



**In-Home Supportive Services (IHSS) Program
Care Supplement Eligibility Criteria**

IHSS 20% CUT IN IHSS SERVICES

The 2011-2012 California budget required a cut in IHSS services by 20%. The cut in IHSS hours will take place as of January 1, 2012. For more information about the cut please see Disability Rights California publication entitled: In-Home Supportive Services—20% Cut in Services.

The rest of this publication will discuss eligibility for an IHSS Care Supplement. Individuals who qualify for an IHSS Care Supplement will have some or all of their IHSS services restored.

IHSS CARE SUPPLEMENT ELGIBILITY CRITERIA

Consumers whose hours are cut by 20% can apply for an IHSS Care Supplement. State law says IHSS consumers can get an IHSS Care Supplement only there is a serious risk of out-of-home placement. “Out-of-home placement” means that you would have to leave your own home and go live somewhere else such as a board and care home or a nursing home. If you apply for and are approved to receive an IHSS Care Supplement you will have all or part of the 20% cut in your IHSS hours restored.

Examples of consumers who qualify for an IHSS Care Supplement might include:

- Individuals who are on a wait list to receive nursing facility services,
- Individuals with mental health disabilities who are not getting protective supervision and,
- Individuals with cognitive disabilities who are not getting protective supervision.

The county is planning on using more restrictive criteria than this to determine eligibility for the IHSS Care Supplement. We believe the county is wrong. However, you should know what process the county is going to use. If you qualify under the county’s

process, then you don't have to dispute the county's determination. If you don't qualify under the county's process we believe you can still qualify under the criteria listed above. In other words, you can get an IHSS Care Supplement if you are at serious risk of out-of-home placement unless you get back some or all of your IHSS hours

The county will go through two steps to decide eligibility for an IHSS Care Supplement.

STEP ONE - The county will first look at the following:

A) You must meet any three or more of the following conditions:

- Paramedical Services must be authorized to monitor medical condition and/or give injections.
- A functional ranking for Mobility Inside of 4 or 5;
- A functional ranking for Bathing and Grooming of 4 or 5;
- A functional ranking for Dressing of 4 or 5;
- A functional ranking for Bowel, Bladder or Menstrual of 3, 4 or 5, or Paramedical Services must be authorized for catheter or colostomy care;
- A functional ranking for Transfer of 4 or 5, or Paramedical Services must be authorized for bed sore care;
- A functional ranking for Eating of 3, 4 or 5; or
- A functional ranking for Respiration of 5.

OR

B) The sum of your functional rankings for Memory, Orientation and Judgment is equal to 7 or greater.

See the last page of this flyer for information about what the functional index rank numbers mean. Information about your functional index rankings can be obtained by you or your authorized representative by contacting your IHSS social worker and asking for a copy of your SOC 293 form. The SOC 293 form is a computer generated form. You have the right to this information. You should explain to the IHSS social worker that you need this information to determine if you will be affected by the cuts and to challenge a denial of an IHSS Care Supplement application.

STEP TWO - The county will need to decide whether or not the reduction in hours will create a serious risk of out-of-home care. This means that even if you meet the

conditions in the first part of this section, the county can still find that you are not eligible for the IHSS Care Supplement. The county will deny the application for an IHSS Care Supplement if the county finds that your hours can be reduced in whole or in part without creating a serious risk of out-of-home placement. Attachment H at the end of this publication is a copy of the assessment worksheet used by the county to determine eligibility for an IHSS Care Supplement.

Here is what the county will do:

- Assist you to revise the way your authorized hours are used so that the serious risk is eliminated. In other words, assist you to prioritize the hours available so that the most essential tasks are completed.
- Arrange for you to receive services from an alternative resource. For example, your local church or food bank. Note: The alternative resource has to agree in writing to provide the resource for free.
- Restore part of the hours to ensure that the serious risk is eliminated; or
- Restore all of the hours to ensure that the serious risk is eliminated.

You will need to explain to the county that you need all or some of the authorized IHSS hours in order to avoid a serious risk of out-of-home placement. You will also need to explain to the county why prioritizing the hours won't work. You should explain this on the IHSS Care Supplement application form in as much detail as possible. For example:

- there is a risk of pest infestation as a result of not getting domestic services or,
- there is a risk of deterioration in medical condition as a result of not getting transportation to and from a medical appointment or,
- the consumer needs prompting to eat and not getting the prompting means the consumer will not eat or,
- the consumer has a problem with hoarding and cluttering and needs all of the IHSS services to avoid eviction or,
- a provider will quit and the consumer can't find anyone else who will do the work.

