 42 U.S.C. § 1396r-5(b)(1).
- 218 Recipients of certain Medi-Cal HCBS waivers were also eligible for spousal impoverishment protections, however, the waiver programs are limited and often have significant waiting lists making it difficult to access them.
- 219 Public Law No. 111-148, Section 2404 (2010) amending 42 U.S.C. 1396r-5(h)(1)(A).

- 220 *Kelley v. Kent*, BS170173, filed in the California Superior Court, County of Los Angeles.
- 221 ACWDL 17-25 (July 19, 2016), available at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2017/17-25.pdf>; ACWDL 18-19 (August 21, 2018), available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2018/18-19.pdf>.
- 222 The IHSS-Residual program is not linked to Medi-Cal eligibility, however, less than 1% of IHSS beneficiaries are enrolled in IHSS-Residual.
- 223 Cal. Code Regs., tit. 22, § 50015.
- 224 An individual has an affirmative responsibility to report changes in income to the county welfare department within 10 days and to provide current proof of income at annual redetermination. See Welfare and Institutions Code § 14005.37(h) (change of circumstance reporting) and 14005.37(f) (annual redetermination).
- 225 ACWDL 17-03 (January 25, 2017), available at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2017/17-03.pdf>.
- 226 <http://www.disabilityrightsca.org/pubs/559601.pdf>.
- 227 See *Goldberg v. Kelly*, 397 U.S. 254, 260 (1970); 42 C.F.R. § 431.200 *et seq.*
- 228 Cal. Code Regs., tit. 22, § 50015.
- 229 Western Center on Law and Poverty, 2016 Health Care Eligibility Guide, available at <http://wclp.org/advocate-resources/manuals-2/2016-health-care-guide/>.
- 230 Cal. Code Regs., tit. 22, § 50179.
- 231 Cal. Code Regs., tit. 22, § 431.231.
- 232 Western Center on Law and Poverty, 2016 Health Care Eligibility Guide, available at <http://wclp.org/advocate-resources/manuals-2/2016-health-care-guide/>.
- 233 42 C.F.R. § 431.211; Cal. Welf. & Inst. Code § 10951. The appeal can be made after 90 days if good cause exists for the delayed filing.
- 234 42 C.F.R. § 431.231.
- 235 For more information, see Disability Rights California, *How the AIDS Medi-Cal Waiver Can Help You Get the Care You Need At Home*, (August, 2017), available at <https://www.disabilityrightsca.org/system/files?file=file-attachments/543501.pdf>; DHCS, AIDS Medi-Cal Waiver Program, available at <http://www.dhcs.ca.gov/services/ltc/Pages/AIDS.aspx>.
- 236 For more information, see DHCS, Assisted Living Waiver, available at <http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx>; Disability Rights California, *Medi-Cal Programs to Help You Stay in Your Own Home or Leave a Nursing Home*, (August 2017), available at <https://www.disabilityrightsca.org/system/files/file-attachments/539201.pdf>.
- 237 For more information, see DHCS, Home and Community-Based Alternatives (HCBA) Waiver, available at [http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-\(HCB\)-Alternatives-Waiver.aspx](http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx); Disability Rights California, *The Home and Community Based Alternatives (HCB Alternatives) Waiver (formerly known as the Nursing Facility/Acute Hospital Waiver): The Basics*, (August 2017), available at <https://www.disabilityrightsca.org/system/files?file=file-attachments/559101.pdf>.

- 238 For more information, see DHCS, Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD), available at <http://www.dhcs.ca.gov/services/medi-cal/Pages/HCBSDDMediCalWaiver.aspx>.
- 239 For more information, see DHCS, Multipurpose Senior Services Program, available at <http://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx>; California Department of Aging, Multipurpose Senior Services Program, available at <https://www.aging.ca.gov/programsproviders/mssp/> and <https://www.aging.ca.gov/ProgramsProviders/MSSP/Contacts/>; Disability Rights California, *The Multipurpose Senior Services Program may be the Answer to Staying at Home Rather than Going to a Nursing Home*, (August 2016), available at <https://www.disabilityrightsca.org/system/files?file=file-attachments/539501.pdf>.

Chapter 4: IHSS Services Overview

This chapter will provide an overview of services available through the IHSS program. There are nine different categories of services available through the IHSS program including: domestic, heavy cleaning, related services, personal care, accompaniment to medical appointments, yard hazard abatement, teaching and demonstration, paramedical services, and protective supervision.²⁴⁰ Each of these types of services is described in-depth in Chapter 5. In this chapter, there are five sections: (1) Hours and Need; (2) Monthly Limits; (3) Unmet Need; (4) Shared Living and Proration; and (5) Protective Supervision.

1. HOURS AND NEED

In order to receive any of the services described above, the applicant or recipient must have a need for that particular service.²⁴¹ Because both applicants and recipients are subject to the following rules, the term “recipient” will be used to include both. If separate rules apply to an applicant, that difference will be identified.

1.1 Needs Assessment

The county will conduct a needs assessment of the recipient, which must include information about the recipient’s living environment, alternative resources available to meet the recipient’s need,²⁴² and the recipient’s functional abilities.²⁴³

As a part of its assessment, the county social worker will conduct a face-to-face visit in the recipient’s home.²⁴⁴ The county must determine that the performance of the specific service by the recipient would constitute “such a threat to his/her health/safety that he/she would be unable to remain in his/her own home.”²⁴⁵

Although the face-to-face home visit is an important part of the assessment, it is not the sole criterion for establishing or continuing eligibility.²⁴⁶ The county must also evaluate the recipient’s statement of need, the available medical information, and any other information the social services staff person considers necessary and appropriate to assess the recipient’s need.²⁴⁷

In emergency situations, IHSS can be authorized prior to a completed needs assessment.²⁴⁸ In order to constitute an emergency situation, the applicant must meet one of three criteria: (1) the applicant is disabled, not employed, and has no expectation of employment within the next 45 days, and, in the county’s judgment, the applicant appears to have mental or physical impairments that will last for more than one year or end in death; (2) the applicant is blind as defined by MPP § 30-771.2;²⁴⁹ or (3) the applicant must meet the eligibility criteria established in MPP § 30-755.²⁵⁰ In addition to meeting one of the foregoing, the applicant’s needs must warrant the immediate provision of service.²⁵¹ If emergency services are authorized, the county must subsequently perform a complete needs assessment within 30 days after the date of application.²⁵²

1.2 Assessment before Discharge from a Hospital or Long Term Care Facility

Recipients who are currently residing in institutional settings like hospitals and skilled nursing facilities are eligible to apply for IHSS, but most services cannot begin until after they are discharged from the facility.²⁵³ Additionally, the county welfare department must conduct a preliminary needs assessment while the recipient is still in the facility so that services can begin immediately once the recipient is back home.²⁵⁴ Recipients living in institutional settings who wish to return home may need to advocate for themselves or contact a legal services provider in order to ensure the county fulfills its duty to conduct a preliminary assessment. The county will conduct a second needs assessment after the recipient returns home and may make adjustments in the authorized hours at that time.²⁵⁵

1.3 Frequency of Assessment

Generally, the needs assessment will be performed prior to the authorization of IHSS services and prior to the end of the 12th calendar month since the last assessment.²⁵⁶ However, the county may opt to extend the reassessment date by six months on a case-by-case basis.²⁵⁷ In order to extend the reassessment, the county must document that all the following conditions exist:

1. The recipient has had at least one reassessment since the initial intake assessment; and
2. The recipient's living arrangement has not changed, and either the recipient lives with others or has regular meaningful contact with someone other than the provider who is interested in the recipient's well-being; and
3. The recipient, the recipient's parent (if the recipient is a minor), or the recipient's conservator is able to satisfactorily direct his or her care; and
4. There has not been any known change in the recipient's needs for supportive services in the last 24 months; and
5. There have not been any reports or involvement of adult protective services in the case record since the last assessment; and
6. The recipient has not reported a change in provider in the previous six months; and
7. The recipient has not been hospitalized in the previous three months.²⁵⁸

In very limited circumstances the county may consider other factors, including involvement of a social services case manager or certification by a licensed health care professional that a recipient's condition is unlikely to change.²⁵⁹

1.4 Functional Impairments and Rankings

All counties use the same assessment tool in order to assess recipient need.²⁶⁰ This tool is used to rank the recipient's level of ability and dependence upon verbal or physical assistance by another person.²⁶¹ This assessment evaluates the effects of recipient's physical, cognitive, and emotional impairment on their functioning with respect to a specific type of service.²⁶² That level of functioning is quantified into a five-point scale. A rank of "1" in any service category means the recipient does not need that service.²⁶³

RANK 1: INDEPENDENT—The recipient is able to perform this function without human assistance. Although the recipient may have difficulty performing the function, the completion of the task, with or without a device or mobility aid, poses no substantial risk to the recipient’s safety.²⁶⁴ A recipient who ranks a “1” in any function shall not be authorized the correlated service activity.²⁶⁵

RANK 2: VERBAL ASSISTANCE NEEDED—The recipient is able to physically perform the task, but requires verbal assistance to do so. Verbal assistance includes reminding, guidance, or encouragement.²⁶⁶

RANK 3: SOME HUMAN ASSISTANCE NEEDED—The recipient requires some physical assistance with a task. This can include direct physical assistance from the provider.²⁶⁷

RANK 4: SUBSTANTIAL HUMAN ASSISTANCE NEEDED—The recipient can only perform the task with substantial human assistance from the provider.²⁶⁸

RANK 5: CANNOT PERFORM THE TASK—The recipient cannot perform that task with or without human assistance.²⁶⁹

When establishing the functional impairment, the county can look at a number of factors to make its determination.²⁷⁰ This can include the recipient’s diagnosis to the extent it provides information to substantiate functional impairment, the recipient’s actual capacity to perform tasks safely, and the mechanical aids and durable medical equipment (e.g., wheelchairs, hospital beds, etc.) used.²⁷¹

Only the following services or activities are evaluated using these numbered rankings:

1. Housework;
2. Laundry;
3. Shopping and errands;
4. Meal preparation and cleanup;
5. Mobility inside the home;
6. Bathing and grooming;
7. Dressing;
8. Bowel, bladder, and menstrual care;
9. Repositioning;
10. Eating;
11. Respiration;
12. Memory;
13. Orientation; and
14. Judgment.²⁷²

The first ten tasks are evaluated using the full five-point scale. The Respiration task can only be ranked as 1 or 5. Memory, Orientation, and Judgment can only be ranked as 1, 2, or 5.²⁷³ This is because including additional rankings within these particular tasks does not result in a significantly different need for human assistance.²⁷⁴

If a recipient is receiving a particular type of service that is met entirely through Paramedical Services, the corresponding service is ranked as a "1."²⁷⁵ For example, if a recipient has a pressure sore, the care for that sore will fall under Paramedical Services as skin and wound care, and the recipient would receive a "1" under the Rubbing Skin task. However, if the recipient requires additional repositioning and skin rubbing in addition to the care for the pressure sore, the county should not rank the need for Repositioning and Rubbing Skin Service as "1" because the recipient's entire need is not met through the Paramedical Service.

1.5 Hourly Task Guidelines

As noted above, the functional rankings are linked to a range of times for each task, referred to as the Hourly Task Guidelines, or HTGs. The guidelines serve the dual purpose of providing counties with a tool for "consistently and accurately assessing service needs and authorizing service hours to meet those needs."²⁷⁶ It is important to note, however, that despite the adoption of these standardized guidelines, the county is required to authorize hours "based on the recipient's individual level of need necessary to ensure his/her health, safety, and independence based on the scope of tasks identified for service."²⁷⁷ As such, the functional rankings are a contributing factor, but not the sole factor in determining the amount of time per task a recipient receives.²⁷⁸

The HTGs specify a specific range of time that is correlated with each task and each functional ranking.²⁷⁹ For example, if a recipient receives a functional ranking of "3" in Meal Preparation, meaning some human assistance is needed, the HTGs authorize the county social worker to approve between 3.5 and 7.0 hours per week.²⁸⁰ The recipient's individual needs should inform the social worker's decision of where in that range to set the final hours determination, or if the recipient's needs justify more or less time than the range.

In 2017, CDSS released guidance in an effort to standardize the county's use of the HTGs.²⁸¹ The stated purpose of the guidance is to clarify the IHSS assessment process including use of the HTGs, however, the new guidance has resulted in some confusion among county social workers, recipients, and advocates. Additionally, some recipients and advocates believe the new guidance has led to the incorrect reduction of IHSS hours. It is not completely clear what is causing the confusion, however, the guidance introduced a middle time range and linked the low, middle, and high hourly ranges to functional rankings. So, for example, if a social worker evaluates someone as a Rank 4 in preparation of meals and believes they have a "typical" level of need for someone in that rank they are directed to give them 6:08 hours per week.²⁸² For some recipients, this formula could represent an increase in time, but for others it could represent a decrease.

Despite the issuance of the new guidance, if a recipient's individual needs require more or less time to perform a specific task, the county social worker is authorized to set the hours outside of the guideline range.²⁸³ An exception can be granted if the social worker makes the determination

that the recipient requires more or fewer hours in order to establish and maintain an independent living arrangement or to remain safely in their own home.²⁸⁴ Making an exception should be considered a normal part of the authorization process.²⁸⁵ The social worker must document the reason for the exception in the case file.²⁸⁶ An exception to the HTGs cannot be used to increase a recipient's hours above the 195 hour limit for those who are non-severely impaired or the 283 hour limit for those who are severely impaired.²⁸⁷ For an explanation of the difference between severely and non-severely impaired, see section 2 of this chapter. An individual who needs more than the monthly hourly cap should consider seeking alternative services, such as applying for a Medi-Cal waiver that can provide additional personal care services through one of the Medi-Cal waiver programs, which are discussed in Chapter 3, section 5.

1.6 IHSS Hours and the State Budget

As the California economy has expanded and contracted over the last several years, the IHSS program has been targeted for significant budget cuts in the lean years. Two of these efforts have been focused squarely at reducing the hours awarded to recipients. In 2009, California attempted to reduce or terminate IHSS hours based on a recipient's functional index score. In 2011, California attempted to implement a 20% cut across the board to most recipients' IHSS hours, regardless of individual need. These attempts at reductions were halted by court orders in a lawsuit called *V.L. v. Wagner*, later renamed *Oster v. Lightbourne*.

The *V.L./Oster* case was combined with a separate case about IHSS provider wages, *Dominguez v. Lightbourne*, in which the state, unions, and consumer advocates agreed to a Settlement Agreement that meant that neither reduction went into effect as originally intended.²⁸⁸ The Settlement Agreement replaced the 20% cut in IHSS hours with a temporary 8% reduction in IHSS hours beginning July 1, 2013.²⁸⁹ It then reduced the 8% cut to a 7% beginning July 1, 2014. The Settlement Agreement also provided a path to restore the budget cuts as early as 2015. The Budget Act of 2015 restored the 7% reduction for fiscal year 2015-16.²⁹⁰ The Budget Act of 2016 extended that restoration of the 7% cuts until June 30, 2019.²⁹¹ As of April 2019, the restoration has not been made permanent, however, the Governor's January budget proposed restoring the cut in FY 2019-20. Advocates are continuing to push for a permanent restoration.

2. MONTHLY LIMITS

There are monthly limits on the total number of hours a recipient can receive. A recipient enrolled in the CFCO, IPO, and IHSS-R can receive no more than 283 hours per month if they are "severely impaired" and no more than 195 hours per month if they are "non-severely impaired."²⁹² Recipients enrolled in PCSP can receive no more than 283 hours per month regardless of the severity of the impairment.²⁹³

Recipients who are eligible for protective supervision are always given the maximum number of monthly hours, even if a county cuts their hours for some other IHSS service. Those who are considered non-severely impaired and receive protective supervision will be eligible for 195 hours of protective supervision, plus hours for other services, up to a maximum of 283 hours per month.

In order to be considered severely impaired, a recipient must have a total assessed need for 20 hours or more per week of service in one or more of the following areas: any personal care service, preparation of meals, meal cleanup when meal preparation and consumption of food are required, or paramedical services.²⁹⁴ Any recipient who does not meet these criteria is considered non-severely impaired.²⁹⁵ The determination about whether a recipient is severely or non-severely impaired for purposes of the IHSS program must be included in the recipient's needs assessment.²⁹⁶ Formerly, an asterisk next to the total assessed hours indicated that a recipient was severely impaired. Currently, the Notice of Action should contain that information, but it is not clear that it always does in a clear and understandable way.

A recipient who is severely impaired has the option to choose "advance payment."²⁹⁷ Advance payment is a payment for IHSS services that is sent directly to the recipient in advance of the service actually being provided.²⁹⁸ This payment option can provide greater flexibility for recipients and may speed up the provision of services. Only recipients in CFCO, IPO, and IHSS-R are eligible for advance payment.²⁹⁹ Recipients in PCSP are not eligible for advance payment.³⁰⁰ The county welfare department must inform eligible recipients of their right to choose advance payment.³⁰¹

Once a recipient has agreed to advance payment (also called advance pay), they are responsible for ensuring the provider is paid and that the time sheets are submitted at the end of each month to the county social services office.³⁰² The county should, however, assist recipients if they appear to have trouble managing advance pay.³⁰³ If a recipient fails to submit a reconciling time sheet within 45 days from the date of payment, there is a rebuttable presumption that the unreconciled amount is an overpayment.³⁰⁴ Additionally, if a recipient fails to use the direct advance pay for the purchase of authorized hours it will be deemed an overpayment and the recipient will be responsible for repaying the county.³⁰⁵ If a county attempts to withdraw advance pay from a recipient, the recipient should file for an administrative law hearing and request aid paid pending. Additionally, advocates should check the CDSS website because, as of February 2019, the Department is actively working on guidance regarding advance pay.

3. UNMET NEED

Despite statutory hour maximums, the State recognizes that an individual may need additional hours in order to live safely at home. Although these hours may not be authorized through the IHSS program, the counties are required to indicate on all Notices of Action and needs assessments the hours of unmet need for each recipient.³⁰⁶ Documented unmet need is "a recipient's total hours for non-Protective Supervision In-Home Supportive Services that are in excess of the statutory maximum."³⁰⁷

For example, if a recipient needs 12-hours per day (360 hours per month) of IHSS services, that individual will receive the maximum 283 hours per month and will have 77 hours per month of unmet need. When unmet need exists, the IHSS Case Management, Information and Payrolling System (CMIPS) will automatically prorate the difference between the documented unmet need and the maximum statutory hours across all authorized non-protective supervision services.³⁰⁸

Given the cap on the total number of hours available, recording unmet need may seem irrelevant. However, it is important for the county to document unmet need for two main reasons. First, if and when budget cuts and across-the-board hours reductions take effect, there may be language requiring the cuts to first come from unmet need. As discussed above in subsection 2.5, the *Oster* settlement and its implementing legislation codified that the mandatory 8% and 7% cuts were to be taken first from the documented unmet need.³⁰⁹ Using the example above where a recipient has 77 hours of documented unmet need, the practical importance of unmet need becomes clear—this recipient should not experience any actual reduction in hours received.

The second reason it is important to document unmet need is that the recipient may be entitled to additional assistance through an HCBS waiver program. For example, a recipient enrolled in IHSS through the PCSP program who needs additional hours may be eligible for a Medi-Cal waiver program administered through the Department of Health Care Services' In Home Operations Division that provides Waiver Personal Care Services.³¹⁰ Moreover, daily hours of incurred costs for unmet need are allowable as an expense to spend down a recipient's share-of-cost (SOC).³¹¹ Additional information about Waiver Personal Care Services and Medicaid waiver programs can be found in Chapter 3.

4. SHARED LIVING AND PRORATION

A shared living arrangement may affect a recipient's allocation of IHSS hours. A shared living arrangement, for purposes of IHSS, exists when one or more recipient(s) resides in the same living unit with one or more persons, unless the recipient is living only with an able and available spouse.³¹² For more information about able and available spouse, see section 4.3 below.

4.1 Proration

Proration is the process of determining the recipient's individual need when they live with other people. IHSS only pays for that recipient's share of services met in common with other household members. Domestic Services and Heavy Cleaning, Related Services, Protective Supervision, Teaching and Demonstration, and Yard Hazard Abatement (in certain circumstances) may be affected by a shared living arrangement.³¹³ Personal care services are never prorated.

Prorating Protective Supervision is different than proration of other services, such as meal preparation, clean-up, and other related or domestic services. For an in-depth explanation about how to prorate Protective Supervision when an IHSS provider provides Protective Supervision to two or more recipients living in the same house, see Disability Rights California's publication, "How to Prorate Protective Supervision" fact sheet.³¹⁴

4.2 Effects of Shared Living

If a recipient lives with a person **other** than an able and available spouse, the county will assess how the living arrangement affects the allocation of hours.³¹⁵ With regard to Domestic Services and Heavy Cleaning, the county will determine what areas of the living space are used solely by the recipient, what areas are used in common, and what areas are not used by the

recipient.³¹⁶ Once this determination is made, no need can be assessed for areas not used by the recipient.³¹⁷ For areas commonly used, the need will be prorated between all the members of the household.³¹⁸ For areas used solely by the recipient, the assessment shall be based on the individual need.³¹⁹

For example, if two unmarried people share a two-bedroom apartment and both have their own bedrooms and share all other living spaces equally, the county will assess the recipient's need for assistance in cleaning the recipient's bedroom, will assess no need and no hours for cleaning the roommate's bedroom, and will prorate the cleaning needs of the rest of the house by one-half since two people live there.

