APPLICATION PACKET
IN-HOME SUPPORTIVE SERVICES (IHSS)

The IHSS program is available for eligible seniors and disabled individuals to help them remain safely in their own homes. If you feel you are in need of these services and would like to apply, please take the following steps:

1. Review the "In-Home Supportive Services Frequently Asked Questions." These questions and answers will give you more details on the program and basic eligibility criteria.

2. If you want to submit an application, you must complete the following forms:

   - "Application for Social Services"

   - "Applicant Questionnaire"

   - "Medical Certification Form"

   Enclosed is a blank copy the Medical Certification Form (SOC873) that you can give to your Licensed Health Care Provider (LHCP) to complete. The county can fax the Medical Certification form to your LHCP for you, if you would like the county to do so, **please sign section B Authorization to Release Medical Information on page one of the Medical Certification Form.**

3. Mail the application in the enclosed envelope (Shasta County Adult Services, PO Box 496005, Redding, CA 96049-6005), or you may bring it to our office directly at 2640 Breslauer Way, Redding, CA 96001.

When we have received these completed papers, your application will be assigned to a social worker who will contact you to set up a home visit and interview, so that we can determine whether or not you will be eligible for the IHSS program. You may also be required to complete additional paperwork, in order for us to determine eligibility.

If you have any questions or need additional information, please contact Adult Services at 225-5507.

In-Home Supportive Services (IHSS)
Frequently Asked Questions

What is IHSS?

IHSS stands for "In-Home Supportive Services." IHSS is a State program to assist eligible recipients who are elderly or disabled to stay in their own homes by paying providers to come into their homes and assist them with essential chores that they are not able to manage on their own.

What kind of services are offered?

Providers can be set up to assist with needs that would put a recipient at risk if not assisted. This may range from help with simple domestic chores to help with personal care such as dressing, bathing, and transfers. The number of hours of help will be determined by a home visit from a social worker, and will take into account not only a recipient's physical and mental needs, but also the living arrangement. (If a recipient has alternative resources to assist with some or all of the work, these resources will be subtracted from the calculation of hours.)

Who is eligible?

To be eligible for IHSS, a person must normally receive full-scope Medi-Cal coverage, and have a disability or need that is expected to last at least one year or longer (or end in death.) Please contact the Medi-Cal department at 877-652-0731 for information regarding Medi-Cal eligibility or to apply for Medi-Cal.

Does IHSS cost anything?

A Medi-Cal "share of cost" is calculated by the Medi-Cal department, and is similar to a "deductible" on other insurance plans. Since IHSS is part of the Medi-Cal program, a recipient will have to pay any remaining Medi-Cal "share of cost," or if the "share of cost" has already been spent on other allowable medical expenses in the month, then there will be no cost for the IHSS.

Who are the providers?

The recipient is considered the employer, and may hire whomever he or she wishes, including friends and relatives. If a client does not know anyone who is interested in doing the work, the IHSS – Public Authority

office maintains a list of potential providers, and they will be referred to the recipient.

However, these are only referrals, and are not state or county employees. It is solely the responsibility of the client to interview the potential providers and to determine who to hire. After a provider is hired, it is also the responsibility of the recipient to supervise the provider's work, and to terminate the provider if necessary.

How does one apply?

If you are interested in applying for IHSS, or know someone who might be eligible, you will need to contact Shasta County Adult Services at 225-5507. An application packet will be sent to the person. If this person completes the application packet and sends it back to Shasta County, the paperwork will be reviewed, and a home visit will be scheduled by a social worker to determine eligibility and need for services.

How long does an application take?

Once a recipient has submitted an application, a home visit and a determination are normally made within 30 days. A "notice of action" will then be sent to the recipient, which will tell whether the case has been approved (and for which tasks and how many hours of help) or denied.

Where can I get more information?

You may telephone our office on weekdays from 8:00am to 5:00pm at 225-5507. Our office is located at 2640 Breslauer Way in Redding, CA.

Shasta County does not discriminate on the basis of disability. Our ADA Coordinator may be reached at:
(530) 225-5515; relay service (800) 735-2922; fax (530)225-5345.

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

APPLICATION FOR SOCIAL SERVICES

To the Applicant: All sections of this form must be completed. Information provided is subject to verification.

NOTE: Retain your copy of your completed application. Regarding your Social Security Number, it is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP Section 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

Date of Application:	Case Number (if known):

Section 1 – Personal Information

Name:		Social Security Number:
Street Address:		City:
State:	Zip Code:	Telephone:
Birthdate:		Sex: Male Female

Section 2 – Veteran Information

Are you a Veteran? Yes No	Are you a Spouse/Child of a Veteran? Yes No .
If YES, give Veteran name and Claim Number:	

Section 3 – SSI/SSP Information

Do you receive SSI/SSP benefits? Yes No
If yes, check your type of living arrangement: Independent Living Board and Care Home of Another
Services being requested:

Section 4 – Past IHSS Information

Have you received In-Home Support Services (IHSS) in the past?	Yes	No
If Yes, complete the following. Date and county where service was last received:		
Total Monthly Hours:	Name Used (if different from above):	

Section 5 – Household Information

List Family Members in Household:

Name of: Spouse Parent	
Birthdate:	Social Security Number:
Name of: Child Other Relative	
Birthdate:	Social Security Number:
Name of: Child Other Relative	
Birthdate:	Social Security Number:
Name of: Child Other Relative	
Birthdate:	Social Security Number:
Name of: Child Other Relative	
Birthdate:	Social Security Number:

Section 6 – Ethnic and Language Information

The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.

A. My Ethnic Origin is: Please choose one (See Page 7 for a list of Ethnicities and Codes)	B. I speak and understand English: Yes No If not English, my primary language is: Please choose one (See Page 7 for a list of Languages and codes)

Section 7 – Communication Accommodations

To accommodate blind or visually-impaired applicants, IHSS information is available in the following alternative formats. Please indicate which format you would prefer, if applicable. Providing information in this section will not affect your eligibility for services.

I am Blind: Yes No

If yes, please choose one of the following for each of the three types of DSS documents listed.

For Notices of Action: No accommodation is needed Braille Documents Audio CD Data CD County Support
(If County Support, describe requested support)
For IHSS Required forms: No accommodation is needed Braille Documents Audio CD Data CD County Support
(If County Support, describe requested support)
For Timesheets: No accommodation is needed Telephonic System (4 Digit RAN:) County Support
(If County Support, describe support requesting)

I am Visually Impaired:	Yes	No

If yes, please choose one of the following for each of the three types of DSS documents listed.

For Notices of Action:	No accommodation is needed		
18 Point font documents	Audio CD	Data CD	County Support
(If County Support, describe requested support)			
For IHSS Required forms:	No accommodation is needed		
18 Point font documents	Audio CD	Data CD	County Support
(If County Support, describe requested support)			
For Timesheets:	No accommodation is needed		
18 point font documents			County Support
(If County Support, describe requested support, including blind-only services)			

Section 8 – Affirmation

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1) Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2) Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3) Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4) Notify the County IHSS office when I hire or fire a provider.

In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1) In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2) If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3) The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4) I will be responsible for paying for any services I receive that are not included in my IHSS authorization.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity, I may be subject to unannounced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

Section 9 – Signature(s)

Signature of Applicant:	Date:
Signature of Applicant's Representative (only if applicable):	Date:
Representative's Relationship to Applicant (only if applicable):	Representative Telephone Number (only if applicable):
Representative's Address (only if applicable):	

To report suspected fraud or abuse in the provision or receipt of IHSS services, please call the fraud hotline at 1-800-822-6222, email at stopmedicalfraud@dhcs.ca.gov , or go to http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx .

FOR AGENCY USE ONLY

Income Eligible: Yes No	Status Eligible: Yes No	Verification:
Signature of Social Worker or Agency Representative:		Telephone Number:
Recipient Status: Refugee Cuban/Haitian Entrant Neither	Source of Verification for Refuge or Entrant Status (explain):	

Ethnic Codes:

1. White.
2. Hispanic.
3. Black.
4. Other Asian or Pacific Islander.
5. American Indian or Alaskan Native.
7. Filipino.
C. Chinese.
H. Cambodian.
J. Japanese.
K. Korean.
M. Samoan.
N. Asian Indian.
P. Hawaiian.
R. Guamanian.
T. Laotian.
V. Vietnamese.

Language Codes:

O. American Sign Language (AMISLAN or ASL).
1. Spanish - NOA will be issued in Spanish.
2. Cantonese.
3. Japanese.
4. Korean.
5. Tagalog.
6. Other non-English.
7. English.
9. Spanish - NOA will be issued in English.
A. Other Sign Language.
B. Mandarin.
C. Other Chinese Languages.
D. Cambodian.
E. Armenian.
F. Ilacano.
G. Mien.
H. Hmong.
I. Lao.
J. Turkish.
K. Hebrew.
L. French.
M. Polish.
N. Russian.
P. Portuguese.
Q. Italian.
R. Arabic.
S. Samoan.
T. Thai.
U. Farsi.
V. Vietnamese.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
HEALTH CARE CERTIFICATION FORM

A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name:	Date of Birth:
Address:	
County of Residence:	IHSS Case #:
IHSS Worker Name:	
IHSS Worker Phone #:	IHSS Worker Fax #:

B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (To be completed by the applicant/recipient)

I, _____, authorize the release of health care information
(PRINT NAME)
related to my physical and/or mental condition to the In-Home Supportive Services program as it pertains to my need for domestic/related and personal care services.

Signature: _____ Date: _____/_____/_____
(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

Witness (if the individual signs with an "X"): _____ Date: _____/_____/_____

TO: LICENSED HEALTH CARE PROFESSIONAL* –

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This health care certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual's present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

**Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.*

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM HEALTH CARE CERTIFICATION FORM

Applicant/Recipient Name:	IHSS Case #:

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.

1.	**Is this individual unable to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)?**	☐ **YES** ☐ **NO**
2.	**In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?**	☐ **YES** ☐ **NO**

***If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below**, and complete the rest of the form including the certification in PART D at the bottom of the form.*

***If you answered "YES" to both Question #1 AND #2, respond to Questions #3 and #4 below,** and complete the certification in PART D at the bottom of the form.*

3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program:

4.	**Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months OR expected to result in death within 12 months?**	☐ **YES** ☐ **NO**

Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

6. How long have you provided service(s) to this individual?

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

8. Indicate the date you last provided services to this individual: ____ / ____ / ____

NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and all information provided above is correct.

Name:	Title:
Address:	
Phone #:	Fax #:
Signature:	Date:
Professional License Number:	Licensing Authority:

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.

Applicant Questionnaire

Your name:
_____

Do you currently receive Medi-Cal benefits: ☐ yes ☐ no

What is the nature of your disability or illness? _____
_____
_____
_____
_____

Who is your primary physician? _____

Names, ages, and relationship to you of <u>all</u> people living with you:
_____
_____
_____
_____
_____
_____

Does anyone help you now? (Name :)_____

What time of day would be best to call you? _____

Directions to your home: _____
_____
_____
_____
_____
_____
_____

HOW DID YOU LEARN OF IHSS? _____