Attached is a form that a consumer may use to get information from their doctor about their functional limitations and serious risk of out-of-home placement if IHSS hours are reduced. There will also be a place on the form where the doctor can explain why the

consumer needs all of their authorized IHSS hours in order to avoid serious risk of out-of-home placement.

NOTE: You have the right to determine how IHSS tasks will be prioritized or rearranged to best meet your needs after the 20% reduction. No one can tell you how to prioritize your IHSS tasks to stay within the 20% reduction.

APPEAL RIGHTS

Consumers who are denied an IHSS Care Supplement have the right to request a hearing. If you request a hearing before the date the cuts go into effect be sure to ask for aid paid pending. Aid paid pending will allow the services to continue at the same level pending the outcome of a fair hearing.

Consumers also have the right to request a reassessment or apply for an IHSS Care Supplement at any time when there has been a change in circumstances that requires a change in the amount of hours a consumer needs or there is a risk of out-of-home placement. Be sure to explain what the change in circumstances is if you are asking for a reassessment. Consumers can request a hearing when denied reassessment or an IHSS Care Supplement or to challenge a notice of action with which a consumer disagrees.

EXPLANATION OF FUNCTIONAL INDEX RANKINGS

Rank 1: Independent: able to perform function without human assistance, although the consumer 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 consumer who ranks a "1" in any function shall not be authorized the correlated service activity.

Rank 2: Able to perform a function, but needs **verbal assistance**, such as reminding, guidance, or encouragement.

Rank 3: Can perform the function with **some human assistance**, including, but not limited to, direct physical assistance from a provider.

Rank 4: Can perform a function but only with **substantial human assistance**.

Rank 5: Cannot perform the function, with or without human assistance.

Physician's Survey Regarding Functional Limitations

Your patient is a recipient of In-Home Supportive Services (IHSS). The IHSS program provides attendant care services for people who cannot perform certain tasks (i.e. activities of daily living) for themselves. The services are provided in a person's home so the person can continue to live safely at home.

As of January 1, 2012, IHSS hours will be cut by 20% for individuals who are not at serious risk of out-of-home placement. Some or all of the hours can be reinstated if your patient qualifies for the IHSS Care Supplement. The County will decide eligibility for the IHSS Care Supplement based, in part, on your patient's Functional Index Ranks. Functional Index Ranks are measures of functional limitations.

You can help your patient provide the county with up to date information about their functional limitations by completing the attached survey.

PLEASE COMPLETE THIS SURVEY

Patient Name:

DOB:

Diagnosis:

Prognosis:

Date Patient Last Seen By You:

INSTRUCTIONS

For each Activity of Daily Living (ADL), please place a check by the patient's level of functional ability and need for assistance. At the end of each section or on a separate sheet of paper, please indicate the potential consequences if the patient is not provided with appropriate assistance.

(AMBULATION) MOBILITY INSIDE: MPP § 30-757.14(k)

Walking or moving around inside the house, changing locations in a room, moving from room to room. Can respond adequately if (s) he stumbles or trips. Can step over or maneuver around pets or obstacles, including uneven floor surfaces. Climbing or descending stairs if stairs are inside dwelling. Does **not** refer to transfers, to abilities or needs once destination is reached, to ability to come into or go out of the house, or to moving around outside.

- Independent: Requires no physical assistance though consumer may experience some difficulty or discomfort. Completion of the task poses no risk to his/her safety.

 - Can move independently with only reminding or encouragement. For example, needs reminding to lock a brace, unlock a wheelchair or to use a cane or walker.

 - Requires physical assistance from another person for specific maneuvers; e.g., pushing wheelchair around sharp corner, negotiating stairs or moving on certain surfaces.

 - Requires assistance from another person most of the time. At risk if unassisted.

 - Totally dependent upon others for movement. Must be carried, lifted or pushed in a wheelchair or gurney at all times.
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Please briefly describe how your patient's functional limitations limit your patient's mobility and the potential consequences if the patient does not get help:

inappropriate or inadequate clothed.

