(IHSS)

In-Home Supportive Services

IHSS Program Services and Eligibility Requirements

- Purpose
- Residency
- Linkage
- Financial Eligibility
- Services Provided
- Need Determination
- Application Methods
- Providers

Purpose of IHSS

- To provide services to eligible individuals (disabled, blind, or aged over 65) to remain in the home safely. The goal of this program is to allow people to remain safely in their own homes and avoid placement outside the home.

Residency

IHSS applicant must be:

- California resident

Meet U.S. Residency Requirements

- U.S. Citizen
- Eligible Alien
- Lawfully admitted for permanent residency
- PRUCOL-Permanently Residing Under Color of Law
- Live in their “own home”
- Not living in a Board & Care facility, skilled nurse facility, intermediate care facility or hospital.

Linkage

IHSS applicant must have active Medi-Cal and meet one of the following:

- Aged, Blind, or *Disabled
- SSI / SSP eligible

*Disability has lasted or is expected to last 12 consecutive months or can be expected to result in death within 12 months.

Financial Eligibility

- Funded by Federal, State and County Funds.
- If on SSI/SSP, financial eligibility is automatic. (Must still meet all medical eligibility requirements to receive IHSS services)
- If not on SSI/SSP, an IHSS Medi-Cal Eligibility Worker will determine eligibility by reviewing client's income and resources. Client's income will determine his/her Share of Cost.

Services Provided Under IHSS

Domestic & Related Services

- Housecleaning (light)
- Laundry
- Shopping for food
- Errands
- Meal Preparation
- Meal Cleanup

Continued…

Personal Care Services:

- Transferring
- Ambulation
- Bathing / Grooming
- Bowel & Bladder Care
- Feeding
- Rubbing Skin / Repositioning
- Dressing
- Menstrual Care
- Assistance with Medications
- Respiration
- Medication set up

Paramedical Services

Services which include:

- Administering medication (beyond nonmedical personal care)
- Puncturing the skin
- Inserting medical device into an orifice
- Activities requiring sterile procedures
- Other activities requiring judgement based on training given by a Licensed Health Care Professional

Service must be ordered and directed by a Licensed Health Care Professional with completion of SOC 321 form.

Accompaniment / Transportation Services

- Accompaniment to and from Medical Appointments
- Accompaniment to and from Alternative Resources
- Wait Time
  - Under certain circumstances this service is allowable while the provider waits for client if any of the above are authorized.

Protective Supervision

- Available to safeguard a non-self-directing, confused, mentally impaired or mentally ill person from injury, hazard, or accident
- Client must have the physical ability to put themselves in danger.
- The individual needs 24-Hour-a-Day supervision, behavior is not episodic and has to be unpredictable in nature.
- IHSS cannot fund 24-hour but a 24-hour care plan must be in place.