Related Services are similarly evaluated based on the extent to which the recipient's need for services is reduced by tasks being shared by the others living in the house.³²⁰ If the service is not being provided by a housemate, the assessment should only be based on the recipient's individual need.³²¹ This is an important point, because if a recipient lives in a home where tasks like meal preparation, meal cleanup, and laundry are not shared, the recipient's hours should not be prorated for those services.³²²

Generally, the need for Yard Hazard Abatement is not assessed in a shared living arrangement.³²³ However, if the housemates fall into one or more of the following categories, yard hazard abatement services can be provided: (1) the housemate is also an IHSS recipient who is unable to provide the service; (2) the housemate is physically or mentally unable to provide such services; (3) the housemates are children under the age of fourteen years old.³²⁴

A recipient's need for Personal Care Services, Paramedical Services, and Transportation Services must be assessed based on the recipient's individual need and cannot be prorated because of a shared living arrangement.³²⁵

4.3 Able and Available Spouse

Special rules apply when a spouse is able and available to assist a recipient. The special rules will apply instead of the general shared living arrangement rules explained above.³²⁶ These rules are based on the presumption that a spouse, if able and available, will typically help the recipient-spouse with certain tasks by virtue of being married to the recipient. A spouse is considered able unless they provide medical verification of their inability to perform these tasks.³²⁷ If the spouse is able, the county will determine if employment, health, or other unavoidable reasons make that spouse unavailable when a task must be performed.³²⁸

If a spouse is able and available to assist the recipient-spouse, the county will not pay for the spouse or any other provider to provide domestic services, related services, yard hazard abatement, teaching demonstration, or heavy cleaning.³²⁹ If a spouse is able, but not available, the county can pay for someone else to provide the services during the able spouse's absence for meal preparation, transportation, and protective supervision.³³⁰ For example, if a spouse works from 9:00-5:00 and the recipient-spouse needs assistance with meal preparation, the county can pay for someone else to provide these services during lunch, but would not pay for that assistance during dinnertime when the spouse is back at home.

An able and available spouse will be paid as a provider for providing Personal Care Services and Paramedical Services.³³¹ Additionally, if a spouse leaves full-employment or is prevented from seeking employment, they may be paid for providing protective supervision and transportation.³³² The net result of these rules may be significantly fewer hours assessed to a married recipient with an able and available spouse.

5. IN-DEPTH: PROTECTIVE SUPERVISION

As explained above, Protective Supervision is one of the services offered by the IHSS program.³³³ It consists of observing a recipient's behavior and intervening when appropriate to prevent injury or accident.³³⁴ Although in some respects Protective Supervision is simply another service offered by IHSS, it has its own criteria for evaluation and can be a challenging service for potentially eligible recipients to qualify for.

5.1 Adult Eligibility for Protective Supervision

IHSS recipients eligible for Protective Supervision are "non-self-directing, confused, mentally impaired, or mentally ill persons only."³³⁵ The county must find there is a need for 24-hour supervision in order for a recipient to stay in the home.³³⁶ Additionally, a health care professional must complete form SOC 821 (Social Services Form—Assessment of Need for Protective Supervision for IHSS Program)³³⁷ certifying the recipient's need for 24-hour protective supervision.³³⁸ The health care professional's certification is not sufficient by itself to authorize Protective Supervision.³³⁹ In determining the need for Protective Supervision, the county social worker will evaluate the recipient's memory, judgment, and orientation on the three-point scale described above in section 2.4.³⁴⁰ Recipients who are eligible for Protective Supervision always receive the maximum number of hours available: 195 for non-severely impaired and 283 for severely impaired.³⁴¹ In households with two or more individuals receiving protective supervision, the hours granted will be prorated if the need can be met in common.³⁴² The rules governing protective supervision proration are extremely complex and beyond the scope of this manual, but are explained in depth in Disability Rights California's "How to Prorate Protective Supervision."³⁴³

In order to be approved for Protective Supervision a recipient must have a mental impairment or illness **and** be non-self-directing.³⁴⁴ Two court cases, *Marshall v. McMahon*,³⁴⁵ and *Calderon v. Anderson*,³⁴⁶ make clear that mental impairment or mental illness alone are not sufficient for approval of protective supervision and that additional requirements must be met before a recipient qualifies.

For the purpose of Protective Supervision eligibility, non-self-direction is defined as "an inability, due to a mental impairment/mental illness, for individuals to assess danger and the risk of harm, and therefore, the individuals would most likely engage in potentially dangerous activities that may cause self-harm."³⁴⁷ It is important to note that a recipient need only have a *propensity* for self-harm, the county cannot require that the recipient actually self-harm before approving Protective Supervision.³⁴⁸ Indeed, a recipient who has received supervision in the past may have successfully avoided past harmful incidents.

One example of a potentially eligible recipient who has a mental impairment and is non-self-directing is a senior with dementia who wanders away from their home and doesn't know how to find their way back. The purpose of approving Protective Supervision in that case would be to make sure the senior does not wander outside and get lost or harm themselves. A diagnosis of dementia alone is not sufficient.

Another example of non-self-direction would be an adult with a cognitive impairment who turns on the stove or grabs a sharp object without realizing the danger of engaging in those activities. The purpose of approving Protective Supervision in that case would be to ensure the recipient doesn't accidentally engage in those types of harmful activities and to instead redirect the recipient to other activities. Again, a diagnosed cognitive impairment alone is not sufficient.

Additionally, the recipient must have the physical capacity to engage in self-harming behavior.³⁴⁹ If the recipient is unable to move independently and therefore cannot self-harm, protective supervision is not available. However, a recipient who uses a wheelchair or is bedridden may still be able to self-harm and should be evaluated for Protective Supervision based on individual needs.³⁵⁰ Moreover, modifications or restraints—such as locking the recipient in a room to prevent wandering—shall NOT be considered an appropriate modification.³⁵¹

Finally, the county must determine that the recipient needs to be observed 24 hours a day in order to safely remain at home.³⁵² A recipient or the person assisting them to apply for Protective Supervision must be prepared to show how the recipient will be observed 24 hours per day. Additionally, a recipient must fill out form SOC 825 (Protective Supervision 24-Hours-A-Day Coverage Plan).³⁵³ Due to the overall IHSS monthly limits on hours, Protective Supervision cannot be authorized for 24-hour-a-day care, so this need is typically met through a combination of services such as adult day health care, enrollment in a waiver program, and voluntary care during certain parts of the day.

In addition to these restrictions, Protective Supervision is not available in the following five situations:

1. For friendly visiting or social activities;
2. When the need is caused by a medical condition and the person needs medical supervision;
3. In anticipation of a medical emergency;
4. To control anti-social or aggressive behavior;
5. To guard against deliberate self-destructive behavior, such as suicide, or when an individual knowingly intended to harm themselves.³⁵⁴

All County Letter 15-25 provides numerous specific examples of situations where the recipient's behavior falls into one of the enumerated categories above.³⁵⁵ While theoretically these non-eligible categories may seem easily separated from the eligible categories, more complicated situations might blur these lines. For example, if a recipient suffers from both

physical and mental impairments, it may be necessary to carefully document how the mental impairment, not the physical impairment, is causing the need for Protective Supervision.

The case of *Norasingh v. Lightbourne* is instructive.³⁵⁶ In *Norasingh*, a recipient was receiving Protective Supervision until the county determined at reassessment that she was no longer eligible.³⁵⁷ Recipient Norasingh had both epileptic seizures and psychogenic seizures, which were uncontrolled and occurred frequently.³⁵⁸ The county terminated Protective Supervision because (among other reasons) it believed that the service had been improperly granted in anticipation of a medical emergency, not because of a mental illness or impairment.³⁵⁹ In remanding the case, the appeals court found that psychogenic seizures were a mental, not a physical impairment, and that Norasingh's IHSS provider was watching her to prevent injury and accident during these psychogenic seizures.³⁶⁰ As is clear from this example, the conditions underlying a need for protective supervision can be complex, and it may be necessary to guide health care professionals through the standard for protective supervision and to show the county social worker how the recipient's mental illness or impairment impacts the recipient's functional abilities to ensure the proper outcome for a recipient.

5.2 Protective Supervision and Children

Both children and adults are eligible for Protective Supervision. If a child has a mental impairment or mental illness, the county must assess the recipient's needs based on the child's individual need and using the same rules for protective supervision described above.³⁶¹ Protective Supervision cannot be authorized as a substitute for routine child care or supervision.³⁶²

As part of the assessment, the county will follow a four-step process to determine whether the child is eligible for protective supervision.³⁶³ These steps are based on the settlement agreement in *Garrett v. Anderson* and can be found in ACL 15-25.³⁶⁴

1. Is the minor non-self-directing due to the mental impairment or mental illness?
 - a. If no, the minor is not eligible for Protective Supervision.
 - b. If yes, go to question 2.
2. Is the minor likely to engage in potentially dangerous activities?
 - a. If no, the minor is not eligible for Protective Supervision.
 - b. If yes, go to question 3.
3. Does the minor need more supervision than a minor of comparable age who is not mentally impaired or mentally ill? More supervision can be more time, more intensity or both.
 - a. If no, the minor is not eligible for Protective Supervision.
 - b. If yes, go to question 4.
4. Does the minor need 24-hour-a-day supervision in order to remain at home safely?
 - a. If no, the minor is not eligible for Protective Supervision.
 - b. If yes, the minor qualifies if otherwise eligible.³⁶⁵

Although a child's age is a reference point for the county to compare other children of a similar age's abilities and limitations, it is improper to deny a child based solely on the child's age.³⁶⁶ Recognizing that further guidance is needed, CDSS has announced plans to release updated Protective Supervision regulations, however, no timeline for their release has been set.³⁶⁷

Given the complexities of Protective Supervision, Disability Rights California has another publication that may be useful entitled "In-Home Supportive Services Protective Supervision."³⁶⁸ This publication contains additional practical information about how to qualify and detailed instructions for obtaining a sample doctor's letter.

Chapter 4 Endnotes

- 240 Cal. Welf. & Inst. Code § 12300; California Dept. of Social Services Manual of Policies & Procedures (“MPP”) § 30-757 (Provides in-depth information about each service offered through the IHSS program).
- 241 Cal. Welf. & Inst. Code § 12300(a); MPP § 30-761.12.
- 242 For more information about Alternative Resources, see Chapter 2.
- 243 Cal. Welf. & Inst. Code § 12309(b).
- 244 MPP § 30-761.13.
- 245 MPP § 30-761.14.
- 246 MPP § 30-761.26.
- 247 MPP § 30-761.26.
- 248 MPP § 30-761.211.
- 249 MPP § 30-771.2 defines blindness as an individual who “has central visual acuity of 20/200 or less in the better eye with use of a correcting lens” or “is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.”
- 250 MPP § 30-755.11 states “a person is eligible for IHSS who is a California resident living in his/her own home, and who meets one of the following conditions: (1) currently receives SSI/SSP benefits; (2) meets all SSI/SSP eligibility criteria including income, but does not receive SSI/SSP benefits; (3) meets all SSI/SSP eligibility criteria, except for income in excess of SSI/SSP eligibility standards or immigration criteria, and meets applicable share of cost obligations; or (4) was once eligible for SSI/SSP benefits, but became ineligible because of engaging in substantial gainful activity, and meets all of the following conditions: (a) the individual was determined to be disabled in accordance with Title XVI of the Social Security Act, (b) the individual continues to have the physical or mental impairments which were the basis of the disability determination; (c) the individual requires assistance in one or more of the areas specified under the definition of “severely impaired individuals” in Section 30-753; and (d) the individual meets applicable share of cost obligations.
- 251 MPP § 30-759.8
- 252 Id.
- 253 MPP § 755.12. The only two services that can be authorized prior to a recipient’s return home are yard hazard abatement and heavy cleaning. These two services are authorized to ensure the recipient’s home is safe for their return.
- 254 Id.; All County Letter (“ACL”) 02-68 (August 30, 2002), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-68.pdf>; All County Information Notice (“ACIN”) I-43-06 (June 8, 2006), available at http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin06/pdf/I-43_06.pdf. ACIN I-43-06 was issued as a result of a Superior Court writ brought by Disability Rights California.
- 255 Id.
- 256 MPP § 30-761.2.

257 MPP § 30-761.215.

258 Id.

259 MPP § 30-761.216.

260 Cal. Welf. & Inst. Code § 12301.1(a); MPP § 30-760.2.

261 MPP § 30-756.1.

262 Id.

263 MPP § 30-756.11.

264 MPP § 30-756.11.

265 Id.

266 MPP § 30-756.12.

267 MPP § 30-756.13.

268 MPP § 30-756.14.

269 MPP § 30-756.15.

270 MPP § 30-756.3.

271 Id.

272 MPP § 30-756.2; MPP § 30-780(b).

273 MPP § 30-756.35.

274 Id.

275 MPP § 30-756.4

276 Cal. Welf. & Inst. Code § 12301.2; MPP § 30-757.1(a); ACIN I-82-17 (December 5, 2017), available at http://www.cdss.ca.gov/Portals/9/ACIN/2017/I-82_17.pdf?ver=2017-12-08-145619-190; ACL 06-34 (August 31, 2006), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl06/pdf/06-34.pdf>; ACIN I-06-34 Errata 2 (May 4, 2007), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl06/pdf/06-34E2.pdf>.

277 MPP § 30-757.1(a).

278 MPP § 30-757.1(a)(1).

279 Cal. Welf. & Inst. Code § 12301.2; MPP § 30-757.1(a).

280 MPP § 30-757-.131(a).

281 ACIN I-82-17 (December 5, 2017), available at http://www.cdss.ca.gov/Portals/9/ACIN/2017/I-82_17.pdf?ver=2017-12-08-145619-190.

282 Id.

283 MPP § 30-757.1(a).

284 MPP § 30-757.1(a)(3).

- 285 Id.
- 286 MPP § 30-757.1(a)(6).
- 287 MPP § 30-757.1(a)(4).
- 288 The entire Settlement Agreement can be found at ACIN I-18-13 (April 5, 2013), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acin/2013/I-18-13.pdf>.
- 289 The 8% reduction was codified as Welfare and Institutions Code § 12301.01. There was a 3.6% cut in effect so the Settlement Agreement added an additional 4.4% to the existing cut to make the full 8 percent reduction.
- 290 Item 5180-111-0001(6) of Section 2 of SB 97; All County Letter 15-57 (June 29, 2015), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-57.pdf>.
- 291 Health and Human Services Budget Summary pg. 4, available at <http://www.ebudget.ca.gov/2016-17/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>.
- 292 Cal. Welf. & Inst. Code §§ 12303.4(a); 12300(h)(3); MPP § 30-757.1(a)(4).
- 293 Cal. Welf. & Inst. Code § 14132.95(g); MPP § 30-780.2(b).
- 294 Cal. Welf. & Inst. Code § 12304; MPP § 30-701(s)(1).
- 295 Cal. Welf. & Inst. Code § 12303.4(a).
- 296 MPP § 30-761.271.
- 297 MPP § 30-769.731.
- 298 Cal. Welf. & Inst. Code § 12304(a); MPP § 30-701(d)(3).
- 299 Cal. Welf. & Inst. Code § 12304(a).
- 300 Cal. Welf. & Inst. Code § 14132.95(k)(2); MPP § 30-780.3(4). Although this may sound like an issue, if a recipient needs advance pay he or she is directed into one of the programs that allows for it.
- 301 ACIN I-29-18 (May 16, 2018), available at <http://www.cdss.ca.gov/Portals/9/ACIN/2018/ACIN%20I-29-18.pdf?ver=2018-05-17-141015-830>.
- 302 MPP § 30-769.737.
- 303 ACIN I-29-18 (May 16, 2018).
- 304 MPP § 30-768.213.
- 305 MPP § 30-768.21.
- 306 MPP § 30-761.274, ACL 13-66 (September 30, 2013), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-66.pdf>.
- 307 Only non-protective supervision services in excess of the statutory maximum are considered an unmet need. Protective supervision, which requires that a recipient have a 24-hour need for care, would by its own definition always result in unmet need. See MPP § 30-757.173; All County Letter 13-66 (September 30, 2013), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-66.pdf>.
- 308 Id.

- 309 Cal. Welf. & Inst. Code §§ 12301.01(a)(4) (8% reductions); 12301.02(a)(4) (7% reductions).
- 310 Cal. Welf. & Inst. Code § 14132.97; All County Letter 03-24 (May 20, 2003), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl03/pdf/03-24.pdf>.
- 311 The reduction may be applied either to meet the SOC in the month in which the expense was incurred or, if the beneficiary is still financially responsible for paying the expenses and the *Hunt v. Kizer* guidelines are met, in future months. Pursuant to the *Hunt v. Kizer* court order, individuals are allowed to apply medical bills from previous months (old medical bills) toward their current month's SOC provided these old medical bills were unpaid at the time they were submitted to the county. Individuals are allowed to use credit card or collection agency statements as evidence of medical expenses. 22 CCR § 5064. See also, ACWDL 15-02 (January 12, 2015), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2015/15-02.pdf>.
- 312 MPP § 30-701(s)(2).
- 313 MPP § 30-763.31-.34.
- 314 At <https://www.disabilityrightsca.org/publications/how-to-prorate-protective-supervision>. The referenced publication discusses proration of Protective Supervision only, not the other categories that must be prorated when a shared living arrangement exists.
- 315 MPP § 30-763-.3.
- 316 MPP § 30-763.31.
- 317 MPP § 30-763.312.
- 318 MPP § 30-763.313.
- 319 MPP § 30-763.314.
- 320 MPP § 30-763.321.
- 321 MPP § 30-763.322.
- 322 *Id.*
- 323 MPP § 30-763.352.
- 324 *Id.*
- 325 MPP § 30-763.351.
- 326 MPP § 30-763.4.
- 327 MPP § 30-763.411.
- 328 MPP § 30-763.412.
- 329 MPP § 30-763.413.
- 330 MPP § 30-763.414.
- 331 MPP § 30-763.415.
- 332 MPP § 30-763.416.
- 333 Cal. Welf. & Inst. Code § 12300(b).

- 334 MPP § 30-757.17.
- 335 MPP § 30-757.171.
- 336 MPP § 30-757.173(a).
- 337 SOC 821 can be found at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC821.PDF>.
- 338 Cal. Welf. & Inst. Code § 12301.21; MPP § 30-757.173(a)(1).
- 339 MPP § 30-757.173(a)(3).
- 340 MPP § 30-756.372.
- 341 Cal. Welf. & Inst. Code § 12303.4; ACIN I-27-11 (May 16, 2011), Attachment B for IHSS-R, PCSP, and IPO, available at http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2011/I-27_11.pdf; ACL 14-60 (August 29, 2014) for CFCO, available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>.
- 342 MPP § 30-763.33.
- 343 Disability Rights California, "How to Prorate Protective Supervision", available at <https://www.disabilityrightsca.org/publications/how-to-prorate-protective-supervision>.
- 344 MPP § 30-757.171; ACL 15-25 (March 19, 2015), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2015/15-25.pdf>.
- 345 *Marshall v. McMahan*, (1993) 17 Cal.App. 4th 1841.
- 346 *Calderon v. Anderson*, (1996) 45 Cal.App. 4th 607.
- 347 ACL 15-25 (March 19, 2015), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2015/15-25.pdf>.
- 348 *Id.*
- 349 *Calderon v. Anderson*, 45 Cal.App. 4th 607; All County Letter 15-25 (March 19, 2015).
- 350 ACL 15-25 (March 19, 2015).
- 351 ACL 17-95 (September 12, 2017), available at <http://www.cdss.ca.gov/Portals/9/ACL/2017/17-95.pdf?ver=2017-09-14-113431-017>.
- 352 MPP § 30-757.173.
- 353 SOC 825 can be found at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/soc825.pdf>.
- 354 MPP § 30-757.172.
- 355 ACL 15-25 (March 19, 2015).
- 356 *Norasingh v. Lightbourne*, (2014) 229 Cal. App. 4th 740.
- 357 *Id.* at 748.
- 358 *Id.* at 747.
- 359 *Id.* at 748.
- 360 *Id.* at 758.

- 361 Cal. Welf. & Inst. Code § 12300(d)(4); MPP § 30-763.456; ACL 98-87 (October 30, 1998), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl98/98-87.PDF>; ACL 15-25.
- 362 Id.
- 363 ACL 15-25 (March 19, 2015).
- 364 Id. See also, All County Letter 98-87 (October 30, 1998), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl98/98-87.PDF>.
- 365 ACL 15-25 (March 19, 2015).
- 366 ACL 98-87 (October 30, 1998), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl98/98-87.PDF>.
- 367 ACL 15-25 (March 19, 2015).
- 368 Disability Rights California, "In-Home Supportive Services Protective Supervision," (December 1, 2017), available at <https://www.disabilityrightsca.org/publications/in-home-supportive-services-protective-supervision>.

Chapter 5: Types of Services

This chapter will provide an in-depth look at the services available through the IHSS program.

1. TYPES OF SERVICES

There are nine different categories of services available through the IHSS program including: domestic, heavy cleaning, related services, personal care, accompaniment to medical appointments, yard hazard abatement, teaching and demonstration, paramedical services, and protective supervision.³⁶⁹ State law authorizes specific types of services within the categories of personal care and domestic and related services.³⁷⁰ A description of each category is provided below.

Not every IHSS recipient receives every type of service. The State intends for specific services to be offered in a uniform manner in every county based on an individual's need.³⁷¹ To this end, all counties are required to use a universal needs assessment tool.³⁷² A social worker will come to the recipient's home to do an assessment using this tool.³⁷³ Each applicant and recipient receives a functional ranking score, which is discussed in detail in the section titled "Hours and Need" below. The social worker's assessment will provide the basis for the types of services and the number of hours per service each recipient receives.