- Unable to dress self at all. Requires complete assistance from another.
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Please briefly describe how your patient's functional limitations limit your patient's ability to dress and the potential consequences if the patient does not get help:

BOWEL, BLADDER, AND MENSTRUAL: MPP §§ 30-757.14(A) & 30-757.14(J)

Assisting person to and from, on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads. Menstrual care limited to external application of sanitary napkin and cleaning. (NOTE: Catheter insertion, ostomy irrigation and bowel program are evaluated as Paramedical Services.* Getting to and from bathroom is evaluated as Mobility Inside.)

- Independent: Able to manage bowel, bladder and menstrual care with no assistance from another person.
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- Requires reminding or direction only.
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- Requires minimal assistance with some activities but the constant presence of the provider is not necessary.
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- Unable to carry out most activities without assistance.
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- Requires physical assistance in all areas of care.
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Please briefly describe how your patient's functional limitations limit your patient's ability manage bowel, bladder and menstrual care and the potential consequences if the patient does not get help:

TRANSFER: MPP § 30-757.14(H)

Moving from one sitting or lying position to another sitting or lying position; e.g., from bed to and from a wheelchair, or sofa, coming to a standing position and/or repositioning to prevent skin breakdown. (NOTE: If pressure sores have developed, the need for care of them is evaluated as a Paramedical Service.)

- Independent: Able to do all transfers safely without assistance from another person.
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- Able to transfer but needs encouragement or direction.
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- Requires some help from another person; e.g., routinely requires a boost or
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assistance with positioning.

- Unable to complete most transfers without physical assistance. Would be at risk if unassisted.
 - Totally dependent upon another person for all transfers. Must be lifted or mechanically transferred.
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Please briefly describe how your patient's functional limitations limit your patient's ability to transfer and the potential consequences if the patient does not get help:

FEEDING: MPP § 30-757.14(c)

Reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, chewing, swallowing food and liquids, manipulating food on plate. Cleaning face and hands as necessary following a meal.

- Independent: Able to feed self.
 - Able to feed self, but needs verbal assistance such as reminding or encouragement to eat.
 - Assistance needed during the meal e.g., to apply assistive device, fetch beverage or push more food within reach, etc., but constant presence of another person not required.
 - Able to feed self some foods, but cannot hold utensils, cups, glasses, etc., and requires constant presence of another person.
 - Unable to feed self at all and is totally dependent upon assistance from another person.
 - Is tube fed. All aspects of tube feeding are evaluated as a Paramedical Service.*
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Please briefly describe how your patient's functional limitations limit your patient's ability to feed herself/himself and the potential consequences if the patient does not get help:

RESPIRATION: MPP § 30-757.14(B)

Respiration is limited to non-medical services such as assistance with self-administration of oxygen and cleaning oxygen equipment and IPPB machines.

- Does not use respirator or other oxygen equipment or able to use and clean
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independently.

Needs help with self-administration and/or cleaning.

Needs Paramedical Service such as suctioning.*

Please briefly describe how your patient's functional limitations limit your patient's ability to respire and the potential consequences if the patient does not get help:

MENTAL FUNCTIONING ASSESSMENT

Please check appropriate box
(No more than 1 box for each mental functional limitation)

Memory: Recalling learned behaviors and information from distant and recent past.

- No problem: Memory is clear; consumer is able to give you accurate information about his/her medical history; is able to talk appropriately about comments made earlier in the conversation; has good recall of past events.

 - Memory loss is moderate or intermittent: Consumer shows evidence of some memory impairment, but not to the extent where (s)he is at risk; consumer needs occasional reminding to do routine tasks or help recalling past events.

 - Severe memory deficit: Consumer forgets to start or finish activities of daily living which are important to his/her health and/or safety. Cannot maintain much continuity of thought in conversation with you.
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Please briefly describe how your patient's memory limitations limit his/her ability to complete ADL and the potential consequences if the patient does not get help:

Orientation: Awareness of time, place, self and other individuals in one's environment.

- No problem: Orientation is clear. Consumer is aware of where (s)he is and can give you reliable information when questioned about activities of daily living, family, etc.; is aware of passage of time during the day.

 - Occasional disorientation and confusion apparent but does not put self at risk: Consumer has general awareness of time of day; is able to provide limited information about family, friends, daily routine, etc.

 - Severe disorientation which puts consumer at risk: wanders off; lacks awareness or concern for safety or well-being; unable to identify significant
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others or relate safely to environment or situation; no sense of time of day.

