



# In-Home Supportive Services (IHSS): A Guide for Advocates

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## About this Guide

The In-Home Supportive Services (IHSS) Advocates Guide is designed for advocates and individuals who provide assistance to low-income older adults, as well as children and adults with disabilities. This Guide provides in-depth information about the IHSS program and is divided into eight chapters: (1) IHSS Program Overview; (2) Eligibility and Applying for IHSS; (3) Medi-Cal Programs and IHSS; (4) IHSS Services Overview; (5) Types of Services; (6) IHSS Providers; (7) Post-Eligibility Issues; and (8) Appeals and Hearings. Justice in Aging strives to make the information in this Guide as accurate as possible as of the publication date. To get more information on the IHSS program and to sign-up for alerts, Justice in Aging webinars, and other trainings, please visit our website at [www.justiceinaging.org](http://www.justiceinaging.org).

## Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972 we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

## Acknowledgment

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Due to the changing Medi-Cal and IHSS landscape, the prior version is outdated and should be discarded. We wish to thank Elizabeth Zirker, Senior Attorney at National Health Law Program, for her significant contributions to this updated Guide, and to our colleagues at Disability Rights California for their contributions.

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# Chapter 1: IHSS: Program Overview

## 1. BACKGROUND

The In-Home Supportive Services (IHSS) program is a Medi-Cal program in California that pays for in-home care for people with disabilities, including children, adults, and seniors.<sup>1</sup> The purpose of the IHSS program is to provide supportive services to Medi-Cal recipients “who are unable to perform the services themselves and who cannot safely remain in their homes...unless these services are provided.”<sup>2</sup> Services include domestic and related services, personal care services, paramedical services, and protective supervision.<sup>3</sup> With roots in the 1970s disability rights movement, IHSS is the oldest and largest consumer self-directed program of personal care services.

IHSS is also the largest of California’s Home and Community-Based Services and Supports (HCBS) programs, and can be used in conjunction with other HCBS services.<sup>4</sup> In Fiscal Year 2024-2025, the IHSS program served more than 846,000 recipients.<sup>5</sup> IHSS recipients are a diverse group— 57% are women, 46% speak a language other than English as their primary language, 41% are older adults age 65-84, 14% are 85 years of age or older, 37% are adults with disabilities, and 11% are children under the age of 18.<sup>6</sup> This diversity of recipients reflects the diversity of California and speaks to the importance of the IHSS program for California residents of all backgrounds.

The IHSS Advocate Manual provides in-depth information about the IHSS program for advocates and consumers. It is divided into eight chapters: (1) IHSS: An Introduction; (2) Eligibility and Applying for IHSS; (3) Medi-Cal Programs and IHSS; (4) IHSS Services Overview; (5) Types of Services; (6) IHSS Providers; (7) Post-Eligibility Issues; and (8) Appeals and Hearings.

## 2. IMPORTANT DEFINITIONS

Like many social services programs, IHSS has its own vocabulary. These terms have special meaning within the IHSS program. The following terms are used throughout the “IHSS Advocates Manual” and are defined here. Additional definitions related to the IHSS program can be found in the Welfare and Institutions Code section 12300 *et. seq.* and the California Department of Social Services’ Manual of Policies and Procedures section 30-700 *et. seq.*<sup>7</sup>

- **ACTIVITIES OF DAILY LIVING (ADL)** refer to basic tasks of everyday life, and includes any of the following: dressing, feeding, toileting, bathing, grooming, and mobility and associated tasks.<sup>8</sup>

- **ADVANCE PAY** means a payment to be used for the purchase of authorized IHSS services, which is sent directly to the recipient of the services being provided.<sup>9</sup> To be eligible for advance pay a recipient must be “severely impaired” which means they require in-home supportive care for at least 20 hours per week to assist with activities of daily living or paramedical services. Additionally, advance pay recipients must be capable of handling their own financial and legal affairs.<sup>10</sup> For individuals who do not receive advance pay, payment is sent directly to the individual’s provider for services rendered.
- **ASSESSMENT** means a written document that contains information relevant to the case situation and an assessment of case service needs.<sup>11</sup>
- **AUTHORIZED REPRESENTATIVE** means a person authorized in writing by the recipient of services to act on their behalf.<sup>12</sup> An authorized representative can be a relative, a friend, or an attorney.<sup>13</sup>
- **CONSUMER** means an individual who is a current or past user of personal care services provided by an IHSS program.<sup>14</sup>
- **ELIGIBLE** means entitled to receive IHSS services.<sup>15</sup>
- **FEDERAL FINANCIAL PARTICIPATION (FFP)** is a formula used to determine the amount of money that the federal government contributes toward each state’s Medicaid services. California currently receives a 50% federal match for the Personal Care Services Program and IHSS Plus Option Program. The federal match for the Community First Choice Option is 50% plus an additional 6% for an enhanced rate of 56%. The IHSS-Residual program does not receive federal monies.
- **FULL-SCOPE FEDERAL FINANCIAL PARTICIPATION (FFP)** means an individual is eligible for complete Medi-Cal services funded partially by the federal government. In order to be eligible for full-scope Medi-Cal, individuals must meet income and resource criteria. This group primarily includes people who are: aged 65 or older, blind, disabled, under 21, pregnant, in a skilled nursing or intermediate care home, a parent or caretaker relative of a child under age 21, and low-income adults.<sup>16</sup> Services for an individual who is not eligible for full-scope FFP are funded entirely by the state and county.
- **HOME AND COMMUNITY-BASED SERVICES AND SUPPORTS (HCBS)** are long-term services and supports provided in home and community-based settings.<sup>17</sup> Some other HCBS programs include the Multipurpose Senior Services Program (MSSP), Community Based Adult Services (CBAS), the Home and Community-Based Alternative Waiver (HCBA), Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD), the Medi-Cal Waiver Program (formerly HIV/AIDS Waiver) and the Assisted Living Waiver (ALW).<sup>18</sup>

- **INSTITUTIONAL DEEMING** means an individual is assessed for Medi-Cal eligibility as if they were living in a long-term care facility. The income, property, and assets of the individual's spouse or parents are treated differently when determining the individual's Medi-Cal eligibility.<sup>19</sup> Without the application of institutional deeming, the spouse or parent of the individual who requires services at an institutional level of care would have too much income or resources and the individual would not be eligible for Medi-Cal. Institutional deeming between spouses is also related to the spousal impoverishment provision and is discussed in more detail in Chapter 3.<sup>20</sup>
- **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)** are related to independent living and include any of the following: housework, meals, laundry, taking of medication, money management, appropriate transportation, correspondence, telephoning, and related tasks.<sup>21</sup> Some IADLS are covered by the IHSS programs.
- **LEGALLY RESPONSIBLE RELATIVE PROVIDER** is a relative who is responsible to contribute to the cost of health care services received by a Medi-Cal beneficiary.<sup>22</sup> The responsibility of a relative to contribute to the cost of health care for a Medi-Cal applicant or beneficiary is limited to spouses and parents of children under 18.<sup>23</sup>
- **LIVE-IN PROVIDER** means a provider who is not related to the recipient and who lives in the recipient's home expressly for the purpose of providing IHSS-funded services.<sup>24</sup>
- **MEDI-CAL** is California's Medicaid program, which provides health insurance for low-income Californians. It is a joint federal-state program. Medi-Cal can pay for a wide variety of health care services including IHSS and many other Home and Community-Based Services.
- **NOTICE OF ACTION** is a written document which provides applicants and beneficiaries with an explanation of their eligibility and services, and is also used to notify a recipient of a denial, change, or termination of services.<sup>25</sup> A Notice of Action is commonly referred to as a "NOA." The county social services agency will issue NOAs when a change occurs in Medi-Cal or IHSS.
- **OWN HOME** means the place where an individual chooses to reside, including alternative living situations such as homeless shelters, recreational vehicles, and homes of family members or friends.<sup>26</sup> An individual's own home does not include institutional facilities including acute care hospitals, skilled nursing facilities, intermediate care facilities, or board and care facilities.<sup>27</sup> A person receiving an enhanced Supplemental Security Income (SSI) or a State Supplemental Payment (SSP) because they live in a nonmedical out-of-home living arrangement, such as a board and care home or a residential care facility, is not considered to be living in his/her own home.<sup>28</sup>
- **PAYMENT PERIOD** means the time period for which wages are paid. There are two IHSS payment periods per month corresponding to the first through the fifteenth of the month and the sixteenth through the end of the month.<sup>29</sup>

- **PERSONAL ATTENDANT** means a provider who is employed by the recipient and who spends at least 80% of their time performing the following services for the recipient: meal preparation; meal clean-up; meal planning; help consuming food; routine bed baths; bathing, oral hygiene, and grooming; dressing; and protective supervision.<sup>30</sup>
- **PERSONAL CARE SERVICES** includes all the following: assistance with ambulation; bathing, oral hygiene, and grooming; dressing; care and assistance with prosthetic devices; bowel, bladder, and menstrual care; repositioning, skin care, and range of motion exercises; transfers; feeding and assurance of adequate fluid intake; respiration; assistance with self-administration of medications.<sup>31</sup>
- **PROTECTIVE SUPERVISION** is a specialized type of IHSS service that consists of observing recipient behavior and intervening as appropriate to safeguard the recipient against injury, hazard, or accident.<sup>32</sup>
- **PUBLIC AUTHORITY** is a public agency set up to assist IHSS recipients and providers. There are 56 public authorities statewide serving all 58 counties.<sup>33</sup> The scope of services varies by public authority, but all offer a provider registry and act as the employer of record for IHSS providers.<sup>34</sup>
- **REASSESSMENT** means a written document which reviews all past assessments and examines the current condition of the recipient.<sup>35</sup>
- **RECIPIENT** means a child or adult receiving IHSS, including an applicant for such services when clearly implied by the context of the regulations.<sup>36</sup>
- **REGIONAL CENTERS** provide and coordinate services and support for individuals with developmental disabilities. The California Department of Developmental Services contracts with 21 Regional Centers statewide.<sup>37</sup>
- **RELATIVE PROVIDER** means a mother, father, grandfather, grandmother, son, daughter, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, niece, half-brother, half-sister, any such person of a preceding or succeeding generation denoted by a prefix of grand, great or great-great or the suffix in-law, who is providing care to the recipient.<sup>38</sup>
- **RESTAURANT MEAL ALLOWANCE** is an alternative service for recipients who have adequate cooking facilities at home, but whose disabilities prevent them from cooking for themselves.<sup>39</sup>
- **SEVERELY IMPAIRED** means a recipient with a total assessed need of 20 hours or more *per week* in one or more of the following types of services: any personal care services, preparation of meals, meal clean-up, and paramedical services.

- **SHARE OF COST** means the amount a person or family must pay toward the cost of their health care services each month in order to be eligible for Medi-Cal in the same month.<sup>40</sup>
- **STATE PLAN** means a comprehensive written document created by the State of California that describes the nature and scope of the Medi-Cal program.<sup>41</sup>
- **SUPPORTIVE SERVICES** include domestic and related services, heavy cleaning, personal care services, accompaniment by a provider to health-related appointments, yard hazard abatement, protective supervision, teaching and demonstration, and paramedical services.<sup>42</sup>
- **WAIVER PERSONAL CARE SERVICES (WPCS)** are supportive and health-related services authorized by the Department of Health Care Services for participants in specific Medicaid waiver programs.<sup>43</sup> WPCS is often used by participants to provide additional in-home care on top of a significant number of IHSS hours, however WPCS is a separate program.

### **3. THE FOUR TYPES OF IHSS PROGRAMS**

The statewide IHSS program is comprised of four different programs. The different programs have slightly different eligibility criteria and funding sources. The programs are:

1. Community First Choice Option,
2. Personal Care Services Program,
3. IHSS Plus Option, and
4. IHSS-Residual Program.

The Community First Choice Option, the Personal Care Services Program, and the IHSS Plus Option are federally-funded Medicaid programs. The IHSS-Residual Program is not a Medicaid-funded program and only receives state and county funds. Typically, the applicant or recipient will not know which IHSS program they are enrolled in although it should be noted on their notices of action. Except where noted, the IHSS rules described in this manual are the same for all four programs. Differences in eligibility, maximum hours, and services available are discussed in-depth in Chapter 2. This section provides an overview of each program.

#### **1. Community First Choice Option (CFCO)**

The CFCO program was established as a new State Plan Option by the Affordable Care Act (ACA).<sup>44</sup> It allows the state to receive more federal money to pay for IHSS services.<sup>45</sup>

The state began enrolling consumers in the CFCO program on December 1, 2011, and by 2025 it served 53% of IHSS consumers.<sup>46</sup> Beginning July 1, 2013, the eligibility requirements became more stringent.<sup>47</sup> Consumers who no longer meet the more stringent standards are now served in the Personal Care Services Program or the IHSS Plus Option. These three programs account for 99% of IHSS enrollment.<sup>48</sup>

In order to be eligible for the CFCO program as of July 1, 2013, an applicant must be (1) eligible for full-scope, federal financial participation Medi-Cal and (2) meet CFCO Nursing Facility Level of Care eligibility.<sup>49</sup>

Consumers enrolled in the CFCO program are eligible for four services:

1. Assistance with ADLs, IADLs, and health-related tasks;
2. Acquisition, maintenance, and enhancement of skills necessary to perform ADLs, IADLs, and health-related tasks;
3. Back-up systems to ensure continuity of services and supports; and
4. Voluntary recipient training.<sup>50</sup>

Consumers enrolled in the CFCO program are eligible for the restaurant meal allowance and advance pay. Additionally, their services can be provided by their spouse or by their parent.<sup>51</sup> Effective September 1, 2014, consumers who are non-severely impaired are eligible to receive a maximum of 195 hours per month of protective supervision, plus hours for other services, and consumers who are severely impaired are eligible to receive a maximum of 283 hours per month, including protective supervision and hours for other services.<sup>52</sup>

## 2. Personal Care Services Program (PCSP)

The PCSP was implemented in April 1993 for categorically needy Medi-Cal recipients.<sup>53</sup> It is part of the Medicaid state plan, and serves 40% of the IHSS population.<sup>54</sup> Consumers who are not eligible for the CFCO program, typically because they do not meet the Nursing Facility Level of Care eligibility criteria, are enrolled in the PCSP. In order to be eligible for PCSP, the applicant must be eligible for full-scope, federal financial participation Medi-Cal.<sup>55</sup>

The PCSP began as a way to obtain Medi-Cal funding to support IHSS. In 1999, the program was expanded to include children under 18 years of age who were Medi-Cal eligible through institutional deeming.<sup>56</sup> Effective May 1, 2004, PCSP services were expanded to include ancillary services including domestic and related services and protective supervision as long as neither are provided by a parent or spouse.<sup>57</sup>

The PCSP has some restrictions with regard to services offered and allowable providers. Specifically, PCSP recipients cannot be authorized for the restaurant meal allowance or for advance pay,<sup>58</sup> and are not allowed to have a spouse or parent provider.<sup>59</sup> Consumers enrolled in PCSP are eligible to receive a maximum of 283 hours per month regardless of whether they are designated non-severely or severely impaired.<sup>60</sup> Consumers who require any of these services, or who wish to hire a spouse or parent provider and who do not meet the CFCO level of care criteria, are enrolled in the IHSS Plus Option.

