County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

AGING & INDEPENDENCE SERVICES
P.O. BOX 23217, SAN DIEGO, CALIFORNIA 92193-3217

Select Date

Enter Client's Name
Enter Address
Enter City, State and Zip Code

This letter is to inform you that your application for In-Home Supportive Services (IHSS) has been received. The IHSS Program assists eligible aged, blind, and disabled individuals who are unable to remain safely in their own homes without assistance. IHSS is an alternative to out-of-home care. You must have the enclosed "IHSS Health Certification" form completed by your doctor, and it must be returned within 45 days of the above date, or the application may be denied. A return envelope is enclosed.

To be eligible for an IHSS evaluation, you must be eligible to Medi-Cal. When you receive a Medi-Cal application packet in the mail, complete the Medi-Cal application immediately and return it with photocopies of any requested verifications in the return envelope provided. **Your application for Medi-Cal must be approved before your IHSS application can be processed.** If you are unable to complete the application, arrange to have a relative or a friend assist you.

If you are *currently paying for* or *within the last three months* have paid out-of-pocket for medically necessary services:

- Keep your receipts and payment records of your expenses
- Request that your Medi-Cal be retroactive when you complete the Medi-Cal application

If you are approved for IHSS services, you may file a claim for reimbursement of caregiver expenses with the California Department of Social Services. To file a claim:

- Contact the Department of Health Care Services (DHCS) Beneficiary Services Center (BSC) at (916) 403-2007 to request a Conlan II claim packet for IHSS.
- Complete the claim packet and return it directly to the BSC at the address provided on the claim packet.

To request the status of your claim, call the toll free number at (877) 508-1327.

If you have specific questions regarding your ***Medi-Cal application***, please contact the ACCESS Center at 1-866-262-9881 or by e-mail at: pubassist.hhsa@sdcounty.ca.gov

If you have any questions related to your ***IHSS application***, or if you receive information on the status of your application for Medi-Cal or Social Security, call the Social Worker listed below.

Enter SW Name Enter SW Number
Enter SW Telephone Number
Select District Office

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April 12, 2013

Enter Client's Name
Enter Address
Enter City, State and Zip Code

Case Number: CMIPS Case Number

Select Menu 1 Text

Enter SW Name Enter SW Number Enter SW Telephone Number

Select Menu 2 Text

Select Menu 3 Enclosed Information Text

Select District Office

12-53B INITIAL CONTACT-CASE REASSIGNMENT MENU OPTIONS

INTAKES

SELECT FIRST CHOICE ON DROP DOWN MENU

Menu 1

This letter is to inform you that the Social Worker assigned to your In-Home Supportive Services (IHSS) application is

Esta carta es para informarle que el trabajador social asignado a su solicitud de Servicios de Apoyo en el Hogar (IHSS, por sus siglas en inglés) es

Menu 2

You will be contacted by phone or letter regarding a visit in your home to discuss your application for services.

Usted será contactado por teléfono o por escrito con respecto a una visita a su hogar para hablar sobre su solicitud de servicios.

Menu 3 - Enclosed Information

The enclosed Medical Certification form must be completed by your doctor and returned to your Social Worker within 45 days or your application will be denied. A return envelope has been enclosed.

El formulario adjunto "Medical Certification Form" debe ser completado por su médico y regresado a su trabajador social dentro de 45 días o su aplicación será negada. Un sobre ha sido incluido.

SOCIAL WORKER REASSIGNMENT

SELECT SECOND CHOICE ON DROP DOWN MENU

Menu 1

This letter is to inform you that your In-Home Supportive Services (IHSS) case has been assigned to a different Social Worker. Your new Social Worker is

Esta carta es para informarle que el trabajador social asignado a su caso de Servicios de Apoyo en el Hogar (IHSS, por sus siglas en inglés) a cambiado. Su Nuevo trabajador social es

Menu 2

The Social Worker will contact you once a home visit needs to be scheduled.

El trabajador social se comunicara con usted cuando sea necesario programar una cita.

Menu 3 - Enclosed Information

A response to this letter is not required.

No se requiere una respuesta a esta carta.

IHSS CASE ASSIGNMENT LOG

REFFERAL DATE	CASE NAME	LANGUAGE	CLIENT NUMBER (AIS SUITE	AID CODE	CASE NUMBER	SW ASSIGNED	DATE ASSIGNED	ASSIGNED BY	COMMENTS

Case Name: _____ SSN: _____

CMIPS II Case Number: _____

SUBMITTED FOR SCANNING (SWS / SW)		DOCUMENT(S) PREPARED		SCANNED AND VALIDATED INTO KOFAX		WEBTOP VERIFICATION		SHREDDING OF DOCUMENT(S)	
Name	**Date**	**Name**	**Date**	**Name**	**Date**	**Name**	**Date**	**Name**	**Date**

- Documents submitted for scanning must be placed in a *Scanning Folder* and include the form 12-90 HHSA - *Document Imaging Log.*
- The form 12-90 should be placed on top of the documents to be scanned.
- The Social Worker is responsible for completing the case name and CMIPS II case number.
- Worker numbers should not be used in lieu of a name.
- The date the documents are submitted for scanning must not reflect the date that the documents are submitted to a Social Work Supervisor for review.
- Documents can be prepared, scanned and verified by the same individual.
- Documents that have been scanned must be retained in the *Scanning Folde*r for 30 business days and cannot be shredded by the same individual who scanned and validated the documents.
- Once completed, the log will be scanned into WebTop when the case has been denied, withdrawn, terminated or transferred.
- The log will be retained in the *Scanning Folder* for all other cases.

Call Center Case Note Template

Instructions: Copy the information and paste into a case note CMIPSII.

Note: Tables, bold italicized, and underlined text; indents; and check boxes do not convert into CMIPSII.

Referring Person:		**Phone:**		**Relationship:**	
RP Organization:	N/A			**Referral Type:**	

Client's Name:				**Marital Status:**	
SSN:		**DOB:**		**CIN:**	

Client's Address:		**City:**		**Zip:**	
Residence Type:		**Lives with:**		**Current Location:**	HOME
Home Phone:		**Cell:**	---	**Message:**	---

Ethnicity:		**Language:**	

Medi-Cal (Y/N):	YES	**SOC $$$:**	$0	**Medicare (Y/N):**	
Insurance/HMO:		**VA (Y/N):**	NO		
Monthly Income:	$	**Source:**	UNK		

Total Assets:	<$2000	**Source:**	N/A

- **If Applicant is married, provide combined monthly income. If a minor without Medi-cal, provide Name, SSN of one parent and combined income of both parents.**
- **If applicant is married, provide combined savings/assets.**

Applicant Agrees with IHSS Referral (Y/N):	YES
Other IHSS Recipient(s) at same address: No/Unknown/Yes • **Do not include Companion case referrals currently being taken.**	NO
Name:	N/A

Emergency Contact Same As Referring Party Y/N:	YES				
Emergency Contact:	---	**Relationship:**	---	**Phone:**	---

MD Name:		**Phone:**	
Hospitalized in Last 6 Mo./ Where/ When/ Why:			
Health History:	03/05/2013:		

Qualifying Service Needs:	PERSONAL AND DOMESTIC
Family/Friends Employed by HHSA:	NO
COMMENTS:	

In Home Supportive Services
Active Medi-Cal (FAX) Referrals

Fax

To:	**IHSS/Medi-Cal Office Assistant**	**From:**	**IHSS District Office** Select a district office.
Fax:	**(858) 495-5883**	**Pages:**	Select number of pages.
Phone:	(858) 495-5625	**Date:**	Select date sent.
Re:	IHSS Applicants with Active Medi-Cal		

APPLICANTS WITH ACTIVE MEDS/CalWIN HISTORY

The individuals listed below have applied for IHSS. A fully completed IHSS/Medi-Cal Communication form is necessary to process the IHSS application.

Case Name	Application Date	Case Number	Social Security Number	SW Number

IHSS CASE FOLDER FILING GUIDE

All forms are filed chronologically – most recent on top.
Abbreviations Used: C=Current M=Months P=Permanent NM=No Mandate to Retain
Duplicates of NCR forms may be shredded as long as one completed copy is kept in the case file.

Case Folder-Left Side			Case Folder-Right Side		
Form No.	**Name and Location**	**Retain**	**Form No.**	**Name and Location**	**Retain**
	Top of Left Side			**Top of Right Side**	
HHSA 12-43	Service Activities Narrative	P	SOC 293A	IHSS Needs Assessment Face Sheet	13 M
HHSA 12-43A	Intake/Recert Narrative	P		AIS Suite Printouts	NM
HHSA 12-12	18 Month Review Checklist	24 M			
	Application Tab			**Medical Tab**	
SOC 295	Application for Social Services	P	HHSA 12-37	Medical Statement	P
MEDS	INQN, INQO, INQX	13 M	HHSA 12-37A	Spouse Medical Statement	P
SOC 332	Recipient Employer Responsibility Checklist	13 M	SOC 425	Physicians Certification of Medical Necessity	P
HHSA 12-58	Client/Employer Responsibility Checklist	P			
HHSA 12-58A	Provider Responsibility Checklist	P	SOC 321	Order and Consent Paramedical Services	P
HHSA 20-46	Language Needs Determination	C	SOC 821	Assessment of Need Protective Supervision	P
HHSA 20-49	Interpreter Confidentiality Agreement	C	SOC 825	P/S 24 Hour Plan-State	P
	Photo Identification and SSN Card	P	HHSA 12-89	P/S 24 Hour Plan-County	P
			IEP Report	Individual Education Plan	P
			MC 220	Authorization/Release of Information	13 M
			MC 221	Disability Determination Transmittal	13 M
			MC 223	App/Supplemental Statement of Facts	13 M
			SOC 873	Health Certification form	P
			SOC 874	Notice to Applicant of Health Cert Req.	P
			SOC 875	Notice to Recipient of Health Cert Req.	P
			HHSA 12-21A	Paramedical Services Calculation	C
			HHSA 12-21B	Accompaniment to Medical Appointment Calculation	C
	Share-of-Cost Tab			**Miscellaneous Tab**	
SAWS1	Application for Aid/Fax Referral	P	ABCDM 228 DSS	Release of Information	13 M
SOC Gram	IHSS/Medi-Cal Communication	13 M	07-94 DSS	Inquiry/Response to DSS/SSA	13 M
HHSA 12-52	SOC Contact/Appointment Letter	13 M	HHSA 12-02	Voter Registration Interest/Declination	24 M
	Other Medi-Cal Documentation including CalWIN printouts showing Medi-Cal Activity	NM	HHSA 12-44	Time Sheet Authorization	P
			HHSA 12-51	No Time Sheet Activity	13 M
			HHSA 12-53	Appointment-Home Visit Contact Letter	13 M
			HHSA 12-53B	Initial Contact-Case Assignment Letter	13 M
			HHSA 12-53C	Request for Information Letter	13 M
			HHSA 12-63	Post Office Box Authorization	P

Note: Any State or County form not specifically listed should be retained in the case file under the miscellaneous tab until instructions are issued.

			HHSA 12-77	Inter-County Transfer	P
			SOC 827	Emergency Backup Plan	13 M
			SOC 864	Individualized Back-up Plan/Assessment	P
			SOC 450	Voluntary Services Certification	P
				Appointment of Conservator/Guardian/Power of Attorney	P
				Workers Compensation Forms and Info.	P
				Quality Control Tab	
			QCA-01	QC Review Summary	P
				All QC Data and Forms	P
			HHSA 12-54	IHSS SWS Case Review	P
			HHSA 12-88	300 + Hour Contact Letter	C
			HHSA 12-88A	300 + Hour Worksheet	C
			HHSA 12-57	Supervisory Telephone Review	P
			HHSA 12-50	Fraud Referral & all results	P
			HHSA 12-50A	Program Integrity Unit Referral	P
			HHSA 12-62	IHSS Overpayment Referral & Info.	P
				All Appeal and OHR Information	P
Service Folder-Left Side			**Service Folder-Right Side**		
Form No.	**Name and Location**	**Retain**	**Form No.**	**Name and Location**	**Retain**
	Top			**Top**	
SOC 311	Provider Eligibility Update	NM	SOC 293	Legacy CMIPS IHSS Needs Assessment	NM
HHSA 06-30	Urgent Services Referral	13 M	SOC 293	CMIPS II Needs Assessment	P
HHSA 12-64	Complaints to Contracted Services	13 M	HHSA 12-42	IHSS Assessment Worksheet	13 M
	Response to Complaints	13 M	HHSA 12-42 PS	PS Calculation Worksheet	
	PCSP TAB				
SOC 426	Provider Enrollment Agreement	P			
SOC 426A	Recipient Designation of Provider	P			
	Any previous PCSP documentation	P			
HHSA 12-78	SW Response to Request for Waiver	P			
HHSA 12-78A	Cancellation of Waiver	P			
HHSA 12-78B	Request for Waiver Denial Letter	P			
HHSA 12-97	Recipient Letter S&I Provider	P			
HHSA 12-97A	Provider Letter S&I	P			
	NOA TAB				
NA 690	IHSS Notice of Action	13 M			
	All other NOAs	13 M			
HHSA 12-41	Waiver of 10-Day NOA	P			

IHSS Case Tracking System Quick Reference

Available fields for entry are as follows:

* The red asterisk indicates that this is a required field.

CMIPS II Case No.* _____ (7 characters long)

Required. The CMIPS II case number must be seven numbers exactly. No letters should be entered into this field.

Legacy Case No. _____ (10 characters long)

The Legacy case number must be 10 digits exactly, including the 37 county code and eight digit case number (e.g. 37xxxxxxxx). No letters should be entered into this field.

Last Name* _____ (may be up to 35 characters long)

Required. This is the recipient's last name.

First Name* _____ (may be up to 25 characters long)

Required. This is the recipient's first name.

MI _____ (one character)

This is the recipient's middle initial. If it is available, it must be entered.

Date* _____ (mm/dd/ccyy format, for ex: 01/22/2013)

Required. This is the date the action is being taken. *Hint: By clicking on the calendar icon, you can select a date.*

Action Taken*: _____

Required. This is a drop-down menu with a list of actions. Select the action that is being taken. A case can be sent to or received by several departments, or it can be requested from the Record Room.

****Very important: You must select *Requested From Record Room* in order for Record Room staff to identify that the case is being requested. If a different action is erroneously selected, Record Room will not be alerted that the case is being requested.**

Action Taken By (Office)*: _____

Required. This is a drop-down menu with a list of locations and mail stops. Select the location where the IHSS Case Tracking member that is taking the action is located.

Action Taken By (Staff)*: _____

Required. This is the name of the IHSS Case Tracking member who is sending, requesting, or receiving the case.
Hint: *By clicking on the address book icon, you can select a name.*

Comments:

Any relevant comments may be entered here.

Click the *Save* button to save your entry. Click the *Cancel* button if you do not want to save your entry.

(04/13)

KOFAX FILING GUIDE

FORM NAME	SCANNING PERIOD	CATEGORY
06-30 Urgent Services Referral	13 M	Misc.
07-94 Inquiry/Response to DSS/SSA	13 M	Misc.
12-02 Voter Registration Interest/Declination	24 M	Misc.
12-06 Receipt of OP Review Request	SCAN ALL	Overpayment-Recipients
12-06 Receipt of OP Review Request (Provider OP)	SCAN ALL	Provider
12-07 Overpayment Worksheet	SCAN ALL	Overpayment-Recipients
12-07 Overpayment Worksheet (Provider OP)	SCAN ALL	Provider
12-08 Notice of Supervisory Review Results	SCAN ALL	Overpayment-Recipients
12-08 Notice of Supervisory Review Results (Provider OP)	SCAN ALL	Provider
12-12 IHSS 18 Month Recertification	24 M	Narratives-Assessments
12-21A Paramedical Services Calculation	CURRENT	Medical
12-21B Accompaniment to Medical Appointment Calculation	CURRENT	Medical
12-21C Medication and Physician Inforamtion	CURRENT	Medical
12-37 IHSS Medical Statement	SCAN ALL	Medical
12-37A IHSS Medical Statement Spouse	SCAN ALL	Medical
12-38 Responsibility of Advance Pay	SCAN ALL	Misc.
12-41 10-Day NOA Waiver	SCAN ALL	Notice of Action (NOA)
12-42 Worksheet	13 M	Narratives-Assessments
12-42PS Protective Supervision Worksheet	13 M	Narratives-Assessments
12-43 A Intake/Recert Narrative Page One	SCAN ALL	Narratives-Assessments
12-43 A Intake/Recert Narrative Page Two	SCAN ALL	Narratives-Assessments
12-43 Services Activities Narrative	SCAN ALL	Narratives-Assessments
12-44 Signature Authorization Form	SCAN ALL	Provider
12-50 Fraud Referral	SCAN ALL	Fraud
12-50A IHSS Program Integrity Referral	SCAN ALL	Program Integrity|Oversight
12-51 No Timesheet Activity	13 M	Contact Letters
12-52 SOC Specialist Contact Letter	13 M	Contact Letters
12-53 Appointment/Contact Letter	13 M	Contact Letters
12-53B Intake Contact Letter	13 M	Contact Letters

KOFAX FILING GUIDE

12-53C Request for Information	13 M	Contact Letters
12-54 Supervisory Review Checklist	SCAN ALL	Quality Control
12-57 Supervisors Telephone Review	SCAN ALL	Quality Control
12-58 Client/Employer Responsibility Checklist	SCAN ALL	Application
12-58A Client/Employer Responsibility Checklist	SCAN ALL	Application
12-62 Overpayment Referral	SCAN ALL	Overpayment-Recipients
12-62 Overpayment Referral (Provider OP)	SCAN ALL	Provider
12-63 Post Office Box Authorization	SCAN ALL	Misc.
12-75 Critical Incident Report	SCAN ALL	Quality Control
12-77 Inter-County Transfer	SCAN ALL	Misc.
12-86 Overpayment Notice of Action	SCAN ALL	Overpayment-Recipients
12-86 Overpayment Notice of Action (Provider OP)	SCAN ALL	Provider
12-88 300 + Contact Letter	CURRENT	Program Integrity|Oversight
12-88A 300 + Worksheet	CURRENT	Program Integrity|Oversight
12-89 Protective Supervision 24 Hours A Day County Plan	SCAN ALL	Medical
12-90 Document Imaging Tracking Form	SCAN ALL	Misc.
12-95 IHSS In the Workplace	13 M	Notice of Action (NOA)
12-97 S&I Provider - Recipient Letter	SCAN ALL	Contact Letters
12-97A S&I Provider - Provider Letter	SCAN ALL	Contact Letters
16-42 Sworn Statement	SCAN ALL	Misc.
20-46 Language Determination Needs	CURRENT	Application
20-49 Interpreter Confidentiality Agreement	CURRENT	Application
ABCDM 228 Release of Information	13 M	Misc.
AIS Vendor Complaint Form	13 M	Misc.
Appeal Decisions and Instructions	SCAN ALL	Appeals
Appointment of Conservator/Guardian/Power of Attorney	SCAN ALL	Misc.
CMIPS II Notice of Action	13 M	Notice of Action (NOA)
IEP Report Individual Education Plan	SCAN ALL	Medical
IHSS Program Integrity Results	SCAN ALL	Program Integrity|Oversight
MC 220 Authorization/Release of Information	13 M	Medical
MC 221 Disability Determination Transmittal	13 M	Medical

MC 223 App/Supplemental Statement of Facts	13 M	Medical
MEDS INQM, INQN, INQX	13 M	Application
NA690 IHSS Notice of Action	13 M	Notice of Action (NOA)
Out of Hearing Resolution	SCAN ALL	Appeals
Overpayment Calculation Worksheet	SCAN ALL	Overpayment-Recipients
Overpayment Calculation Worksheet (Provider OP)	SCAN ALL	Provider
Photo ID and SSN Card (Provider)	SCAN ALL	Provider
Photo ID and SSN Card (Recipient)	SCAN ALL	Identification
Provider Designation of Personal Physician	SCAN ALL	Provider
QC Review Summary	SCAN ALL	Quality Control
Response From DHCS	SCAN ALL	Fraud
Response From PAFD	SCAN ALL	Fraud
Response to Vendor Complaints	13 M	Misc.
SAWS1 Application for Aid/Fax Referral	SCAN ALL	Share of Cost
SCIF 3167 Employees Report of Occupational Injury or Illness	SCAN ALL	Provider
SOC 293 CMIPS II Needs Assessment	SCAN ALL	Narratives-Assessments
SOC 293A IHSS Needs Assessment Face Sheet	13 M	Narratives-Assessments
SOC 295 Application For Social Services	SCAN ALL	Application
SOC 312 IHSS Pre-Authorized Transactions	SCAN ALL	Overpayment-Recipients
SOC 321 Request For Order And Consent - Paramedical Services	SCAN ALL	Medical
SOC 332 Recipient/Employer Checklist	13 M	Application
SOC 409 Elective SDI Form	SCAN ALL	Provider
SOC 412 Workers Comp Eligibility Notice	SCAN ALL	Provider
SOC 425 Physicians Certification of Medical Necessity	SCAN ALL	Medical
SOC 426 IHSS Provider Enrollment Form	SCAN ALL	Provider
SOC 426A IHSS Recipient Designation of Provider	SCAN ALL	Provider
SOC 450 Voluntary Services Certification	SCAN ALL	Misc.
SOC 810 Applicant Certification of Contact with SSA	13 M	Misc.
SOC 821 Assessment of Need For Protective Supervision	SCAN ALL	Medical
SOC 825 Protective Supervision 24-Hours-A-Day Coverage Plan	SCAN ALL	Medical
SOC 827 Emergency Backup Plan	13 M	Misc.

KOFAX FILING GUIDE

SOC 838 Recipient Request Form Hours Assignment	SCAN ALL	Provider
SOC 839 Time Sheet Signature Authorization	SCAN ALL	Provider
SOC 840 Change of Address/Phone (Provider)	SCAN ALL	Provider
SOC 840 Change of Address/Phone (Recipient)	SCAN ALL	Misc.
SOC 846 Provider Enrollment Agreement	SCAN ALL	Provider
SOC 864 IHSS Individualized Back-Up Plan and Risk Assessment	SCAN ALL	Misc.
SOC 873 IHSS Health Certification Form	SCAN ALL	Medical
SOC 874 IHSS Notice to Applicant of Health Certification Requirement	SCAN ALL	Medical
SOC 875 IHSS Notice to Recipient of Health Certification Requirement	SCAN ALL	Medical
SOC Gram IHSS/Medi-Cal Communication	13 M	Share of Cost
SPEC Transaction Requests	SCAN ALL	Provider

*Any documents that are not located on the *Kofax Filing Guide* , and are dated less than 13 months from the date of scanning, must also be scanned. Any documents that are not located on the Kofax Filing Guide, and are dated more than 13 months from the date of scanning, must be flagged by the IHSS Social Worker in order for them to be scanned into IHSS WebTop.

SCANNING DESK AID

BATCH PREPARATION:

SECTION 1

Steps to print Separator Sheet(s)

The purpose for the Separator Sheets is to separate different complete forms. The Separator Sheet will not show any image. It just tells the scanning soft ware that a new form will be image.

1. Click on the **START** button on the bottom left of your screen.
2. Click on **PROGRAMS** so a short menu will pop up.
3. On the short menu, find and click on **KOFAX Capture 8.0** so another short menu will pop up.
4. Select **Separator Sheets** and click.
5. A window will open with a picture of the separator sheet and option fields. What must be selected in the option field are the following steps:

TITLE OF FIELD	SELECTED OPTIONS
Separator Sheet Type	**Portrait**
Batch Class Name	**HHSA-IHSS-Case**
Patch Code Type	**Patch T**
Form Type for **CASE** FORM **(OR)**	Case Document **Case** Form
Form Type for **PROVIDER** FORM	Case Document **PROVIDER** Form

6. Click Print (at this point you can print as many as you would like)

SECTION 2

Steps to PREPARE the documents (Batch Preparation):

1. Remove fasteners from the documents. (e.g. staples, paperclips, sticky notes, etc…)
2. Document must not have: dog-ears, extend folds, etc.
3. **MUST** have one separator sheet on top of each form that is to be scanned.
    a. If you missed a separator sheet between two separate forms, **go to Section 4 (QC); Number 5b**.
4. Place your documents face down. (Scanner only holds 50 pages at a time).

BATCH CREATION

SECTION 3

Steps to IMAGING your documents

1. Double click on the short cut icon **BATCH MANAGER** on your desk top.
    a. If there is no short cut icon (**BATCH MANAGER**) on your desk top, do the following instructions.
        i. Click on the **START** button on the bottom left of your screen.
        ii. Click on **PROGRAMS** and a short menu will pop up.
        iii. On the short menu, find and click on **KOFAX Capture 8.0** and another short menu will pop up.
        iv. On this short menu select **BATCH MANAGER** and a new window will pop up with a list of batches in progress for {Scan, Validation, and Quality Control under the Queue column}.
2. At this point if you are ready to **NAME and CREATE** a new batch of documents for the imaging process,
3. Click on the first icon, **CREATE BATCH** on the tool bar. If you want to process a batch that is listed and ready for validation, go to Batch Validation; Section 4 and follow the steps.
4. A window titled “Create Batch” will pop up. Under this window, complete the following steps.

TITLE OF FIELD	SELECTED OPTIONS
Batch class:	HHSA-IHSS-**CASE OR PROVIDER** (Select one)
Name:	Type the name of the batch creating (**Case** number and Last name, First name) **OR** (**Provider** number and Last name, First name).
Description:	N/A
Click **Save** button	Note: After you click the **SAVE** button, the batch that you have created will appear in **Batch Manager** list.
Click **Close** button	Note: To complete this process, you must click the close button.

5. Click once on the **BATCH** in the list, (to highlight if not yet all ready), you want to work on. The list will be on the window titled "KOFAX Capture Batch Manager".
6. Click once on the **Process Batch** icon on the tool bar.
7. A window with the title **"KOFAX Capture Scan"** will appear.
8. You will see similar ICONS on the top to of the tool bar.
9. Below the tool bar, you will see three oval shapes (different colors) over lapping.
    a. **FIRST (Green)** oval shape, "on the left", will be for "Scan/Import **PAGE**.
    b. **SECOND (Purple)** oval shape, "in the middle", will be for Scan/Import **BATCH**. (This is the one used for multiple pages.)
    c. **THIRD (Red)** oval shape, "on the right", will be to **STOP** the process of scanning.
10. At this point, put your documents face down on your scanner. (Review **Section 1** for document preparation.)
11. Click once on the **SECOND (Purple) Oval Shaped Icon** (for multiple documents). The scanner will make images of your documents.
12. Below the oval shapes there is a tab, "**Batch Contents**". Once you scan your documents, here is where you will see the document images.

BATCH VALIDATION:

SECTION 4

Quality Control

The purpose of this step is to review the scanned pages for any bad quality images; any images that should not be included; to make any alterations to the image; insert a space between forms if there was no separator sheet inserted.

1. Click on the **PAPER HOLDER ICON** that is in the tab **"Batch Contents**" to view the documents in the order that they were scanned. **The images will be in the PDF format.**
2. Below the **PAPER HOLDER ICON**, an outline of images will appear. (Images of the scanned documents.)
3. Click on anyone to review and correct. (Steps for correction are 4 & 5.)
4. On the menu tool bar, there are options to alter the image. (Rotate/ delete/ split: put a space between images.) Make sure the image you want to alter in on the screen (highlight).
5. On the outline of images, **BEFORE** each scanned document (image), there is an **ICON**, which divides one complete document (form). There **MUST** be one between all individual documents. The documents can consist of more than one page. To insert a break between documents (images) on the outline, follow these steps:
    a. Right click on the image you want to separate. A short menu will pop up.
    b. Click on **SPLIT**. This will insert an **ICON** before the image you want to separate.

Blank or bleed through pages that are not automatically removed by the system, can be deleted.
To delete the unwanted/damage/bad/blank page, do the following steps:

6. **Right click** on the unwanted/damage/bad/blank image. A short menu will pop up.
7. Select **DELETE**.

After inspecting all images, do the following step

8. Click once on the **CLOSE BATCH** icon on the top tool bar. The fourth icon from the left with an arrow pointing right.
9. Click Yes.

SECTION 5

VALIDATION:

Validation is the step that assigns data to the images, (scanned documents), for retrieval on DOCUMENTUM. Validation can be run once the user has completed the scanning process.

1. After the completion of the section 4, it is now time to validate your images.
2. The window titled **"Kofax Capture Batch Manager"** will be open with the lists of batches.
3. For the batch you are working on, it will show "VALIDATION" under the Queue column. Meaning it is ready for the validation process.
4. Find the one you are working on and make sure it is highlighted. If not, right click on it **once**.
5. Click on the **PROCESS BATCH ICON**. (The second one from the left on the top tool bar.)
6. **{VERY IMPORTANT} The window titled "Kofax Capture Validation" will open with the first scanned image that is on the outline. On this window, all pertinent data for the case you are working on needs the correct information in each field for each image (form)**. Fields with the "*"asterisk, has to be completed before you are allowed to going forward.

TITLE OF FIELD	PURPOSE AND OPTIONS
CLIENT SSN:	If the clients SSN is already in the system, the name and address fields will be automatically have the information of the client. If the SSN does not exist, the panel will inform us of this fact and we can continue to populate the form manually.
CASE NUMBER:	The case number to the client you are working on.
Date of Birth:	Will populate **if** SSN in the system.
First Name:	Will populate **if** SSN in the system.
Last Name:	Will populate **if** SSN in the system.
Client Index No.:	Will populate **if** SSN in the system. (CIN number of the client)
Client Street:	Will populate **if** SSN in the system.
Client City:	Will populate **if** SSN in the system.
Client State:	Will populate **if** SSN in the system.
Client Zip:	Will populate **if** SSN in the system.
Location of Office:	The office number where the case will be located.
Worker Number:	Social Worker Number (It will only show the worker at the location of Office selected.)
Worker Name:	Manually type the Social Worker's Name
Category: (Tab that the form goes under)	The name of the some tabs that are currently in the case files. **DROP DOWN menu to select from.**
Form Name:	**DROP DOWN menu to select from. (Title or Form Number)**
Case Type:	**DROP DOWN menu to select from. (Standard or Confidential)**
Case Status:	**DROP DOWN menu to select from. (Open or Close case}**

7. Press the **ENTER** button when completed all fields required. This will end the validation for this image.
8. The next image will appear and the process for validating will start at step 6 until all the images in this batch are done.
9. Click on the **CLOSE BATCH ICON** to close this window. It will ask you to **SAVE**, click **Yes**.
10. The window titled "Kofax Capture Batch Manger" will be open. The batch you just finished will show the word 'PROCESSING" and then "KCN Server" on the Queue column of the window. At this point, you do not need to do anything else. The batch will be uploaded to the server automatically in the next few minutes. You can now close this window and follow the steps in for Documentum if you have access.

Steps for WebTop

1. Double click on the short cut icon **WebTop** on your desk top.
2. Login in steps:

TITLE OF FIELD	SELECTED OPTIONS
Login Name:	**You username goes here**
Password:	**You password**
Repository:	**HHSA**

3. This is to search for Clients/Providers folders/cases
4. The WebTop interface has 4 main sections.

Section 1: Navigation Tree (Outline)

You can double-click on the icon in the Navigation Tree (Outline), to launch the content.

Section 2: Menu Area

- Click on IHSS Search on the tool bar for different methods of searching: (Client/Case Search; Clients Search; or Providers Search.

Section 3: Navigation Location Text

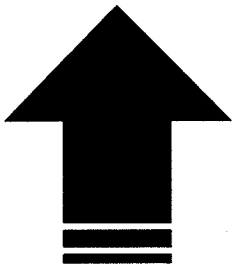
- Input the data known in the desired field.
- Click on the Search button on the bottom of the Navigation Location Text section of the interface.

Section 4: Navigation Location Contents and Details

- A list of file/folders will appear on the "Navigation Location Contents and Detail" section.
- Click on the desired file/folder.

This is a Patch T type separator sheet.

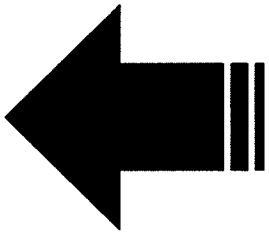
Form Type = "Case Form"
CODE128 type barcode



Portrait Feed

New Form Follows...

Printed on 12/17/2012 7:01:15 AM



Landscape Feed

New Form Follows...

Printed on 12/17/2012 7:01:15 AM

This is a Patch T type separator sheet.

Form Type = "Case Form"
CODE128 type barcode

APPLICATION FOR SOCIAL SERVICES

TO THE APPLICANT: *This form is subject to verification.*
NOTE: *Retain your copy of this application.*

*** SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

CASE NUMBER:	DATE OF APPLICATION:

1. NAME			*SOCIAL SECURITY NUMBER
ADDRESS			SEX ☐ Male ☐ Female
CITY	ZIP CODE	TELEPHONE ( )	BIRTHDATE

2. Are you a veteran? ☐ Yes ☐ No	ARE YOU A SPOUSE/CHILD OF A VETERAN? ☐ Yes ☐ No	IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER:

3. 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:	

4. 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)

5. LIST FAMILY MEMBERS IN HOUSEHOLD	BIRTHDATE	*SOCIAL SECURITY NUMBER
NAME OF SPOUSE ☐ NAME OF PARENT ☐		
CHILD/OTHER RELATIVE		
CHILD/OTHER RELATIVE		

6. 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 (*see reverse side for correct code):* ☐	B. I speak and understand English: ☐ Yes ☐ No My primary language is *(see reverse side for correct code:)* ☐

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 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.

SIGNATURE OF APPLICANT:	DATE:
SIGNATURE OF APPLICANT'S REPRESENTATIVE: *(ONLY IF APPLICABLE)*	DATE: *(ONLY IF APPLICABLE)*
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 800-822-6222 or go to www.stopmedicalfraud@dhcs.ca.gov.

FOR AGENCY USE ONLY

INCOME ELIGIBLE:	STATUS ELIGIBLE:	VERIFICATION:	SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTATIVE:	TELEPHONE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO			( )
RECIPIENT STATUS: ☐ Refugee ☐ Cuban/Haitian Entrant			SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS *(EXPLAIN)*	

A. 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

B. 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?	☐ **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/or certified as a Medi-Cal provider, 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.

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,
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.

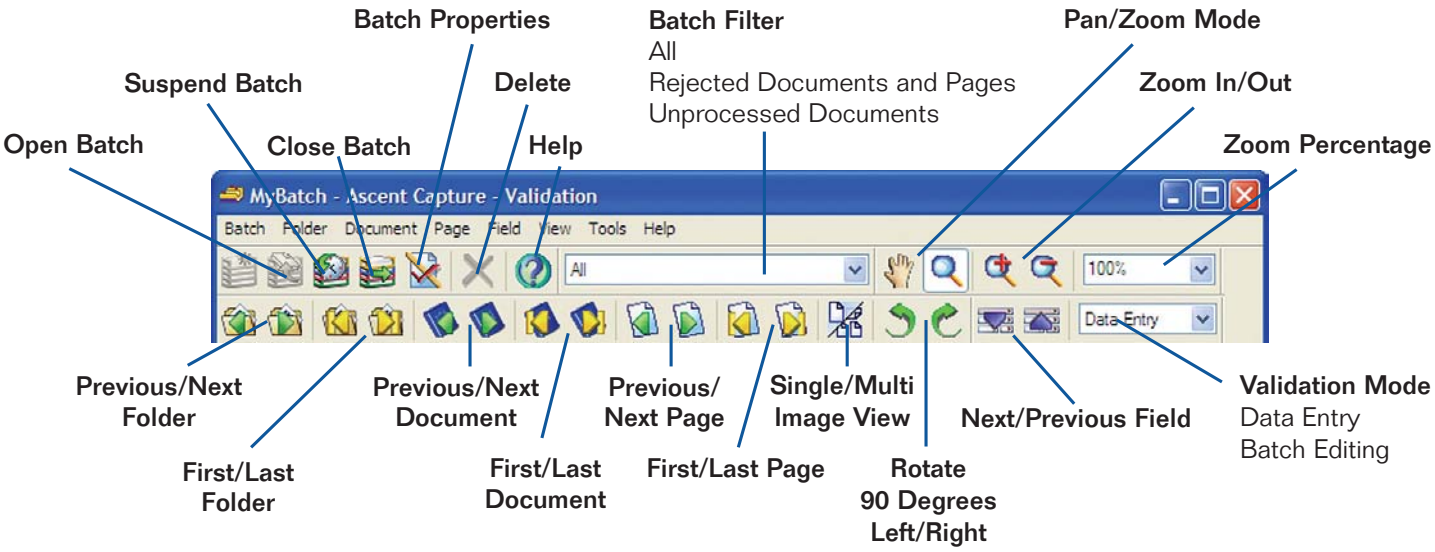
If you have questions about the health care certification requirement, ask the social worker who has been assigned to your case.

DUE BY: ____/____/____

Validation Module
Quick Reference

ASCENT® Capture®

TOOLBAR OPTIONS



DATA ENTRY ACCELERATOR KEYS

KEY	DESCRIPTION
Tab	Move to the next field
Shift-Tab	Move to the previous field
Ctrl-Tab	Select the entire field
Enter	If “Enter key moves to next field” is selected (from the Tools/Options menu), the Enter key works the same as the Tab key
Shift-Enter	If “Enter key moves to next field” is selected, Shift-Enter works the same as Shift-Tab.
Shift-Del	Deletes entire selection. If nothing is selected, deletes one character to the left of the insertion point
Up/Down	Move up/down in a drop-down list
Left/Right	Move the cursor left or right

BATCH EDITING ACCELERATOR KEYS

NUM KEY	DESCRIPTION
*	Expand everything under selection
+ or -	Expand / collapse selection

KEY	DESCRIPTION
-	Reject document or page (then press a number or type a rejection reason)
=	Unreject document or page
Enter	Move to next document or page
‘	Change form type
/	Edit document properties
] or [	Rotate image right / left and save
C	Create a document
S	Split a document
D	Combine documents/pages

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