Services Not Available

Moving furniture

• Paying bills

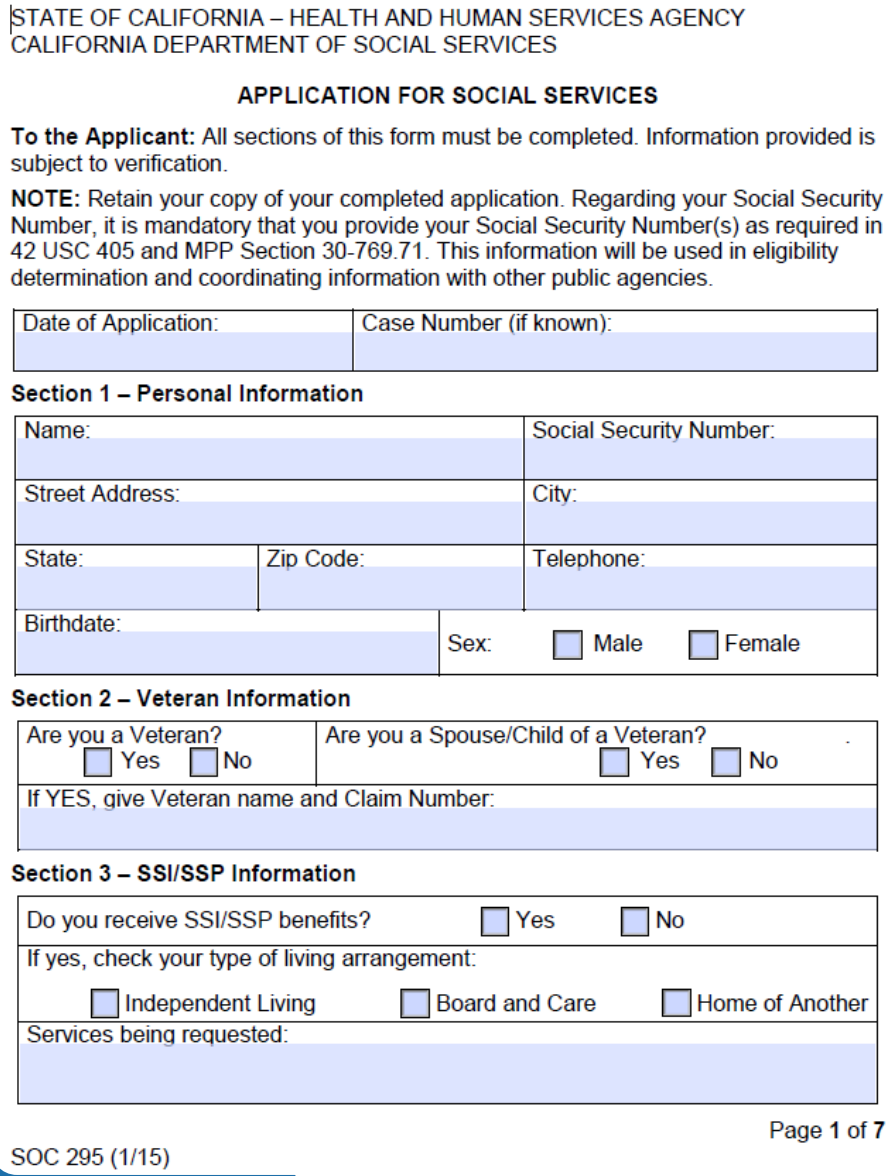
• Reading the mail to the recipient

• Caring for pets

• Gardening

• Sitting with the recipient to visit or to watch TV

• Taking the recipient on social outings



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:

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SOC 295 (1/15)

Application

Complete SOC 295 Application

- **In Person or Mail-In**

IHSS Ventura/Oxnard Regional Office
4245 Market St., Suite 204
Ventura CA 93003
805-654-3260 Fax 654-3206

IHSS Simi Valley Regional Office
2900 N. Madera Rd., Suite 110
Simi Valley CA 93065
805-306-7935 Fax 306-7910

- **Email** : hsa-ihss-applications@ventura.org

Application continued

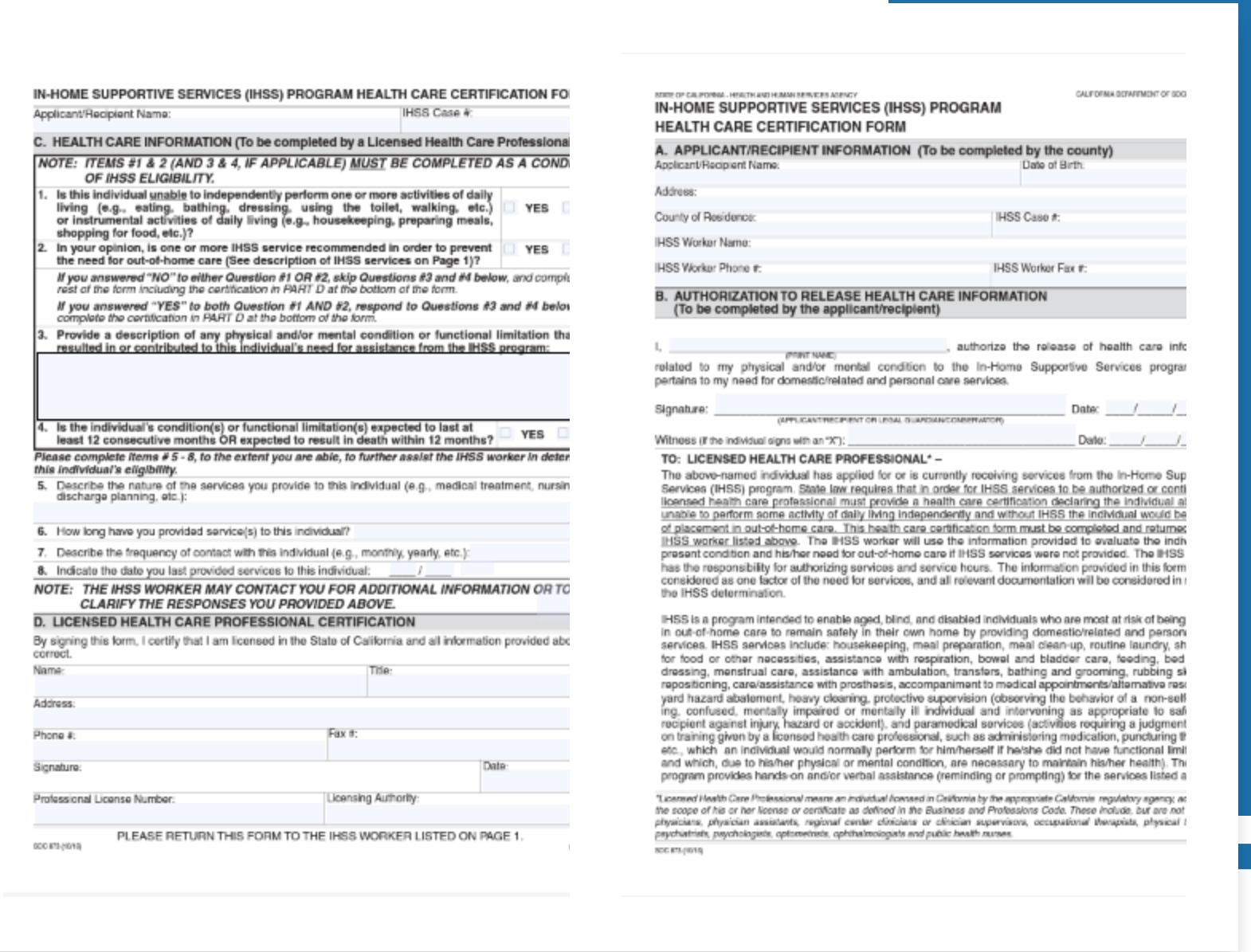
If MEDS eligibility is found, the SOC 873 is mailed out with a 45-day deadline

a physician or other licensed health care professional must fill out the Health Care Certification Form (SOC 873) and you must return it to the county before care services can be evaluated.

*Two exceptions allow the authorization of IHSS services prior to the receipt of the SOC 873 or alternative documentation:

– When IHSS services are needed to enable the individual just discharged from a health care facility to return safely to their own home or community.

– When the county determines that there is a risk of out-of-home placement and receipt of the certification is pending.



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

Applicant/Recipient Name: IHSS Case #:

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professiona

NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A COND 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
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

If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below, and compl 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 belo 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 tha 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

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

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursin 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 abo 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.

SOC 873 (10/13)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOC

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

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

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

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

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

SOC 873 (10/13)

IHSS Need Determination

Intake Social Worker conducts an initial assessment of the client in their own home. The Social Worker will evaluate and observe:

- Physical & Mental Limitations
- Functional Abilities
- Living Arrangements

Assessments----What to expect

Reassessments

IHSS recipients can expect annual Face 2 Face assessments in their home to ensure their needs are being appropriately met through program services.

Change assessments

- Due to circumstance change such as:

Post Hospitalizations

Post Surgeries

IHSS Providers

- Any individual can be selected by the IHSS client to provide the approved IHSS services
- The client/AR selects, hires, supervises, and manages the provider
- The individual must register with Public Authority