Please briefly describe how your patient's orientation limitations limit his/her ability to complete ADL and the potential consequences if the patient does not get help:

Judgment: Making decisions so as not to put self or property in danger; safety around stove. Capacity to respond to changes in the environment, e.g., fire, cold house. Understands alternatives and risks involved and accepts consequences of decisions.

- Judgment unimpaired: Able to evaluate environmental cues and respond appropriately.
 - Judgment mildly impaired: shows lack of ability to plan for self; has difficulty deciding between alternatives but is amenable to advice; social judgment is poor.
 - Judgment severely impaired: fails to make decisions or makes decisions without regard to safety or well-being.
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Please briefly describe how your patient's judgment limitations limit his/her ability to complete ADL and the potential consequences if the patient does not get help:

Other Functional Limitations

Please list any other functional limitations that were not described above. For example: breathing, seeing, hearings, walking, standing, bending, reaching, grasping, carrying, sitting, turning, weakness in limbs, loss of use of limbs, endurance, fatigue, etc.

Does your patient need paramedical services to monitor medical condition and/or give injections? Yes No

Does your patient need paramedical services for catheter or colostomy care? Yes No

Does your patient need paramedical services for bed sore care? Yes No

Does your patient need all of their IHSS hours in order to avoid a serious risk of out-of-home placement? Yes No

Please explain:

I certify that I am licensed to practice medicine in the State of California and that the information provided above is correct.

Signature of Professional: _____	Print Name: _____
Date: _____	Medical specialty: _____
Address: _____	License No.: _____
City: _____ State: _____	Telephone: _____

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
SUPPLEMENTAL CARE WORKSHEET**

Recipient/Applicant Name:	Case #:
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SERIOUS RISK OF OUT-OF-HOME PLACEMENT

BASIS: 20% reduction puts recipient/applicant at serious risk of out-of-home placement.

A	YES	NO	STANDARD: Three (3) or more "YES" responses for the following items indicate serious risk in this category.
1	<input type="checkbox"/>	<input type="checkbox"/>	Paramedical Services authorized to monitor medical condition and/or give injections (SOC 293, Field YY, or SOC 321)
2	<input type="checkbox"/>	<input type="checkbox"/>	Ranked 4 or 5 for Mobility Inside (SOC 293, Field H1)
3	<input type="checkbox"/>	<input type="checkbox"/>	Ranked 4 or 5 for Bathing and Grooming (SOC 293, Field H1)
4	<input type="checkbox"/>	<input type="checkbox"/>	Ranked 4 or 5 for Dressing (SOC 293, Field H1)
5	<input type="checkbox"/>	<input type="checkbox"/>	Ranked 3, 4 or 5 for Bowel, Bladder and Menstrual Care (SOC 293, Field H1), or Paramedical Services authorized for catheter or colostomy care (SOC 293, Field YY, or SOC 321)
6	<input type="checkbox"/>	<input type="checkbox"/>	Ranked 4 or 5 for Transfer (SOC 293, Field H1), or Paramedical Services authorized for bed sore care (SOC 293, Field YY, or SOC 321)
7	<input type="checkbox"/>	<input type="checkbox"/>	Ranked 3, 4 or 5 for Eating (SOC 293, Field H1)
8	<input type="checkbox"/>	<input type="checkbox"/>	Ranked 5 for Respiration (SOC 293, Field H1)

B	YES	NO	STANDARD: A "YES" response for the following item indicates serious risk in this category.
1	<input type="checkbox"/>	<input type="checkbox"/>	Ranks for Memory, Orientation and Judgment total 7 or more (SOC 293, Field H1)

IHSS SUPPLEMENTAL CARE REQUEST DISPOSITION

Complete this section only if recipient/applicant is determined to be at serious risk. Stop at first "YES".

	YES	NO	ACTION
1	<input type="checkbox"/>	<input type="checkbox"/>	Not at serious risk for out-of-home placement – Recipient/applicant has changed assignment of tasks.
2	<input type="checkbox"/>	<input type="checkbox"/>	Not at serious risk for out-of-home placement – Following alternative resource(s) will provide essential services:
3	<input type="checkbox"/>	<input type="checkbox"/>	At serious risk for out-of home placement – Proposed reduction partially restored. Number of hours restored: _____
4	<input type="checkbox"/>	<input type="checkbox"/>	At serious risk for out-of home placement – Total proposed 20% reduction restored.

D	IHSS Worker Name:	Signature:	Date:
	Supervisor Name:	Signature:	Date: