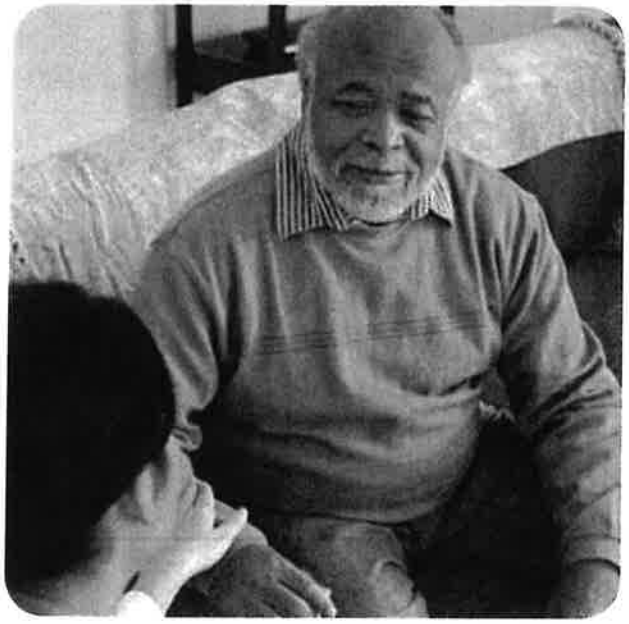
Overview of the IHSS Program

The IHSS program provides services to eligible people over the age of 65, the blind and/or disabled.

The goal of the IHSS program is to allow you to live safely in your own home and avoid the need for out of home care.

Services almost always need to be provided in your own home. This could be a house, apartment, hotel, or the home of a relative.

If you receive Supplemental Security Income (SSI) or meet all Medi-Cal income eligibility requirements, you may be able to receive IHSS services. IHSS is a Medi-Cal program and is funded by federal, state, and county dollars.



Services

These are the types of services IHSS can provide:

- Personal care services like dressing, bathing, feeding, toileting
- Paramedical services like helping with injections, wound care, colostomy and catheter care under the direction of a licensed medical professional
- House cleaning
- Cooking
- Shopping
- Laundry
- Accompaniment to and from medical appointments

Some of the things IHSS cannot pay for include:

- Moving furniture
- Paying bills
- Reading mail to you
- Caring for pets, including service animals
- Gardening
- Repair services
- Sitting with you to visit or watch TV
- Taking you on social outings
- Waiting for you in the doctor's office

Mono County
Department of Social Services
452 Old Mammoth Road
PO Box 2969
Mammoth Lakes, CA 93546
760-924-1770
ask for IHSS assistance

Application Process

1. How to Apply

Contact the In-Home Supportive Services program in your county. A county representative will ask you questions to gather information about the nature of your disability, things that you need help with, your income, and assets. This may take up to 20 minutes.

2. Home Visit

A social worker will come to your home to determine the types of authorized services that you need and the number of hours for each service. Some of the things the county will consider are your medical condition, living arrangement, and any resources that may already be available.

3. Health Care Certification Form

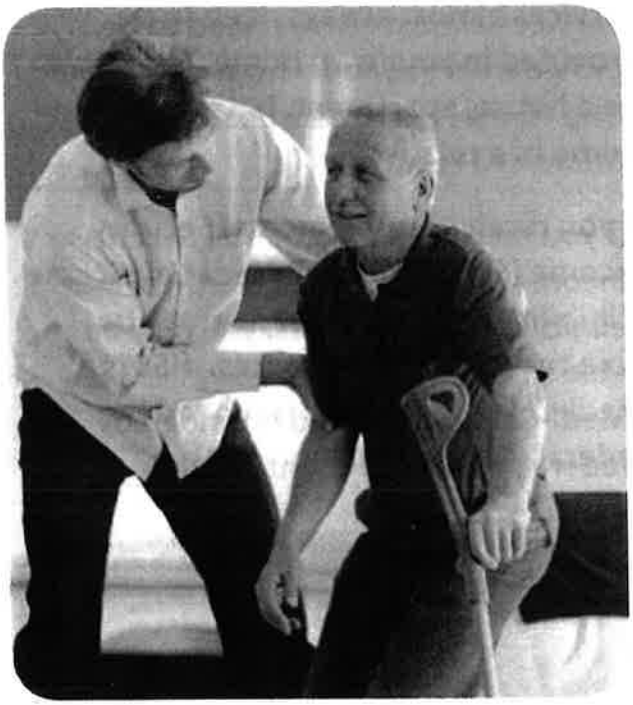
You will receive a form for your doctor to complete, certifying your need for IHSS. This form must be completed before services can be authorized.

4. Authorization

The county will send you a Notice of Action (NOA) telling you if you have been approved for IHSS. The NOA will specify what services have been approved, how much time is authorized for each service, and how many total monthly hours have been approved.

Hiring Provider(s)

Once eligibility is established, you can hire one or more people to provide your care. A friend or relative may serve as your care provider, or a referral may be obtained through the IHSS Public Authority Caregiver Registry. Your care provider must complete all the necessary provider enrollment steps prior to starting work. You or your provider can contact your social worker or Public Authority for more information about provider enrollment requirements.



Mono County Public Authority:
Community Service Solutions
26 HFU Circle Unit 1
PO Box 346
Coleville, CA 96107
530-495-2700

APPLICATION FOR IN-HOME SUPPORTIVE 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, or that you apply for a Social Security Number(s) with the Social Security Administration. 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 of Applicant:			**Social Security Number:**
Street Address:			**City:**
State:	**Zip Code:**	**Telephone:**	
		Email:	
Date of Birth:		**Sex:** ☐ **Male** ☐ **Female**	

Section 2 – Sexual Orientation and Gender Identity (Optional)

Providing responses in the sections below is optional and confidential. Any information you provide in this section will not be used in your eligibility determination.

What is your gender identity?
(check the box that best describes your current gender identity)

- ☐ Female
- ☐ Male
- ☐ Transgender: male to female
- ☐ Transgender: female to male
- ☐ Non-Binary (neither male nor female)
- ☐ Another gender identity
- ☐ Decline to state

What sex was listed on your original birth certificate? ☐ Female ☐ Male
How do you describe your sexual orientation? Select one answer. ☐ Straight/heterosexual ☐ Another sexual orientation ☐ Gay or lesbian ☐ Unknown ☐ Bisexual ☐ Decline to state ☐ Queer

Section 3 – 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 4 – 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 5 – Past IHSS Information

Have you received In-Home Supportive 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 6 – Household Information

List Household Members:

Name of Spouse:	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**

Section 7 – 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 8 for a list of Ethnicities and Codes)	**B1. What language do you prefer to read?** Please choose one **B2. What language do you prefer to speak?** Please choose one (Please choose one from the list of Languages and Codes on Page 8)

Section 8 – 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 Department of Social Services (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
☐ Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)

(If County Support, describe requested support)

I am Visually Impaired: ☐ Yes ☐ No

If yes, please choose one of the following for each of the three types of Department of Social Services (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 ☐ Telephonic System (4 Digit RAN:) ☐ 18 point font documents ☐ County Support ☐ Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)
(If County Support, describe requested support, including blind-only services)

Section 9 – 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. Notifying the County IHSS office within 10 days 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.
5. I will be responsible for paying my Share-of-Cost (SOC) and informing my individual provider(s) of that SOC.

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

To promote program integrity and quality assurance, I may be subject to (un)announced 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 10 – Signature(s)

Signature of Applicant:	**Date:**
Signature of Applicant's Representative (only if applicable):	**Date:**
Representative's Relationship to Applicant (only if applicable):	**Representative's 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	**Medi-Cal Aid Code:**
MAGI Eligible Recipient: ☐ Disabled 12 months or longer ☐ At risk without IHSS	**Verification:**	
Notes:		
Signature of Social Worker or Agency Representative:	**Telephone Number:**	

Ethnic Codes:

A. White.
B. Hispanic.
C. Black.
D. Other Asian or Pacific Islander.
E. American Indian or Alaskan Native.
F. Filipino.
G. Chinese.
H. Cambodian.
I. Japanese.
J. Korean.
K. Samoan.
L. Asian Indian.
M. Hawaiian.
N. Guamanian.
O. Laotian.
P. Vietnamese.
Q. Other.
R. Mixed Ethnicity.

Language Codes:

1. American Sign Language (AMISLAN or ASL).
2. Spanish - NOA will be issued in Spanish.
3. Cantonese.
4. Japanese.
5. Korean.
6. Tagalog.
7. Other non-English.
8. English.
9. Spanish - NOA will be issued in English.
10. Other Sign Language.
11. Mandarin.
12. Other Chinese Languages.
13. Cambodian.
14. Armenian.
15. Ilacano.
16. Mien.
17. Hmong.
18. Lao.
19. Turkish.
20. Hebrew.
21. French.
22. Polish.
23. Russian.
24. Portuguese.
25. Italian.
26. Arabic.
27. Samoan.
28. Thai.
29. Farsi.
30. Vietnamese.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
NOTICE TO APPLICANT OF HEALTH CARE CERTIFICATION REQUIREMENT

State Law (Welfare and Institutions Code section 12309.1) requires that each person applying for IHSS provide a health care certification from a licensed health care professional (LHCP) before they can get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Health Care Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

The county may accept alternative documentation in place of the SOC 873 as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own and without services you are at risk of placement in out-of-home care,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP within the last 60 days.

Whether you give the SOC 873 to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within **45 days** from the date the county worker requested it.

If you do not provide the SOC 873 or alternative documentation to the county within 45 days, your application for IHSS will be denied. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

Under certain limited circumstances, such as when services are requested because you are being discharged from a hospital or nursing facility and you need services to return safely to your home, or the county determines that you are at risk of placement in out-of-home care, the county may grant an exception that would allow you to get IHSS on a temporary basis before the county receives the completed SOC 873 or alternative documentation. However, even if an exception is granted, you will still be required to provide one of these documents for the county within the 45-day timeframe to determine if you can continue getting IHSS. If you have been granted an exception but you are not able to get the SOC 873 from your LHCP within 45 days, call your social worker **before the due date** to tell him/her why you are not able to meet the due date and ask if the county can grant you more time.

If you have questions about the health care certification requirement, ask the social worker who has been assigned to your case.

DUE BY: ____/____/____

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.

IHSS
IN-HOME SUPPORTIVE SERVICES
TRAINING ACADEMY

A PROJECT OF SAN DIEGO STATE UNIVERSITY SCHOOL OF SOCIAL WORK

Finding, Interviewing, and Hiring a Provider

FINDING A PROVIDER

Hiring a provider is an important task, and you should take the time to find the right person.

As the employer, you can hire anyone who meets IHSS provider enrollment requirements and can meet your needs. This may be a family member, friend, or someone referred from the Public Authority Registry. Other ways to find a provider may be through your church, posting a flyer, placing an ad in your local newspaper, or simply by word of mouth.

Remember to be careful about what personal information you give out about yourself in this process. Never put your home address on a flyer. If you cannot find a provider, contact your county IHSS office or Public Authority for assistance.

INTERVIEWING PROVIDERS

Before you interview a provider, you should take the time to review the services that have been authorized for you and how much time has been authorized for each service. If you feel that one provider cannot provide all of the services you need or work all of the authorized hours, you may wish to hire more than one provider. If you have specific needs, such as a special diet or finding someone who is capable of lifting, be sure to mention this during the interview.

<u>You may find the following steps helpful:</u>

1. Screen applicants through a telephone interview.
2. Meet in person with the strongest candidates.
3. Check references.

Telephone Screening Interview

During this phone call, you should get a good idea of the person's availability, experience, and ability to perform the needed tasks. This is also a good time to let them know that IHSS providers must attend a provider orientation, be fingerprinted, and pass a background check. If you are satisfied with the person, the next step would be to set up a time to meet with him/her to discuss your needs and authorized services and find out more about him/her.

Face-to-Face Interview

This interview can take place in your home or in a public place nearby. Consider asking a friend or family member to join you so that they can help with the interview and help decide who to hire. If possible, it is a good idea to interview more than one person. Make notes during the interview that you can refer to later when checking references or choosing who to hire.

Here is some additional information to talk about during the interview:

- Ask to see identification. This may be a valid California driver's license or identification card with a photo.
- Explain your expectations for work behavior including the use of your belongings, arrival and departure times, and other information that will be important for the person you hire to know.
- Go over the services and hours authorized for you.
- Ask if they have been an IHSS provider before, and if they have gone through the provider enrollment process, including being fingerprinted.
- Give them a chance to ask you questions about the job and the services that you need.

CHECKING PROVIDER REFERENCES

Checking references will provide you with valuable information about the person you are thinking about hiring. When calling references, ask questions that will give you an idea of the kind of work they did, how long they were employed, their reliability, and their strengths and weaknesses. Keep notes about what the references tell you as this may help you decide who to hire.

MAKING THE DECISION

Look at your notes and compare the strengths, qualifications, and references of each person you interviewed and decide which one best meets your needs. Once you have made your decision, let the person know and then contact your county IHSS office so that your provider can begin the enrollment process if they have not already done this.

For more information, contact your local county IHSS office.

CDSS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES | SAN DIEGO STATE UNIVERSITY

IHSS
IN-HOME SUPPORTIVE SERVICES
TRAINING ACADEMY

A PROJECT OF SAN DIEGO STATE UNIVERSITY SCHOOL OF SOCIAL WORK

Getting Started With Your New Provider

STARTING OFF ON THE RIGHT FOOT

During your first meeting with a new provider, it is important to tell them what you expect. It is best to talk about any difficult issues and agree on things before he/she starts work.

Some of the things you may want to talk to your provider about are listed below.

- **Authorized tasks review**
  Explain what tasks the provider will be doing for you and how much time he/she can spend on each task. The county will send you a list of authorized tasks and the amount of time authorized when they approve or change your hours. Be sure to tell your provider how you would like to have the tasks done.
- **Health issues**
  Tell your provider about any allergies, special diet needs, and other issues that require special care.
- **Infectious diseases**
  It is best for you and your provider to tell each other if either of you have any infectious diseases, including HIV, Hepatitis, Tuberculosis (TB), and others.
- **Supplies**
  Show the provider where supplies are kept and how to correctly use any special equipment.
- **Medications**
  Explain what help you need, if any, and go over your daily medication schedule.
- **Emergency information**
  Share all of the information your provider needs to know if an emergency happens. Include who to call in case of an emergency and how to get out of the house. Post emergency information in an easy to see place at all times.

- **Work schedule**
  Be clear on what days your provider will be coming and how many hours he/she will work each day. Agree on a way to keep track of hours so you can make sure the timesheet is filled out correctly. Consider using a calendar or note pad as a way to keep track of tasks and hours worked each day.
- **Contact information**
  Give each other all the telephone numbers where you can be reached and the best times for you to contact each other.
- **Transportation for medical appointments and errands**
  IHSS does not pay for the cost of gas, car insurance, or public transportation. Make sure you are clear on who will pay these costs, and that your provider has car insurance and a valid driver's license.

For more information, contact your local county IHSS office.

CDSS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
SAN DIEGO STATE UNIVERSITY

IHSS
IN-HOME SUPPORTIVE SERVICES
TRAINING ACADEMY

A PROJECT OF SAN DIEGO STATE UNIVERSITY SCHOOL OF SOCIAL WORK

Deciding When to Fire a Provider

As an employer, you have the right to fire your provider for any reason, but you should think about this decision carefully before you take action.

Can the problems be solved?

- It can be hard to tell someone that you no longer need their services. Try to work on any minor problems with your provider before you decide to fire him/her.

Talk to your provider about your concerns.

- Try to tell your provider as soon as you see a problem. It is best not to let problems build up, but if they do, make a list of the things you are unhappy about and decide what must change in order for you to keep your provider. Have an open talk with your provider and reach agreements about any improvements you need to see in his/her job performance. Tell him/her when the improvements will need to be made.
- Remember that communication is a two-way street. Allow your provider to ask questions and be open to any thoughts and concerns he/she may have.
- If you are not comfortable about having this talk alone, ask a friend or family member to be there to support you.

If your provider is not willing to improve.

- If your provider does not improve his/her performance, it may be time to end his/her employment. If it is possible, it is best to give your provider two weeks' notice. This will give him/ her time to get a new provider.

Terminate an unsafe provider right away!

- If your provider is treating you in an abusive or threatening manner, you should call 911 and fire him/her immediately. Your personal safety is most important. If you need help doing this, call your IHSS county office, friends, or family members to help you.

Some reasons for firing your provider might be:

- Not meeting your care needs
- Stealing your money or personal property
- Coming in late often or not coming to work at all
- Using your personal property without permission

If you have to fire your provider without notice, you have several options to find a new person quickly:

- Contact your Public Authority for a list of available providers.
- Ask a family member or friend for short-term help (remember all providers must be fingerprinted and pass a criminal background check to be paid by IHSS).

Always contact your IHSS county office if you change providers.

For more information, contact your local county IHSS office.

CDSS California Department of Social Services | San Diego State University

IHSS
IN-HOME SUPPORTIVE SERVICES
TRAINING ACADEMY

A PROJECT OF SAN DIEGO STATE UNIVERSITY SCHOOL OF SOCIAL WORK

Share-of-Cost

What is a Share-of-Cost?

Most people receive IHSS as a part of their Medi-Cal benefits. Depending on the amount of income received, some people must agree to pay a certain amount each month toward their Medi- Cal expenses, before Medi-Cal will pay. The money that must be paid before Medi-Cal will pay is called a Share-of- Cost (SOC). The SOC allows a person with income above the allowed amount to receive IHSS if he/she agrees to pay the SOC. Your SOC may be paid to your IHSS provider, a pharmacy, doctor's office, or when purchasing other medical services or goods.

How does the Share-of-Cost Work?

You will pay your share to the provider when you receive an "Explanation of Share-of-Cost" letter that identifies the amount of the SOC to be paid that pay period. The SOC amount will also appear on your provider's timesheet under "Share-of-Cost Liability." The amount you need to pay your provider may change each pay period, depending on whether you have paid your SOC for other medical expenses before the timesheet is processed each pay period. If you have more than one IHSS provider, you will not be able to choose which provider your SOC is paid to. Any SOC that you have not paid will be subtracted from the first IHSS provider's timesheet that is processed by the county.

If you or your provider have questions about the SOC, contact your county IHSS or Public Authority office.

CDSS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES | SAN DIEGO STATE UNIVERSITY

Here are some examples of how Share-of-Cost works:

Example 1:

Mrs. Smith has a SOC of $200 for the month of June.	$200
She sees her doctor on the 5th and pays $50 at the doctor's office.	-$50
She fills a prescription on the 6th and pays $60 at the pharmacy.	-$60
The total amount Mrs. Smith has paid toward her SOC is $110 ($50 + $60).	$110
When Mrs. Smith's provider submits his timesheet on the 16th, Mrs. Smith has a remaining SOC balance of $90 ($200 – $110).	$90
The State will deduct $90 from her provider's paycheck.	
Mrs. Smith will need to pay her IHSS provider/employee $90.	$90

Example 2:

Mr. Lee has a SOC of $100 for the month of June.	$100
He sees his doctor on the 5th and pays $75 at the doctor's office.	-$75
He fills a prescription on the 6th and pays $25 at the pharmacy.	-$25
The total amount of Mr. Lee's expenses is $100 ($75 + $25).	$100
Mr. Lee has met his SOC for the month.	$0
Mr. Lee's provider submits her timesheet on the 16th.	
The State will pay for all of the authorized hours worked in June, and Mr. Lee will not have to pay any money to his IHSS provider.	$0

IHSS
IN-HOME SUPPORTIVE SERVICES
TRAINING ACADEMY

A PROJECT OF SAN DIEGO STATE UNIVERSITY SCHOOL OF SOCIAL WORK

Recognizing Abusive Behaviors

Sometimes a provider, family member (including a child), or friend steps over the line and becomes abusive.

In California, abusing a child, a person over 65, or anyone between the ages of 18 and 64 who has physical or mental limitations, is a crime punishable by law.

Abuse can occur in many ways including physical or sexual abuse, financial abuse, neglect, and psychological abuse or intimidation. Here are some examples of abuse:

- Being slapped, hit, choked, pinched, kicked, shoved, raped, or molested.
- Being constantly yelled at, threatened with bodily harm, or threatened to be left alone.
- Being left alone by a care provider when you cannot get necessary food, water, clothing, shelter, or health care.
- Being kept from getting mail, telephone calls, or visitors; or prevented from leaving your home without good reason.
- Having money, property, or items of value being taken by force or without your approval.
- Being neglected by someone who should be providing care, food, or water.

Report Abuse!

If you are being abused, even by a family member, you should get help right away by contacting:

- 911
- Adult Protective Services (APS)

For more information, contact your local county IHSS office.

CDSS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
SAN DIEGO STATE UNIVERSITY