Each authorized service is allocated to recipients in tenths of an hour per week. This means that a recipient who is authorized for .8 hours per week of meal preparation is authorized for 48 minutes per week. In an effort to standardize the counties' allocation of hours to each recipient, state regulations authorize a range of hours for certain services and that range is linked to a recipient's functional ranking score.³⁷⁴ The range of hours authorized by these Hourly Task Guidelines (HTGs) is included with the description of each service and an explanation of how exceptions to the HTGs work. Additionally, Appendix B contains a chart of the specific services, functional ranks and HTGs.

1.1 Domestic Services

Domestic Services includes a wide variety of household chores and tasks such as: sweeping, vacuuming, and washing/waxing floors; washing kitchen counters and sinks; cleaning the bathroom; storing food and supplies; taking out garbage; dusting and picking up; cleaning oven and stove; cleaning and defrosting refrigerator; bringing in fuel for heating or cooking purposes from a fuel bin in the yard; changing bed linen; changing light bulbs, and wheelchair cleaning and changing/recharging wheelchair batteries.³⁷⁵ Domestic services are distinct from Related Services which are described below. Domestic Services are generally authorized for six hours per month and assessments are not typically individualized, however, if needed, a social worker can authorize an exception.³⁷⁶ In shared living arrangements, domestic services may be prorated.³⁷⁷ Proration is discussed in more detail in Chapter 4. Minors under the age of 18 are not eligible to receive Domestic Services.³⁷⁸

1.2 Heavy Cleaning

Heavy Cleaning includes thorough cleaning of the home to remove hazardous debris or dirt, such as throwing away large amounts of clutter into a dumpster.³⁷⁹ Heavy Cleaning can only be authorized at the time IHSS is initially granted or if a lapse of at least 12 months occurs.³⁸⁰ The social worker has the authority to approve this service if the recipient's living conditions present a threat to their safety or if the recipient is at risk of an eviction for failure to prepare their home for fumigation as required by statute or ordinance.³⁸¹

1.3 Related Services

Related Services includes the following services: laundry, shopping and errands, meal preparation, and meal clean-up. Each of these services is individually assessed and allotted a specific amount of time.

Laundry

Laundry includes such tasks as: gaining access to machines; sorting laundry; manipulating soap containers; reaching into machines; handling wet laundry; operating machine controls; hanging laundry to dry; folding and sorting laundry; mending and ironing.³⁸² Laundry Services can be authorized for 1.0 hour per household per week if there are laundry facilities in the home.³⁸³ CDSS guidance makes clear that providers are expected to perform other tasks for the recipient while clothes are washing and drying.³⁸⁴ If the laundry facilities are out of the home, services can be authorized for 1.5 hours per week per household.³⁸⁵ The county can authorize exceptions over the guideline range when needed, including if a recipient is incontinent.³⁸⁶

Meal Cleanup

Meal Cleanup includes such tasks as: loading and unloading dishwasher; washing, rinsing, and drying dishes, pots, pans, utensils, and culinary appliances and putting them away; storing/putting away leftover foods/liquids; wiping up tables, counters, stoves/ovens, and sinks; and washing/drying hands.³⁸⁷ Meal Cleanup can be authorized for between 1.17 and 3.5 hours per week, depending on the recipient's level of need.³⁸⁸ The county can authorize exceptions under and over the guideline range when needed.³⁸⁹ It is important to note that Meal Cleanup does not include general cleaning of the refrigerator, stove/oven, or counters and sinks. These services are assessed under Domestic Services.³⁹⁰

Meal Preparation

Meal Preparation includes such tasks as: planning menus; removing food from refrigerator or pantry; washing/drying hands before and after meal preparation; washing, peeling, and slicing vegetables; opening packages, cans and bags; measuring and mixing ingredients; lifting pots and pans; trimming meat; reheating food; cooking and safely operating stove; setting the table; serving the meals; puréeing food; and cutting the food into bite-size pieces.³⁹¹ Meal Preparation can be authorized for between 3.02 and 7.00 hours per week.³⁹² The county can authorize exceptions, under and over the guideline range when needed, including when a recipient needs food puréed or cut up into bite-sized pieces, or when they need more frequent meals.³⁹³

Restaurant Meal Allowance

Restaurant Meal Allowance, a direct cash benefit, may be provided when a recipient who has adequate cooking facilities at home, but whose disabilities prevent their use, chooses to receive a restaurant meal allowance in lieu of Meal Preparation, Meal Cleanup and Food Shopping.³⁹⁴ If a recipient doesn't have adequate cooking facilities, they will be referred to the SSI/SSP program.³⁹⁵ It is important to note that services under the PCSP do not include the RMA.³⁹⁶ If a recipient requires this service, they will be placed in a non-PCSP program, like CFCO or IHSS Plus Option (IPO).³⁹⁷

If an individual recipient chooses the Restaurant Meal Allowance, they will receive \$62 per month.³⁹⁸ A couple will receive \$124 per month.³⁹⁹ A recipient receiving the Restaurant Meal Allowance will have the amount they receive deducted from the statutory maximum service hours per month, which is determined by multiplying the statutory maximum hours of service by the county wage, subtracting the Restaurant Meal Allowance from this product and dividing the remainder by the county hourly wage rate.⁴⁰⁰ A recipient who receives a Restaurant Meal Allowance as part of their SSP grant cannot receive a Restaurant Meal Allowance from IHSS.⁴⁰¹

Shopping and Errands

Shopping and Errands includes such tasks as: compiling a grocery or shopping list; traveling to/from the store; bending, reaching, lifting, and managing cart or basket; identifying items needed; transferring items to home and putting items away; telephoning in and picking up prescriptions; and buying clothing.⁴⁰² Food shopping can be authorized for 1.0 hour per week per household⁴⁰³ and other shopping and errands for .5 hours per week per household.⁴⁰⁴ The county can authorize exceptions over the guideline range when needed.⁴⁰⁵ The county will not authorize additional time for the recipient to accompany the provider on these errands.⁴⁰⁶

1.4 Personal Care Services

Personal Care Services include the following activities: ambulation, bathing, oral hygiene, and grooming, routine bed bath, bowel and bladder care, dressing, repositioning, menstrual care, feeding, respiration assistance, assistance with prosthetic devices, and assistance with self-administration of medication.⁴⁰⁷ Not every recipient will need or receive every type of personal care service. Each of these services is individually assessed and allotted a specific amount of time. The county should consider universal precautions, like handwashing, when assessing time for personal care services.⁴⁰⁸ As with other services, exceptions over or under the HTGs can be approved if supported by the recipient's need.

Ambulation

Ambulation includes such tasks as: assisting the recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving and retrieving assistive devices, such as a cane, walker, or wheelchair, etc. and washing/drying hands before and after performing these tasks.⁴⁰⁹ Ambulation also includes assistance to/from the front door to the car (including getting in and out of the car) for medical

accompaniment and/or alternative resource travel.⁴¹⁰ Ambulation services can be authorized for between .58 and 3.50 hours depending on the severity of the recipient's needs.⁴¹¹

Bathing, Oral Hygiene, and Grooming

Bathing includes such tasks as: cleaning the body in a tub or shower; obtaining water/supplies and putting them away; turning on/off faucets and adjusting water temperature; assisting with getting in/out of tub or shower; assistance with reaching all parts of the body for washing, rinsing, drying, and applying lotion, powder, deodorant; and washing/drying hands.⁴¹²

Oral Hygiene includes such tasks as: applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.⁴¹³

Grooming includes such tasks as: combing/brushing hair; hair trimming when the recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care when these services are not assessed as "paramedical" services for the recipient; and washing/drying hands.⁴¹⁴

Bathing, Oral Hygiene and Grooming Services can be authorized for between .5 hours and 5.1 hours depending on the severity of the recipient's needs.⁴¹⁵ It is important to note that Bathing, Oral Hygiene, and Grooming do not include getting to and from the bathroom, which is assessed as mobility under Ambulation Services.⁴¹⁶

Routine Bed Bath

Routine Bed Bath includes such tasks as: cleaning basin or other materials used for bed sponge baths and putting them away; obtaining water and supplies; washing, rinsing, and drying body; applying lotion, powder, and deodorant; and washing/drying hands before and after bathing.⁴¹⁷ Routine Bed Bath Services can be authorized for between .5 hours and 3.5 hours per week depending on the severity of the recipient's needs.⁴¹⁸

Bowel and Bladder Care

Bowel and Bladder Care includes such tasks as: assisting with using, emptying, and cleaning bedpans/bedside commodes, urinals, ostomy, enema, and/or catheter receptacles; application of diapers; positioning for diaper changes; managing clothing; changing disposable barrier pads; putting on/taking off disposable gloves; wiping and cleaning recipient; assisting with getting on/off commode or toilet; and washing/drying hands.⁴¹⁹ Bowel and Bladder Care Services can be authorized for between .58 hours and 8.00 hours depending on the severity of the recipient's needs.⁴²⁰ It is important to note that Bowel and Bladder Care does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program, or colostomy irrigation. These tasks are assessed under Paramedical Services.⁴²¹

Care of and Assistance with Prosthetic Devices and Self-Administration of Medication

Care of and Assistance with Prosthetic Devices includes such tasks as: taking off/putting on, maintaining, and cleaning prosthetic devices, vision/hearing aids; and washing/drying hands before and after performing these tasks.⁴²²

Assistance with Self-Administration of Medication includes such tasks as: reminding the recipient to take prescribed and/or over-the-counter medications and setting up Medi-sets.⁴²³ Direct administration of medication, including injections are authorized under Paramedical Services.

Care of and Assistance with Prosthetic Devices and Self-Administration of Medication can each be authorized for between .47 hours and 1.12 hours per week.⁴²⁴ Functional rankings do not apply for this service.⁴²⁵ The county must consider a number of factors when determining time, including the amount and frequency of medication, special preparations required, number of prosthetic devices, the recipient's independence, and the recipient's behavior, both helpful and unhelpful.⁴²⁶

Dressing and Undressing

Dressing and Undressing includes tasks such as: washing/drying of hands; putting on/taking off, fastening/unfastening, buttoning and unbuttoning, zipping and unzipping, and tying and untying of garments, undergarments, corsets, elastic stockings, and braces; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.⁴²⁷ Dressing and Undressing Services can be authorized for between .56 hours and 3.50 hours per week.⁴²⁸

Feeding Services

Feeding Services include tasks such as: assisting with consumption of food and assurance of adequate fluid intake, which consists of eating or related assistance to recipients who cannot feed themselves or require other assistance with special devices in order to feed themselves or to drink adequate liquids.⁴²⁹ It includes assistance with reaching for, picking up, and grasping utensils and cup; cleaning face and hands; and washing/drying hands.⁴³⁰ Feeding Services can be authorized for between .7 hours and 9.33 hours per week.⁴³¹ It is important to note that Feeding Services do not include cutting food into bite-size pieces or puréeing foods, as these tasks are assessed in Meal Preparation Services.⁴³²

Menstrual Care Services

Menstrual Care Services include tasks such as: the external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes, using and/or disposing of barrier pads, managing clothing, wiping and cleaning, and washing/drying hands.⁴³³ In assessing Menstrual Care, it may be necessary to assess additional time in other service categories such as Laundry, Dressing, Domestic, Bathing, Oral Hygiene, and Grooming.⁴³⁴ Menstrual Care services can be authorized for between .28 hours and .80 hours per week.⁴³⁵

It is important to note that if a recipient wears diapers, time for menstrual care should not be necessary and any needed hours would be assessed as part of Bowel and Bladder Care.⁴³⁶

Repositioning/Rubbing Skin Services

Repositioning/Rubbing Skin Services include such tasks as: rubbing skin to promote circulation and/or prevent skin breakdown; turning in bed and other types of repositioning; and range of motion exercises when specific criteria are met.⁴³⁷ Those criteria include general supervision of exercises, which have been taught to the recipient and maintenance therapy when the specialized knowledge and judgment of a therapist is not needed.⁴³⁸ Repositioning and Rubbing Skin services can be authorized for between .75 hours and 2.80 hours per week.⁴³⁹

Repositioning and Rubbing Skin Services do not include care of pressure sores. Skin and wound care is assessed as part of Paramedical Services and the set up and monitoring of equipment for ultraviolet treatments of the pressure sores and/or application of medicated cream to the skin is assessed as part of Care and Assistance with Prosthetic Devices.⁴⁴⁰

Respiration Services

Respiration Services include such tasks as: assistance with self-administration of oxygen and cleaning oxygen equipment and IPBB (intermittent positive pressure breathing) machines.⁴⁴¹ All tasks approved under Respiration Services are limited to non-medical services.⁴⁴² There is no guideline range for Respiration services.

Transfer Services

Transfer Services include tasks such as: assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, coach, wheelchair, walker, or other assistive device generally occurring within the same room.⁴⁴³ Transfer services can be authorized for between .50 hours to 3.50 hours per week.⁴⁴⁴ It is important to note that Transfer Services do not include assistance on/off toilet, which is assessed as part of Bowel and Bladder Care.⁴⁴⁵ Changing position to prevent breakdown and promote circulation is assessed as Repositioning/Rubbing Skin.⁴⁴⁶

1.5 Paramedical Services

Paramedical Services include such tasks as: administration of medication, puncturing the skin, inserting a medical device into a body orifice, activities requiring sterile procedures and other activities requiring judgment based on training given by a licensed health care professional.⁴⁴⁷ The Manual of Policies and Procedures provides specific examples of tasks that can be administered as Paramedical Services, including: tracheostomy care and suctioning,⁴⁴⁸ tube feeding,⁴⁴⁹ skin and wound care,⁴⁵⁰ catheter insertion,⁴⁵¹ and ostomy irrigation and bowel program.⁴⁵² CDSS has issued proposed regulations related to paramedical services that may change some of the information in this manual. Advocates should check to confirm all cited information remains accurate.

Paramedical Services are skilled tasks, which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health.⁴⁵³ Unlike other IHSS services,

Paramedical Services are only provided when ordered by the recipient's licensed health care professional⁴⁵⁴ and performed under the health care professional's direction.⁴⁵⁵

The time for the needed Paramedical Services is based on the amount of time indicated by the health care professional.⁴⁵⁶ In order to authorize Paramedical Services, the county must have a signed and dated order from a licensed health care professional.⁴⁵⁷ The order must include a signed statement of informed consent saying that the individual has been informed of the potential risks arising from the receipt of the services.⁴⁵⁸ Once the needed documentation has been submitted to the county and the Paramedical Services are part of the approved IHSS tasks, the needed services are provided by the same provider who ordinarily provides IHSS and at the same rate of pay as regular IHSS services.⁴⁵⁹

PRACTICE TIP: We strongly advise recipients or their authorized representatives to contact their doctor directly and explain what they need—do not let the county take over and consult the doctor for the recipient. If the recipient has a specialist, they should be involved, rather than a primary care physician who may not understand what the specialist does for every paramedical service. It is important to confirm that the doctor has included enough time to complete an entire service, from preparation to clean-up, including record keeping—such as diabetes testing and administration of injections.

1.6 Protective Supervision

Protective Supervision is a distinct category of IHSS service. Unlike all the other services, which are task-based, Protective Supervision consists of observing recipient behavior and intervening as appropriate in order to safeguard the recipient against injury, hazard, or accident.⁴⁶⁰ It is only available for observing the behavior of non-self-directing, confused, mentally impaired, or mentally ill persons.⁴⁶¹ Because of the complexities of the rules, regulations, and case law surrounding Protective Supervision it is discussed more fully below in Chapter 4, Section 5.

1.7 Miscellaneous Services

Teaching and Demonstration Services

Teaching and Demonstration Services are provided by IHSS providers to enable recipients to perform for themselves services which they currently receive from IHSS.⁴⁶² Teaching and Demonstration Services are limited to instruction in those tasks covered under the domestic, related, personal care, and yard hazard abatement services categories.⁴⁶³ For example, if a recipient wants to learn how to do laundry and has the necessary skills to do so safely and effectively, time can be authorized for a provider to teach the recipient how to complete the task.⁴⁶⁴ However, Teaching and Demonstration Services shall be authorized for no more than three months and only when there is a reasonable expectation that there will be a reduction in the need for a specified IHSS service as a result of these services.⁴⁶⁵ This service is provided by a recipient's IHSS provider at the same rate of pay as all other services.⁴⁶⁶ Within seven months

after the completion of this task, a social worker will follow-up with the recipient to evaluate the results of the teaching and demonstration.⁴⁶⁷

Accompaniment to Medical Appointment and Alternative Resource Sites

Accompaniment to Medical Appointments and Alternative Resource Sites is an allowable service when the recipient requires the provider's assistance with other IHSS approved tasks in transit or at the destination.⁴⁶⁸ Services will not be authorized just to fill a transportation need.⁴⁶⁹ Medi-Cal offers a separate transportation benefit, non-emergency medical transportation, or NEMT. If a recipient is receiving that benefit for the same appointment, they are not eligible for IHSS accompaniment services.⁴⁷⁰

When a recipient is required to travel to a medical appointment and provider assistance is needed to accomplish the travel, providers may be eligible to receive payment for wait time associated with Medical Accompaniment.⁴⁷¹ There are two types of wait time: one compensable type referred to as Wait Time–On Duty, and one non-compensable type referred to as Wait Time–Off Duty.⁴⁷²

WAIT TIME—On Duty means periods of unpredictable periods of time, usually of short duration, during which a provider is unable to use the time effectively for their own purposes.⁴⁷³ During periods when the provider is using "Wait Time–On Duty," they may not be actively performing authorized services but cannot effectively use the time for their own purposes because they may be called on to start providing services at any time. A recipient should receive authorized hours as a part of their Medical Accompaniment hours and a provider must be paid for time they spend in "Wait Time–On Duty."⁴⁷⁴ An example of time spent in "Wait Time–On Duty" is when a provider accompanies a recipient to a primary care physician's appointment and the provider doesn't know if the appointment will take 10 minutes or 30 minutes and therefore cannot leave. Instead they must sit and wait until the recipient is finished with the appointment. The recipient should receive an allocation for that time (usually an average of how long the appointment normally takes), and the provider will be paid for that time.

WAIT TIME—Off Duty are periods during which the employee is completely relieved from duty and that are long enough to enable the provider to use the time effectively for their own purposes.⁴⁷⁵ These waiting periods are not a part of the recipient's IHSS authorized hours. The provider must be informed in advanced that they may leave the job and will not have to return to work until a specified time. For example, if a provider takes a recipient to a dialysis appointment and the provider knows that the recipient's appointment will take three hours then the provider may leave and go home, run their own errands, etc. For this type of appointment, the recipient will not receive an IHSS allotment of time and the provider will not be paid for waiting.

The county social workers are directed to assess recipients for wait time by phone or in person by asking how frequently they have medical or other health-related appointments, the purpose of the appointments, and if accompaniment by an IHSS provider is needed during travel to and from the facility.⁴⁷⁶

Yard Hazard Abatement

Yard Hazard Abatement is light work in the yard which may be authorized for removal of high grass or weeds, and rubbish when this constitutes a fire hazard.⁴⁷⁷ This service is also available for the removal of ice, snow, or other hazardous substances from entrances and essential walkways when access to the home is hazardous.⁴⁷⁸

Chapter 5 Endnotes

- 369 Cal. Welf. & Inst. Code § 12300; California Dept. of Social Services Manual of Policies & Procedures (“MPP”) § 30-757 (Provides in-depth information about each service offered through the IHSS program).
- 370 Id.
- 371 Cal. Welf. & Inst. Code § 12301.
- 372 Cal. Welf. & Inst. Code § 12309. See CDSS’s website for additional assessment tools: <http://www.cdss.ca.gov/inforesources/IHSS/Training-Academy>.
- 373 MPP § 30-761.13.
- 374 Cal. Welf. & Inst. Code § 12301.2; MPP § 30-757.1(a); MPP § 30-756.11-.115 provides the definitions for Rank 1 through Rank 5. Rank 1 is defined as “Independent: able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety. A recipient who ranks a “1” in any function shall be authorized the correlated service activity.” Rank 2 is defined as “Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement.” Rank 3 is defined as “Can perform the function with some human assistance, including but not limited to, direct physical assistance from a provider.” Rank 4 is defined as “Can perform a function but only with substantial human assistance.” Rank 5 is defined as “Cannot perform the function, with or without human assistance.” See also *V.L. v. Wagner*, 669 F.Supp.2d 1106 (N.D. Cal. 2009) (the ranks “have never before been used to determine IHSS eligibility.” Rather, “the purpose of the ranks was to help social workers determine with uniformity the number of hours of a particular service elderly and disabled individuals needed.”).
- 375 MPP § 30-757.11; 22 Cal. Code of Regs., tit. 22, § 51183(b)(1), also listed as MPP § 30-780.1(b)(1).
- 376 MPP § 30-757.11(k)(1); 22 Cal. Code of Regs., tit. 22, § 51183(b), also listed as MPP § 30-780.1(b).
- 377 MPP § 30-763.31.
- 378 MPP § 30-763.456.
- 379 MPP § 30-757.12; 22 Cal. Code of Regs., tit. 22, § 51183(b)(6), also listed as MPP § 30-780.1(b)(6).
- 380 MPP § 30-757.121.
- 381 Id.
- 382 MPP § 30-757.134; 22 Cal. Code of Regs., tit. 22, § 51183(b)(2), also listed as MPP § 30-780.1(b)(2).
- 383 MPP § 30-757.134(c); 22 Cal. Code of Regs., tit. 22, § 51183(b), also listed as MPP § 30-780.1(b).
- 384 MPP § 30-757.134(c)(1).
- 385 MPP § 30-757.134(d).
- 386 MPP § 30-757.134(e).
- 387 MPP § 30-757.132; 22 Cal. Code of Regs., tit. 22, § 51183(b)(4), also listed as MPP § 30-780.1(b)(4).
- 388 MPP § 30-757.132(b).
- 389 MPP § 30-757.132(d).

- 390 MPP § 30-757.132(a).
- 391 MPP § 30-757.131; 22 Cal. Code of Regs., tit. 22, § 51183(b)(4), also listed as MPP § 30-780.1(b)(4).
- 392 MPP § 30-757-131(a).
- 393 MPP § 30-757.131(c).
- 394 Cal. Welf. & Inst. Code § 12303.7; MPP § 30-757.133.
- 395 MPP § 30-757.133(a)(3).
- 396 All County Letter (“ACL”) 93-21 (March 16, 1993), pg. 2, available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl93/93-21.PDF>.
- 397 Id.; For more information on specific IHSS programs, see Chapter 1.
- 398 Cal. Welf. & Inst. Code § 123303.7; MPP § 30-757.133(1)(A).
- 399 Id.
- 400 MPP § 30-765.133.
- 401 MPP § 30-765.133(a)(3).
- 402 MPP § 30-757.135(c).
- 403 MPP § 30-757.135(b)(1).
- 404 MPP § 30-757.135(c)(1).
- 405 MPP § 30-757.135(d).
- 406 MPP § 30-757.135(a).
- 407 Cal. Welf. & Inst. Code § 12300(c); MPP § 30-757.14.
- 408 MPP § 30-757.1(a)(1)(A).
- 409 Cal. Welf. & Inst. Code § 12300(c)(1); MPP § 30-757.14(k); 22 Cal. Code of Regs., tit. 22, § 51183(a)(1), also listed as MPP § 30-780.1(a)(1).
- 410 Id. Alternative resource travel may be authorized when accompaniment is needed during necessary travel to alternative resource sites such as an adult day care or community resource center.
- 411 MPP § 30-757.14(k)(1).
- 412 MPP § 30-757.14(e)(1); MPP § 30-780.1(a)(2).
- 413 MPP § 30-757.14(e)(2).
- 414 MPP § 30-757.14(e)(3); 22 Cal. Code of Regs., tit. 22, § 51183(a)(2), also listed as MPP § 30-780.1(a)(2).
- 415 MPP § 30-757.14(e)(5).
- 416 MPP § 30-757.14(e)(4).
- 417 MPP § 30-757.14(d).
- 418 MPP § 30-757.14(d)(1).

- 419 MPP § 30-757.14(a); MPP § 30-780.1(a)(4).
- 420 MPP § 30-757.14(a)(2).
- 421 MPP § 30-757.14(a)(1).
- 422 MPP § 30-757.14(i).
- 423 MPP § 30-757.14(i)(1); 22 Cal. Code of Regs., tit. 22, § 51183(a)(7), also listed as MPP § 30-780.1(a)(7).
- 424 MPP § 30-757.14(i)(2).
- 425 MPP § 30-757.1(i)(2).
- 426 MPP § 30-757.1(i)(3) and (4).
- 427 MPP § 30-757.14(f); 22 Cal. Code of Regs., tit. 22, § 51183(a)(3), also listed as MPP § 30-780.1(a)(3).
- 428 MPP § 30-757.14(f)(1).
- 429 MPP § 30-757.14(c).
- 430 MPP § 30-757.14(c)(1); 22 Cal. Code of Regs., tit. 22, § 51183(a)(6), also listed as MPP § 30-780(a)(6).
- 431 MPP § 30-757.14(c)(3).
- 432 MPP § 30-757.14(c)(2).
- 433 MPP § 30-757.14(j); 22 Cal. Code of Regs. tit. 22, § 51183(a)(4), also listed as MPP § 30-780.1(a)(4).
- 434 MPP § 30-757.14(j)(1).
- 435 MPP § 30-757.14(j)(3).
- 436 MPP § 30-757.14(j)(2).
- 437 MPP § 30-757.14(g).
- 438 MPP § 30-757.14(g)(1)(2); 22 Cal. Code of Regs., tit. 22, § 51183(a)(5), also listed as MPP § 30-780.1(a)(5).
- 439 MPP § 30-757.14(g)(4).
- 440 MPP § 30-757.14(g)(3).
- 441 MPP § 30-757.14(b); 22 Cal. Code of Regs., tit. 22, § 51183(a)(8), also listed as MPP § 30-780.1(a)(8).
- 442 Id.
- 443 MPP § 30-757.14(h); 22 Cal. Code of Regs., tit. 22, § 51183(a)(5), also listed as MPP § 30-780.1(a)(5).
- 444 MPP § 30-757.14(h)(2).
- 445 MPP § 30-757.14(h)(1)(A).
- 446 MPP § 30-757.14(h)(1)(B).
- 447 Cal. Welf. & Inst. Code § 12300.1; MPP § 30-757.191(c); 22 Cal. Code of Regs., tit. 22, § 51183(a)(9), also listed as MPP 30-780.1(a)(9).
- 448 MPP § 30-756.42.

- 449 MPP § 30-756.41.
- 450 MPP § 30-780.1(a)(5).
- 451 MPP § 30-757.14(a)(1); MPP § 30-780.2(g).
- 452 Id.
- 453 MPP 30-757.191.
- 454 Cal. Welf. & Inst. Code § 12300.1; MPP § 30-757.192.
- 455 MPP § 30-757.193.
- 456 MPP § 30-757.194.
- 457 MPP § 30-757.196; MPP § 30-780.2(e). SOC 321 Request for Order and Consent – Paramedical Services can be found at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC321.pdf>.
- 458 Id.
- 459 MPP § 30-757.195.
- 460 MPP § 30-757.17.
- 461 MPP § 30-757.171.
- 462 Cal. Welf. & Inst. Code § 12300(b); MPP § 30-757.18.
- 463 MPP § 30-757.18.
- 464 See MPP § 30-757.182.
- 465 MPP §§ 30-757.183; 30-757.184. The reduction in cost must be at least equivalent to the cost of services provided for Teaching and Demonstration. The reduction in cost is equivalent if the full cost of service authorized under this category is recovered within six months after the conclusion of the training period.
- 466 MPP § 30-757.181.
- 467 MPP § 30-757.185.
- 468 Cal. Welf. & Inst. Code § 12300(b); MPP § 30-757.15; ACL 17-42 (June 23, 2017), available at <http://www.cdss.ca.gov/Portals/9/ACL/2017/17-42.pdf?ver=2017-06-26-111014-097>.
- 469 ACL 17-42 (June 23, 2017), available at <http://www.cdss.ca.gov/Portals/9/ACL/2017/17-42.pdf?ver=2017-06-26-111014-097>.
- 470 Id.
- 471 Cal. Welf. & Inst. Code § 12300(b); MPP § 30-757.15; 22 Cal. Code of Regs., tit. 22, § 51183(b)(5) also listed as MPP § 30-780.1(b)(5).
- 472 See 29 C.F.R. §§ 785.15-.16 (Federal regulations define two different types of wait time: “engaged to wait” and “waiting to be engaged.”); ACL 16-01 (January 7, 2016), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2016/16-01.pdf>.
- 473 29 C.F.R. § 785.15.
- 474 ACL 16-01 at 14.

- 475 See 29 C.F.R. § 785.16.
- 476 ACL 14-82 (November 25, 2014), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-82corrected.pdf>.
- 477 Cal. Welf. & Inst. Code § 12300(b); MPP § 30-757.16; 22 Cal. Code of Regs., tit. 22, § 51183(b)(7) also listed as MPP § 30-780.1(b)(7).
- 478 MPP § 30-757.16; 22 Cal. Code of Regs., tit. 22, § 51183(b)(7) also listed as MPP § 30-780.1(b)(7).

Chapter 6: IHSS Providers

There are approximately 509,000 individuals working as IHSS providers in 2019.⁴⁷⁹ These providers serve more than 540,000 IHSS recipients across California. About two thirds of IHSS providers are family members.⁴⁸⁰ Provider turnover is high in the IHSS program, with the Legislative Analyst's Office estimating it may be as high as 33%.⁴⁸¹ The overwhelming majority of homecare workers in California, which include IHSS providers, are women and people of color.⁴⁸²

As the IHSS program has become more administratively complex, so have rules surrounding provider employment. This chapter contains important information about the IHSS program for providers. There are five sections: (1) IHSS Provider Eligibility Criteria; (2) Selection, Hiring, and Termination; (3) Payment Issues, Including Share-Of-Cost; (4) Timesheets and Workweeks; and (5) Overtime, Exemptions, Travel Time, Wait Time and Violations.

1. IHSS PROVIDER ELIGIBILITY CRITERIA

An IHSS provider is someone who is paid to provide services to an IHSS recipient. IHSS recipients have the right to choose their provider. There are only two restrictions on who a recipient can choose to be a paid IHSS provider: (1) the individual must be eligible to work in the United States; and (2) the individual must pass a criminal background check conducted by the Department of Justice.⁴⁸³

Minors can work as IHSS providers subject to restrictions under California labor law.⁴⁸⁴ Even minors need to pass a background check in order to be eligible to work as an IHSS provider.⁴⁸⁵

1.1 Provider Enrollment Process and Timeline

A provider must complete the following four steps within 90 calendar days of initiating the enrollment process.⁴⁸⁶

1. Complete and sign the IHSS Program Provider Enrollment Form (SOC 426) and return it in-person to the County IHSS office or IHSS Public Authority.⁴⁸⁷ Applicants must report if they have been convicted of any Tier 1 or Tier 2 disqualifying crime(s) within the last ten years.⁴⁸⁸ Tier 1 and Tier 2 disqualifying crimes are described below. The information provided in SOC 426 will be verified by a criminal background check by the Department of Justice.⁴⁸⁹ When returning a completed form, the applicant provider must bring and allow the county to photocopy the following original documents:⁴⁹⁰
 - » A valid (unexpired) photo ID issued by a U.S. federal or state government agency or by a federally-recognized Native American or Alaskan Native tribal organization.⁴⁹¹
 - » An original Social Security card or a replacement card issued by the Social Security Administration (SSA).⁴⁹² Official correspondence from the SSA demonstrating that the individual's Social Security number may be accepted in lieu of the Social Security card.⁴⁹³

2. Be fingerprinted and undergo a criminal background check by the Department of Justice that will establish whether a prospective provider has been convicted of, or incarcerated following a conviction for, any Tier 1 or Tier 2 disqualifying crime(s) within the last ten years.⁴⁹⁴ The county will provide the form(s) and instructions for having fingerprints scanned and transmitted to the Department of Justice.⁴⁹⁵ The applicant provider bears the expense of the criminal background check.⁴⁹⁶
3. Attend an in-person IHSS Program Provider Orientation given by the county.⁴⁹⁷
4. Sign an IHSS Program Provider Enrollment Agreement (SOC 846) acknowledging that they understand and agree to the rules and requirements for being an IHSS provider.⁴⁹⁸

Tier 1 and Tier 2 Disqualifying Crimes

The criminal background check is used to determine whether an individual has been “convicted of, or incarcerated following a conviction for, any Tier 1 or Tier 2 disqualifying crime(s) within the last 10 years.”⁴⁹⁹ Tier 1 disqualifying crimes include fraud against a government health care or supportive services program,⁵⁰⁰ specified child abuse,⁵⁰¹ and abuse of an elder or dependent adult.⁵⁰² Anyone who has been convicted for a Tier 1 crime in the past ten years is not eligible to be a provider, even if the Tier 1 crime was expunged from their record.⁵⁰³

A complete list of Tier 2 crimes is available at all county IHSS offices and online.⁵⁰⁴ In general, Tier 2 disqualifying crimes include violent or serious felonies,⁵⁰⁵ sex crimes,⁵⁰⁶ and felony offenses for fraud against a public social services program.⁵⁰⁷ The Department of Social Services (CDSS) recently published All County Letter 19-14 further explaining Tier 2 crimes and when they are disqualifying.⁵⁰⁸ Under certain circumstances, applicants with a Tier 2 conviction may still be eligible.⁵⁰⁹ First, an individual recipient can grant a waiver to the prospective provider, which allows that provider to work for that one recipient. Alternatively, a prospective provider can apply directly to CDSS for a general exception. CDSS is in the process of promulgating regulations to explain the general exception process for waiving Tier 2 crimes. Additionally, SOC 847 contains additional information on exceptions to a Tier 2 conviction.⁵¹⁰

2. SELECTION, HIRING, AND TERMINATION

2.1 Finding a Provider

IHSS recipients are responsible for interviewing, hiring, and, if needed, firing their IHSS provider. Recipients may hire anyone who meets the IHSS provider enrollment requirements and can meet their needs. This can be a family member, friend, or someone referred from the Public Authority Registry. Each county maintains a database registry made up of IHSS providers who have already completed the program enrollment process. The contact information for the Public Authority in each county is available online.⁵¹¹ Recipients who cannot find a provider should contact the county IHSS office or Public Authority for assistance.

2.2 Interviewing a Provider

Before interviewing a provider, recipients should review their authorized services and know the hours they have been awarded for each service. If one provider cannot provide all of the services the recipient needs or is unavailable to work all of the authorized hours, the recipient may need to hire more than one provider. Recipients with specific needs, such as a special diet or assistance with transfers, should mention this during the interview. CDSS recommends first screening applicants through a telephone interview, meeting in person with the strongest candidates, and checking their references to get an idea of the kind of work they used to do, how long they were employed, their reliability, and their strengths and weaknesses.

There is a section on the CDSS website devoted to finding, hiring, and working with providers. Recipients can find fact sheets on a variety of topics, from selection and hiring to setting and maintaining boundaries with a provider. These fact sheets are available online.⁵¹²

2.3 Terminating a Provider

A recipient has the right to fire their provider for any reason as long as it is not discriminatory. In determining to fire a provider, a recipient should consider the severity of the problem or disagreement, whether it can be fixed, and the time it will take to find a new provider. For more information on deciding when to fire a provider is available at the CDSS website.⁵¹³

3. PAYMENT ISSUES, INCLUDING SHARE-OF-COST

3.1 IHSS and Medi-Cal Share of Cost

IHSS is a covered Medi-Cal benefit; therefore, financial eligibility for IHSS is established through the Medi-Cal determination process. IHSS recipients who are on a free Medi-Cal program have all IHSS hours paid for by the State. For more information on Medi-Cal programs, see Chapter 3.

IHSS recipients enrolled in Medi-Cal with a Share of Cost (SOC) must incur the amount of their SOC before Medi-Cal will pay for any services. This means that the state, before paying for IHSS, will apply any owed IHSS wages, to the recipient's SOC. This results in recipients with an SOC owing wages to their providers. Depending on how many IHSS hours the recipient is authorized, sometimes they owe the entire share of cost amount to the provider, and sometimes they owe less. Recipients may also pay down their share of cost by utilizing and paying for other Medi-Cal covered services unconnected to IHSS during the pay period.

Example 1—IHSS with a Share of Cost (SOC)

Juanita receives \$1,500 in monthly retirement income and has an \$880 SOC per month. Juanita is authorized for 150 hours of IHSS per month and her county pays \$12.50/hour. This means if her provider, Monica, works all her authorized hours, she will earn \$1,875/month. There are two pay periods per month so if Monica works 75 hours per pay period, she will earn \$937.50 for each pay period.

Because of Juanita’s share of cost, however, Monica’s first check may have as much as \$880 deducted from it. This means that the state would pay Monica \$57.50 and it will expect Juanita to pay the remaining \$880 of owed wages to Monica. At this point, Juanita has met her SOC for the month so all other medical expenses will be paid for and Monica’s second check will be paid in full. This cycle will repeat every month because share of cost is a per month cost.

Recipients who have a Medi-Cal SOC and their providers will receive an “Explanation of Share-of-Cost” letter that identifies the SOC amount to be paid that pay period. The SOC amount will also appear on their provider’s timesheet under “Share-of-Cost Liability.” The SOC amount may change each pay period, depending on whether the recipient has incurred their SOC for other medical expenses before the timesheet is processed each pay period. Additionally, recipients with more than one IHSS provider cannot choose to which provider the SOC amount will be incurred. Any unpaid SOC will be subtracted from the first IHSS provider’s timesheet that is processed by the county.

Example 2—IHSS with a Share of Cost (SOC) and Two Providers

Juanita has hired a second provider, Felix, because Monica only wants to work 100 hours per month. Felix agrees to work 50 hours per month. As in Example 1, a total of \$1,875 per month will be paid in IHSS wages between the two providers.

In January, Monica works 50 hours during the first pay period and Felix works 25 hours. Felix submits his timesheet first. Because of Juanita’s \$880 SOC, Felix will not be paid anything by the state for those 25 hours of work. Instead, Juanita will owe him \$312.50 ($\12.50×25). When Monica submits her timesheet for 50 hours, she will receive a check for \$57.50 from the state. Juanita will owe Monica \$567.50 ($\$880 - \312.50) in wages. Both Monica and Felix will be paid by the state for all their hours for their second pay period.

In February, Monica works 50 hours during the first pay period and Felix works 25 hours. Monica submits her timesheet first. Because of Juanita’s \$880 SOC, Monica will not be paid anything by the state for those 50 hours of work. Instead, Juanita will owe her \$625 ($50 \times \12.50). When Felix submits his timesheet for 25 hours, he will receive \$57.50 from the state. Juanita will owe Felix \$254.50 ($\$880 - \57.50) in wages.

Because a recipient’s SOC can result in unpaid wages to the provider for which the recipient is responsible, a recipient who has a SOC may have a difficult time keeping a provider. It is worthwhile to determine if the IHSS recipient is eligible or can make themselves eligible for a free Medi-Cal program. More information about IHSS and Medi-Cal SOC is available in Chapter 3. There are also explanatory handouts on CDSS’s website.⁵¹⁴

3.2 Advance Pay

The overwhelming majority of IHSS providers are paid in arrears from the State after they have worked their hours. However, there is an alternative. Advance Pay allows severely impaired IHSS recipients to receive an advanced payment for their monthly IHSS services to pay the provider(s) directly for their service.⁵¹⁵ Advance pay is optional and only available in the IHSS Residual (IHSS-R), IHSS Plus Option (IPO), and Community First Choice Option (CFCO) programs.⁵¹⁶

To be eligible for Advance Pay, the IHSS recipient must meet all of the following conditions:

1. Qualify as a “severely impaired individual” which means the recipient is authorized for 20 or more hours per week in one or more of the following areas: personal care services; preparation of meals; meal cleanup when preparation of meals and consumption of food are required; and paramedical services;⁵¹⁷ and
2. Are capable of handling their own financial and legal affairs;⁵¹⁸ and
3. Agree that the amount advanced cannot exceed the amount needed to pay for authorized IHSS service hours.⁵¹⁹

The Advance Pay recipient, or their legal guardian or conservator, must submit their provider’s semi-monthly timesheets to the appropriate county social services office.⁵²⁰ If the Advance Pay recipient does not submit the provider’s timesheets within 90 days from the date of payment, counties can remove the Advance Pay and change the recipient’s payment delivery method.⁵²¹

3.3 Paper Checks

Timesheets are processed at the CDSS timesheet processing facility in Chico, CA. After the timesheet is checked for accuracy, it is sent for further processing to a second facility in Roseville, CA. The Roseville facility sends a request to the State Controller, who then issues the paper check within two business days. Providers should receive their next timesheet around the same time as their paycheck.⁵²² For more information on submitting paper timesheets, see section 5.1.A of this chapter below.

3.4 Direct Deposit

Direct Deposit is another way for providers to receive their IHSS paychecks. With Direct Deposit, IHSS paychecks are deposited directly into the provider’s account at a bank, savings and loan, or credit union. Providers will also receive a Direct Deposit Remittance Advice that contains the same information as the Statement of Earnings (pay stub) they are currently receiving attached to the IHSS payroll check. In addition to the pay stub, providers will also receive a new timesheet for the next pay period. Direct Deposit is optional, has advantages over paper checks because it eliminates the possibility of checks being lost or stolen, and allows providers to be paid more quickly.⁵²³

All IHSS providers are eligible for Direct Deposit if they:

1. Have a checking or savings account; and
2. Are presently receiving paper checks twice a month; and
3. Have worked for the IHSS program for **at least 90 days**; and
4. Are not planning to send 100% of the funds deposited to their bank account to another bank outside the U.S.⁵²⁴

Providers are not eligible for Direct Deposit if they receive Advance Pay from their recipient. Additionally, providers must submit timesheets for each recipient promptly following the end of each pay period in order to remain eligible for Direct Deposit.⁵²⁵

To enroll in direct deposit, providers must complete form SOC 829 (Direct Deposit Enrollment/Change/Cancellation Form).⁵²⁶ They can also call the Direct Deposit Help Desk toll free at (866) 376-7066 and request that a form be sent to them. If a provider works for more than one recipient, they must fill out and submit a separate enrollment form for each recipient for whom they work and want their wages directly deposited.

It can take up to 60 days from the time a provider sends their enrollment form until the first Direct Deposit is made. Until then, providers will continue to receive paper checks by mail until the Direct Deposit account has been established.⁵²⁷

3.5 IHSS Payments and Federal Taxes for Certain Providers

On March 1, 2016, CDSS received a ruling from the IRS that IHSS wages received by IHSS providers who live in the same home with the recipient of those services are excluded from gross income for purposes of federal and state income tax.⁵²⁸ A live-in provider must fill out an SOC 2298 (In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) Live-In Self-Certification Form for Federal and State Tax Wage Exclusion) in order to receive this benefit.⁵²⁹ If the provider prefers to pay taxes out of their check, they do not have to file the self-certification form.

4. TIMESHEETS AND WORKSHEETS

4.1 Timesheets

Timesheets must be submitted two times per month in order to receive payment for providing IHSS services. The counties are required to train providers on how to properly complete timesheets as a part of their orientation.⁵³⁰

For payroll purposes, each month is divided into two payment periods.⁵³¹ The first pay period (also known as Part A) is for hours worked from the 1st to 15th of the month.⁵³² The second pay period (also known as Part B) is for hours worked from the 16th until the end of the month.⁵³³ The days on a timesheet are split up into workweeks.⁵³⁴ The workweek begins at 12:00 A.M. Sunday until 11:59 P.M. Saturday.⁵³⁵ Workweeks do not correspond to payment periods, which can make correctly submitting timesheets difficult.

PRACTICE TIP: It is strongly recommended that both the recipient and their provider use a calendar to track hours and minutes worked each day. Because of the complexities of calculating hours in the IHSS program, using a calendar to track time worked makes it easier to add up workweek hours, calculate overtime hours correctly, and ensure hours are billed to the proper pay period.⁵³⁶

Providers have the option to receive paper timesheets and submit their timesheets by mail or to enroll in the Electronic Timesheet System (ETS) and submit their timesheets electronically online.

If a provider chooses paper timesheets, they will receive two paper timesheets each month. The front of the timesheet contains the name of the provider and provider number, recipient's name and case number, program type (IHSS or WPCS), timesheet number, pay period, and remaining hours. Before filling out the timesheet, providers should confirm that all of the information is correct.

To avoid any unnecessary delays in payment, a provider should carefully follow the instructions listed on the front of the timesheet. Failure to follow instructions, such as entering time outside of the pay period or forgetting to sign the timesheet, can cause a delay in receiving your paycheck. Both the recipient and provider must sign the timesheet in order to receive payment. After it is completed and signed by both parties, cut the timesheet along the dotted line and mail it in the enclosed envelope.

Timesheets must be mailed on or after the end of the pay period or after the last day worked. For example, if you worked until October 31st, you must mail the timesheet on or after October 31st. Timesheets received before the last day worked will not be processed and payment will be delayed. It can take up to 10 calendar days for timesheets to be processed.

As of June 5, 2017, IHSS providers and recipients in all California counties have the option to submit and approve timesheets online using the new Electronic Timesheet Service (ETS).⁵³⁷ Use of electronic timesheets is optional and not required.⁵³⁸ ETS allows IHSS providers and recipients to do the following:

- Register and enroll to electronically submit and approve timesheets
- Enter time worked and submit timesheets
- Approve and/or reject electronically submitted timesheets
- View the previous three (3) months of timesheet history
- Stop electronic timesheets⁵³⁹

To register and begin using electronic timesheets, providers must create an account as a new user.⁵⁴⁰ Although ETS is an optional service, recipients **must enroll** in order to approve electronic timesheets for their providers. If the recipient does not enroll, the provider cannot use ETS to submit timesheets, but can still use the service to view timesheet history.⁵⁴¹

The CDSS website has a more complete overview of ETS, as well as information regarding registration for providers and recipients, time entry, and approving timesheets.⁵⁴²

5. OVERTIME, EXEMPTIONS, WAIT TIME, TRAVEL TIME AND VIOLATIONS

5.1 Overtime

In response to federal Department of Labor regulations, the state of California agreed to pay overtime for in-home care workers in the IHSS and Waiver Personal Care Services (WPCS) programs. As of February 1, 2016, IHSS providers will be paid overtime at a rate equal to one and one-half times the regular rate of hourly pay, when their time exceeds 40 hours per workweek.⁵⁴³

Example: If the IHSS wage is \$10/hour and the provider works 50 hours in one workweek, they will receive \$10/hour for 40 of those hours and \$15/hour for 10 hours.

If a provider works for more than one recipient, the combined total hours worked for all recipients will be used to calculate overtime.

Example: Provider works 25 hours for IHSS recipient #1 and 33 hours for IHSS recipient #2. Provider's total weekly hours are 58. Provider gets 18 hours per week of overtime.

The State has limited the amount of overtime a provider can work within a workweek. Providers who work for **one** consumer cannot work more than 70 hours and 45 minutes per workweek for IHSS and/or WPCS combined.⁵⁴⁴ Providers who work for **multiple** consumers cannot work more than 66 hours per workweek for IHSS and/or WPCS combined, unless they are approved for IHSS Exemption 1 or 2 (discussed further below).⁵⁴⁵

5.2 Overtime Exemptions

As of July 1, 2017, there are two IHSS overtime exemptions codified in California state law.⁵⁴⁶ The goal of these exemptions is to maintain continuity of care and ensure that IHSS recipients who are at risk of out-of-home placement can remain safely in their own homes. When granted, either exemption allows IHSS providers to work above the 66-hour workweek limit up to a maximum of 360 hours per month combined for all IHSS recipients they serve.⁵⁴⁷

During the assessment or reassessment, the county IHSS program will evaluate recipients and determine if circumstances indicate that their provider may be eligible for Exemption 1 or 2. The county will inform potentially qualifying recipients about the exemption(s) and the process by which a recipient or their provider may apply.⁵⁴⁸

Please note that even with an overtime exemption, the state will not pay a provider for more than 360 hours per month. This means that a provider cannot work more than 360 hours per month regardless of how many hours their recipient or recipients are approved for. If a recipient has a provider who cannot fulfill all their authorized hours because it would exceed 360 hours per month, that recipient must hire an additional IHSS provider to work the remaining hours.

Exemption 1 is available to providers who met all of the following conditions on or before January 31, 2016:

- Provide services to two or more IHSS recipients; and
- Live in the same home as all of the recipients for whom they provide services; and
- Are related biologically, by adoption, or as a foster caregiver, legal guardian, or conservator, to all of the recipients for whom they provide services as the recipients' parent, stepparent, foster or adoptive parent, grandparent, legal guardian, or conservator.⁵⁴⁹

Before Exemption 1 was codified in statute, CDSS sent a letter and form to providers who were identified as meeting the criteria so many eligible provider have received an exemption. However, if a provider meets all of the criteria above, they are still eligible to apply for an exemption. The application (SOC 2279 is available at CDSS's website.⁵⁵⁰ Providers can mail completed applications to:



CDSS – Adult Programs Division
744 P Street, M.S. 9-7-96
Sacramento, CA 95814

Exemption 2 is available to providers who work for two or more recipients who each meet at least ONE of the following conditions that puts the recipient at serious risk of out-of-home placement, if the services are not provided by that provider:

1. Has complex medical and/or behavioral needs that must be met by a provider who lives in the same home as the recipient; OR
2. Lives in a rural or remote area where available providers are limited, and as a result, the recipient is unable to hire another provider; OR
3. Is unable to hire another provider who speaks the same language as the recipient, and as a result, the recipient is unable to direct his or her own care.⁵⁵¹

Before Exemption 2 was codified in statute, CDSS required both the county and recipients to explore and exhaust all possible options for finding another provider to work within the recipient's authorized weekly and monthly hours.⁵⁵² This exhaustion requirement is no longer required and the county should no longer require it as part of its analysis. Instead, the county must consider any of the circumstances listed in 1-3 above that put the recipient at risk of out-of-home placement without an exemption.⁵⁵³ So while the recipient must still explore available options for hiring an additional provider, the county must help the recipient, if needed, and must consider prior documented attempts to find or utilize other providers.⁵⁵⁴ For more information, see Disability Rights California's "Recent Changes to In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) Workweek Exemptions for Providers (March 1, 2019)."⁵⁵⁵

CDSS was required to mail a written informational notice and Exemption 2 application to all providers of multiple recipients who may be eligible for Exemption 2 and to their respective recipients.⁵⁵⁶ The county is required to review all Exemption 2 applications and mail a written decision to the provider and recipients stating whether their application has been approved or denied within 30 days.⁵⁵⁷ If an Exemption 2 request is denied, the notification letter must state the reason for the denial and provide information on how to request an independent review by CDSS.⁵⁵⁸

When a request for Exemption 2 is denied, the provider or recipient can request an administrative review through the Exemption State Administrative Review (ESAR) process.⁵⁵⁹ Anyone seeking a review of an Exemption 2 denial must fill out and mail form SOC 2313 (Workweek Limits for Extraordinary Circumstances (Exemption 2) State Administrative Review Request Form). An ESAR may not be requested by telephone.⁵⁶⁰

SOC 2313 must be postmarked within 45 calendar days of the date of the Notice to Provider of Ineligibility for Exemption from the IHSS Program Workweek Limits for Extraordinary Circumstances (SOC 22123) and mailed to:



California Department of Social Services
Appeals, Administrative Review and Reimbursement Bureau
Attention: Exemption 2 State Administrative Review Unit
744 P Street, MS 9-12-04
Sacramento, CA 95814

Failure to submit a complete ESAR or submitting an untimely request (i.e. more than 45 calendar days from the denial notice), may be denied by the ESAR unit and cause an ESAR unit denial.⁵⁶¹

During the ESAR process, overtime violations will be suppressed regardless of the outcome of the ESAR review.⁵⁶² This means a provider cannot accrue another violation during the ESAR process. For more information about overtime violations, see Section 5.6 below. The ESAR Unit will send written notice to the provider and the recipients stating the telephone conference date and time, within ten (10) business days of the date the ESAR request was received, and confirm the telephone number that the ESAR Unit will use to contact the provider.⁵⁶³

PRACTICE TIP: Providers and recipients have a right to present additional information at or prior to the conference that substantiates their qualifications for an exemption. It is helpful to include letters from healthcare providers, family members, or friends explaining their observations or experience with how the recipients' health and/or safety is negatively impacted by the introduction of a different provider. If applicable, the additional information should also include documentation about past incidents where the recipient was harmed when their services could not be provided by their live-in caregiver.

Individuals who have submitted an ESAR can request more time to submit additional written documentation.⁵⁶⁴ The ESAR Unit will allow ten business days from the date of the review for the information to be sent via facsimile or mail (postmarked).⁵⁶⁵ If additional information is not submitted within ten business days, the ESAR Unit will make a decision based solely on the information it has obtained through the SOC 2313 (and any accompanying documentation), the telephone conference, and the county's documentation.

The ESAR Unit will make a final decision to either uphold or overturn the county's ineligibility determination, and will mail written notice to the provider, recipients, and the county within 20 business days of the telephone conference, unless additional time to submit information has been requested. If the county's decision is overturned (i.e. approved for Exemption 2), the ESAR Unit will process and approve the Exemption 2 request and the provider will be required to complete the Exemption from Workweek Limits for Extraordinary Circumstances Approved Exemption Provider Agreement (SOC 2308) to the county IHSS office. If the county's decision is upheld (i.e. denial of Exemption 2), providers will be informed that they must adhere to existing workweek limits and recipients will need to hire additional provider(s) to work additional authorized IHSS hours.⁵⁶⁶

5.3 Travel Time

Providers with multiple recipients may be eligible to be paid for travel time between two recipients on the same day. Travel time means the "time spent traveling directly from a location where authorized services...are provided to one recipient to another location where authorized services are to be provided to another recipient."⁵⁶⁷ Providers may not be paid for travel of more than seven hours per week,⁵⁶⁸ and travel time will not be deducted from the recipient's service hours.⁵⁶⁹ A provider cannot get paid for the travel time to and from his or her own home to any IHSS recipient's location.⁵⁷⁰ Providers of multiple recipients should complete form SOC 2255 (IHSS Program Provider Workweek & Travel Time Agreement) and submit it to the local IHSS office. This form must be completed in order for providers to be compensated for their travel time.⁵⁷¹

5.4 Medical Accompaniment and Wait Time

Providers can also be paid for time spent waiting at medical appointments.⁵⁷² This change went into effect on February 1, 2016, after the United States Department of Labor published its final rule related to the Fair Labor Standards Act for Domestic Services.⁵⁷³ In order to be paid for wait time, the provider must demonstrate that, while they are at a recipient's medical appointment, they are unable to leave because they cannot predict how long the recipient's appointment will take.⁵⁷⁴ This time is called "engaged to wait" or "Wait Time—On Duty."

However, providers cannot be paid for time spent "waiting to be engaged," otherwise known as "Wait Time—Off Duty."⁵⁷⁵ Off-duty wait time occurs when a provider does not have to perform work duties and may use the set time for their own purposes.⁵⁷⁶ Providers must be told in advance that they may leave the location and will not have to resume work until a specific time. For example, if a provider accompanies their recipient to a treatment that is scheduled to last

for three hours, the provider must be told that they do not have to wait, but must return in three hours to pick up the recipient. In this example, the provider is able to use that time for their own personal business and therefore would not be paid for that time.

If a recipient is authorized for medical accompaniment, the provider will be considered “off-duty” and will not be paid for any time spent waiting for the recipient, if all of the following conditions are met:

1. The amount of time the appointment will take is known in advance, which would allow the provider plenty of notice that they will not be needed to provide services during that time and which can then be used for their own purposes; and
2. The appointment is scheduled to last enough time for the provider to conduct personal business; and
3. The provider is not required to perform any other authorized service such as food shopping or other shopping/errands during the appointment time.⁵⁷⁷

If all of the above conditions are met, then the provider must be informed by the recipient that they do not have to work until a specified time when they must return to accompany the recipient home and will not be compensated for this time. If all of the above conditions are NOT met, the provider is considered “on-duty,” and must be paid for the time spent waiting for the recipient.⁵⁷⁸

5.5 Medical Accompaniment and Wait Time for Minors

While CDSS considers taking a child to a medical appointment part of the parent or parents’ “typical” responsibilities, in some circumstances, parents can be paid for time required to take their minor child to a medical appointment, and for wait time. Specifically, CDSS evaluates three criteria to determine whether accompaniment for a minor recipient is reimbursable: (1) the minor has an extraordinary assessment need; (2) the appointment must be with a licensed health care professional in a specialty care field; and (3) the minor must require IHSS services to or from the medical appointment. For more detailed information, see All County Letter 17-42.⁵⁷⁹

5.6 Overtime and Travel Time Violations

Providers can be penalized for failing to adhere to the overtime and travel time rules.⁵⁸⁰ If a provider submits a timesheet that reports hours above the workweek overtime limits or the travel time limits, the provider will incur a violation.⁵⁸¹ There are escalating consequences for each violation. First and second violations result in a written warning to the provider. A third violation results in a three-month suspension from work in the IHSS program and a fourth violation results in a one-year suspension from the IHSS program.⁵⁸² Providers are given an opportunity to cure one violation by reading training materials after the second violation. A provider can only accrue one violation per month even though there are two pay periods each month.

A violation accrues each time any of the following occurs:

- A provider works more than 40 hours in a workweek for a recipient without the recipient getting approval from the county when that recipient is authorized less than 40 hours in a workweek;
- A provider works more hours for his/her recipient than he/she is authorized for in a workweek, which causes the provider to work more overtime hours than normal that month;
- A provider works for multiple recipients and claims more than 66 hours in a workweek;
- More than seven (7) hours of travel time is claimed in a workweek.⁵⁸³

Given the seriousness of the penalties for violating the overtime and/or travel time rules, CDSS has created processes for counties to ensure violations are correctly determined.⁵⁸⁴ CDSS also has the ability to review county decisions. Providers seeking to challenge a violation decision at the county level should use form SOC 2272 (IHSS Program Notice to Provider of Right to Dispute Violation for Exceeding Workweek and/or Travel Time Limits).⁵⁸⁵

Additionally, if a provider disagrees with a county's decision to uphold a third or fourth violation, the provider has the right to appeal the decision to CDSS Adult Programs Division's Appeals Unit.⁵⁸⁶ To appeal a third or fourth level violation to the Appeals Unit, a provider must submit form SOC 2273 (IHSS Program State Administration Review Request of Third or Fourth Violation for Exceeding Workweek and/or Travel Time Limits).⁵⁸⁷ The appeal must be postmarked within 10 calendar days from the date on the SOC 2282 or 2284.⁵⁸⁸ CDSS Appeals Unit has 15 days to make its decision.⁵⁸⁹

For more information about the consequences for each violation, and tips on how to avoid them, CDSS has created timesheet violation learning modules.⁵⁹⁰

Chapter 6 Endnotes

- 479 California Department of Social Services, Local Assistance Estimate Methodologies, 2019-20 Governor's Budget, pg. 224, available at <http://www.cdss.ca.gov/Portals/9/ADM/FFPB/8.%20Updated%2019-20%20Est%20Meth.pdf?ver=2019-01-29-095833-243>.
- 480 Beck, *Just the Facts: California's In-Home Support Program*, Public Policy Institute of California, November 2015, available at: <https://www.ppic.org/publication/californias-in-home-support-program/>.
- 481 Thomason and Bernhardt, *California's Homecare Crisis: Raising Wages is Key to the Solution*, UC Berkeley Labor Center, November 2017, pg. 3, available at <http://laborcenter.berkeley.edu/pdf/2017/Californias-Homecare-Crisis.pdf>.
- 482 *Id.* at pg. 6.
- 483 See California Department of Social Services Manual of Policies and Procedures ("MPP") § 30-776.4.
- 484 All County Letter ("ACL") 19-14 (February 7, 2019), available at <http://www.cdss.ca.gov/Portals/9/ACL/2019/19-14-2.pdf?ver=2019-02-12-091252-203>.
- 485 *Id.*
- 486 MPP § 30-776.2. A complete copy of the four-step process is available online at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC847.pdf>.
- 487 MPP § 30-776.413. Blank copies of SOC 426 are available at the County IHSS Office, Public Authority, or online at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC426.PDF>.
- 488 MPP § 30-776.411(a).
- 489 MP § 30-776.411(6); *see also*, MPP § 30-776.411(l)(4).
- 490 MPP § 30-776.414.
- 491 MPP § 30-776.414(a),(b). Examples of acceptable identification include: a driver license or identification card issued by a state department of motor vehicles, U.S. passport, U.S. military identification card, or a Native American or Alaskan Native tribal identification card.
- 492 MPP § 30-776.414(b).
- 493 MPP § 30-776.414(b)(1).
- 494 MPP § 30-776.441; .44.
- 495 MPP § 30-776.53.
- 496 MPP § 30-776.442.
- 497 MPP § 30-776.42.
- 498 MPP § 30-776.43.
- 499 MPP § 30-776.441.
- 500 MPP § 30-701(t)(1)(A).

- 501 MPP § 30-701(t)(1)(B). Penal Code § 273a(a) includes “any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of that child to be injured, or willfully causes or permits that child to be placed in a situation where his or her person or health is endangered...”
- 502 MPP § 30-701(t)(1)(C). Penal Code § 368 includes “any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered...”
- 503 See MPP § 30-776.411(l)(4).
- 504 Available at http://www.cdss.ca.gov/agedblinddisabled/res/Tier2_Crimes.pdf.
- 505 MPP § 30-701(t)(2)(A).
- 506 MPP § 30-701(t)(2)(B).
- 507 MPP § 30-701(t)(2)(C). Felony offense for fraud is defined in WIC § 10980(c)(2) and 10980(g)(2).
- 508 All County Letter 19-14 (February 7, 2019), available at <http://www.cdss.ca.gov/Portals/9/ACL/2019/19-14-2.pdf?ver=2019-02-12-091252-203>.
- 509 *Id.*
- 510 SOC 847 is available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC847.pdf>.
- 511 Available at <https://capaihss.org/contact-us/contact-ihss-in-your-county/>.
- 512 Available at <http://www.cdss.ca.gov/inforesources/IHSS/Fact-Sheets>.
- 513 Available at http://www.cdss.ca.gov/agedblinddisabled/res/FactSheets/IHSS_Firing_a_Provider_Color.pdf.
- 514 See CDSS, IHSS Share-of-Cost, available at http://www.cdss.ca.gov/agedblinddisabled/res/FactSheets/IHSS_Share_of_Cost_Color.pdf; CDSS, IHSS Training Academy Share-of-Cost, available at <http://www.cdss.ca.gov/Portals/9/Documents/Share%20of%20Cost%20final-2.9.17.pdf?ver=2017-03-08-151828-303>.
- 515 Welf. & Inst. Code § 12304; MPP § 30-767.133.
- 516 42 C.F.R. § 441.545(b)(2) allows for advance payment of direct cash to individuals in the CFCO program. The CFCO program allows the Advance Pay recipient to further exercise their self-discretion by making a direct payment to their provider. CFCO also allows these recipients to exercise as much control as desired to select, train, supervise, schedule, determine duties, and fire an attendant care provider.
- 517 Welf. & Inst. Code § 12304(d); MPP § 30-701(s)(1).
- 518 Welf. & Inst. Code § 12304(a).
- 519 Welf. & Inst. Code § 12304(b).
- 520 MPP § 30-769.737.
- 521 MPP § 30-767.133.

522 See UDW, *How do I get my IHSS timesheet and paycheck*, available at <http://www.udwa.org/wp-content/uploads/2015/09/Timesheet-Handout.pdf>.

523 <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC831.pdf>.

524 *Id.*

525 *Id.*

526 SOC 829 Direct Deposit Enrollment/Change/Cancellation Form, available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC829.pdf>.

527 <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC831.pdf>.

528 Internal Revenue Code § 131; IRS Notice 2014-7, available at <http://www.cdss.ca.gov/cdssweb/entres/pdf/IRSNotice.pdf>. See also <http://www.cdss.ca.gov/inforesources/IHSS/Live-in-provider-self-certification>.

529 Available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2298.pdf>.

530 MPP § 30-776.431(c).

531 MPP § 30-701(p)(2).

532 *Id.*

533 *Id.*

534 Welf. & Inst. Code § 12300.4(a).

535 Welf. & Inst. Code § 12300.4(b)

536 A provider should use the information provided by SOC 2271, which explains the total number of authorized hours for their recipient and the maximum weekly hours to fill out a blank calendar to ensure they understand how many hours they may work each week. The provider can use this information to discuss their schedule with their recipient. SOC 2271 is available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2271.pdf>.

537 ACL 17-76 (July 14, 2017), available at <http://www.cdss.ca.gov/Portals/9/ACL/2017/17-76.pdf?ver=2017-07-17-131202-080>.

538 *Id.*, see also, <http://www.cdss.ca.gov/inforesources/IHSS-Providers/Resources/Timesheet-Information>.

539 ACL 17-76 at 2.

540 To register, providers should go to: <https://www.etimesheets.ihss.ca.gov>.

541 *Id.*

542 Available at: <http://www.cdss.ca.gov/inforesources/IHSS-Providers/Resources/Timesheet-Information>

543 All-County Letter 16-01 (January 7, 2016), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2016/16-01.pdf>.

544 Welf. & Inst. Code § 12300.4.

545 Welf. & Inst. Code §§ 12300.4(d)(3); 14132.99(d)(1)(B)(2).

546 Welf. & Inst. Code § 12300.4(d)(3).

547 Id.

548 Welf. & Inst. Code § 12300.4(d)(3)(C).

549 Welf. & Inst. Code § 12300.4(d)(3)(A).

550 Available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2279.pdf>.

551 Welf. & Inst. Code § 12300.4(d)(3)(B); ACL 18-31 (March 22, 2018), available at <http://www.cdss.ca.gov/Portals/9/ACL/2018/18-31.pdf>.

552 ACL 16-22 (April 1, 2016) at 3, available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-22.pdf>.

553 Welf. & Inst. Code §12300.4(d)(3)(E)(i).

554 ACL 18-31 (March 22, 2018), available at <http://www.cdss.ca.gov/Portals/9/ACL/2018/18-31.pdf?ver=2018-03-23-130932-073>.

555 Available at <https://www.disabilityrightsca.org/publications/recent-changes-to-in-home-supportive-services-ihss-and-waiver-personal-care-services>.

556 Welf. & Inst. Code §12300.4(d)(3)(D).

557 Welf. & Inst. Code §12300.4(d)(3)(E).

558 Welf. & Inst. Code §12300.4(d)(3)(E)(iii)(I).

559 ACL 18-58 (May 31, 2018), available at <http://www.cdss.ca.gov/Portals/9/ACL/2018/18-58F.pdf?ver=2018-10-16-135434-733>.

560 Id.

561 Id. at 4.

562 Id.

563 Id.

564 Id. at 5.

565 Id.

566 Id.

567 Welf. & Inst. Code §12300.4(f)(1); See also ACL 16-01 (January 7, 2016), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-01.pdf>.

568 Id.

569 Welf. & Inst. Code §12300.4(f)(4); ACL 16-01.

570 ACL 16-01 at 13.

571 Id. at 14.

572 Welf. & Inst. Code § 12301.24(a)(6); ACL 16-01 at 14.

573 Id.; ACL 16-01 at 2.

- 574 ACL 16-01 at 14-15.
- 575 ACL 16-01 at 15.
- 576 Id.
- 577 Id.
- 578 Id.
- 579 ACL 17-42 (June 23, 2017), available at: <http://www.cdss.ca.gov/Portals/9/ACL/2017/17-42.pdf?ver=2017-06-26-111014-097>.
- 580 Welf. & Inst. Code § 12300.4(b)(5); ACL 16-01; ACL 16-36 (April 21, 2016), available at: <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-36.pdf>.
- 581 Id.
- 582 See SOC 846 (11/15), pg. 4 for an explanation of consequences of each violation, available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC846.pdf>.
- 583 ACL 16-01.
- 584 ACL 16-44 (May 10, 2016), available at: <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-46.pdf>; ACL 16-44 (May 10, 2016), available at: <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-44.pdf>.
- 585 SOC 2272 (5/16), available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2272.pdf>.
- 586 Id.; ACL 16-46 (May 16, 2016), available at <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-46.pdf>.
- 587 SOC 2273 available at: <http://www.cdss.ca.gov/Portals/9/FMUForms/Q-T/SOC2273.pdf>.
- 588 ACL 16-46 at 9.
- 589 Id.
- 590 Available at: <http://www.cdss.ca.gov/inforesources/IHSS/IHSS-Providers/Resources/TimesheetTraining>.

Chapter 7: Post-Eligibility Issues

This chapter will provide an overview of post-eligibility IHSS issues. There are eight sections: (1) Annual Reassessments; (2) Change of Circumstance Reassessments; (3) Inter-County Transfers; (4) Overpayments; (5) Institutional Placement and its Effect on IHSS; (6) County Social Worker Issues; (7) Third Party Liability; and (8) Estate Recovery.

1. ANNUAL REASSESSMENTS

The county welfare department must generally conduct a reassessment of a recipient's need "prior to the end of the twelfth calendar month from the last face-to-face assessment."⁵⁹¹ The county may extend this reassessment to 18 months if the recipient meets specific criteria, which focuses on the stability of the recipient's circumstances.⁵⁹² This provision can be used to lessen the frequency of reassessments for some IHSS recipients. Conversely, the county may shorten the length of time between assessments if it has information that the recipient's need for IHSS is likely to decrease in less than 12 months.⁵⁹³ Recipients with disabilities or conditions that are expected to improve or decline within a year may find the county conducting more frequent assessments.

A recipient is **not** required to provide a new health care certification form (SOC 873) at each subsequent reassessment.⁵⁹⁴ However, if determined necessary, the county can request a new SOC 821 form (Assessment of Need for Protective Supervision for IHSS) from a recipient who receives protective supervision.⁵⁹⁵ The county may also request a new SOC 321 (Request for Order and Consent-Paramedical Services) if a recipient needs additional paramedical services that were not authorized by the previous form.⁵⁹⁶

If the county performs a reassessment before the twelfth calendar month, the time for the next reassessment shall be adjusted to the 12-month requirement.⁵⁹⁷ This means that if a recipient is normally assessed in January, but has a reassessment in April, the next annual reassessment should happen in April of the following year. This helps ensure that recipients are not constantly being reassessed especially after a change of circumstances reassessment or a reassessment ordered as part of a hearing decision or conditional withdrawal.

2. CHANGE OF CIRCUMSTANCE REASSESSMENTS

As discussed above, an IHSS recipient's eligibility for services is typically reassessed annually. However, when a recipient experiences a change of circumstances that requires an adjustment in their IHSS services, they have the right to request a reassessment at any time.⁵⁹⁸ A change of circumstances can relate to a change in a recipient's functional needs, living arrangement, or the severity of their condition or disability. A recipient is not required to submit a new health care certification form to show or verify a change of circumstances.⁵⁹⁹

Unfortunately, although the county is required to perform a reassessment, there is no fixed mandated timeline. However, if a recipient has requested a reassessment due to a change of circumstances and the county has failed to set a date for the in-home assessment or has delayed issuing the new Notice of Action, the recipient has the right to file for an administrative law judge hearing at any time.⁶⁰⁰ See Chapter 8 for more information about Hearings and Appeals.

It should be noted that a reassessment based on a change in circumstances does not guarantee additional hours. The social worker could find the recipient's needs have not changed in a way that affects their IHSS hours or could find that a decrease in hours is appropriate. If the reassessment does not result in an appropriate number of hours to ensure the recipient can remain safely at home, the recipient has the right to file for an administrative law judge hearing to challenge the reassessment.⁶⁰¹

3. INTER-COUNTY TRANSFERS

If a recipient moves from one county into another county, while enrolled in the IHSS program, their IHSS case will need to be transferred from the "transferring county" to the "receiving county."⁶⁰² The transferring county (i.e. the county of origin) is responsible for initiating the intercounty transfer once they have been informed of the recipient's move to a new county.⁶⁰³ The transferring county must send to the receiving county a notice of transfer⁶⁰⁴ and additional documents within 10 days of notification of the move.⁶⁰⁵

The receiving county is responsible for completing and returning the notification of transfer form within 30 days of receipt.⁶⁰⁶ The transferring county is responsible for following up if they have not received the form from the receiving county.⁶⁰⁷ This transition time is known as the transfer period.⁶⁰⁸ The transferring county is responsible for authorizing and funding services until the transfer period expires.⁶⁰⁹ The transfer period "shall end as soon as administratively possible but no later than the first day of the month following 30 calendar days after the notification of transfer form is sent to the receiving county or as allowed in Section 30-759.96."⁶¹⁰

The intercounty transfer shall not interrupt or cause an overlap of recipient's IHSS services.⁶¹¹ A recipient should continue to use their IHSS hours throughout the transfer period and their provider should continue to submit their timesheets for any work performed.

The receiving county is required to complete a face-to-face assessment with the recipient during the transfer period.⁶¹² This assessment can result in a change of hours for the recipient. The most likely reason for a change in the recipient's hours is the change in the living arrangement. For example, if a recipient lived alone in the transferring county, but is moving in with a roommate in the receiving county that could have an effect on their IHSS hours. Additionally, and sometimes more problematically, the receiving county can disagree with the transferring county's assessment of the recipient's needs.

PRACTICE TIP: It is important to scrutinize any decrease in hours to determine if the receiving county is inappropriately disregarding the assessments of the transferring county. The receiving county should not determine the recipient's hours as if they are a new applicant, but instead should only change hours if there has been a change in circumstances or a medical improvement.⁶¹³

4. OVERPAYMENTS

The state requires counties to respond to and resolve potential IHSS overpayments.⁶¹⁴ An IHSS overpayment is defined as the amount of aid paid by the Department of Social Services or the Department of Health Care Services to a provider or recipient in excess of the amount of services authorized or furnished.⁶¹⁵ Overpayments can be collected from the recipient or the provider based on who received the IHSS funds.⁶¹⁶

The specific rules governing overpayments are dependent on whether the IHSS program is funded through federal Medicaid dollars or through state and county only dollars. Approximately 99% of IHSS recipients receive IHSS linked to federal financial participation Medicaid. The state Medi-Cal regulations governing overpayments state that a potential overpayment occurs when:

- ❑ A beneficiary has been informed verbally **and** in writing about their responsibility to completely and accurately report changes that would affect eligibility or share of cost within 10 days;
- ❑ A beneficiary has completed and signed the appropriate paperwork and has, within their competence, done any of the following, which when considered in conjunction with other information available on the beneficiary's circumstances would result in ineligibility or an increased share of cost:
 - » Provided incorrect written or oral information;
 - » Failed to provide required information that affects eligibility or share of cost;
 - » Failed to report changes in circumstances that affect eligibility or share of cost.⁶¹⁷

In the IHSS program, an overpayment can occur because of an underlying issue with the beneficiary's Medi-Cal eligibility or because of an issue directly related to IHSS eligibility. In either situation, overpayments cannot be assessed if the beneficiary informed the county about a change in circumstances, but the county failed to make the change.⁶¹⁸

Overpayments in the IHSS-Residual (IHSS-R) program are not governed by Medicaid rules. Instead, the Department of Social Services has promulgated specific overpayment regulations.⁶¹⁹ An IHSS-R overpayment is defined as a "cash payment [that] was made for the purchase of IHSS or services were delivered in an amount to which the recipient was not entitled."⁶²⁰

Under no IHSS program will a payment made while a beneficiary is receiving aid paid pending an administrative law judge hearing be considered an overpayment.⁶²¹ This means a beneficiary can continue to use their IHSS services while waiting for their hearing without fear of having to

repay those costs if they lose. Once an administrative law judge has issued a decision, however, the recipient must abide by that decision unless it is overturned at a rehearing or by writ.

5. INSTITUTIONAL PLACEMENT AND ITS EFFECT ON IHSS

An individual cannot receive IHSS while in an out-of-home setting.⁶²² Out-of-home settings include acute care hospitals, skilled nursing facilities, intermediate care facilities, community care facilities, and board and care facilities.⁶²³

If an individual who is authorized to receive IHSS goes into an institutional setting, their overall eligibility for IHSS is not immediately affected. They should not, however, use services or sign a timesheet that authorizes payment for the days they stayed in the out-of-home setting. This is true even if the individual or the provider do not think the individual is receiving the necessary assistance with their personal care needs at the out-of-home setting.

Individuals who enter an out-of-home setting must inform the county welfare department of this change of circumstance within 10 days if it is material to their eligibility and level of need.⁶²⁴ The longer the stay in the out-of-home setting, the more likely it will affect an individual's eligibility for IHSS. For example, it is not necessary to inform the county welfare department about a three-day stay in the hospital, but becomes necessary if that three-day stay is followed by a month in a skilled nursing facility.

If an individual is moving out of their own home and into an out-of-home setting permanently, they will no longer be eligible for IHSS.⁶²⁵ However, if circumstances change and the individual can live safely at home again, the county must assess the individual's IHSS eligibility pursuant to the discharge rules.⁶²⁶ For more information on these rules, see Chapter 2.

6. COUNTY SOCIAL WORKER ISSUES

The IHSS program refers to its eligibility workers as county social workers. A county social worker is responsible for assessing an applicant's initial need for IHSS and for conducting reassessments for current recipients. There are times when an applicant or recipient may run into a problem or disagreement with their county social worker. Complaints about social worker behavior may not be adjudicated through the state hearing process.⁶²⁷

If a recipient believes they are being illegally discriminated against by their county social worker, they have three administrative complaint options:

1. The recipient can talk to their county welfare department's civil rights representative.⁶²⁸ The complainant must contact their county civil rights representative within 180 days from the date of the alleged discrimination and provide information about what type of discrimination occurred, the name of the social worker, and the facts surrounding the incident(s). If the representative fails to resolve the complaint in a satisfactory manner, the complainant can request an investigation. The county is required to investigate and provide the complainant with information about the resolution of the case.

2. The recipient can file a discrimination complaint through the California Department of Social Services by mail, email, fax, or phone.⁶²⁹ The CDSS website also provides links in 15 languages to ensure broad access to the complaint process.⁶³⁰
3. The recipient can file a federal discrimination complaint through the U.S. Department of Health and Human Services by sending a letter to:



U.S. Department of Health and Human Services
Office of Civil Rights
Western Region
90 Seventh Street, Suite 10-100
San Francisco, CA 94103.⁶³¹

If the individual's complaint does not involve discrimination, the individual should try to work through the county's administrative hierarchy. Although, there is no statewide legal right to change social workers, an applicant or recipient can still make that request to the county or ask to speak to the social worker's supervisor.

7. THIRD PARTY LIABILITY

County welfare departments are required to identify any third parties that have obligations to pay for supportive services similar to IHSS.⁶³² These third parties include but are not limited to: long-term care insurance, worker's compensation insurance, victim compensation program payments, and civil judgment/pending litigation.⁶³³ If the county determines that there is a potential source of third party liability, the county must make the appropriate referrals.⁶³⁴

8. ESTATE RECOVERY

California is required by federal law to seek estate recovery from certain Medi-Cal beneficiaries if they used specific Medi-Cal services.⁶³⁵ Prior to 2017, California's estate recovery law extended estate recovery to a wider array of Medi-Cal services than is required under federal law. However, this changed with the passage of SB 833 in 2016—for deaths that occur on or after January 1, 2017, California has conformed its estate recovery law to the minimum required by federal law.⁶³⁶

As a part of this change, receipt of IHSS services was exempted from estate recovery.⁶³⁷ This means that the State cannot seek to collect reimbursement for IHSS services provided during a person's life.⁶³⁸ Institutional long-term care and certain other home and community-based services are subject to estate recovery.⁶³⁹

An exploration of all the estate recovery rules is beyond the scope of this manual, however, CANHR (California Advocates for Nursing Home Reform) has created two helpful FAQs explaining the estate recovery rules in detail for those who died before January 1, 2017 and those who died on or after January 1, 2017.⁶⁴⁰

Chapter 7 Endnotes

- 591 Cal. Welf. and Inst. Code § 12301.1(b)(1); MPP § 30-761.212.
- 592 Cal. Welf. and Inst. Code § 12301.1(c); MPP § 30-761.215(a)-(h); see also MPP §§ 30-761.216, 30-761.217.
- 593 Cal. Welf. and Inst. Code § 12301.1(c)(3); MPP § 30-761.218.
- 594 MPP § 30-754.13.
- 595 Cal. Welf. and Inst. Code § 12301.21(c); MPP § 30-757.173(b); SOC 821, available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC821.PDF>.
- 596 SOC 321, available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC321.pdf>.
- 597 MPP § 30-761.212(a).
- 598 Cal. Welf. and Inst. Code § 12301.1(d); MPP § 30-761.219(a).
- 599 MPP § 30-754.13.
- 600 Cal. Welf. and Inst. Code § 10950; MPP § 22-003.1.
- 601 *Id.*
- 602 MPP § 30-701(i).
- 603 MPP § 30-759.9.
- 604 The California Welfare Director’s Association’s website has an intercounty transfer form that transferring counties can use, available at: <https://www.cwda.org/formguidelines/ihss-inter-county-transfer-form>.
- 605 MPP § 30-759.91. MPP § 30-759.911 specifies that the documents required in section 30-759.1 “include, but are not limited to, an application for In-Home Supportive Services (SOC 295, 10/90); the most recent IHSS assessment, an IHSS provider eligibility update, a personal care services program provider enrollment form (SOC 428, 5/90), if applicable; a paramedical authorization form (SOC 321, 10/88), if applicable; current NOAs, and any information pertaining to overpayments and fraud investigations, if applicable.” Please note that all the specific forms cited have more recent versions that must be used.
- 606 MPP § 30-759.93.
- 607 MPP § 30-759.931.
- 608 MPP § 30-701(i)(1)(C).
- 609 MPP § 30-759.921.
- 610 MPP § 30-701(i)(1)(D); Section 30-759.96 provides that the transferring county shall retain responsibility for a recipient’s IHSS case if they are actively appealing an adverse action by the transferring county.
- 611 MPP § 30-759.92.
- 612 MPP § 30-759.94.
- 613 MPP § 30-759.5.
- 614 Cal. Welf. & Inst. Code § 12305.71(c); MPP § 30-702.16.

- 615 Cal. Welf. & Inst. Code § 12305.8(b).
- 616 See Id.; Cal. Welf. & Inst. Code § 12305.83.
- 617 Cal. Code Regs., tit. 22, § 50781.
- 618 Id.
- 619 MPP § 30-768.
- 620 MPP § 30-768.11.
- 621 For IHSS-R, see MPP § 30-768.111; for all other IHSS programs, see MPP §§ 22-072; 22-073.
- 622 MPP § 30-701(o)(2).
- 623 MPP § 30-701(o)(1).
- 624 MPP § 30-760.14,.15.
- 625 MPP § 30-755.1.
- 626 MPP § 30-755.12.
- 627 MPP § 22-003.13.
- 628 CDSS, When and How to File a Discrimination Complaint, available at <http://www.cdss.ca.gov/Reporting/File-a-Complaint/Discrimination-Complaints>.
- 629 Id.
- 630 CDSS has links to English, Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Lao, Portuguese, Russian, Spanish, Tagalog, Ukrainian, and Vietnamese.
- 631 CDSS, When and How to File a Discrimination Complaint, available at <http://www.cdss.ca.gov/Reporting/File-a-Complaint/Discrimination-Complaints>.
- 632 Cal. Welf. & Inst. Code §§ 12300(d)(1)(employer responsibilities when IHSS is provided at places of employment); 12305.71(c)(1),(2)(general quality assurance responsibility to identify sources of third party liability).
- 633 MPP § 30-702.17.
- 634 Id.
- 635 42 U.S.C. § 1396p(b)(1).
- 636 Cal. Welf. & Inst. Code § 14009.5; DHCS has created a handout explaining the changes implemented because of SB 833, available at https://www.dhcs.ca.gov/services/Documents/Changes_to_Estate_Recovery_effective_January_1.pdf.
- 637 Id.
- 638 Id.
- 639 42 U.S.C. § 1396p(b)(1); Cal. Welf. & Inst. Code § 14009.5.
- 640 CANHR, Medi-Cal Recovery Frequently Asked Questions (FAQ), available at http://www.canhr.org/medcal/medcal_recoveryinfo.htm.

Chapter 8: Appeals and Hearings

IHSS recipients and applicants have the right to challenge a county's decision to deny, change, or terminate their IHSS benefits by filing an administrative appeal. This chapter provides information about IHSS administrative appeals and hearings. There are nine sections: (1) Appeals Basics; (2) Adequate Notice; (3) Deadlines; (4) Requesting a Hearing; (5) Authorized Representatives; (6) Before the Hearing; (7) Preparing for the Hearing; (8) At the Hearing; and (9) Decisions, Rehearings and Administrative Writs.

1. APPEALS BASICS

An individual has the right to an impartial hearing if they disagree with any action by the county relating to their IHSS benefits, including: a denial, reduction, or termination of services; if their application is not acted upon with reasonable promptness; if they were not awarded all of the hours they think they need; and if needed services, such as protective supervision, are not awarded.⁶⁴¹ An appeal is a formal request by an applicant or recipient for a third party adjudicator, specifically an administrative law judge (ALJ), to determine whether the county made the correct determination. If the county later agrees it made a mistake, or the ALJ finds that the county made the wrong decision, the county must correct its mistake.

An individual can appeal by phone, in person, or in writing. It is helpful to make the appeal in writing and keep a copy of the request.

The Department of Health Care Services has contracted with the California Department of Social Services to provide for state fair hearings.⁶⁴² The State Hearings Division (SHD) is responsible for the overall administration of the hearing process, including processing hearing requests and providing support.⁶⁴³ The SHD is a state agency overseen by the California Department of Social Services (CDSS).

Once an applicant or recipient requests a hearing, they are called a "claimant." The county social services agency (also known as the county welfare department or CWD) then assigns an Appeals Specialist from the county's appeals unit, which is a department within the CWD to the matter.⁶⁴⁴ Appeals Specialists are sometimes called Appeals Workers or county representatives. The Appeals Specialist represents the county and gathers information to prepare for the hearing, and should attempt to resolve the issue prior to a hearing.

If the Appeals Specialist is unable to resolve the issue with the claimant, then the claimant attends a hearing and presents their issues to the ALJ. The ALJ then issues a decision either agreeing with the claimant in whole or in part, or upholding the county action. However, the Director of CDSS has the authority to set aside, or overturn, the ALJ's ruling.⁶⁴⁵ If the recipient is unhappy with the ALJ or the Director's decision, they can file for a rehearing,⁶⁴⁶ or file an Administrative Writ in Superior Court.⁶⁴⁷ Both rehearings and writs are discussed in more detail in section 9 of this chapter.

2. ADEQUATE NOTICE

The County must send adequate notice in the form of a Notice of Action (NOA) to tell a recipient when there is a change in their IHSS services.⁶⁴⁸ The notice must include the following:

- The action the county intends to take;
- The reasons for that action;
- The specific regulations supporting the action;
- An explanation of the right to request a hearing, and, if appropriate;
- The circumstances under which aid will be continued if a hearing is requested (this is also called "Aid Paid Pending," which is discussed later in Section 3).⁶⁴⁹

In addition, the notice must also tell the claimant what, if any, information the county still needs, and what the claimant must do to reestablish eligibility for IHSS or to determine the correct number of IHSS hours for a claimant.⁶⁵⁰

The NOA must also be written in the primary language of the recipient, if the language is listed in the translated forms on the CDSS website.⁶⁵¹ This is known as a "language compliant" notice. If CDSS cannot provide a NOA written in the claimant's primary language, the county must offer and provide interpretive services for the NOA if: (1) the claimant tells the county that they need an interpreter within 90 days of the date on the NOA, or (2) the claimant already told the county that they wanted notices in their primary language and tells the county within 90 days of the date on the NOA.⁶⁵²

A NOA is considered "timely," if it is mailed at least 10 days before the effective date of the action.⁶⁵³ The 10 days does not include the date of mailing or the date that the action is to take effect.⁶⁵⁴ The "effective date" is the date that the changes in IHSS services will take effect. For example, if an action will be effective on November 1, then a timely notice must be sent by October 20.

If the county does not send adequate notice, the recipient can still file an appeal. Once an appeal is filed, the claimant can explain the NOA's deficiency to the Appeals Specialist and, if necessary, the ALJ at the hearing.⁶⁵⁵ The Appeals Specialist and the ALJ will then look at the NOA and determine whether it meets the requirements for adequate notice. If the ALJ finds that adequate notice was required but not provided, and the case involves a termination or reduction of IHSS hours, then the county must restore the services back to the effective date on the NOA pending a hearing decision.⁶⁵⁶ If the notice is defective, the claimant can agree either to postpone the hearing until the county sends a proper NOA, or go ahead with the hearing without requesting proper notice.⁶⁵⁷ If the ALJ determines that adequate and language compliant notice was provided, then the claimant must go ahead with the hearing, or the case will be dismissed.⁶⁵⁸

PRACTICE TIP: Inadequate notice should be raised as a violation of the claimant’s due process rights, although practically speaking, it will most likely not have any effect on the substantive decision. However, claimants may also raise the issue of inadequate notice to prevent the county from raising issues at the hearing that were not contained in the notice. In addition, if it is determined that adequate notice was not provided, the county must rescind the notice and send a new one, and the claimant’s deadline for aid paid pending will be extended.

3. APPEALS DEADLINES

Generally an appeal, also called a hearing request, must be filed within 90 calendar days after an adequate and language-compliant NOA was mailed by the county or given to the claimant.⁶⁵⁹ If adequate notice or language-compliant notice was not provided, any hearing request will be accepted, even if it is made later than 90 days after the date the NOA was mailed by the county or given to the claimant.⁶⁶⁰ Recipients should consider saving the envelope that the notice was mailed in because sometimes there is a significant difference between the date on the notice and the postmarked date.⁶⁶¹

A recipient can request a hearing after the 90-day deadline has expired if good cause exists.⁶⁶² Good cause means “a substantial and compelling reason beyond the claimant’s control,” and considers the length of the delay, the diligence of the claimant making the request, and the potential prejudice to the other party.⁶⁶³ The recipient or applicant’s inability to understand an adequate and language-compliant notice, in and of itself, does not constitute good cause.⁶⁶⁴ However, it is important to determine whether an individual’s disability affected their ability to understand the notice and raise that issue, if relevant. A claimant filing a hearing request after the 90-day deadline with good cause must request the hearing within 180 days after the NOA was mailed by the county or given to the claimant.⁶⁶⁵

If the claimant is already receiving IHSS services, the request for appeal must be filed **before** the Notice of Action is effective to maintain their benefits while waiting for a hearing. If the request is filed within this period, their benefits will not change until there is a hearing and a decision is issued.⁶⁶⁶ This is known as “aid paid pending.” If the hearing request is filed after the effective date, then the claimant will not continue receiving the same benefits while they wait for a hearing and decision. If the claimant withdraws or abandons⁶⁶⁷ their hearing request, then aid paid pending ends.

If the recipient believes they have not been granted enough IHSS hours, they may challenge the county’s decision at any time. This can be useful if a recipient didn’t file an appeal at the time of a notice.⁶⁶⁸ However, the ALJ may only review the 90-day period prior to the hearing request.⁶⁶⁹ For example, if a claimant’s hours are reduced on January 1 and they file a hearing request on June 1 challenging that county decision, the ALJ may only consider retroactive restoration of the hours for March, April, and May. The claimant would not be able to restore hours for January and February.

4. REQUESTING A HEARING

A claimant can make a hearing request over the phone, in person, or in writing.⁶⁷⁰ If requesting a hearing in writing, the request can take any form, including completing the form on the back of the NOA, submitting a request online, or writing a letter.⁶⁷¹ The claimant can request assistance from the county in filling out the hearing request.⁶⁷² Although some counties accept hearing requests, it is generally best practice to send a hearing request directly to the State Hearing Division.⁶⁷³ Written hearing requests can be faxed to (916) 651-5210 or (916) 651-2789, or mailed to the following address:



California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, California 94244-2430

Written hearing requests should include the claimant's full name, address, telephone number, the name of the county involved, and an explanation of why a hearing is being requested. If a claimant requires a hearing over the phone or in their home,⁶⁷⁴ or needs an interpreter at the hearing, they can include that information in their written request.⁶⁷⁵ If asked, the county must provide a duplicate copy of the NOA if the back of that form is used to request a hearing.⁶⁷⁶ A copy of the hearing request should be kept for the claimant's records.

If requesting a hearing by phone, the claimant can call (855) 743-8525 or (855) 795-0634.⁶⁷⁷ For claimants with hearing impairments, the TDD number is (800) 952-8349. To request a hearing online, use this website: <https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx>.

After submitting a hearing request, claimants will receive two notices from the SHD. The first notice is a confirmation of the request for a hearing. The second notice will be mailed to both the claimant and the county and will contain the date, time, and place of the hearing and must be sent at least 10 days prior to the hearing.⁶⁷⁸ However, both parties can agree to a shorter time period for notice.⁶⁷⁹ If either the claimant or the county does not receive notice of the hearing at least 10 days prior to the hearing date, the hearing can be postponed if the claimant requests a postponement.⁶⁸⁰

PRACTICE TIP: Claimants sometimes receive notices of action reinstating benefits, which essentially reflect that they are receiving aid paid pending a hearing. Claimants should not assume that this notice means the appeal has been resolved. If a claimant is unsure why their benefits have been restored, they should call the county appeals specialist working on their case and inquire.

Claimants may also request an expedited hearing for urgent issues. Expedited hearings are scheduled 10 working days from the date the claimant's request for expedited hearing is received when the Presiding Judge finds it necessary to have an expedited hearing.⁶⁸¹ For expedited hearings, the ALJ must issue a decision within five working days from the date the record is closed.⁶⁸²

5. AUTHORIZED REPRESENTATIVES

The claimant may authorize a person or organization to communicate with the Appeals Specialist and to represent them at the hearing.⁶⁸³ The claimant can choose to authorize a lawyer, a friend, an advocate, or a family member. To do so, the claimant must sign and date an authorized representative form or a statement saying they are authorizing someone to act on their behalf.⁶⁸⁴

If a claimant has a conservator or has appointed an attorney-in-fact or agent through a durable power of attorney that individual can act as the authorized representative or appoint someone else to act on the claimant's behalf.⁶⁸⁵

A claimant may also appoint an authorized representative at their hearing by telling the ALJ that the person is authorized to represent them.⁶⁸⁶ An authorized representative may represent the claimant at a hearing even if the claimant is not at the hearing and they do not have a signed authorization, as long as the ALJ determines that the claimant wishes to proceed with the hearing and an amended authorization is submitted after the hearing.⁶⁸⁷

If the claimant has not authorized a representative in writing and is not present at the hearing, an individual may still act as the authorized representative if: (1) the person is an attorney, and (2) the attorney states on the hearing record that the claimant is mentally competent and has authorized the attorney to act as the authorized representative regarding the issues at the hearing.⁶⁸⁸ If the person is not an attorney, they may still act as an authorized representative if they affirm that (1) the claimant is mentally competent, and (2) the claimant has authorized them to act as the claimant's authorized representative.⁶⁸⁹ If the proposed representative cannot affirm on the record that the claimant is mentally competent, or that the claimant has authorized them to act on the claimant's behalf, then the case will be dismissed.⁶⁹⁰

If the claimant is incompetent, and does not have a conservator or attorney-in-fact appointed through a durable power of attorney, the hearing may proceed at the ALJ's discretion if the person is a relative, or a person who has knowledge of the claimant's circumstances, and who completed and signed the Statement of Facts on the claimant's behalf.⁶⁹¹

6. BEFORE THE HEARING

After the hearing request is filed, SHD sends the claimant information about their hearing rights, and the name, address, and phone number of the Appeals Specialist assigned to the case. The Appeals Specialist is required to resolve the issue without the need for a hearing and at the lowest level possible.⁶⁹²

The Appeals Specialist must provide claimants with information regarding the administrative process, including preparing a Statement of Position, which provides information regarding the action(s) taken by the county.⁶⁹³ Information about the Statement of Position can be found later in this chapter, at Section 7(B).

6.1 Conditional Withdrawals

The Appeals Specialist may offer a “conditional withdrawal” of the claimant’s hearing request. This means that the claimant withdraws their hearing request on the condition that the county do something to fix the problem, such as conducting a reassessment to determine the claimant’s IHSS hours of need. Conditional withdrawals must be accompanied by an agreement signed by the claimant and the county.⁶⁹⁴

PRACTICE TIP: Although an Appeals Specialist may offer to remedy the issue without the need for a hearing, they might only authorize benefits from the date of the conditional withdrawal, and not the date of action the claimant is disputing. When agreeing to a conditional withdrawal, remember to request benefits retroactive to the date of action. Get this assurance in writing as part of the conditional withdrawal.

The conditional withdrawal must provide that the actions of both parties will be completed within 30 days from the date the conditional withdrawal is signed by both parties and received by the county.⁶⁹⁵ The county then issues a new NOA for the redetermination. The claimant has the right to have their hearing rescheduled if they disagree with the new assessment or a decision not to authorize retroactive benefits. The claimant can reinstate the hearing request based on the new NOA, but the request for reinstatement must be made within 90 days.⁶⁹⁶

6.2 Postponements

Claimants may also request a postponement of the hearing. However, a claimant must show good cause for postponing the hearing and waive their right to a decision within 90 days if they receive a postponement.⁶⁹⁷ Good cause includes, but is not limited to:

- A death in the family.
- Personal illness or injury.
- Sudden and unexpected emergencies that prevent the claimant or the claimant’s authorized representative from appearing.
- A conflicting court appearance that cannot be postponed.
- The claimant contends that they are not adequately prepared to discuss the issues because they did not receive an adequate and/or language-compliant notice, and the ALJ determines that the required notice was not received.
- The county does not make a position statement available to the claimant at least two working days prior to the date of the scheduled hearing, or the county has modified the position statement, and the claimant agrees that the ALJ can issue a decision at a later date.⁶⁹⁸

If a postponement is granted for good cause, then aid paid pending will continue until the next scheduled hearing date.⁶⁹⁹ The county also has the right to request a postponement.⁷⁰⁰ In addition, a hearing shall be postponed if either party has not received notice of the time and place of the hearing at least 10 days prior to the hearing and that party requests a postponement.⁷⁰¹ Any requests for postponements may not exceed 30 days.⁷⁰²

7. PREPARING FOR THE HEARING

7.1 Requesting the IHSS File

Upon request, the county must allow the claimant to examine their case file during regular working hours.⁷⁰³ Prior to the hearing, the claimant should request to see their entire IHSS file. In addition, the claimant has the right to examine the information used by the county in making its decision to change, deny, or terminate the claimant's IHSS hours, including any policy materials and regulations.⁷⁰⁴ If the claimant's IHSS hours were reduced, they should ask their IHSS worker for copies of the regulations listed on the NOA. These materials can help to determine whether a hearing should be requested, and to prepare for a scheduled hearing.

PRACTICE TIP: After a hearing request is made, request the IHSS case file from the claimant's IHSS social worker, and once it has been provided, request a postponement so the claimant has the opportunity to review the case file and gather necessary information.

7.2 Gathering Information

In addition to requesting the claimant's IHSS case file, it is important to gather information about how the county IHSS social worker determined the hours for which the claimant was authorized.

1. Ask the claimant's social worker for a copy of the latest needs assessment forms. These county forms will include notes about why hours were or were not authorized or reduced. Also ask for a copy of the most recent SOC 293 form. The SOC 293 form includes information on the functional ranking of what the claimant can and cannot do. If the claimant is challenging a reduction in hours, ask for copies of both new and old county assessment forms and new and old SOC 293 forms.
2. Ask for a copy of the sheets in the file where notes were made about contacts and visits with the claimant over the last year.
3. Ask the claimant's social worker for copies of any doctor or medical reports in their file and for copies of any paramedical forms.

It is also helpful to have a letter or declaration from the claimant's physician or other treating professional explaining why the claimant requires IHSS services, and what services they need. The letter should outline the claimant's functional limitations, such as not being able to lift heavy items or bend over, or that the claimant requires assistance in remembering to take medications.

The claimant should have the physician review any information provided to the county, check for accuracy and correct mistakes by obtaining current information about functional limitations. The claimant's physician should also explain any changes in the claimant's condition. If the condition varies on a day-to-day basis, the physician should determine the claimant's ranks based on the bad days. A supporting letter or declaration can also help establish the claimant's need for paramedical services. The claimant should tell the physician about what services IHSS provides so that the letter can explain what services the claimant needs in relation to their functional limitations.

If the claimant is contesting the denial or termination of protective supervision, the letter or declaration from their treating physician or mental health provider should explain that the claimant is non-self-directing and provide reasons and examples for that determination. The treating provider should also explain how the claimant's impaired memory or judgment, and confusion cause the claimant to engage in potentially dangerous activities or behaviors. Claimants contesting the denial or termination of protective supervision should also get an updated SOC 821 form, with as much detail as possible, from the treating provider. Although the SOC 821 provides supporting evidence of a claimant's need for protective supervision, it is not determinative and the county may use the SOC 821 in conjunction with other information about the claimant's needs.⁷⁰⁵

PRACTICE TIP: Physicians are often very busy and hard to reach. Drafting a letter on the physician's behalf, as outlined above, can be helpful. Be sure that everything is completely accurate, and provide the physician with time to review.

7.3 Self-Assessments

If the claimant is challenging a reduction in their IHSS hours, or disagrees with the social worker's assessment of the need for IHSS hours, it is helpful for the claimant to do a self-assessment. This will help the claimant figure out how many minutes/hours are needed in the respective categories, and will help rebut the county's determination. You can find a copy of a self-assessment worksheet on Disability Rights California's website, called "Challenge IHSS Reductions and/or Terminations and Prepare for Hearing."⁷⁰⁶

7.4 County's Statement of Position

The county must provide a copy of its Statement of Position at least two business days before the hearing.⁷⁰⁷ The position statement is a document written by the Appeals Specialist that supports the county's decision to change or deny IHSS services. It should summarize all the facts of the case, including facts that are helpful to the claimant, and the regulatory justification for the county action.⁷⁰⁸ It must include copies of documentary evidence and a list of witnesses whom the county intends to use during the hearing.⁷⁰⁹ The position statement can help the claimant identify other witnesses and evidence they might need to support their claims. If the county welfare department does not make the position statement available to the claimant at least two business days before the hearing, or if the county welfare department decides to modify

the position statement after providing it to the claimant, the claimant will have good cause to postpone the hearing.⁷¹⁰ If the claimant requests a postponement on this basis, then aid paid pending will continue.⁷¹¹

The claimant can authorize the county to send them a copy of the position statement electronically or by mail.⁷¹² However, in order to receive a copy of the position statement electronically, the claimant must authorize electronic transmission, and the county agency must be able to comply with all state and federal privacy laws in transmitting the document electronically.⁷¹³ If those two requirements are met, then the county welfare department must send the claimant the position statement at least two business days before the hearing.⁷¹⁴ Otherwise, the county welfare department can “choose whether to mail the position statement or make it available at the appropriate county welfare department.”⁷¹⁵ However, CDSS policy “encourages” counties to discuss with claimants how they prefer to receive the position statement.⁷¹⁶

8. AT THE HEARING

IHSS hearings are administrative hearings conducted by an ALJ in an impartial manner “in order to encourage free and open discussion by participants.”⁷¹⁷ An IHSS hearing is considered informal because the rules of evidence and civil procedure, are not strictly enforced.⁷¹⁸ However, all testimony, whether from the claimant, the county, or the claimant’s authorized representative, is still submitted under oath.⁷¹⁹

When the hearing begins, the ALJ will ask the Appeals Specialist, to testify first and explain why the claimant’s hours were reduced or terminated, or why the claimant does not need additional hours. The Appeals Specialist may present evidence from the county, or have someone from the county testify, such as the social worker who conducted the assessment, the claimant’s IHSS case worker, or a supervisor. When the Appeals Specialist has finished their explanation, the ALJ will have the claimant explain why they believe the county made the wrong decision. The claimant can submit documents to the ALJ as evidence, ask the county questions or have someone testify on their behalf.

The hearing will involve the presentation of evidence (testimony by witnesses, letters, diary log, medical reports) about the claimant’s needs in the service category areas where the claimant and the county disagree. The evidence should explain what the claimant needs, how long it takes to provide the service, the reason the claimant needs more time than that set out in the assessment or the county guidelines, and what risks the claimant may be exposed to if they do not receive the level of services requested. Witnesses may include—in addition to the IHSS recipient—past and present IHSS providers, regional center case managers, friends and family, etc.

The hearing will be recorded.⁷²⁰ Speak clearly and loudly to ensure everything is recorded. The transcript can be important when there is an unfavorable decision and the claimant files an Administrative Writ in Superior Court, discussed below.

9. DECISIONS, REHEARINGS, AND ADMINISTRATIVE WRITS

The ALJ will issue a decision within 90 days of the conclusion of the hearing, unless a claimant waives their right to have a decision within the 90 day timeframe.⁷²¹ The Director of CDSS can adopt the decision of the ALJ as final, or can overturn the decision and issue a new one. If either the claimant or the county is unhappy with the decision, they can either (1) file for a rehearing, or (2) file an Administrative Writ in Superior Court.

9.1 Rehearing

If a claimant disagrees with the hearing decision, they must request a rehearing within 30 days of receiving the final decision.⁷²² However, if a claimant is able to show good cause, a request for rehearing may be filed more than 30 days from the date of the decision. The Director must agree that good cause exists, and any late rehearing request must be filed within 180 days of the decision.⁷²³ The Director of CDSS then serves the request for rehearing on the other party, and the other party has five days to file a statement supporting or objecting to the request.⁷²⁴ The Director must grant or deny the rehearing request within 35 working days after the request for rehearing is made, although rehearsings in practice are often granted or denied many months past this deadline.⁷²⁵

The grounds for requesting a rehearing are:

- » The adopted decision is inconsistent with the law.
- » The adopted decision is not supported by the evidence in the record.
- » The adopted decision is not supported by the findings.
- » The adopted decision does not address all of the claims or issues raised by the parties.
- » The adopted decision does not address all of the claims or issues supported by the record or evidence.
- » The adopted decision does not set forth sufficient information to determine the basis for its legal conclusion.
- » Newly discovered evidence, that was not in custody or available to the party requesting rehearing at the time of the hearing, is now available and the new evidence, had it been introduced, could have changed the hearing decision.
- » For any other reason necessary to prevent the abuse of discretion or an error of law, or for any other reason consistent with Section 1094.5 of the Code of Civil Procedure.⁷²⁶

PRACTICE TIP: It can take many months for CDSS to issue a decision granting or denying the request for a rehearing. If the claimant receives an unfavorable hearing decision, the best thing to do is to request a rehearing, and include any relevant evidence that was not presented at the hearing. Claimants can also file an Administrative Writ, as discussed below. Note that you do not have to file for a rehearing before filing a writ. A writ must be filed in state superior court within one year of the decision whether or not a rehearing is pending.⁷²⁷

9.2 Petition for Writ of Administrative Mandate

A claimant may also choose to file a **Writ of Administrative Mandate** in Superior Court. A writ asks a Superior Court judge to review the hearing decision and to set aside that decision and issue a new one. Petitions for Writ of Administrative Mandate must be filed within one year after receiving the decision.⁷²⁸

An Administrative Writ challenging a decision by CDSS is brought under California Code of Civil Procedure § 1094.5. The court reviews the underlying administrative proceedings to ensure that CDSS proceeded in accordance with the law, that the claimant received a fair trial, and that CDSS' decision is supported by the findings, or that the findings are supported by the evidence.⁷²⁹ The party filing the writ is called a "Petitioner," and CDSS is the "Respondent." Evidence in Administrative Mandate proceedings is limited to the underlying hearing record, including anything submitted at the time of the hearing, the hearing transcript, and rehearing. This is why it is important to prepare for the hearing by submitting evidence of the claimant's need for IHSS services, and to speak clearly at the hearing so that the proceedings can be properly recorded. It is also important to include additional evidence (if it exists) in the rehearing request because that will become part of the record whether or not a rehearing is granted.

For more information on filing Administrative Writs, claimants and advocates should review practice guides and online resources.⁷³⁰ Keep in mind that each Superior Court has different filing procedures and rules, and some have special rules for filing Administrative Writs.

PRACTICE TIP: Petitioners who file for an Administrative Writ under Welfare and Institutions Code Section 1094.5 are not required to pay a filing fee.⁷³¹ In addition, successful Petitioners are entitled to reasonable attorney's fees and costs.⁷³²

Chapter 8 Endnotes

- 641 Cal. Welf. & Inst. Code § 10950(a); California Dept. of Social Services Manual of Policies & Procedures (“MPP”) § 22-003.1, available at <http://www.cdss.ca.gov/ord/entres/getinfo/pdf/4cfcman.pdf>; see also 45 C.F.R. § 205.10. For instances of when an individual does not have a right to a hearing, see Cal. Welf. & Inst. Code § 10950(d) and MPP §§ 22-003.11-.15.
- 642 Cal. Welf. & Inst. Code § 10950(f); MPP § 22-000.11.
- 643 Cal. Welf. & Inst. Code § 10950(f); MPP § 22-000.11.
- 644 Contact information for each county’s appeals unit, including names of supervisors, can be found at <http://www.cdss.ca.gov/Portals/9/Countylist%20for%20Web.July.17.pdf>.
- 645 MPP § 22-001(d)(2).
- 646 Cal. Welf. & Inst. Code § 10960.
- 647 See Cal. Welf. & Inst. Code § 1094.5.
- 648 MPP § 22-071.1. Notice is required for IHSS recipients and applicants in the following instances: when services are granted or increased; when services are denied, decreased, suspended, cancelled, discontinued, or terminated; when the county does something after a claimant has conditionally withdrawn their request for a hearing; when the county determines that immediate need does not exist; when the county does something after a hearing; and when the county makes changes to the payment of services.
- 649 MPP § 22-001(a)(1); MPP § 10-116.4; 22 C.C.R. § 51014.1(c)(1)-(3); 42 C.F.R. § 431.210(a)-(c).
- 650 MPP § 22-071.6.
- 651 MPP § 21-115.2; California Department of Social Services, Translated Forms and Publications, <http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications> (accessed January 2, 2018).
- 652 MPP §22-071(L)(1)(b).
- 653 MPP § 22-001(t)(1).
- 654 MPP § 22-072.4.
- 655 Cal. Welf. & Inst. Code § 10967.
- 656 MPP § 22-049.523; Welfare and Institutions Code § 10967 (“If the notice was not adequate and involved termination or reduction of aid, retroactive action shall be taken by the county to reinstate aid pending.”).
- 657 MPP § 22-049.52; Cal. Welf. & Inst. Code § 10967.
- 658 *Id.*
- 659 Cal. Welf. & Inst. Code § 10951(a)(1); MPP § 22-009.1.
- 660 MPP § 22-009.11.
- 661 Bet Tzedek, Chapter 7: In-Home Support Services (IHSS), available at <https://www.bettzedek.org/wp-content/uploads/2017/09/Chapter-7-IHSS-20174837-2664-5836.pdf>.
- 662 Cal. Welf. & Inst. Code § 10951(a)(1).

- 663 Cal. Welf. & Inst. Code § 10951(a)(2); see also All County Information Notice (“ACIN”) No. I-66-08 (November 19, 2008), available at http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin08/I-66_08.pdf.
- 664 Id.
- 665 Id.
- 666 MPP § 22-072.5.
- 667 If the claimant fails to appear personally or by authorized representative at the scheduled hearing, the request for hearing shall be considered abandoned and a written decision shall be issued dismissing the claim. MPP § 22-054.221.
- 668 Id.
- 669 MPP § 22-009.2.
- 670 MPP § 22-004.1.
- 671 MPP § 22-004.21. An online hearing request can be made at <https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx>.
- 672 MPP § 22-004.211.
- 673 MPP § 22-004.22.
- 674 MPP §§ 22-045.11, 22-045.13.
- 675 MPP § 22-004.211.
- 676 MPP § 22-071.5.
- 677 For more information on state hearing requests, visit <http://www.cdss.ca.gov/Hearing-Requests>.
- 678 MPP § 22-045.3.
- 679 MPP § 22-045.31.
- 680 MPP § 22-045.33.
- 681 All County Appeals Letter (January 19, 2004), available at <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/coletters/pdf/ExpeditedHearingACL.PDF>.
- 682 Id.
- 683 MPP § 22-001(a)(6); MPP § 22-085.1.
- 684 MPP § 22-085.1. For state hearings, use DPA 19 (12/2010) to authorize a representative, available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/DPA19.PDF>. Individuals can also appoint a representative using the NA Back 9 (4/2013), available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/NABACK9.PDF>.
- 685 See Probate Code § 4120 et seq.; All County Welfare Directors Letter 94-70 (August 23, 1994), available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/94-70.pdf>.
- 686 MPP § 22-085.11.
- 687 MPP § 22-085.12.

- 688 MPP § 22-085.21.
- 689 MPP § 22-085.22. In addition, the representative must submit a written authorization within 10 days of the hearing, or the case will be dismissed. MPP § 22-085.221-222.
- 690 MPP § 22-085.24.
- 691 MPP § 22-085.23.
- 692 MPP § 22-073.23.
- 693 MPP §§ 22-073.232 and .25; All County Letter 17-102 (September 29, 2017), available at <http://www.cdss.ca.gov/Portals/9/ACL/2017/17-102.pdf?ver=2017-10-05-085426-067>.
- 694 MPP § 22-054.211(b)(3).
- 695 MPP § 22-054.211(b)(3)(B).
- 696 MPP § 22-054.211(b)(3)(C).
- 697 MPP § 22-053.112.
- 698 MPP § 22-053.113. For a detailed description of CDSS' State Hearings Division Postponement Procedures, visit http://www.cdss.ca.gov/shd/res/pdf/SHD_PostponementProcedures.pdf.
- 699 MPP § 22-053.43.
- 700 MPP § 22-053.121.
- 701 MPP § 22-053.141.
- 702 MPP § 22-053.3.
- 703 MPP § 22-051.1. Cal. Welf. & Inst. Code § 10850(c) authorizes CDSS to issue regulations concerning access to case files, including access to case files by applicants and recipients. MPP § 19-005.1 says any recipient or applicant, or their authorized representative, may review the file "made or kept by the county welfare department in connection with the administration of the public assistance program." A claimant can review medical records in their file. (MPP § 19-006 note). The only records a claimant cannot see are those covered by a specific "privilege" such as the lawyer-client privilege (and the claimant does not own the privilege). (MPP § 19-006; see, also, the state hearing regulations at MPP § 22-051).
- 704 MPP § 22-051.3.
- 705 MPP § 30-757.173(a)(2)-(3).
- 706 You can also find a copy here: <https://www.disabilityrightsca.org/publications/challenge-ihss-reductions-and-or-terminations-and-prepare-for-hearing>.
- 707 Cal. Welf. & Inst. Code § 10952.5(a); All County Letter ("ACL") 17-21 (February 16, 2017), available at <http://www.cdss.ca.gov/Portals/9/ACL/2017/17-21.pdf?ver=2017-02-23-144123-927>; ACL 17-102 (September 29, 2017), available at <http://www.cdss.ca.gov/Portals/9/ACL/2017/17-102.pdf?ver=2017-10-05-085426-067>.
- 708 ACL 17-21 (February 16, 2017).
- 709 Id.
- 710 Cal. Welf. & Inst. Code § 10952.5(b); All County Letter No. 17-21 (February 16, 2017).
- 711 Id.

- 712 Cal. Welf. & Inst. Code § 10952.5(a); All County Letter No. 17-21 (February 16, 2017).
- 713 Id.
- 714 Id.
- 715 Id.
- 716 Id.
- 717 Welfare and Institutions Code § 10955.
- 718 Id.
- 719 Id.
- 720 Cal. Welf. & Inst. Code § 10956; MPP § 22-049.4.
- 721 MPP § 22-060.1.
- 722 Cal. Welf. & Inst. Code § 10960(a); ACIN I-66-08 (November 19, 2008), available at http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin08/I-66_08.pdf.
- 723 Cal. Welf. & Inst. Code § 10960(f)(2).
- 724 Cal. Welf. & Inst. Code § 10960(a).
- 725 Id.
- 726 Cal. Welf. & Inst. Code § 10960(b).
- 727 Cal. Welf. & Inst. Code § 10962.
- 728 Id.
- 729 Cal. Civ. Proc. Code § 1094.5(b). “The inquiry in such a case shall extend to the questions whether the respondent has proceeded without, or in excess of, jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion. Abuse of discretion is established if the respondent has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.”
- 730 Claimants and advocates may want to review the Writ of Mandate Outline by Richard Rothschild here: <http://laaonline.org/wp-content/uploads/Writ-of-Mandate-Outline.pdf>.
- 731 Cal. Welf. & Inst. Code § 10962.
- 732 Id.

Appendix A

IHSS Program Chart

AUTHORITY?	IHSS COMMUNITY FIRST CHOICE OPTION (CFCO), PUBLIC LAW 111-148 (2010); 42 U.S.C. § 18001 ET SEQ	IHSS MEDI-CAL PERSONAL CARE SERVICES PROGRAM (PCSP), WELF. & INST. CODE § 14132.95	IHSS PLUS OPTION (IPO), WELF. & INST. CODE § 14132.952	IHSS RESIDUAL (IHSS-R) PROGRAM, WELF. & INST. CODE § 12300 ET SEQ.
ELIGIBILITY?	Beneficiary receives full-scope Medi-Cal with federal financial participation (FFP), and meets CFCO Nursing Facility Level of Care eligibility. ⁷³³	Beneficiary receives full-scope Medi-Cal with FFP. Includes SSI beneficiaries; 1619 SSI beneficiaries (people who work even though disabled); Pickles; other Medi-Cal programs including A&D FPL; or Working Disabled; DD Waiver & HCBA Waiver people. ⁷³⁴	Beneficiary receives full-scope Medi-Cal with FFP. Includes SSI beneficiaries; 1619 SSI beneficiaries (people who work even though disabled); Pickles; other Medi-Cal programs including A&D FPL; or Working Disabled; DD Waiver & HCBA Waiver people. Does not require a disability determination. ⁷³⁵	Recipient does not receive (1) full-scope Medi-Cal or (2) Medi-Cal with FFP. Includes individuals with state-only Medi-Cal, primarily lawful permanent residents and persons residing in the United States under color of law (PRUCOL) who are not eligible for full-scope Medi-Cal with FFP ⁷³⁶
FUNDING?	Federal Medicaid 50% + 6%; State and County contribute remaining 44%.	Federal Medicaid 50%, 32.5% State, and 17.5% County ⁷³⁷	Federal Medicaid 50%; of remaining 50%, County pays 35% and State pays 65% ⁷³⁸	County pays 35% & State 65% of total cost ⁷³⁹
SERVICES AND PROVIDERS?	<ul style="list-style-type: none"> All services, including Restaurant Meal allowance All providers, including spouses and parents of minor children⁷⁴⁰ 	<ul style="list-style-type: none"> All Services except Restaurant Meal Allowance All providers except spouses and parents of minor children. No Advance Pay⁷⁴¹ 	<ul style="list-style-type: none"> All services, including restaurant meal allowance All providers, including spouses and parents of minor children⁷⁴² 	<ul style="list-style-type: none"> All Services including Restaurant Meal Allowance All providers including spouses and parents of minor children. Advance Pay⁷⁴³

IHSS Program Chart

AUTHORITY?	IHSS COMMUNITY FIRST CHOICE OPTION (CFCO), PUBLIC LAW 111-148 (2010); 42 U.S.C. § 18001 ET SEQ	IHSS MEDI-CAL PERSONAL CARE SERVICES PROGRAM (PCSP), WELF. & INST. CODE § 14132.95	IHSS PLUS OPTION (IPO), WELF. & INST. CODE § 14132.952	IHSS RESIDUAL (IHSS-R) PROGRAM, WELF. & INST. CODE § 12300 ET SEQ.
SEVERELY/ NON-SEVERELY IMPAIRED?	Maximum 283 hours/month (including protective supervision: 195 hours for non-severely impaired, 283 hours for severely impaired) ⁷⁴⁴	Maximum 283 hours/month ⁷⁴⁵ (except for Protective Supervision: 195 hours for non-severely impaired, 283 hours for severely impaired) ⁷⁴⁶	Maximum 283 hours/month for severely impaired, 195 hours/month for non-severely impaired ⁷⁴⁷	Maximum 283 hours/month for severely impaired (needs 20 or more hours/week for personal care, paramedical and meal prep) or 195 hours/month for non-severely impaired ⁷⁴⁸
CAN SOMEONE ELSE SUPPLEMENT PAY?	No	No, but can pay for hours not covered such as time in between tasks if pay provider directly; others can pay provider directly for share of cost.	No	Yes, if given directly to provider.
SPOUSE PROVIDER?	Covered ⁷⁴⁹	Not covered because relative provider. ⁷⁵⁰	Covered ⁷⁵¹	Covered for nonmedical personal care services, paramedical services and, if prevented from working, protective supervision & transportation. ⁷⁵²
PARENT PROVIDER FOR MINOR?	Covered ⁷⁵³	Not covered because relative provider. ⁷⁵⁴	Covered ⁷⁵⁵	Covered ⁷⁵⁶

Appendix A Endnotes

- 733 ACL 14-60.
- 734 See, generally, Welfare and Institutions Code 14132.95; ACWDL 05-21; ACIN I-18-08.
- 735 ACL 11-19.
- 736 MPP §30-755.113; ACIN I-18-08; ACIN I-28-06.
- 737 <http://www.cdss.ca.gov/inforesources/IHSS>.
- 738 http://www.cicaihss.org/sites/default/files/ihss_overview_for_senate_budget_sub_3_hearing_3-2-2017_v2.pdf at p. 5 (50% federal funds); Welf. & Inst. Code § 14132.952(g) (To the extent permitted by federal law, reimbursement rates for services under the IHSS Plus option shall be equal to the rates in each county for the same mode of services in the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3).
- 739 http://www.cicaihss.org/sites/default/files/ihss_overview_for_senate_budget_sub_3_hearing_3-2-2017_v2.pdf at p. 23; ACL 14-60.
- 740 ACL 14-60.
- 741 ACWDL 05-21.
- 742 ACL 11-19.
- 743 Welfare and Institutions Code § 12300.
- 744 ACL14-60.
- 745 WIC § 51350.
- 746 ACIN I-28-06.
- 747 ACL 11-19.
- 748 Welfare and Institutions Code § 12303.4(a); MPP § 30-765.12; ACIN I-28-06.
- 749 ACL 14-60.
- 750 ACWDL 05-21; Welfare and Institutions Code §§ 14132.95(c) (Services provided), 14132.95(f) (prohibition on spouse or parent providers in PCSP).
- 751 ACL 11-19.
- 752 ACIN I-28-06.
- 753 ACL 14-60.
- 754 ACWDL 05-21; Welfare and Institutions Code §§ 14132.95(c) (Services provided), 14132.95(f) (prohibition on spouse or parent providers in PCSP).
- 755 ACL 11-19.
- 756 ACIN I-28-06.

Appendix B

IHSS Hourly Tasks Chart

#	TASK	HTG RANGE PER FUNCTIONAL RANK			
		RANK 2	RANK 3	RANK 4	RANK 5
1	Meal Preparation (see MPP 30-757.131(a))	3.02 - 7.00	3.50 - 7.00	5.25 - 7.00	7.00 - 7.00
2	Meal Cleanup (see MPP 30-757.132(b))	1.17 - 3.50	1.75 - 3.50	1.75 - 3.50	2.33 - 3.50
3	Bowel and Bladder Care (see MPP 30-757.14(a)(2))	0.58 - 2.00	1.17 - 3.33	2.91 - 5.83	4.08 - 8.00
4	Feeding (see MPP 30-757.14(c)(3))	0.70 - 2.30	1.17 - 3.50	3.50 - 7.00	5.25 - 9.33
5	Bed Baths (see MPP 30-757.14(d)(1))	0.50 - 1.75	1.00 - 2.33	1.17 - 3.50	1.75 - 3.50
6	Bathing, Oral Hygiene, and Grooming (see MPP 30-757.14(e)(5))	0.50 - 1.92	1.27 - 3.15	2.35 - 4.08	3.00 - 5.10
7	Dressing (MPP 30-757.14(f))	0.56 - 1.20	1.00 - 1.86	1.50 - 2.33	1.90 - 3.50
8	Repositioning or Rubbing Skin (MPP 30-757.14(g)(4))	0.75 - 2.80			
9	Transfer (MPP 30-757.14(h)(2))	0.50 - 1.17	0.58 - 1.40	1.10 - 2.33	1.17 - 3.50
10	Care and Assistance with Prosthetic Devices (MPP 30-757.14(i)(2))	0.47 - 1.12			
11	Menstrual Care (MPP 30-757.14(j)(3))	0.28 - 0.80			
12	Ambulation (MPP 30-757.14(k)(1))	0.58 - 1.75	1.00 - 2.10	1.75 - 3.50	1/75 - 3.50

Appendix C

NOTICE OF ACTION IN-HOME SUPPORTIVE SERVICES (IHSS) APPROVAL

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Case Number : _____
Social Worker Name : _____
Social Worker Number : _____
Social Worker Telephone : _____
Social Worker Address : _____

NOTE: This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

(ADDRESSEE)

Total Hours:Minutes of IHSS you can get each month: _____.

Based on an assessment done on _____, you can get the services shown below for the amount of time shown in the column "Authorized Amount of Service You Can Get."

- 1) If there is a zero in the "Authorized Amount of Service You Can Get" column or the amount is less than the "Total Amount of Service Needed" column, the reason is explained on the next page(s).
- 2) "Not Needed" means that your social worker found that you do not require assistance with this task. (MPP 30-756.11)
- 3) "Pending" means the county is waiting for more information to see if you need that service. See the next page(s) for more information.

SERVICES	TOTAL AMOUNT OF SERVICE NEEDED	ADJUSTMENT FOR OTHERS WHO SHARE THE HOME	AMOUNT OF SERVICE YOU NEED	SERVICES YOU REFUSED OR YOU GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HOURS: MINUTES	(PRORATION)	HOURS: MINUTES		HOURS: MINUTES
Note: See the back of the next page for a short description of each service.					
DOMESTIC SERVICES (per MONTH):					
RELATED SERVICES (per WEEK):					
Prepare Meals					
Meal Clean-up					
Routine Laundry					
Shopping for Food					
Other Shopping/Errands					
NON-MEDICAL PERSONAL SERVICES (per WEEK):					
Respiration Assistance (Help with Breathing)					
Bowel, Bladder Care					
Feeding					
Routine Bed Bath					
Dressing					
Menstrual Care					
Ambulation (Help with Walking, including Getting In/Out of Vehicles)					
Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)					
Bathing, Oral Hygiene, Grooming					
Rubbing Skin, Repositioning					
Help with Prosthesis (Artificial Limb, Visual/ Hearing Aid) and/or Setting up Medications					
ACCOMPANIMENT (per WEEK):					
To/From Medical Appointments					
To/From Places You Get Services in Place of IHSS					
PROTECTIVE SUPERVISION (per WEEK):					
PARAMEDICAL SERVICES (per WEEK):					
TOTAL WEEKLY HOURS:MINUTES OF SERVICE YOU CAN GET:					
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS:MINUTES: x 4.33 =					
SUBTOTAL MONTHLY HOURS:MINUTES OF SERVICE YOU CAN GET:					
ADD MONTHLY DOMESTIC HOURS:MINUTES OF SERVICE YOU CAN GET (from above):					
TOTAL HOURS:MINUTES OF SERVICE YOU CAN GET PER MONTH:					
TIME LIMITED SERVICES (per MONTH):					
Heavy Cleaning:					
Yard Hazard Abatement					
Remove Ice, Snow					
Teaching and Demonstration					
TOTAL HOURS:MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:					

Questions?: Please contact your IHSS social worker. See top of page for phone number.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.