### 3. IHSS Plus Option (IPO)

The IPO program is part of the Medicaid state plan.<sup>61</sup> Enrollment into the IPO program began in 2009, serving 3% of IHSS consumers.<sup>62</sup> Consumers who are eligible for full-scope, federal financial participation Medi-Cal, do not require a nursing facility level of care, but who require the restaurant meal allowance, advance pay, or a spouse or parent provider, are enrolled in the IPO program.<sup>63</sup> These consumers are eligible for all IHSS services allowed by the PCSP program, except for teaching and demonstration.<sup>64</sup> Consumers who are non-severely impaired are eligible to receive a maximum of 195 hours per month and consumers who are severely impaired are eligible to receive a maximum of 283 hours per month.<sup>65</sup>

### 4. IHSS Residual (IHSS-R)

Consumers who do not qualify for full-scope, federal financial participation Medi-Cal are enrolled in IHSS-R.<sup>66</sup> Approximately 3% of IHSS consumers are in the IHSS-R program. Under IHSS-R, non-severely impaired recipients may receive up to a total of 195 hours, including any needed protective supervision.<sup>67</sup> The entire 195 hours can be for protective supervision if no other needed services are paid for by IHSS.<sup>68</sup> Severely impaired recipients may receive up to a total of 283 hours, including any needed protective supervision.<sup>69</sup>

The Counties must evaluate all applicants for Medi-Cal eligibility before evaluating eligibility for IHSS-R program.<sup>70</sup> The state and counties have a strong financial incentive to ensure that all Medi-Cal eligible IHSS-applicants are enrolled in CFCO, PCSP, or IPO because the federal government will pay for at least 50% of the care provided, whereas the IHSS-R program is funded only through state and county funds.<sup>71</sup>

Certain applicants who are pending a final disability eligibility determination may be presumptively eligible<sup>72</sup> for IHSS and enrolled in the IHSS-R program.<sup>73</sup> An applicant will be considered presumptively eligible if either (1) the applicant is disabled, not employed, and has no expectation of employment within the next 45 days; and if in the county's judgment the applicant appears to have mental or physical impairments that will last for more than one year or end in death, or (2) if the applicant is blind as defined by MPP § 30-771.2.<sup>74</sup>

Additionally, in some counties individuals are temporarily transitioned onto IHSS-R when they are suspended or terminated from Medi-Cal. This transitional use of the IHSS-R program allows individuals to receive one month of IHSS services while Medi-Cal eligibility issues are addressed. It also allows the county to recover from the state any funds spent on IHSS services for these recipients.

Because federal law prohibits the use federal dollars for most Medicaid services for those with unsatisfactory immigration status, the IHSS-R program also serves undocumented IHSS recipients. Between 2016 and 2024 California expanded IHSS-R access for undocumented state residents, first to kids under age 18, then to older adults over 65 years old, and finally to all Californians.

As of 2025, more than 3,000 older adults with unsatisfactory immigration status are in the IHSS-R program.<sup>75</sup> However, starting in 2026, undocumented individuals over 19 years old who are not yet enrolled in Medi-Cal will again no longer be able to enroll in Medi-Cal.<sup>76</sup> The IHSS-R program will continue to serve undocumented individuals enrolled in Medi-Cal prior to the freeze.

#### **4. IMPORTANT AGENCIES**

The California Department of Health Care Services (DHCS) administers the Medi-Cal program.<sup>77</sup> DHCS is the single state agency responsible for administration of the Medicaid program in California.<sup>78</sup> Although DHCS retains ultimate authority over all Medicaid programs, it delegates the administration of the IHSS program to the California Department of Social Services (CDSS).

CDSS is the agency responsible for the state-level administration of the IHSS program. The county welfare departments in each of the 58 California counties handle the day-to-day administration of the program, including determining eligibility for Medi-Cal.<sup>79</sup> Separate units of the county welfare departments are responsible for Medi-Cal and IHSS eligibility. With regard to the IHSS program, the county welfare departments:

- Determine eligibility for the IHSS program;
- Evaluate applicant need;
- Determine which IHSS services each applicant will receive;
- Determine the number of hours for each service;
- Perform quality assurance tasks;
- Reassess consumer eligibility; and
- Deny or terminate applicants or recipients who are ineligible to receive services.<sup>80</sup>

The public authority is a separate entity established by a county to manage enrollment of IHSS providers, provide trainings, maintain a registry of available providers, and act as the employer of record for collective bargaining purposes.<sup>81</sup>

The California Department of Developmental Services is the agency through which the State of California provides services and supports to individuals with developmental disabilities. The Department of Developmental Services contracts with 21 Regional Centers<sup>82</sup> to serve as a local resource to help find and access the services and supports available to individuals with developmental disabilities. Although neither the Department of Developmental Services nor the Regional Centers are directly involved in administration of the IHSS program, the Regional Centers must ensure that individuals with developmental disabilities receive appropriate home and community-based services, which can include IHSS.<sup>83</sup>

The California Department of Aging (CDA) “administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state.”<sup>84</sup> CDA administers a number of home and community-based programs, including Community Based Adult Services (CBAS), (formerly known as Adult Day Health Care), and the Multipurpose Senior Services Program (MSSP).<sup>85</sup>

## **5. RELEVANT LEGAL AUTHORITY**

The IHSS Program is a California-specific program, but the laws and rules governing the program are a combination of federal and state statutes and regulations, and extensive state sub-regulatory guidance. The following are the sources of law on which the IHSS program is based. Specific legal authority is cited throughout this manual.

**FEDERAL LAW:** 42 U.S.C. § 1396 *et. seq.* (Medicaid Act).<sup>86</sup>

**FEDERAL REGULATIONS:** 42 Code of Federal Regulations § 430 *et. seq.* (Medicaid Regulations).<sup>87</sup>

**CALIFORNIA LAW:** Welfare and Institutions Code § 12300 *et. seq.* (In-Home Supportive Services); § 14132.95 (Personal Care Services); § 14132.951 (IHSS Plus Waiver); § 14132.952 (IHSS Plus Option); § 14132.955 (Personal Care Services, authorization limitations); § 14132.96 (Personal Care Services, provider rates); § 14132.97 (Waiver of Personal Care Services).<sup>88</sup>

**CALIFORNIA REGULATIONS:** California Code of Regulations, Title 22, §§ 51181, 51183, 51350 (Relating to Personal Care Services).<sup>89</sup> Manual of Policies and Procedures, §§ 30-700 through 30-785 (IHSS Programs); §§ 30-000 through 30-600 (Social Services Standards Manual);<sup>90</sup> §§ 22-000 *et. seq.* (State Hearings).<sup>91</sup>

**CALIFORNIA SUB-REGULATORY GUIDANCE:** All County Letters and All County Information Notices are guidance issued by the Department of Social Services to the counties. These letters and notices provide clarification about programs and policies and their implementation. They are found organized by year of release on the Department of Social Services website.<sup>92</sup>

# Chapter 1 Endnotes

- 1 Cal. Welf. & Inst. Code § 12300 *et. seq.*
- 2 Cal. Welf. & Inst. Code § 12300(a).
- 3 Cal. Welf. & Inst. Code § 12300(b).
- 4 Cal. Welf. & Inst. Code § 12300(g).
- 5 As reflected in most updated program data. California Dept. of Social Services, [IHSS Program Data, \(April 2025\)](#).
- 6 Cal. Dep't. of Soc. Serv. ("CDSS"), [All County Information Notice \("ACIN"\) I-22-19](#) (April 4, 2019).
- 7 CDSS, [Manual of Policies & Procedures \("MPP"\) § 30-700 through 30-764](#), and [MPP §§ 30-765 thru 30-785](#). (effective Oct. 1, 2016)
- 8 Cal. Health & Safety Code § 1569.2(l).
- 9 Cal. Welf. & Inst. Code § 12304(a); [MPP § 30-701\(d\)\(3\)](#).
- 10 Cal. Welf. & Inst. Code § 12304(a) and (d).
- 11 [MPP § 30-002\(a\)\(1\)](#).
- 12 Cal. Welf. & Inst. Code § 12300.3.
- 13 [MPP § 30-002\(r\)\(3\)](#). It is important to note that an authorized representative is distinct from an agent appointed by an advance health care directive, an attorney-in-fact appointed by a power of attorney, a guardian, or a conservator.
- 14 [MPP § 30-701\(c\)\(3\)](#).
- 15 [MPP § 30-002\(e\)\(1\)](#).
- 16 Cal. Department of Health Care Services, ["Do you Qualify for Medi-Cal Benefits?"](#) .(last visited June 13, 2025).
- 17 42 U.S.C. § 1396n(d)(5)(C); 42 C.F.R. §440.182(c).
- 18 For a full list of HCBS waivers go to [Department of Health Care Services, Medi-Cal Waivers](#).
- 19 MPP § 30-701(d)(1) (deeming defined); CDSS, [All County Letter No. 00-83](#), (Dec. 7, 2000) (pg. 2)..(explains how institutional deeming relates to deeming as defined by the MPP).
- 20 [All County Welfare Directors Letter \("ACWDL"\) 17-25](#) (July 19, 2017)..
- 21 Cal. Health & Safety Code § 1569.2(i).
- 22 Cal. Code Regs. tit. 22, § 50088.
- 23 Cal. Code Regs. tit. 22, § 50351.
- 24 [MPP § 30-701\(l\)\(3\)](#).
- 25 [MPP §§ 10-116.1; 30-759.7, 30-763.8](#); 22 C.C.R. § 50179;[MPP §§10-000 et. seq.](#). See also Cal. Welf. & Inst. Code § 12300.2.
- 26 CDSS, [ACIN I-19-20](#) (Feb 25, 2020).

- 27 [MPP § 30-701\(o\)\(2\)](#).
- 28 *Id.*
- 29 [MPP § 30-701\(p\)\(2\)](#).
- 30 [MPP § 30-701\(p\)\(4\)](#).
- 31 Cal. Welf. & Inst. Code § 12300(c); MPP § 30-757.14.
- 32 [MPP § 30-757.17](#).
- 33 Alpine and Tuolumne Counties do not have a Public Authority. See Community Services Solutions, [Eastern Sierra IHSS](#), (last visited 9/11/2025) and Tuolumne County, [IHSS FAQs](#) (last visited 9/11/2025) on how to register as a provider.
- 34 Cal. Welf. & Inst. Code § 12301.6; [MPP § 30-701\(p\)\(8\)](#). See also [California Association of Public Authorities](#) for more information about public authorities and to find links to each county’s public authority,(last visited June 16, 2025).
- 35 MPP § [30-002\(r\)\(1\)](#).
- 36 MPP § [30-002\(r\)\(2\)](#).
- 37 The location and contact information of all 21 Regional Centers are available at [the Department of Developmental Services](#) (last visited 5/29/2025)..
- 38 Cal. Code Regs. tit. 22, § 50084.
- 39 [MPP § 30-757.133](#).
- 40 Cal. Code Regs. tit. 22, § 50090.
- 41 DHCSs, [California’s Medicaid State Plan \(Title XIX\)](#), (last visited 5/29/2025).
- 42 Cal. Welf. & Inst. Code § 12300(b).
- 43 See DHCS, [Waiver Personal Care Services: Frequently Asked Questions](#).(last visited June 13, 2025).
- 44 The Patient Protection and Affordable Care Act of 2010 (Pub.L 111-148); 42 U.S.C. § 18001 et. seq.
- 45 CDSS, [All County Letter \(“ACL”\) 14-60](#), (August 29, 2014).. The State receives an additional 6% for each CFCO enrolled recipient.
- 46 *Id*; CDSS, [IHSS Program Data, \(Oct. 2025\)](#)
- 47 *Id.*
- 48 As reflected in most updated program data. CDSSs, [IHSS Program Data, \(April 2025\)](#).
- 49 CDSS, [ACL 14-60](#) (August 29, 2014)..
- 50 *Id.*
- 51 *Id.*
- 52 Cal. Welf. & Inst. Code § 12303.4; [ACL 14-60](#) (August 29, 2014)..
- 53 [ACL 93-21](#) (March 16, 1993); [ACL 94-47](#) (June 10, 1994);. See also Cal. Welf. & Inst. Code § 51350.

- 54 42 U.S.C. § 1396n(i); CDSS, [IHSS Program Data, \(Oct. 2025\)](#)
- 55 Cal. Welf. & Inst. Code § 14132.95; see also [ACIN No. I-18-08](#) (March 12, 2008), “In general, U.S. citizens, nationals, and individuals who are lawfully residing in the United States are eligible for full-scope Medi-Cal.” Western Center on Law and Poverty, “[Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates](#),” Chapter 1 (March 2016).
- 56 CDSS, [All County Welfare Directors Letter \(“ACWDL”\) 00-59](#) (November 15, 2000).
- 57 Cal. Welf. & Inst. Code § 14132.95(d)(2) (authorizing ancillary services); [ACWDL 05-21](#) (June 13, 2005).
- 58 Cal. Welf. & Inst. Code § 14132.95; Cal. Code Regs. tit. 22, § 51183.
- 59 Cal. Welf. & Inst. Code § 14132.95(f); Cal. Code Regs. tit. 22, § 51181.
- 60 CDSS, [ACL 93-21](#) (March 16, 1993).
- 61 42 U.S.C. §1396n(j).
- 62 Cal. Welf. & Inst. Code § 14132.952; CDSS, [ACL 11-19](#) (February 23, 2011); CDSS, [IHSS Program Data, \(Oct. 2025\)](#)..
- 63 *Id.*
- 64 See [ACL 14-60](#) (August 29, 2014), (implementing the CFCO program).
- 65 Cal. Welf. & Inst. Code § 14132.952; [ACL 11-19](#) (February 23, 2011).
- 66 Cal. Welf. & Inst. Code § 12305.6.
- 67 Cal. Welf. & Inst. Code § 12303.4(a); MPP § 30-765.12.
- 68 Cal. [Dept. of Social Services Para-Regs 612-5](#). (June 2022).
- 69 Cal. Welf. & Inst. Code § 12303.4(b); MPP § 30-765.11.
- 70 [ACL 12-36](#) (July 24, 2012).
- 71 [ACL 14-60](#) (August 29, 2014).
- 72 It is important to note that this paragraph only refers to presumptive disability eligibility for IHSS, which is distinct from presumptive eligibility for Medi-Cal. Beneficiaries who are presumptively eligible for Medi-Cal may be eligible for IHSS under the CFCO, PCPS, or IPO program if they have need and meet the other IHSS eligibility criteria.
- 73 MPP § 30-759.3; [ACL 14-67](#) (November 4, 2014), pg. 2.
- 74 *Id.*; [MPP § 30-771.2](#) defines blindness as an individual who “has central visual acuity of 20/200 or less in the better eye with use of a correcting lens” or “is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.”
- 75 Dir. Jennifer Troia, [CDSS, Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services](#) (May 20, 2024).
- 76 Welf. & Inst. Code §14007.8(2)(b).
- 77 Cal. Code Reg. tit. 22, § 50004.

- 78 42 U.S.C. § 1396a(5); Cal. Welf. & Inst. Code § 10740.
- 79 *Id.*
- 80 [MPP § 30-760.2](#).
- 81 [MPP § 30-701\(p\)\(8\)](#).
- 82 “Regional centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. They have offices throughout California to provide a local resource to help find and access the many services available to individuals and their families.” Department of Developmental Services, [Information about Regional Centers](#), (last visited June 3, 2025).
- 83 For more information about Regional Centers, go to [Department of Developmental Services](#).
- 84 [California Department of Aging](#) (last visited June 3, 2025).
- 85 California Department of Aging, [Programs](#), (last visited June 3, 2025)..
- 86 For the relevant statutes, see the [Government Publishing Office](#), (last visited June 6, 2025).
- 87 For the relevant regulations, see the [Government Publishing Office](#), (last visited June 6, 2025).
- 88 For California Welfare and Institutions Code statutes, see [California Legislative Information](#), (last visited June 6, 2025)..
- 89 For relevant regulations in the California Code of Regulations, Title 22, see [Westlaw California Code of Regulations](#).
- 90 CDSS, [Manual of Policies and Procedures, Chapter 30](#) (Social Services Standards). (last visited June 6, 2025).
- 91 CDSS, [Manual of Policies and Procedures, Chapter 22](#) (State Hearings). (May 2025).
- 92 For sub-regulatory guidance, see CDSS, [Letters and Regulations](#), (last visited June 4, 2025).

# Chapter 2: Eligibility and Applying for IHSS

This chapter will provide an in-depth overview of eligibility requirements and the application process for IHSS. There are six sections: (1) Eligibility Standards and Need for Services; (2) Alternative Resources and Other HCBS Programs; (3) Application Process and Timelines; (4) Presumptive Eligibility and Eligibility for Emergency Services; (5) Home Visit and Assessment Preparation; and (6) Approval and Denial of Applications.

## 1. ELIGIBILITY STANDARDS AND NEED FOR SERVICES

Beyond an applicant's need for IHSS services, which is discussed below in section 1.7, there are five basic eligibility requirements for IHSS:

1. Medi-Cal eligible;<sup>93</sup>
2. Immigration status;<sup>94</sup>
3. California resident;<sup>95</sup>
4. Live in own home or alternative living situations;<sup>96</sup> AND
5. Aged, blind, or disabled.<sup>97</sup>

Each requirement is discussed in detail below.

### 1.1 Medi-Cal Eligibility

In order to qualify for IHSS, an applicant must also qualify for and enroll in Medi-Cal.<sup>98</sup> Chapter 3 discusses a variety of Medi-Cal programs briefly, but an in-depth discussion of Medi-Cal eligibility criteria is beyond the scope of this manual. Extensive materials on Medi-Cal programs and eligibility rules are available online.<sup>99</sup>

If an individual wants to apply for IHSS, but does not already have Medi-Cal, the individual can apply for both programs through the county welfare department in their county of residence. There are separate applications for each program, and different units in the county social services agency process the applications.

Almost all IHSS recipients receive Medi-Cal that is paid, in part, with federal dollars (also known as "federal financial participation" or FFP). A very small percentage of IHSS recipients receive IHSS services through the IHSS-Residual program, which is state and locally funded. These recipients may include non-citizens under the five-year ban who receive state-only Medi-Cal, those who are transitioning off FFP Medi-Cal, children under 19 years of age with unsatisfactory immigration status, and adults who became eligible under the Medi-Cal Undocumented Expansion between 2020 and 2025, which extended full-scope Medi-Cal eligibility to all eligible Californians regardless of immigration status.<sup>100</sup>

## 1.2 Immigration Requirements

Historically the federal government restricted the receipt of FFP Medi-Cal to United States citizens or “qualified” immigrants.<sup>101</sup> In 2025, Congress passed and the President signed into law new restrictions on FFP for formerly qualified immigrants. IHSS services provided through one of the federal Medi-Cal linked IHSS programs are now only available to U.S. citizens and a narrow group of qualified immigrants. Qualified immigrants are:

1. Lawful permanent residents;
2. Cuban/Haitian entrants;
3. Lawful residents from Compact of Free Association countries.

Categories of “not qualified” immigrants are also *potentially* eligible for receipt of IHSS through the state and locally funded IHSS-R program. Starting in 2016, the California legislature extended access to full-scope Medi-Cal to Californians age 19-25 regardless of immigration status.<sup>102</sup> In 2020, the State added older adults fifty years old and older, and by 2024, to the remaining group of adults, age 26-49.<sup>103</sup> Services provided to individuals in this expansion population are paid for only through state funds without federal contribution. IHSS recipients in the expansion population can receive personal care services through the IHSS-R Program. By 2025, 3,000 older adults from the expansion population were receiving Medi-Cal-covered IHSS services.<sup>104</sup>

In 2025, the California legislature froze Medi-Cal enrollment of individuals with unsatisfactory immigration status starting January 1, 2026. Any unqualified individuals who are not yet enrolled by this date will not be eligible for full-scope Medi-Cal or for IHSS services.<sup>105</sup> The IHSS-R program is still available for eligible individuals who maintain their enrollment in full-scope Medi-Cal:

1. Certain immigrants permanently residing in the United States under color of law (PRUCOL);<sup>106</sup>
2. T Visa applicants who are pending certification for federal benefits;
3. U Visa holders and applicants;<sup>107</sup>
4. Persons granted parole status by the U.S. Department of Homeland Security;
5. Refugees, persons granted asylum status, persons granted withholding of deportation, and conditional entrants;<sup>108</sup>
6. Undocumented individuals enrolled in full-scope Medi-Cal before January 2026.<sup>109</sup>

T Visas are issued to victims of human trafficking and their immediate family, while U Visas are issued to victims of certain crimes who cooperate with law enforcement. For updated information on immigration and public benefit eligibility, visit the National Immigration Law Center’s website at [www.nilc.org](http://www.nilc.org).<sup>110</sup>

### 1.3 California Residency

In order to receive IHSS services, an applicant must live in California and apply in their county of residence.<sup>111</sup> If a recipient is physically absent from the State for 30 days or longer, the county must determine whether the absence is temporary or permanent.<sup>112</sup> Although the recipient is not required to affirmatively inform the county of their absence, they must respond to inquiries about residency from the county. The recipient must submit a written statement detailing the anticipated date of return to the state or their intention not to return, the reason for the absence from the state, and information about their current location and household arrangements.<sup>113</sup> The recipient must return this written statement to the county by the specified date or the county will terminate the recipient from the IHSS program.<sup>114</sup>

If an IHSS recipient is absent from the state for more than 60 days, the state will presume that the recipient intends to establish residency outside of California, unless the recipient submits evidence that they are prevented from returning due to illness or for another good cause.<sup>115</sup> In all cases of an absence of 30 days or longer, the county will weigh the evidence and, if it determines the absence is permanent, it will discontinue IHSS.

### 1.4 Lives in Own Home

An IHSS recipient must live in their own home in order to be eligible for the program. "Own home" is defined as the place where an individual chooses to reside and can include a house, an apartment, a motel, or a hotel. To ensure individuals at risk of homelessness or those living in a shelter or other locations can also access IHSS, some alternative settings such as temporary shelters or recreational vehicles can satisfy the "own home" requirement as long as the location is one in which the IHSS participant meets the following criteria:

1. can be assessed<sup>116</sup> and
2. have their authorized services delivered in a safe manner, which take into consideration the necessary "universal precautions."<sup>117</sup>

However, there is explicit guidance stating that living in the open with no shelter would not be considered living in a "home" for IHSS purposes.<sup>118</sup>

An individual's own home does not include certain facilities, including acute care hospitals, skilled nursing facilities, intermediate care facilities, or assisted living facilities. Any person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement, such as at a board and care, is not considered to be living in their own home.<sup>119</sup>

An applicant currently living in an institutional setting, however, may still be assessed and found eligible for IHSS.<sup>120</sup> The institutionalized individual must wish to live in their own home and be capable of doing so safely if IHSS is provided.<sup>121</sup> The county is obliged to perform a preliminary assessment before the applicant leaves the facility.<sup>122</sup> The vast majority of IHSS services can only begin once the recipient returns home.<sup>123</sup> However, the county may authorize heavy cleaning and yard abatement hours to prepare the home before the individual's return.<sup>124</sup>

**PRACTICE TIP:** Advocates working with currently institutionalized individuals who would be eligible for IHSS upon discharge should work with the county and the facility to coordinate the preliminary assessment. It is important to give the county as much notice as possible of discharge so, once a potentially eligible individual has a reasonably firm discharge date, the individual or their authorized representative should start the application process and ask for the pre-discharge preliminary assessment.

## 1.5 Aged, Blind, or Disabled

An applicant must be aged, blind, or disabled as defined by the Social Security Act in order to be eligible for IHSS.<sup>125</sup> Aged means 65 years or older.<sup>126</sup>

The definition of disability differs for adults and children. Disability for adults is defined as “the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”<sup>127</sup> This is the same definition used by the Social Security Administration to determine eligibility for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI).

A child under age 18 will be determined disabled if they have “a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death, or that has lasted or can be expected to last for a continuous period of not less than 12 months.”<sup>128</sup> These two definitions are just the starting point for a complicated area of law regarding disability determinations. For purposes of IHSS, however, it is simply important to know that if an applicant is determined “disabled” for SSI or Medi-Cal purposes, they are disabled for IHSS eligibility purposes as well.<sup>129</sup>

Blind is defined as “central visual acuity of 20/200 or less in the better eye with use of a correcting lens.”<sup>130</sup> An eye with a “limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.”<sup>131</sup> As with the disability determination, if an applicant is determined blind for SSI or Medi-Cal purposes, they are blind for IHSS eligibility purposes as well.<sup>132</sup>

Adults aged 19-64 who are approved for MAGI Medi-Cal do not need a formal disability determination, but still must be disabled to qualify for IHSS.<sup>133</sup> MAGI Medi-Cal is discussed in greater detail in Chapter 3.

It is important to note that being aged, blind, or disabled is necessary, but not sufficient, for receipt of IHSS services. As discussed in section 1.7 below, the applicant must also have a need for the services in order to qualify for the program.

## 1.6 Additional Eligibility Requirements for CFCO

Unlike the other IHSS programs, the CFCO program requires an applicant to meet its Nursing Facility Level of Care standard. There is no separate application for CFCO; all IHSS applicants are screened for CFCO eligibility. There are three ways to meet the CFCO Nursing Facility Level of Care standard:<sup>134</sup>

- 1 Have a total assessed need of 195 or more IHSS hours per month (excluding heavy cleaning and yard hazard abatement);

OR

- 2 Have a total assessed need of less than 195 IHSS hours per month (excluding heavy cleaning and yard hazard abatement) AND
  - » Need three (3) or more from a list of specific services with a high functional ranking;<sup>135</sup> OR
  - » Have a combined functional index rank of 6 or higher in mental functioning (memory, orientation, and judgment, which can each have FI Ranks for 1, 2 or 5).

OR

- 3 Have a combined "Individual Assessed Need" total of 20 hours or more per week from a specific list of services.<sup>136</sup>

Because of the higher reimbursement rate provided by the federal government, the state has moved a significant number of IHSS recipients into the CFCO program.

One benefit of qualifying for the CFCO program is more favorable Medi-Cal eligibility rules for married couples, called the "spousal impoverishment" rule. This rule allows the spouse needing the IHSS services to qualify for Medi-Cal while the other spouse retains significantly more income and assets than allowed under other Medi-Cal eligibility rules.<sup>137</sup> For further discussion of the spousal impoverishment eligibility methodology, see Chapter 3.

## 1.7 Need

If an applicant meets the eligibility requirements outlined above, the county will then determine the applicant's "level of ability and dependence upon verbal or physical assistance by another" for each of the services provided by IHSS.<sup>138</sup> The assessment will evaluate the applicant's physical, cognitive, and emotional impairments and determine if the applicant has a functional limitation that can be supported by an IHSS covered service.

A diagnosis of a specific condition is generally not enough to show need. For example, the fact that an applicant has diabetes is not enough to show need. The county social worker will need to understand what functional limitations are present because of the diabetes. So, the applicant will want to explain if and how the diabetes causes difficulty seeing, walking, eating, etc. Then the social worker will use the information gathered to determine the level of need and how much time should be allotted for the service. In-depth information about the needs assessment can be found in Chapter 4.

## **2. ALTERNATIVE RESOURCES AND OTHER HCBS SERVICES**

### **2.1 Alternative Resources**

As part of the needs assessment, the county will collect information about alternative resources available to the applicant.<sup>139</sup> The purpose is to determine if there are other available ways in which the applicant receives or could receive IHSS-type assistance.<sup>140</sup> Alternative resources include adult and child day care centers, community resource centers, senior centers, and respite centers.<sup>141</sup> Regional centers are not alternative resources for IHSS purposes.<sup>142</sup> The alternative resources must be actually available and cannot result in a cost to the IHSS program or to the applicant unless the applicant chooses to incur the cost or the applicant has a share of cost.<sup>143</sup>

Receipt of alternative resources will be documented and will reduce the number of hours allotted to the applicant for each specific service that is provided through the alternative resource, unless the applicant needs more than the maximum number of IHSS hours.<sup>144</sup>

IHSS hours can be allotted for travel to and accompaniment at an alternative resource if needed by the consumer.<sup>145</sup> Generally, an alternative resource program provides similar or complementary services to those provided by the IHSS program. For example, if a consumer attends a Community-Based Adult Service center (formerly an adult day health center) in the morning, IHSS cannot be approved for the hours while at the center, but could be approved if the consumer needs assistance in the afternoon or evening when the CBAS services aren't available.

### **2.2 Voluntary Services**

Voluntary services provided to the applicant by a family member, housemate or friend are not considered alternative resources.<sup>146</sup> If the service is being provided voluntarily, even though compensation is available through the IHSS program, the county social services worker will obtain a signed statement from the provider.<sup>147</sup> The county cannot require a family member or friend to provide services on a voluntary basis.<sup>148</sup>

### **2.3 Other HCBS Resources**

IHSS is one of several home and community-based services (HCBS) available in California. The goal of HCBS is to allow recipients to receive services in a non-institutional setting. Over the last several years, Medicaid spending has shifted so that now, HCBS spending represents nearly 69% of total Medicaid spending on long-term services and supports.<sup>149</sup>

A list of California HCBS program can be found in Appendix A. Disability Rights California also has separate publications about the Multipurpose Senior Services Program (MSSP), and the Home and Community-Based Alternatives Waiver (formerly the Nursing Facility/Acute Hospital Waiver).<sup>150</sup> Individuals must apply separately for each HCBS program. It is important to note that many non-IHSS HCBS programs have enrollment caps and waiting lists.

## COMMUNITY SUPPORTS

Beginning in January 2022, California transitioned most Medi-Cal services to managed care delivery through the California Advancing and Innovation Medi-Cal (CalAIM) program. Although IHSS is not included in CalAIM, managed care plans can now provide IHSS-like caregiving services through the Personal Care and Homemaker Services Community Support (PCHS) benefit.<sup>151</sup> These services are intended to supplement IHSS services, not replace them.<sup>152</sup> They are available in three different circumstances:

- » During the IHSS application process, including during any waiting period after a referral has been made, up until IHSS services are in place.
- » To IHSS recipients who need additional hours beyond what they were approved for by the county, up to 24 hours per day.
- » For Medi-Cal members who are ineligible for IHSS, up to 60 days of personal care services are available when needed to avoid a short-term stay in a skilled nursing facility.<sup>153</sup>

## 3. APPLICATION PROCESS AND TIMELINES

### 3.1 Application Process

There are six basic steps to the IHSS application process.

- 1 To begin, individuals who need in-home services must contact the county welfare department's IHSS unit in their county of residence. Although a written application is available, most individuals apply to IHSS by phone.<sup>154</sup> The CDSS website lists the contact information for each county's IHSS unit.<sup>155</sup>
- 2 If an IHSS applicant has not already applied for Medi-Cal, the county will refer them to the Medi-Cal benefits eligibility division of the county welfare office. The county welfare office should process the applications separately, but concurrently. However, many counties wait for the Medi-Cal approval before they start processing the IHSS application.
- 3 The applicant will receive a home visit from a county social worker. The social worker will interview the applicant in the home to help determine the applicant's eligibility for services, functional impairment, living arrangement, and any alternative resources that are available. If the applicant is currently residing in a facility, the county must do a preliminary assessment. They will follow-up with an in-home assessment once the applicant has returned to the home.<sup>156</sup>

4 As part of the assessment, the social worker is required to ask whether or not the applicant needs an accommodation due to blindness or visual impairment (this must happen at initial application and at annual reviews). The social worker should record that information as well as any communication needs related to it (e.g., use of a telephone timesheet system for approval of timesheets; requests for timesheets in 18-point font; requests for notices of action in 18-point font, in braille, in audio CD, or in accessible text CD.) If an individual needs a different type of accommodation, they should ask their social worker for it.<sup>157</sup>

5 An applicant must return a completed IHSS Health Care Certification form (SOC 873)<sup>158</sup> or its functional equivalent to the county welfare office.<sup>159</sup> The county will assist an applicant with this process if the applicant requests assistance.<sup>160</sup> A Medi-Cal enrolled health care provider may not charge for the completion of the form.<sup>161</sup>

If an applicant is requesting paramedical services or protective supervision, they are required to submit additional certification. For paramedical services, a health care professional must fill out and submit SOC 321.<sup>162</sup> For protective supervision, a health care professional must fill out and submit SOC 821.<sup>163</sup> These forms are not required as a part of the initial application.

IHSS certifications may be signed by a variety of health care professionals, including nurse practitioners, occupational or physical therapists, or public health nurses. The health care professional must be licensed in California, and have the primary responsibility of diagnosing or treating the physical or mental impairment that cause or contribute to the applicant's functional limitations.<sup>164</sup> An applicant has 45 days from the date of receipt of the blank form to return it completed and signed.<sup>165</sup> The county cannot authorize IHSS without receipt of the Health Care Certification form, unless the applicant is being discharged from a hospital or nursing home or is at imminent risk of out-of-home placement.<sup>166</sup> An applicant can request an additional 45 days to submit the Health Care Certification form if good cause exists for the delay.<sup>167</sup>

6 The county must process the completed application within 30 days.<sup>168</sup> This includes the eligibility determination, needs assessment, and sending the notice of action. It is not uncommon for a county to exceed this 30-day timeline. If a disability determination is pending, the county may extend the 30-day period, but the applicant may be able to receive IHSS services during this time if found presumptively eligible (see below).<sup>169</sup>

7 The county must send a Notice of Action (NOA) describing its determination.<sup>170</sup> If services are approved, the NOA will include information about the particular services and hours allotted to the recipient.<sup>171</sup> An applicant who has applied to Medi-Cal concurrently will receive a separate Notice of Action for that determination.<sup>172</sup>

## APPLICATION CHECKLISTS

### APPLICANT:

- Apply for IHSS by phone, in-person, or by mail to your county's welfare department
- Submit the Health Care Certification form
- Allow the county to conduct the in-home and the needs assessment

### COUNTY:

- Accept the application by phone, in-person, or by mail
- Help the applicant obtain the Health Care Certification form, if needed
- Complete the home visit and needs assessment
- Process the application within 30 days
- Send a Notice of Action approving or denying the application

### 3.2 Application Timeline

Although the state law provides a timeline for processing IHSS applications, federal law requires the states to comply with Medicaid timeliness standards when processing Medicaid applications.<sup>173</sup> Specifically, the states must complete processing within 90 days for applicants who apply on the basis of disability and 45 days for all other applicants.<sup>174</sup> The 45/90 day timeline runs from the date of initial application (or transfer from another insurance program) to the date the agency notifies the applicant of its decision.<sup>175</sup>

Because California regulations require that IHSS applications must be processed within 30 days, the protections afforded by the federal Medicaid Act may seem unnecessary.<sup>176</sup> In practice, however, delays are common.<sup>177</sup> If there is a county pattern of delays, advocates can contact Justice in Aging to discuss advocacy options or go directly to the Department of Social Services, Adult Programs Division.

Although the health care certification form is required before services can be authorized, it is not part of the application itself. Delays in returning the Health Care Certification form (step 4 above) may result in a delay of a Medi-Cal or IHSS determination beyond the 45/90 day deadlines. IHSS eligibility determinations that extend beyond the 45/90 day deadline may violate the federal Medicaid timeliness standards.

## **4. PRESUMPTIVE ELIGIBILITY AND ELIGIBILITY FOR EMERGENCY SERVICES**

### **4.1 IHSS Presumptive Eligibility**

Generally, receipt of IHSS services is dependent upon completion and approval of the Medi-Cal application process. In limited circumstances, however, an applicant may be eligible for presumptive eligibility for IHSS services even without a Medi-Cal determination. If an applicant has applied for Medi-Cal and is complying with all Medi-Cal requirements, but the determination of their Medi-Cal eligibility is pending a disability evaluation determination, that applicant may be eligible for IHSS services through the IHSS-Residual (IHSS-R) program.<sup>178</sup> Although IHSS-R is often thought of as IHSS for those who are not Medi-Cal eligible, it often operates as a catch-all program, serving those on state-only Medi-Cal, those presumptively eligible, and those transitioning off Medi-Cal.

Receipt of IHSS through the IHSS-R program will continue until the disability determination is made and Medi-Cal is approved or denied. If Medi-Cal is approved, the consumer will continue with IHSS, but it will be provided through one of the federal Medi-Cal linked IHSS programs. If the Medi-Cal application is denied, the IHSS temporarily authorized through the IHSS-R program will also be terminated.<sup>179</sup> The county must notify the consumer of its intent to terminate IHSS and provide them with an opportunity to appeal the decision. A consumer seeking to challenge this decision should appeal both the denial of IHSS and the denial of Medi-Cal.

### **4.2 Presumptive Disability**

Certain conditions do not require a disability determination. Instead, for purposes of Medi-Cal and IHSS eligibility, the individual will be considered presumptively disabled if they have one of the articulated conditions; some examples include amputation of a leg at the hip, total deafness, and total blindness.<sup>180</sup> The county will still conduct a needs assessment of the presumptively disabled individual to establish hours of need.

### **4.3 Medi-Cal Presumptive Eligibility**

Separately, there are also several Medi-Cal presumptive eligibility programs which include the Breast and Cervical Cancer Treatment Program, Child Health and Disability Prevention Program, Every Woman Counts, Presumptive Eligibility for Pregnant Women, and Hospital Presumptive Eligibility. These programs provide qualified individuals immediate temporary access to Medi-Cal coverage based on the individual's self-attested preliminary information.<sup>181</sup>

## **5. HOME VISIT AND ASSESSMENT PREPARATION**

### **5.1 Home Visit**

In order to evaluate an applicant's need for IHSS, a county social worker will conduct a home visit.<sup>182</sup> The county will also conduct home visits for reassessments. Since October 2024, individuals with stable needs can also choose to have their reassessments by phone or video every other year, but initial assessments must be completed in person.<sup>183</sup> The applicant must cooperate with the county to conduct these assessments.<sup>184</sup> CDSS also has a protocol for unannounced home visits as part of its quality assurance efforts.<sup>185</sup>

At the home visit, the county social worker will assess the applicant's physical and mental conditions, their living situation, and how long it takes the applicant to perform tasks.<sup>186</sup> It is important to note, however, that the home visit is only a part of the overall needs assessment and the county social worker's determinations about the applicant's needs should not be based only on the home visit. Nonetheless, the home visit is a very important part of the needs assessment, so it is helpful for applicants to be prepared for the visit. Applicants can choose to have a family member, friend, advocate, or other representative with them during the visit.

The California Department of Social Services has created an instructional video that may be helpful for some applicants preparing for a home visit.<sup>187</sup> Disability Rights California has also created a self-assessment guide, which can be used by a consumer or a family member to help show what a consumer's monthly need is.<sup>188</sup> The self-assessment chart is attached to this guide as Appendix B.

## **6. APPROVAL OR DENIAL**

The county must send an IHSS Notice of Action (NOA) to the applicant explaining the eligibility determination. If the services are approved, the NOA will provide a detailed explanation of the hours assigned for each service.<sup>189</sup> Chapter 4 provides information about each service category and the time guidelines for each task. A sample NOA is attached to this guide as Appendix C.

Applicants have a right to a written denial.<sup>190</sup> Verbal denials are not valid. Applicants have the right to appeal an IHSS denial or an award of hours, if they disagree with the number of hours assigned. Chapter 7 provides a more in-depth explanation of appeal rights and procedures.

# Chapter 2 Endnotes

- 93 Cal. Welf. & Inst. Code § 12301.5.
- 94 Cal. Welf. & Inst. Code §14007.8
- 95 California Dept. of Social Services (“CDSS”) [Manual of Policies & Procedures \(“MPP”\) § 30-755.11](#) (Non-PCSP eligibility); [MPP § 30-770.41](#) (PCSP eligibility).
- 96 [MPP § 30-755.11](#); see also [MPP § 30-700.1](#); [DHCS, All-County Information Notice \(“ACIN”\) No. I-19-20](#), (Feb. 25, 2020).
- 97 [MPP § 30-755.11](#); [MPP §§ 30-770.1, 30-770.2](#); see also 20 C.F.R. § 416.202.
- 98 Cal. Welf. & Inst. Code § 14132.95, [MPP § 30-700.2](#) (PCSP); [MPP § 30-755.31](#) (Non-PCSP Programs).
- 99 See [Health Consumer Alliance](#) at [g](#); Western Center on Law & Poverty, “2016 [Health Care Eligibility Guide](#)” (March 1, 2016).
- 100 Cal. Welf. & Inst. Code §12300 et seq; Welf. & Inst. Code §14007.8.
- 101 Cal. Welf. & Inst. Code § 14007.5; Cal. Code Regs., tit. 22, § 50301(b).
- 102 Justice in Aging, [“Justice in Aging’s Analysis of the Final California 2022-23 State Budget,”](#) (July 7, 2022).
- 103 *Id.*
- 104 Dir. Jennifer Troia, [CDSS, Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services](#) (May 20, 2024).
- 105 Welf. & Inst. Code §14007.8.
- 106 [ACIN I-18-08](#), (March 12, 2008); immigrants who are eligible under the PRUCOL definition are described in [POMS SI 00501.420](#), available at.
- 107 [MPP § 30-770.5](#); [All County Letter \(“ACL”\) 08-15](#), (April 4, 2008).
- 108 Cal.Code Regs. Tit. 22, §50302; see also DHCS, [Immigration Status and Changes to Medi-Cal Eligibility](#), (last visited Jan. 5, 2026).
- 109 Cal. Welf. & Inst. Code § 14007.5
- 110 See also National Immigrant Legal Center, [Major Benefit Programs Available to Immigrants in California](#), (April 2023); for information about how sponsor deeming affects IHSS eligibility, see [All County Letter 22-44](#) (June 1, 2022).
- 111 [MPP § 30-770.41](#)
- 112 [MPP § 30-770.42](#)
- 113 [MPP § 30-770.421](#)
- 114 [MPP § 30-770.422](#)
- 115 [MPP § 30-770.441](#). Good cause includes but is not limited to: (1) outpatient medical treatment necessary to maintain the recipient’s health where the medical treatment is not available in California; (2) short-term schooling or training necessary for the recipient to obtain self-sufficiency where such training is not available in California; (3) court-issued subpoena or summons. Welf. & Inst. Code § 11100.1.

- 116 ACIN I-19-20. A person living in a recreational vehicle, for example, “can be assessed” where it is parked in the same location with sufficient length of time that would allow the IHSS case worker to conduct an assessment, reassessments and make unannounced home visits.
- 117 ACIN I-19-20 citing MPP § 30-575.1(a)(1)(A)(1). While utilities are generally needed to meet this requirement, individuals in rural and Native American tribal lands may be eligible if they have access to alternate resources that would allow them to receive services in a safe manner.
- 118 CDSS, [All County Letter \(“ACL”\) 08-18](#) (April 23, 2008), at Question 27.
- 119 [MPP § 30-701\(o\)\(2\)](#).
- 120 [MPP § 30-755.12](#).
- 121 *Id.*
- 122 [MPP § 30-755.12](#).
- 123 [MPP § 30-755.121](#).
- 124 [MPP § 30-755.121](#); [MPP § 30-757.12](#).
- 125 20 C.F.R. § 416.202; Cal. Welf. & Inst. Code § 12300; [MPP 30-700.1](#); [30-755.231](#).
- 126 20 C.F.R. § 416.202(1); Cal. Welf. & Inst. Code § 12050(b).
- 127 20 C.F.R. § 416.905(a); Cal. Welf. & Inst. Code § 12050(d); The disability listings are available in: [The Social Security Blue Book](#).
- 128 20 C.F.R. § 416.906; Cal. Welf. & Inst. Code § 12050(d).
- 129 Cal. Welf. & Inst. Code § 12300; [MPP § 30-755.11](#).
- 130 20 C.F.R. § 416.981.
- 131 *Id.*
- 132 Cal. Welf. & Inst. Code § 12050(c).
- 133 [ACL 14-67](#) (November 4, 2017).
- 134 [ACL 14-60](#) (August 29, 2014), pgs. 2-4.
- 135 Here are the applicable services and functional ranks: Eating, FI Rank of 3-6; Bowel and Bladder/Menstrual Care, FI Rank of 3-6; Bathing/Grooming, FI Rank 4-5; Dressing, FI Rank of 4-5; Mobility Inside, FI Rank of 4-5; Transfer, FI Rank of 4-5; Respiration, FI Rank of 5-6; Paramedical, FI Rank not applicable.
- 136 Here are the applicable services: Preparation of Meals, Meal Clean-Up, Respiration, Bowel and Bladder Care, Feeding, Routine Bed Baths, Dressing, Menstrual Care, Ambulation, Transfer, Bathing, Oral Hygiene, Grooming, Repositioning and Rubbing Skin, Care and Assistance with Prosthesis, and Paramedical.
- 137 [SMD #15-001](#) (May 7, 2015); 42 U.S.C. §1396r-5(a).
- 138 Cal. Welf. & Inst. Code § 12309; [MPP § 30-756.1](#).
- 139 Cal. Welf. & Inst. Code § 12309(b)(2)(B).
- 140 [MPP § 30-763.6](#).
- 141 [MPP § 30-757.171\(a\)\(2\)](#).

- 142 [ACL 98-53](#) (July 9, 1998).
- 143 [MPP §§ 30-763.611](#); [30-763.613](#).
- 144 [MPP § 30-763.63](#).
- 145 [MPP § 30-757.154](#); [ACL 14-82](#) (November 25, 2014).
- 146 [MPP § 30-763.62](#).
- 147 [MPP §§ 30-763.64](#), [30-757.176](#); [ACL 00-28](#) (April 25, 2000);
- See SOC [450 Voluntary Services Certification](#).
- 148 *Id.*
- 149 See Wysocki, Andrea, et al., "[Trends in the Use of and Spending for Home and Community-Based Services as a Share of Total LTSS Use and Spending in Medicaid, 2019-2021](#)," (July 24, 2024); for analysis of the challenges to assessing California's rebalancing ratio see, Justice in Aging, "[Beyond Spending—Measuring California's Progress Towards Equitable HCBS](#)," (August 25, 2022).
- 150 MSSP: <http://www.disabilityrightsca.org/pubs/539501.pdf>; AIDS Waiver: <http://www.disabilityrightsca.org/pubs/543501.pdf>; NF/AH Waiver: <http://www.disabilityrightsca.org/pubs/559101.pdf>.
- 151 DHCS, "[Community Supports Policy Guide Vol. 1](#)," pp. 25-27, (April 2025).
- 152 *Id.*
- 153 *Id.*
- 154 The written application for IHSS is SOC 295 and it was updated in September 2018. The English application is available at the [CDSS form library](#). The large print English application is available [here](#). Applications in Spanish, Chinese and Armenian can be found [here](#).
- 155 Information about County IHSS Offices can be found [here](#).
- 156 [MPP § 30-755.12](#); [ACIN I-43-06](#) (June 8, 2006); [ACL 02-68](#) (August 30, 2002);
- 157 [ACL 15-60](#) (July 22, 2015).
- 158 [CDSS Form SOC 873](#).
- 159 Cal. Welf. & Inst. Code § 12309.1, [MPP § 30-754](#); [ACL 16-78](#) (September 28, 2016). New regulations implementing the health care certification requirements became effective on October 1, 2016. [MPP § 30-701\(l\)\(2\)](#) defines a licensed health care provider for purposes of the health care certification. [MPP § 30-754.2](#) mandates use of the department-approved form, but [MPP § 30-754.21](#) also requires counties to accept alternative documentation that provides counties with the same needed information as the SOC 873 form.
- 160 [SOC 874](#) states that the county can send the Health Care Certification form directly to the applicant's licensed health care provider, but the applicant must provide the LHCP's name and address. SOC 874 provides notice to applicants of the requirement
- 161 Health & Safety Code §123114; 42 USC § 1396t(c)(2)(A).
- 162 CDSS [Form SOC 321](#).
- 163 CDSS [Form SOC 821](#).
- 164 [ACL 11-55](#), (Jul. 27, 2011); [ACL 24-89](#), (Nov. 26, 2024).

- 165 [MPP § 30-754.4](#); [ACL 16-78](#) (September 29, 2016).
- 166 [MPP § 30-754.6](#). Applicants who were granted an exception and received IHSS services before the county received the Health Care Certification form will still need to return the completed and signed form once the county requests it and will then have 45 days from that date to return it per [MPP § 30-754.63](#). Those applicants may also be granted an additional 45 day extension for good cause per [MPP § 30-754.64](#).
- 167 Cal. Welf. & Inst. Code § 12309.1(e)(2).
- 168 [MPP § 30-759.2](#).
- 169 [MPP §§ 30-759.2, 30-771.3](#).
- 170 Cal. Welf. & Inst. Code § 12300.2; [MPP §§ 30-759.7, 30-763.8](#).
- 171 *Id.*
- 172 22 C.C.R. § 50179.
- 173 42 C.F.R. § 435.912.
- 174 42 C.F.R. § 435.912(c)(3).
- 175 Code of Federal Regulation, Title 42, section 435.912(e) contemplates the unusual circumstances where a state may legally not abide by the timeliness guidelines. Subsection (e)(1) creates an exception to the timeliness standards when “the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action.”
- 176 [MPP § 30-759.2](#).
- 177 Per Cal. Welf. & Inst. Code § 12309.1, there are two exceptions to this requirement: (1) services may be authorized prior to receipt if an individual is being discharged from a hospital or nursing home and the services are needed to enable the individual to return home safely or (2) services may be authorized temporarily if the county determines there is a risk of an out of home placement.
- 178 [MPP § 30-759.2](#); [ACL 12-36](#) (July 24, 2012).
- 179 [ACL 12-36](#) (July 24, 2012).
- 180 [MPP § 30-785\(g\)](#); 22 C.C.R. § 50167(a)(1)(C); 20 C.F.R. § 416.934.
- 181 More information about these programs is available [here](#).
- 182 [MPP § 30-761.13](#).
- 183 [ACL 24-72](#), (Oct. 8, 2024).
- 184 [MPP § 30-60.13](#).
- 185 See CDSS, [IHSS Uniform Statewide Protocols](#).
- 186 [MPP § 30-761.261](#).
- 187 The video can be found [here](#). It is also available in Spanish, Chinese, and Armenian.
- 188 The full assessment guide is available [here](#).
- 189 Cal. Welf. & Inst. Code § 12300.2; [MPP §§ 30-759.7, 30-763.8](#).
- 190 [MPP § 22-001\(a\)\(1\)](#).

# Chapter 3: Medi-Cal Programs and IHSS

This chapter will provide an overview of the Medi-Cal program and its relationship to the IHSS program. There are four sections: (1) Overview of Specific Medi-Cal Programs; (2) Spousal Impoverishment Protections; (3) Effects of Changes and Terminations in Medi-Cal on IHSS; (4) IHSS and Medi-Cal Managed Care and (5) Medi-Cal HCBS Waivers.

## 1. OVERVIEW OF SPECIFIC MEDI-CAL PROGRAMS

Medi-Cal is California’s Medicaid program. It currently serves nearly 15 million Californians.<sup>191</sup> Although Medi-Cal is presented as one large insurance program, Medi-Cal actually consists of dozens of different programs with different eligibility requirements. Enrollment in IHSS does not depend on being eligible for a particular Medi-Cal program. However, it is helpful to understand the basics of a few of the different Medi-Cal programs most closely associated with IHSS. This manual only provides a general overview of different Medi-Cal programs. For more in-depth information about Medi-Cal, Western Center on Law and Poverty<sup>192</sup>, the Health Consumer Alliance<sup>193</sup>, and Disability Rights California<sup>194</sup> have additional resources.

Medi-Cal programs fall broadly into two categories: those that determine income eligibility according to Modified Adjusted Gross Income (MAGI Medi-Cal) and those that use traditional Medicaid eligibility groups (non-MAGI Medi-Cal). There are numerous subcategories of non-MAGI Medi-Cal. It is important to note that not all Medi-Cal programs are free. Some programs require a small monthly premium, and others require recipients to incur a monthly share of cost before Medi-Cal will cover any services. A share of cost is the amount a person or family must pay towards the cost of their health care services each month in order to be eligible for Medi-Cal in the same month.<sup>195</sup>

Most Medi-Cal recipients are enrolled in managed care. This shift from fee-for-service to managed care has not significantly affected the administration of the IHSS program, which has remained with the county welfare departments.

### 1.1 MAGI Medi-Cal

There are four broad programs under the umbrella of MAGI Medi-Cal: expansion adults, parents and caretaker relatives, pregnant women, and children. MAGI stands for “Modified Adjusted Gross Income.” It represents a methodology created under the Affordable Care Act for establishing income eligibility for Medi-Cal, based on the Internal Revenue Service (IRS) income rules.<sup>196</sup> Starting January 1, 2014, Medi-Cal began providing free health insurance to two groups of adults who were formerly ineligible for Medi-Cal: low-income single adults without children between the ages of 19-64 and former foster youth up to age 26.<sup>197</sup> More than 5.1 million recipients, or 34% of the Medi-Cal population, qualify for Medi-Cal as a result of this expansion.<sup>198</sup>

Prior to the passage of the Affordable Care Act, having low or no income was not a sufficient basis for Medi-Cal eligibility. Instead, a person had to fit into a specific eligibility group. Now, an adult who (1) has a modified gross adjusted income below 138% of the Federal Poverty Level (FPL)<sup>199</sup>; (2) is not eligible for Medicare Part A or B<sup>200</sup>; (3) is not pregnant; and (4) is a U.S. citizen or qualified immigrant, is eligible for MAGI Medi-Cal under the expansion adult population.<sup>201</sup> MAGI Medi-Cal uses yearly income to determine eligibility.<sup>202</sup> Income is limited to 138% FPL for adults. Generally, Medi-Cal will use household income reported to the Internal Revenue Service (IRS) on the 1040 form. MAGI Medi-Cal does not have an asset or resource test.<sup>203</sup>

Parents and caretaker relatives are eligible for MAGI Medi-Cal if (1) they have a linkage to the child by blood, adoption, or marriage; (2) live with that child; (3) have primary responsibility for the child; (4) have income at or below 109% FPL.<sup>204</sup> Parents and caretakers with income between 109% and 138% can qualify through the expansion adult program if they meet the other criteria described above.

Pregnant people are eligible for MAGI Medi-Cal. There are multiple programs covering pregnant people and eligibility for each largely depends on income. Free full-scope Medi-Cal is available to pregnant people, regardless of immigration status, with income up to 138% FPL and pregnancy-related Medi-Cal is available up to 213% FPL.<sup>205</sup> Practically speaking, all medically necessary services should be covered regardless of whether a woman is on full-scope Medi-Cal or pregnancy-related Medi-Cal.<sup>206</sup>

Children aged 0-19 years old are also eligible for MAGI Medi-Cal as well as coverage under the Targeted Low-Income Children's Program (TLICP).<sup>207</sup> These two Medi-Cal programs cover low-income children regardless of immigration status. The income eligibility limit for both programs varies depending on the age of the child.<sup>208</sup> Generally, children are eligible for Medi-Cal with income up to 266% FPL, and some infants are eligible for Medi-Cal coverage up to 322% FPL.<sup>209</sup> Children between 1 and 19 with family incomes between 161% and 266% FPL will be required to pay a monthly premium of \$13 per child, which is capped at \$39 per family.<sup>210</sup>

MAGI Medi-Cal recipients are eligible for IHSS services.<sup>211</sup> Each county must separately determine IHSS eligibility for MAGI Medi-Cal recipients.<sup>212</sup> The county will determine whether the recipient has full-scope Federal Financial Participation Medi-Cal, whether the recipient is aged, blind, or disabled, and assess whether that recipient needs IHSS services. If the recipient meets all three criteria, they will be eligible to receive IHSS services through the Community First Choice Option (CFCO), the Personal Care Services Program (PCSP), or the IHSS Plus Option (IPO) programs.<sup>213</sup> Medi-Cal members with unsatisfactory immigration status can receive IHSS services through the IHSS-R program. However, any undocumented individuals who are not yet enrolled by this date will not be eligible for full-scope Medi-Cal or for IHSS services.<sup>214</sup> All four programs are described in detail in Chapter 1.

## 1.2 Non-MAGI Medi-Cal

All Medi-Cal programs that do not use the modified adjusted gross income counting methodology are considered non-MAGI programs. Non-MAGI Medi-Cal programs are traditional Medi-Cal programs. Almost all seniors are enrolled in non-MAGI programs. A significant number of adults with disabilities are also in non-MAGI programs. The three largest programs are SSI-linked, Aged & Disabled Federal Poverty Level, and Medically Needy Medi-Cal. A significant number are also served by the 250% Working Disabled Program. Each will be discussed briefly.<sup>215</sup>

In general, traditional Medi-Cal programs have limits on how much income and how many resources individuals can have and still qualify for benefits. Additionally, traditional Medi-Cal determines eligibility based on monthly income, not yearly income. For more information about traditional Medi-Cal property limits see June 30, 2025, All County Welfare Director's Letter No.:25-14, Reinstatement of Asset Limits for Non-Modified Adjusted Gross Income (Non-MAGI) Medi-Cal Programs.<sup>216</sup>

### SSI-Linked Medi-Cal

Seniors and adults with disabilities receiving Supplemental Security Income (SSI) are automatically eligible for free Medi-Cal. These recipients do not have to separately apply for Medi-Cal through the county. However, like all Medi-Cal recipients, they will have to apply for IHSS through the county.

### Aged & Disabled Federal Poverty Level Medi-Cal

The Aged and Disabled (A&D) Federal Poverty Level (FPL) program serves low-income people with disabilities, including seniors.<sup>217</sup> Seniors are defined as individuals aged 65 and over.<sup>218</sup> Disability can be established through a Social Security disability determination or by applying for Medi-Cal.<sup>219</sup> It is a free Medi-Cal program, so eligible individuals do not have a share of cost.

The income limits change every year based on the Federal Poverty Level. The exact income limit is set each April. The income limits are 138 of FPL for a couple or individual.<sup>220</sup> In 2025, seniors or people with disabilities must have net countable income below \$1,801 for an individual and \$2,433 for a couple.<sup>221</sup> In addition to meeting this income limit, the senior or adult with disabilities must also have countable resources below the Medi-Cal resource limit of \$130,000 for an individual and \$65,000 for each additional household member.<sup>222</sup> Resource determinations can be complicated and advocates should consult the manuals recommended above for more details.

There are ways for individuals to reduce their net countable income for Medi-Cal purposes, which may help them qualify for free Medi-Cal through the Aged and Disabled program. For more information, see Disability Rights California's publication, "Determining Eligibility Under the Aged, Blind and Disabled Federal Poverty Level (ABD FPL) Medi-Cal Program."<sup>223</sup>

## Aged, Blind, & Disabled Medically Needy Medi-Cal/Share of Cost

Low-income seniors and adults with disabilities with higher incomes, who do not qualify for other Medi-Cal programs or who have a pending SSI application may be eligible for the Medically Needy Medi-Cal program.<sup>224</sup> The Medically Needy program is free for some ultra-low-income recipients, but most have a Share of Cost.

A share of cost, sometimes called “spend down,” is an amount of money that a recipient must pay or incur each month for medical goods and services before the Medi-Cal program will begin to pay for health care services, including IHSS. The formula used to calculate Medi-Cal share of cost has not been updated in almost 30 years so it often results in unaffordable high shares of cost for recipients.

To determine share of cost, the county will begin by determining total gross income. It then subtracts the standard \$20 deduction, and the earned income deduction, if applicable.<sup>225</sup> Next, it will subtract any medical premiums paid by the applicant, including Medicare Part B premiums.<sup>226</sup> After subtracting all allowable deductions from gross income, the county will have a net countable income for the individual or couple. If the income is below the eligibility limit for the Medi-Cal Aged and Disabled Federal Poverty Level program the person will receive free Medi-Cal; if it is above the limit the individual will be eligible for the Medically Needy program. The share of cost will be the net countable income minus the monthly maintenance need income level of \$600 for an individual and \$934 for a couple.<sup>227</sup>

### Example 1—Share of Cost with no medical premium deductions

Juanita receives \$2,000 in monthly retirement income and pays no medical premiums. The county subtracts the standard \$20 deduction. Juanita’s net countable income is \$1,980. Because this is higher than \$1,801 (the Medi-Cal Aged & Disabled limit in 2025) the county will need to determine her share of cost by subtracting \$600 from \$1,980. Juanita’s share of cost will be **\$1,380 per month**.

### Example 2—Share of Cost with medical premium deductions

James receives \$2,100 in gross monthly Social Security income and pays \$202.90 per month for Part B premiums. The county subtracts the standard \$20 deduction and the \$202.90 medical premium. James’s net countable income is \$1,897.10. Because this is higher than \$1,801 (the Medi-Cal Aged & Disabled limit in 2025) the county will need to determine his share of cost by subtracting \$600 from \$1,897.10. James’s share of cost will be **\$1,297.10 per month**.

### Example 3—No Share of Cost with medical premium deductions

Miriam receives \$2,000 in gross monthly Social Security income and pays \$200 in monthly medical premiums. The county subtracts the standard \$20 deduction and the \$200 medical premium. Miriam’s net countable income is \$1,780. Because this is lower than \$1,801 (the Medi-Cal Aged & Disabled limit in 2025), Miriam is eligible for free Medi-Cal and will not have a share of cost.

*Note that in both Example 1 and 2 above, Juanita and James can also look into purchasing additional insurance in order to bring their income below the \$1,801 threshold amount and thus avoid paying a share of cost.*

## IHSS and Share of Cost

Individuals who have a high share of cost may have difficulty accessing Medi-Cal services, including IHSS. In fact, the IHSS recipients are particularly negatively affected by having a monthly share of cost. This is because the share of cost is directly subtracted from a provider's wages each month that the recipient does not incur other medical bills. This means that the recipient will be responsible to pay the provider any wages not paid by the State.

### Example 4—Effect of Share of Cost on IHSS

Tim has a monthly share of cost of \$1,000. He is eligible for 170 hours per month of IHSS at a rate of \$16 per hour. Based on this information, Tim's provider will earn \$2,720 per month. However, if this is the only Medi-Cal covered expense Tim has each month, the state will deduct \$1,000 every month from Tim's provider's wages and Tim will be responsible for paying that share of cost amount directly to his provider each month. In other words, the provider is owed \$2,720 each month in wages, the state will pay \$1,720 (\$2,720 less the \$1000 share of cost), and Tim owes his provider \$1,000 in wages. Because this accounts for half of Tim's income, it is unlikely that he can afford to pay this amount, which will make it difficult for him to maintain a provider.

## Reducing or Eliminating Share of Cost

It is possible to reduce or eliminate a share of cost, and individuals who need IHSS may have a strong financial incentive to do so. Individuals may purchase dental or vision insurance so they have an additional medical premium deduction.<sup>228</sup> Individuals may also want to contact Disability Rights California or another legal services organization to discuss eligibility for Medi-Cal under a more favorable program like the 250% Working Disabled Program described below.

If individuals cannot eliminate their share of costs, they can try to use other medical expenses, including paying out-of-pocket for additional personal care services as a way to meet their share of cost.<sup>229</sup> It is important to note that as of 2015 out-of-pocket personal care services can no longer be used as an income deduction.<sup>230</sup> For more information about this, see Disability Rights California publication entitled "How Can I Use My Share of Cost to Get More Services I Need?"<sup>231</sup>

## 250% Working Disabled Program

The 250% Working Disabled Program is a Medi-Cal program for adults with disabilities who receive disability-based income. Because this program does not count disability-based income, some individuals may be able to avoid a high share of cost. It is therefore worth determining whether an individual or couple is eligible under the 250% Working Disabled Program.

A qualified individual must meet the Social Security definition of disabled, have net family income less than 250% FPL, and be eligible for SSI benefits if it weren't for their earnings. The individual must also have earnings from work (even a very small amount of work), and have resources below the \$130,000/\$195,000 threshold.<sup>232</sup> Any money earned for work performed is considered earnings for this program.<sup>233</sup> Individuals who received Social Security Disability Insurance benefits that converted to retirement benefits may also participate in this program.

For more information about this program, Western Center on Law and Poverty's "2016 Medi-Cal Eligibility Guide".<sup>234</sup>

## **2. SPOUSAL IMPOVERISHMENT PROTECTIONS**

The spousal impoverishment protection is a specialized Medicaid eligibility rule that benefits married couples when one member of the couple needs long-term services and supports. Spousal impoverishment rules can be used to assist married IHSS applicants to establish Medi-Cal eligibility because it provides an alternative method to allocate, or count, income and resources.

In general, this protection allows a Medi-Cal applicant's income and resources to be allocated to a community spouse so that the Medi-Cal applicant and/or recipient can meet income and resource limitations. Originally, the purpose of the rule was to allow a spouse in need of long-term care to become Medi-Cal eligible so he or she could reside in an institutionalized setting, while preventing the spouse still living at home from becoming destitute.<sup>235</sup> Although this rule helped married couples, it had the unintended consequence of forcing the institutionalization of a spouse who could have been cared for at home with the proper supports.<sup>236</sup>

Beginning on January 1, 2014, the Patient Protection and Affordable Care Act of 2010 ("ACA") expanded the spousal impoverishment protections.<sup>237</sup> The purpose of the expansion, which sunset on December 31, 2018, and was extended several times, most recently until September 30, 2027, is to allow more seniors and adults with disabilities to access needed home and community-based services, including IHSS. By amending the definition of "institutionalized spouse" to include a spouse who is eligible for home and community-based services pursuant to a Medicaid state plan or waiver program at a nursing home level of care, the ACA allowed more couples to avail themselves of the Spousal Impoverishment Protections.

### **CASE EXAMPLE: MR. AND MRS. FUENTES**

Mr. Fuentes has income of \$2000 per month from Social Security retirement. His wife, Mrs. Fuentes, has \$2200 in income from her pension. The couple also has \$200,000 in savings. Because the Medi-Cal income limit is \$1801 in 2025, Mr. Fuentes or Mrs. Fuentes are ineligible for full-scope Medi-Cal.

A few years ago Mr. Fuentes was diagnosed with Alzheimer's and has Medi-Cal with a high share of cost. He now requires in-home support and will need to go into a nursing home without it. After applying for IHSS and being put into the CFCO program the County applied Spousal Impoverishment protections by separating the spouses into separate households and allocating some of Mr. Fuentes' income and assets to Mrs. Fuentes:

- » \$199/month were allocated from Mr. Fuentes to Mrs. Fuentes. \$70,000 of assets were allocated from Mr. Fuentes to Mrs. Fuentes.
- » Mr. Fuentes now has \$1801/month in income, and \$130,000 in assets. He is eligible for full scope Medi-Cal.
- » Mrs. Fuentes now has \$2399/month, and \$70,000 in assets.
- » Mr. Fuentes can now receive IHSS with no share of cost.

In July of 2017, Justice in Aging, Disability Rights California, Western Center on Law and Poverty, Bet Tzedek Legal Services, and pro bono firm, McDermott, Will, & Emery sued the Department of Health Care Services for failure to implement the expanded Spousal Impoverishment protections.<sup>238</sup> After the filing of the lawsuit, *Kelley v. Kent*, the Department of Health Care Services released initial statewide guidance and in 2018 followed up with a second guidance letter. Applicants and recipients, however, are still not consistently being evaluated for eligibility based on the spousal impoverishment protection.<sup>239</sup> For additional information about the spousal impoverishment rule or the *Kelley* case, contact Justice in Aging or Disability Rights California.

### **3. EFFECTS OF MEDI-CAL CHANGES & TERMINATIONS ON IHSS**

Because IHSS eligibility is largely dependent upon Medi-Cal eligibility, changes to a recipient's Medi-Cal coverage can affect that recipient's ability to access IHSS<sup>240</sup>. There are two major categories of Medi-Cal changes that can negatively affect an individual's IHSS: (1) changes that increase a recipient's out-of-pocket costs for IHSS (for example, going from a free Medi-Cal program to a Medi-Cal program which will cost a recipient money) and (2) Medi-Cal terminations.<sup>241</sup>

#### **3.1 Share of Cost**

Changes in income can affect Medi-Cal eligibility.<sup>242</sup> Once a change in income is reported to the county, the county must process that change and determine whether the individual is still eligible for their current Medi-Cal program or if they must be moved into another program. Counties evaluate Medi-Cal eligibility using an established hierarchy.<sup>243</sup> A shift between Medi-Cal programs can result in enrollment into the Medically Needy Share of Cost program.

Share of Cost may limit an individual's ability to access Medi-Cal services, including IHSS. As explained in more detail above, Medi-Cal recipients are required to pay or incur their Share of Cost amount before Medi-Cal will pay for those services. For most recipients, this change means that IHSS is no longer affordable.

If the county correctly assesses a Medi-Cal share of cost, a recipient or an advocate working with a recipient should explore alternatives including (1) determining whether the recipient is eligible or can become eligible for another free or lower cost Medi-Cal program, such as the ones mentioned above, including the 250% Working Disabled Program, or (2) determining whether the recipient wants to purchase services Medi-Cal does not pay for to meet their Share of Cost. For more information about how to meet a share of cost, see Disability Rights California's publication entitled "How Can I Use My Share of Cost to Get More Services I Need?"<sup>244</sup>

If an individual thinks the county has made an error, like incorrectly calculating the Share of Cost or placing the recipient in the wrong Medi-Cal program, the recipient or advocate has the right to appeal. In fact, any adverse actions to a recipient's Medi-Cal eligibility trigger due process rights for the individual.<sup>245</sup> Changes to a recipient's Medi-Cal eligibility such as placing an individual in the Medically Needy Share of Cost program is considered an adverse action.<sup>246</sup> The recipient must be notified of all adverse actions through a county-issued Notice of Action, also referred to as a NOA.

To ensure that services continue pending a hearing (and that the changes proposed in the NOA are put on hold), a request for hearing should be made before the effective date of the change in the Medi-Cal Notice of Action. For more complete information on Medi-Cal due process rights and appeals, see Western Center on Law and Poverty's "2016 Health Care Eligibility Guide".<sup>247</sup>

Appeal rights in the IHSS program are the focus of Chapter 8 of this manual. If a client's Medi-Cal eligibility determination will negatively impact their ability to receive IHSS, a separate appeal to continue IHSS eligibility may need to be filed.

### 3.2 Medi-Cal Terminations

Termination from the Medi-Cal program can happen for a number of reasons. For the purposes of this manual, however, there are two categories of termination: (1) the beneficiary no longer meets Medi-Cal eligibility criteria, or (2) the beneficiary continues to meet eligibility criteria, but has been discontinued for some other reason. This is an important distinction because recipients in Category (1) who are unable to make themselves eligible for a different Medi-Cal program are no longer eligible for IHSS. Recipients in Category (2) may be able to keep IHSS, if they can correct the problem that led to the Medi-Cal discontinuance. Because of this difference, we will look at each category separately.

#### Recipient No Longer Meets Medi-Cal Eligibility Criteria

If a Medi-Cal recipient no longer meets all eligibility criteria for the Medi-Cal program, the county will issue a NOA explaining why the recipient is no longer eligible.<sup>248</sup>

For example, if a recipient is over the resource limit, the recipient will remain ineligible for Medi-Cal unless and until they spend down to below the Medi-Cal resource limit. This underlying Medi-Cal ineligibility will also result in a termination from the IHSS program. A recipient should receive two NOAs—one for the Medi-Cal termination and one for the IHSS termination. The individual should appeal both NOAs. If the recipient appeals before the date on the notice indicating when the change takes place, the recipient can retain their Medi-Cal while awaiting the appeal determination—this is called aid paid pending.<sup>249</sup> For more complete information on Medi-Cal due process rights and appeals, see Western Center on Law and Poverty’s “2016 Health Care Eligibility Guide”.<sup>250</sup>

Generally, an IHSS recipient will receive one additional month of IHSS under the state-funded IHSS-Residual program after Medi-Cal is terminated. However, after that month, services and payment will end. The Medi-Cal termination must be appealed if a recipient wants to continue their IHSS coverage.

### Recipient Meets Medi-Cal Eligibility Criteria

It is not uncommon for recipients to be terminated from the Medi-Cal program even though they still meet all the Medi-Cal eligibility criteria. If a recipient fails to complete redetermination paperwork, for example, they will receive a termination NOA even though their underlying eligibility has not changed. In these cases, the recipient should appeal the Medi-Cal termination within 90 days from the date the NOA is mailed.<sup>251</sup> If possible, the recipient should appeal before the date on the notice that the change takes place, to receive aid paid pending.<sup>252</sup>

A recipient who is actively appealing a Medi-Cal termination, should also file an IHSS appeal to ensure IHSS is not erroneously terminated while the Medi-Cal appeal is pending. Chapter 8 of this manual discusses IHSS appeals in further detail.

## 3.3 Recent Federal Changes to Medicaid

In 2025, significant changes were made to federal Medicaid law impacting eligibility and other Medicaid rules, with most taking effect in 2026 and 2027.

- » Limits retroactive Medi-Cal coverage for 1 month before application for the adult expansion enrollees and 2 months for enrollees in all other Medi-Cal groups.
- » Requires states to conduct Medi-Cal eligibility redeterminations every six months for Medicaid expansion adults ages 19-64.
- » Eliminates Medicaid eligibility for lawfully present immigrants who are not Lawful Permanent Residents
- » Implements work requirements for adults ages 19 to 64 in Medicaid expansion, with exemptions for those who are “medically frail or otherwise has special medical needs”; parents, guardians, and caregivers, among other exemptions.
- » Requires states to charge some level of cost sharing to Medicaid expansion enrollees and allows states to charge copays.

You can go to [Justice in Aging's Medicaid Defense resources](#) page to learn more about important changes to the Medicaid program.

## **4. MEDI-CAL WAIVER PROGRAMS**

The IHSS program is one Medi-Cal program that can help individuals with disabilities live safely in their own homes. For individuals with more intensive care needs, there are a number of Medi-Cal waiver programs that can provide additional home and community-based services (HCBS). There are five HCBS Medi-Cal waivers currently available in California. It is important to note that there are generally restrictions on eligibility for the Medi-Cal waiver programs, including based on medical condition and/or geography, as well as enrollment caps. It is also important to note that individuals cannot be enrolled in more than one waiver.

### **4.1 Medi-Cal Waiver Program**

The Medi-Cal Waiver Program, formerly called the AIDS Waiver, serves children and adults with HIV and AIDS who qualify for a nursing facility level of care and who are Medi-Cal eligible. Services provided include: case management, skilled nursing, attendant care, psychotherapy, home-delivered meals, nutritional counseling, nutritional supplements, medical equipment and supplies, minor physical adaptations to the home, non-emergency medical transportation, and financial supplements for foster care. Medi-Cal Waiver Program agencies can provide additional information regarding eligibility, enrollment, and services.<sup>253</sup>

### **4.2 Assisted Living Waiver (ALW)**

The Assisted Living Waiver serves adults 21 and older with disabilities who qualify for a nursing facility level of care and who are eligible for non-share of cost Medi-Cal. The Assisted Living Waiver pays for assisted living, care coordination, and other benefits for eligible recipients. It is available in Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma counties. There are currently 18,144 authorized slots available statewide.<sup>254</sup>

### **4.3 Home and Community-Based Alternatives Waiver (HCBA Waiver)**

The Home and Community-Based Alternatives Waiver serves individuals with disabilities with long-term medical conditions who meet specified level of care needs and who are Medi-Cal eligible. The waiver provides a wide range of services including: private duty nursing, waiver personal care services, case management/coordination, habilitation, home respite, community transition, continuous nursing and supportive services, environmental accessibility adaptations, facility respite, and many more. Waiver personal care services may be used to increase the amount of in-home care beyond what is allocated through IHSS. The waiver is available statewide, but there is a waiting list.<sup>255</sup>

#### **4.4 Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD Waiver)**

The HCBS-DD Waiver serves individuals with developmental disabilities who are eligible for Medi-Cal, are Regional Center consumers, and meet the level of care requirement. The HCBS-DD Waiver funds many of the home and community-based services available for people with developmental disabilities through the Regional Centers, including homemaker, home health aide services, respite care, habilitation, transportation, communication aides, nutritional consultation, and many others.<sup>256</sup>

#### **4.5 Self Determination Program Waiver (SDP)**

The Self Determination Program serves individuals with developmental disabilities who are eligible for Medi-Cal, are Regional Center consumers, and meet the level of care requirement. SDP allows participants to self-direct their services and manage their own budgets based on their individual HCBS needs.<sup>257</sup>

#### **4.6 Multipurpose Senior Services Program (MSSP)**

The MSSP Waiver serves Medi-Cal eligible individuals 60 and older who qualify for a nursing home level of care. MSSP services include case management, personal care services, respite care, transportation, meal services, money management, housing assistance and home repair, among many others. Enrollment is capped at 12,000 participants and is now available statewide.<sup>258</sup>

# Chapter 3 Endnotes

- 191 DHCS, [Medi-Cal Fast Facts \(Date Represented: May 2025\)](#), (August 2025).
- 192 See Western Center on Law & Poverty "[2016 Health Care Eligibility Guide](#)",(March 1, 2016).
- 193 See Health Consumer Alliance, "[Know Your Rights: Consumer Health Coverage Info](#)" (last visited July 18, 2025).
- 194 See Disability Rights California ("DRC"), "[Public Benefits for People with Disabilities](#)" (Aug, 1, 2026).
- 195 Cal. Code Regs., tit. 22, § 50090.
- 196 42 U.S.C. § 1396a(e)(14); Cal. Welf. & Inst. Code § 14005.64.
- 197 42 U.S.C. § 1396a(k); Cal. Welf. & Inst. Code § 14005.60.
- 198 DHCS, [Medi-Cal Monthly Eligible Fast Facts: August 2025](#), (Nov. 2025)
- 199 42 U.S.C. § 1396a(a)(10)(A)(i)(VII); 42 C.F.R. § 435.119(b)(5); Welf. & Inst. Code § 14005.60(a).
- 200 Medicare beneficiaries are potentially eligible for non-MAGI Medi-Cal programs.
- 201 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), (IX).
- 202 CDSS, All County Welfare Directors Letter ("AWCDL") [18-03E](#) (March 23, 2018 provides real dollar value of 138% FPL in 2018. The Department of Health Care Services updates these numbers yearly.
- 203 42 U.S.C. § 1396a(e)(14)(C).
- 204 42 C.F.R. § 435.110; see also [ACWDL 14-28](#) (July 7, 2014).
- 205 Cal. Welf. & Inst. Code §§ 14005.22, 14005.225; [ACWDL 15-35](#) (Nov. 12, 2015); [Medi-Cal Eligibility Division Information Letter \("MEDIL"\) 15-25](#) (July 22,, 2015).
- 206 For additional information about Medi-Cal eligibility and pregnancy, see DHCS, "[Who Qualifies for MCAP?](#)", (last visited July 9, 2025).
- 207 42 U.S.C. § 1396a(k)(3); Cal. Welf. & Inst. Code § 14005.27.
- 208 See Western Center on Law & Poverty, *supra* note 1, at pg. 2.59.
- 209 Cal. Welf. & Inst. Code §§ 14005.26, 14005.64, 15832. For 2018 eligibility limits in real dollars, see [ACWDL 18-03E](#) (March 23, 2018).
- 210 Cal. Welf. & Inst. Code § 14005.26(d).
- 211 DHCS, [All County Letter \("ACL"\) 14-67](#) (November 4, 2014).
- 212 *Id.*
- 213 *Id.* Those enrolled in IHSS through the IHSS-Residual program are not affected by MAGI Medi-Cal rules.
- 214 Welf. & Inst. Code §14007.8.
- 215 For additional information about all the Medi-Cal programs see Western Center on Law & Poverty, *supra* note 1.
- 216 [Medi-Cal Information Notice 007](#) (07/2019); DHCS, [ACWDL No. 25-14](#), (June 30, 2025).

- 217 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(X), 1396a(a)(m)(1)(authorizing establishment of an aged and disabled program); Cal. Welf. & Inst. Code § 14005.40.
- 218 Cal. Code Regs., tit. 22, § 50221.
- 219 Cal. Code Regs., tit. 22, § 50223
- 220 [ACWDL 20-24](#), (Nov 23, 2020).
- 221 [ACWDL 25-01](#) (January 21, 2025).
- 222 [ACWDL 25-14](#), (June 30, 2025).
- 223 DRC, "[Determining Eligibility Under the Aged, Blind & Disabled Federal Poverty Level \(ABD FPL\) Medi-Cal Program,](#)" (April 11, 2025).
- 224 Cal. Code Regs., tit. 22, § 50203.
- 225 Cal. Code Regs., tit. 22, § 50653.
- 226 Cal. Code Regs., tit. 22, § 50555.2.
- 227 For additional information see DRC, "[ABD FPL Worksheet Single Adult – Not Living in Board & Care](#)" (May 16, 2025).
- 228 Vision and dental insurance premiums are considered health care premiums and are therefore an allowable income deduction per 22 C.C.R. § 50555.2.
- 229 [ACWDL 15-02](#) (January 12, 2015).
- 230 *Id.*
- 231 DRC, "[How Can I Use My Share of Cost to get More Services I Need?](#)" (Apr. 1, 2017).
- 232 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII); Cal. Welf. & Inst. Code § 14007.9(a)(1).
- 233 See [ACWDL 00-51](#) (September 27, 2000).
- 234 Western Center on Law & Poverty, "[Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates](#)" (March 2016), pgs. 83-89.
- 235 42 U.S.C. § 1396r-5(b)(1).
- 236 Recipients of certain Medi-Cal HCBS waivers were also eligible for spousal impoverishment protections, however, the waiver programs are limited and often have significant waiting lists making it difficult to access them.
- 237 Public Law No. 111-148, Section 2404 (2010) amending 42 U.S.C. 1396r-5(h)(1)(A).
- 238 *Kelley v. Kent*, BS170173, filed in the California Superior Court, County of Los Angeles.
- 239 [ACWDL 17-25](#) (July 19, 2017); [ACWDL 18-19](#) (August 21, 2018).
- 240 The IHSS-Residual program is not linked to Medi-Cal eligibility, however, less than 1% of IHSS beneficiaries are enrolled in IHSS-Residual.
- 241 Cal. Code Regs., tit. 22, § 50015.
- 242 An individual has an affirmative responsibility to report changes in income to the county welfare department within 10 days and to provide current proof of income at annual redetermination. See Welfare and Institutions

Code § 14005.37(h) (change of circumstance reporting) and 14005.37(f) (annual redetermination).

- 243 [ACWDL 17-03](#) (January 25, 2017).
- 244 DRC, *supra* note 39.
- 245 See *Goldberg v. Kelly*, 397 U.S. 254, 260 (1970); 42 C.F.R. § 431.200 *et seq.*
- 246 Cal. Code Regs., tit. 22, § 50015.
- 247 Western Center on Law & Poverty, *supra* note 1..
- 248 Cal. Code Regs., tit. 22, § 50179.
- 249 [Manual of Policies and Procedures 22-072.4](#).
- 250 Western Center on Law & Poverty, *supra* note 1. .
- 251 42 C.F.R. § 431.211; Cal. Welf. & Inst. Code § 10951. The appeal can be made after 90 days if good cause exists for the delayed filing.
- 252 42 C.F.R. § 431.231.
- 253 DHCS, [Medi-Cal Waiver Program](#) (last visited Oct 3, 2025).
- 254 For more information, see DHCS, [Assisted Living Waiver](#); DRC, "[Medi-Cal Programs to Help You Stay in Your Own Home or Leave a Nursing Home](#)", (Jan, 1, 2019).
- 255 For more information, see DHCS, [Home and Community-Based Alternatives \(HCBA\) Waiver](#); DRC, "[The Home and Community Based Alternatives \(HCB Alternatives\) Waiver](#)" (Aug. 15, 2023).
- 256 For more information, see DHCS, "[Home and Community-Based Services Waiver for the Developmentally Disabled](#)" <https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx> (last visited November 19, 2025)
- 257 For more information, see Department of Developmental Services, [Self Determination Program](#), (last visited November 19, 2025).
- 258 For more information, see DHCS, "[Multipurpose Senior Services Program](#)" (last visited July 18, 2025); California Department of Aging, [Multipurpose Senior Services Program](#); DRC, "[The Multipurpose Senior Services Program may be the Answer to Staying at Home Rather than Going to a Nursing Home](#)", (Apr. 1, 2016).

# Chapter 4: IHSS Services Overview

This chapter will provide an overview of services available through the IHSS program. There are nine different categories of services available through the IHSS program including: domestic, heavy cleaning, related services, personal care, accompaniment to medical appointments, yard hazard abatement, teaching and demonstration, paramedical services, and protective supervision.<sup>259</sup> Each of these types of services is described in-depth in Chapter 5. In this chapter, there are five sections: (1) Hours and Need; (2) Monthly Limits; (3) Unmet Need; (4) Shared Living and Proration; and (5) Protective Supervision.

## 1. HOURS AND NEED

In order to receive any of the services described above, the applicant or recipient must have a need for that particular service.<sup>260</sup> Because both applicants and recipients are subject to the following rules, the term “recipient” will be used to include both. If separate rules apply to an applicant, that difference will be identified.

### 1.1 Needs Assessment

The county will conduct a needs assessment of the recipient, which must include information about the recipient’s living environment, alternative resources available to meet the recipient’s need,<sup>261</sup> and the recipient’s functional abilities.<sup>262</sup>

As a part of its assessment, the county social worker will conduct a face-to-face visit in the recipient’s home.<sup>263</sup> The county must determine that the performance of the specific service by the recipient would constitute “such a threat to his/her health/safety that he/she would be unable to remain in his/her own home.”<sup>264</sup>

Although the face-to-face home visit is an important part of the assessment, it is not the sole criterion for establishing or continuing eligibility.<sup>265</sup> The county must also evaluate the recipient’s statement of need, the available medical information, and any other information the social services staff person considers necessary and appropriate to assess the recipient’s need.<sup>266</sup>

In emergency situations, IHSS can be authorized prior to a completed needs assessment.<sup>267</sup> In order to constitute an emergency situation, the applicant must meet one of three criteria: (1) the applicant is disabled, not employed, and has no expectation of employment within the next 45 days, and, in the county’s judgment, the applicant appears to have mental or physical impairments that will last for more than one year or end in death; (2) the applicant is blind as defined by MPP § 30-771.2;<sup>268</sup> or (3) the applicant must meet the eligibility criteria established in MPP § 30-755.<sup>269</sup> In addition to meeting one of the foregoing, the applicant’s needs must warrant the immediate provision of service.<sup>270</sup> If emergency services are authorized, the county must subsequently perform a complete needs assessment within 30 days after the date of application.<sup>271</sup>

## 1.2 Assessment before Discharge from a Hospital or Long Term Care Facility

Recipients who are currently residing in institutional settings like hospitals and skilled nursing facilities are eligible to apply for IHSS, but most services cannot begin until after they are discharged from the facility.<sup>272</sup> Additionally, the county welfare department must conduct a preliminary needs assessment while the recipient is still in the facility so that services can begin immediately once the recipient is back home.<sup>273</sup> Recipients living in institutional settings who wish to return home may need to advocate for themselves or contact a legal services provider in order to ensure the county fulfills its duty to conduct a preliminary assessment. The county will conduct a second needs assessment after the recipient returns home and may make adjustments in the authorized hours at that time.<sup>274</sup>

## 1.3 Frequency of Assessment

Generally, the needs assessment will be performed prior to the authorization of IHSS services and prior to the end of the 12th calendar month since the last assessment.<sup>275</sup> However, the county may opt to extend the reassessment date by six months on a case-by-case basis.<sup>276</sup> In order to extend the reassessment, the county must document that all the following conditions exist:

1. The recipient has had at least one reassessment since the initial intake assessment; and
2. The recipient's living arrangement has not changed, and either the recipient lives with others or has regular meaningful contact with someone other than the provider who is interested in the recipient's well-being; and
3. The recipient, the recipient's parent (if the recipient is a minor), or the recipient's conservator is able to satisfactorily direct his or her care; and
4. There has not been any known change in the recipient's needs for supportive services in the last 24 months; and
5. There have not been any reports or involvement of adult protective services in the case record since the last assessment; and
6. The recipient has not reported a change in provider in the previous six months; and
7. The recipient has not been hospitalized in the previous three months.<sup>277</sup>

In very limited circumstances the county may consider other factors, including involvement of a social services case manager or certification by a licensed health care professional that a recipient's condition is unlikely to change.<sup>278</sup>

## 1.4 Telehealth Reassessments for Individuals with Stable Needs

Individuals with stable needs can now choose to complete the annual reassessment by telephone or video.<sup>279</sup> Eligible IHSS participants must opt in to receive telehealth reassessments.<sup>280</sup> Initial IHSS assessments must be complete in-person.<sup>281</sup> Individuals are eligible if:

1. The previous year's reassessment took place in person, unless there is a declared State of Emergency that prevents in-person assessments.
2. They are able to access the technology needed to access and participate in the telehealth reassessment, or have someone who can assist them.
3. The individual has stable needs, defined as
  - a. being 19 years of age or older
  - b. Having no incident involving Adult Protective Services (APS) since the last in-person reassessment.
  - c. No documented concern about the IHSS recipient's health or safety.
  - d. No suspicion of fraud.
  - e. Having no hospitalization or overnight admission to a care facility for 24 hours or more, and not having multiple emergency room or urgent care visits within the previous three months.
  - f. Having no gap in provider services in the last six months.
  - g. Having no change in residence since the last reassessment.
  - h. For participants living alone, having no need for assistance with memory, orientation and judgment.
  - i. Having no authorized representative that directs the recipient's care.
  - j. Does not require an assessment or reassessment for protective supervision.
  - k. Does not have complex paramedical care needs.<sup>282</sup>

Individuals 19 years or older who receive case management services through another program such as the Regional Centers, the Multipurpose Senior Services Program or the Home and Community-Based Alternatives Waiver may be eligible for telehealth reassessments under certain circumstances.<sup>283</sup>

## 1.5 Functional Impairments and Rankings

All counties use the same assessment tool in order to assess recipient need.<sup>284</sup> This tool is used to rank the recipient's level of ability and dependence upon verbal or physical assistance by another person.<sup>285</sup> This assessment evaluates the effects of recipient's physical, cognitive, and emotional impairment on their functioning with respect to a specific type of service.<sup>286</sup> That level of functioning is quantified into a five-point scale. A rank of "1" in any service category means the recipient does not need that service.<sup>287</sup>

**RANK 1: INDEPENDENT**—The recipient is able to perform this function without human assistance, although the recipient may have difficulty performing the function, but the completion of the task, with or without a device or mobility aid, poses no substantial risk to the recipient's safety.<sup>288</sup> A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.<sup>289</sup>

**RANK 2: VERBAL ASSISTANCE NEEDED**—The recipient is able to physically perform the task, but requires verbal assistance to do so. Verbal assistance includes reminding, guidance, or encouragement.<sup>290</sup>

**RANK 3: SOME HUMAN ASSISTANCE NEEDED**—The recipient requires some physical assistance with a task. This can include direct physical assistance from the provider.<sup>291</sup>

**RANK 4: SUBSTANTIAL HUMAN ASSISTANCE NEEDED**—The recipient can only perform the task with substantial human assistance from the provider.<sup>292</sup>

**RANK 5: CANNOT PERFORM THE TASK**—The recipient cannot perform that task with or without human assistance.<sup>293</sup>

When establishing the functional impairment, the county can look at a number of factors to make its determination.<sup>294</sup> This can include the recipient’s diagnosis to the extent it provides information to substantiate functional impairment, the recipient’s actual capacity to perform tasks safely, and the mechanical aids and durable medical equipment (e.g., wheelchairs, hospital beds, etc.) used.<sup>295</sup>

Only the following services or activities are evaluated using these numbered rankings:

1. Housework;
2. Laundry;
3. Shopping and errands;
4. Meal preparation and cleanup;
5. Mobility inside the home;
6. Bathing and grooming;
7. Dressing;
8. Bowel, bladder, and menstrual care;
9. Repositioning;
10. Eating;
11. Respiration;
12. Memory;
13. Orientation; and
14. Judgment.<sup>296</sup>

The first ten tasks are evaluated using the full five-point scale. The Respiration task can only be ranked as 1 or 5. Memory, Orientation, and Judgment can only be ranked as 1, 2, or 5.<sup>297</sup> This is because including additional rankings within these particular tasks does not result in a significantly different need for human assistance.<sup>298</sup>

If a recipient is receiving a particular type of service that is met entirely through Paramedical Services, the corresponding service is ranked as a “1.”<sup>299</sup> For example, if a recipient has a pressure sore, the care for that sore will fall under Paramedical Services as skin and wound care, and the recipient would receive a “1” under the Rubbing Skin task. However, if the recipient requires additional repositioning and skin rubbing in addition to the care for the pressure sore, the county should not rank the need for Repositioning and Rubbing Skin Service as “1” because the recipient’s entire need is not met through the Paramedical Service.

## 1.6 Hourly Task Guidelines

As noted above, the functional rankings are linked to a range of times for each task, referred to as the Hourly Task Guidelines, or HTGs. The guidelines serve the dual purpose of providing counties with a tool for “consistently and accurately assessing service needs and authorizing service hours to meet those needs.”<sup>300</sup> It is important to note, however, that despite the adoption of these standardized guidelines, the county is required to authorize hours “based on the recipient’s individual level of need necessary to ensure his/her health, safety, and independence based on the scope of tasks identified for service.”<sup>301</sup> As such, the functional rankings are a contributing factor, but not the sole factor in determining the amount of time per task a recipient receives.<sup>302</sup>

The HTGs specify a specific range of time that is correlated with each task and each functional ranking.<sup>303</sup> For example, if a recipient receives a functional ranking of “3” in Meal Preparation, meaning some human assistance is needed, the HTGs authorize the county social worker to approve between 3.5 and 7.0 hours per week.<sup>304</sup> The recipient’s individual needs should inform the social worker’s decision of where in that range to set the final hours determination, or if the recipient’s needs justify more or less time than the range.

In 2017, CDSS released guidance in an effort to standardize the county’s use of the HTG’s.<sup>305</sup> The stated purpose of the guidance is to clarify the IHSS assessment process including use of the HTGs, however, the new guidance has resulted in some confusion among county social workers, recipients, and advocates. Additionally, some recipients and advocates believe the new guidance has led to the incorrect reduction of IHSS hours. It is not completely clear what is causing the confusion, however, the guidance introduced a middle time range and linked the low, middle, and high hourly ranges to functional rankings. So, for example, if a social worker evaluates someone as a Rank 4 in preparation of meals and believes they have a “typical” level of need for someone in that rank they are directed to give them 6:08 hours per week.<sup>306</sup> For some recipients, this formula could represent an increase in time, but for others it could represent a decrease.

Despite the issuance of the new guidance, if a recipient’s individual needs require more or less time to perform a specific task, the county social worker is authorized to set the hours outside of the guideline range.<sup>307</sup> An exception can be granted if the social worker makes the determination that the recipient requires more or fewer hours in order to establish and maintain an independent living arrangement or to remain safely in their own home.<sup>308</sup> Making an exception should be considered a normal part of the authorization process.<sup>309</sup> The social worker must document the reason for the exception in the case file.<sup>310</sup> An exception to the HTGs cannot be used to increase a recipient’s hours above the 195 hour limit for those who are non-severely impaired or the 283

hour limit for those who are severely impaired.<sup>311</sup> For an explanation of the difference between severely and non-severely impaired, see section 2 of this chapter. An individual who needs more than the monthly hourly cap should consider seeking alternative services, such as applying for a Medi-Cal waiver that can provide additional personal care services through one of the Medi-Cal waiver programs, which are discussed in Chapter 3, section 5.

## 1.7 IHSS Hours and the State Budget

As the California economy has expanded and contracted over the last several years, the IHSS program has been targeted for significant budget cuts in the lean years. Two of these efforts have been focused squarely at reducing the hours awarded to recipients. In 2009, California attempted to reduce or terminate IHSS hours based on a recipient's functional index score. In 2011, California attempted to implement a 20% cut across the board to most recipients' IHSS hours, regardless of individual need. These attempts at reductions were halted by court orders in a lawsuit called *V.L. v. Wagner*, later renamed *Oster v. Lightbourne*.

The *V.L./Oster* case was combined with a separate case about IHSS provider wages, *Dominguez v. Lightbourne*, in which the state, unions, and consumer advocates agreed to a Settlement Agreement that meant that neither reduction went into effect as originally intended.<sup>312</sup> The Settlement Agreement replaced the 20% cut in IHSS hours with a temporary 8% reduction in IHSS hours beginning July 1, 2013.<sup>313</sup> It then reduced the 8% cut to a 7% beginning July 1, 2014. The Settlement Agreement also provided a path to restore the budget cuts as early as 2015. The Budget Act of 2015 restored the 7% reduction for fiscal year 2015-16.<sup>314</sup> The Budget Act of 2016 extended that restoration of the 7% cuts until June 30, 2019.<sup>315</sup>

IHSS hours were permanently restored in the 2021-2022 budget.<sup>316</sup> However, fluctuations in the California budget continue to threaten IHSS. In 2024, advocates pushed back the Governor's proposal to eliminate IHSS coverage to undocumented individuals.<sup>317</sup> In 2025, proposals to eliminate IHSS access to undocumented adults and limit overtime hours and restrictions to the IHSS-R program also did not pass in the legislature after advocate opposition.<sup>318</sup>

## 2. MONTHLY LIMITS

There are monthly limits on the total number of hours a recipient can receive. A recipient enrolled in the CFCO, IPO, and IHSS-R can receive no more than 283 hours per month if they are "severely impaired" and no more than 195 hours per month if they are "non-severely impaired."<sup>319</sup> Recipients enrolled in PCSP can receive no more than 283 hours per month regardless of the severity of the impairment.<sup>320</sup>

Recipients who are eligible for protective supervision are always given the maximum number of monthly hours (195 for non-severely impaired or 283 for severely impaired), even if a county cuts their hours for some other IHSS service. Those who are considered non-severely impaired and receive protective supervision will be eligible for 195 hours of protective supervision, plus hours for other services, up to a maximum of 283 hours per month.

In order to be considered severely impaired, a recipient must have a total assessed need for 20 hours or more per week of service in one or more of the following areas: any personal care service, preparation of meals, meal cleanup when meal preparation and consumption of food are required, or paramedical services.<sup>321</sup> Any recipient who does not meet these criteria is considered non-severely impaired.<sup>322</sup> The determination about whether a recipient is severely or non-severely impaired for purposes of the IHSS program must be included in the recipient's needs assessment.<sup>323</sup> Formerly, an asterisk next to the total assessed hours indicated that a recipient was severely impaired. Currently, the Notice of Action should contain that information, but it is not clear that it always does in a clear and understandable way.

A recipient who is severely impaired has the option to choose "advance payment."<sup>324</sup> Advance payment is a payment for IHSS services that is sent directly to the recipient in advance of the service actually being provided.<sup>325</sup> This payment option can provide greater flexibility for recipients and may speed up the provision of services. Only recipients in CFCO, IPO, and IHSS-R are eligible for advance payment.<sup>326</sup> Recipients in PCSP are not eligible for advance payment.<sup>327</sup> The county welfare department must inform eligible recipients of their right to choose advance payment.<sup>328</sup>

Once a recipient has agreed to advance payment (also called advance pay), they are responsible for ensuring the provider is paid and that the time sheets are submitted at the end of each month to the county social services office.<sup>329</sup> The county should, however, assist recipients if they appear to have trouble managing advance pay.<sup>330</sup> If a recipient fails to submit a reconciling time sheet within 45 days from the date of payment, there is a rebuttable presumption that the unreconciled amount is an overpayment.<sup>331</sup> Additionally, if a recipient fails to use the direct advance pay for the purchase of authorized hours it will be deemed an overpayment and the recipient will be responsible for repaying the county.<sup>332</sup> If a county attempts to withdraw advance pay from a recipient, the recipient should file for an administrative law hearing and request aid paid pending.

### **3. UNMET NEED**

Despite statutory hour maximums, the State recognizes that an individual may need additional hours in order to live safely at home. Although these hours may not be authorized through the IHSS program, the counties are required to indicate on all Notices of Action and needs assessments the hours of unmet need for each recipient.<sup>333</sup> Documented unmet need is "a recipient's total hours for non-Protective Supervision In-Home Supportive Services that are in excess of the statutory maximum."<sup>334</sup>

For example, if a recipient needs 12-hours per day (360 hours per month) of IHSS services, that individual will receive the maximum 283 hours per month and will have 77 hours per month of unmet need. When unmet need exists, the IHSS Case Management, Information and Payrolling System (CMIPS) will automatically prorate the difference between the documented unmet need and the maximum statutory hours across all authorized non-protective supervision services.<sup>335</sup>

Given the cap on the total number of hours available, recording unmet need may seem irrelevant. However, it is important for the county to document unmet need for two main reasons. First, if and when budget cuts and across-the-board hours reductions take effect, there may be language requiring the cuts to first come from unmet need. As discussed above in subsection 2.5, the Oster settlement and its implementing legislation codified that the mandatory 8% and 7% cuts were to be taken first from the documented unmet need.<sup>336</sup> Using the example above where a recipient has 77 hours of documented unmet need, the practical importance of unmet need becomes clear—this recipient should not experience any actual reduction in hours received.

The second reason it is important to document unmet need is that the recipient may be entitled to additional assistance through an HCBS waiver program. For example, a recipient enrolled in IHSS through the PCSP program who needs additional hours may be eligible for a Medi-Cal waiver program administered through the Department of Health Care Services' Integrated Systems of Care Division that provides Waiver Personal Care Services under the Home and Community Based Alternatives Waiver.<sup>337</sup> Moreover, daily hours of incurred costs for unmet need are allowable as an expense to spend down a recipient's share-of-cost (SOC).<sup>338</sup> Additional information about Waiver Personal Care Services and Medicaid waiver programs can be found in Chapter 3.

## **4. SHARED LIVING AND PRORATION**

A shared living arrangement may affect a recipient's allocation of IHSS hours. A shared living arrangement, for purposes of IHSS, exists when one or more recipient(s) resides in the same living unit with one or more persons, unless the recipient is living only with an able and available spouse.<sup>339</sup> For more information about able and available spouse, see section 4.3 below.

### **4.1 Proration**

Proration is the process of determining the recipient's individual need when they live with other people. IHSS only pays for that recipient's share of services met in common with other household members. Domestic Services and Heavy Cleaning, Related Services, Teaching and Demonstration, and Yard Hazard Abatement (in certain circumstances) may be affected by a shared living arrangement.<sup>340</sup> Personal care services are never prorated. As of 2020, Protective Supervision is no longer prorated.<sup>341</sup>

### **4.2 Effects of Shared Living**

If a recipient lives with a person other than an able and available spouse, the county will assess how the living arrangement affects the allocation of hours.<sup>342</sup> With regard to domestic services and heavy cleaning, the county will determine what areas of the living space are used solely by the recipient, what areas are used in common, and what areas are not used by the recipient.<sup>343</sup> Once this determination is made, no need can be assessed for areas not used by the recipient.<sup>344</sup> For areas commonly used, the need will be prorated between all the members of the household.<sup>345</sup> For areas used solely by the recipient, the assessment shall be based on the individual need.<sup>346</sup>

For example, if two unmarried people share a two-bedroom apartment and both have their own bedrooms and share all other living spaces equally, the county will assess the recipient's need for assistance in cleaning the recipient's bedroom, will assess no need and no hours for cleaning the roommate's bedroom, and will prorate the cleaning needs of the rest of the house by one-half since two people live there.

Related Services are similarly evaluated based on the extent to which the recipient's need for services is reduced by tasks being shared by the others living in the house.<sup>347</sup> If the service is not being provided by a housemate, the assessment should only be based on the recipient's individual need.<sup>348</sup> This is an important point, because if a recipient lives in a home where tasks like meal preparation, meal cleanup, and laundry are not shared, the recipient's hours should not be prorated for those services.<sup>349</sup>

Generally, the need for yard hazard abatement is not assessed in a shared living arrangement.<sup>350</sup> However, if the housemates fall into one or more of the following categories, yard hazard abatement services can be provided: (1) the housemate is also an IHSS recipient who is unable to provide the service; (2) the housemate is physically or mentally unable to provide such services; (3) the housemates are children under the age of fourteen years old.<sup>351</sup>

A recipient's need for Personal Care Services, Protective Supervision, Paramedical Services, and Transportation Services must be assessed based on the recipient's individual need and cannot be prorated because of a shared living arrangement.<sup>352</sup>

### 4.3 Able and Available Spouse

Special rules apply when a spouse is able and available to assist a recipient. The special rules will apply instead of the general shared living arrangement rules explained above.<sup>353</sup> These rules are based on the presumption that a spouse, if able and available, will typically help the recipient-spouse with certain tasks by virtue of being married to the recipient. A spouse is considered able unless they provide medical verification of their inability to perform these tasks.<sup>354</sup> If the spouse is able, the county will determine if employment, health, or other unavoidable reasons such as eviction by the recipient due to domestic violence by the non-recipient spouse make that spouse unavailable when a task must be performed.<sup>355</sup>

If a spouse is able and available to assist the recipient-spouse, the county will not pay for the spouse or any other provider to provide domestic services, related services, yard hazard abatement, teaching demonstration, or heavy cleaning.<sup>356</sup> If a spouse is able, but not available, the county can pay for someone else to provide the services during the able spouse's absence for meal preparation, transportation, and protective supervision.<sup>357</sup> For example, if a spouse works from 9:00-5:00 and the recipient-spouse needs assistance with meal preparation, the county can pay for someone else to provide these services during lunch, but would not pay for that assistance during dinnertime when the spouse is back at home.

An able and available spouse will be paid as a provider for providing Personal Care Services and Paramedical Services.<sup>358</sup> Additionally, if a spouse leaves full-employment or is prevented from seeking employment, they may be paid for providing protective supervision and transportation.<sup>359</sup> The net result of these rules may be significantly fewer hours assessed to a married recipient with an able and available spouse.

## 4.4 Parent Providers

Recent changes to IHSS regulations eliminated previous restrictions on when parents may be paid as IHSS providers for their minor children. Parents may now provide reimbursable IHSS services to their children without having to first prove that they had to leave or were prevented from obtaining full-time employment because no other care for their child was available. Parent providers may only be reimbursed for a limited subset of IHSS services.<sup>360</sup> In addition, rules on when a non-parent can provide services were eliminated.<sup>361</sup> Minor recipients and their authorized representatives have the right to select a provider of their choice as long as that provider has successfully completed provider enrollment.

## 5. IN-DEPTH: PROTECTIVE SUPERVISION

As explained above, Protective Supervision is one of the services offered by the IHSS program.<sup>362</sup> It consists of observing a recipient's behavior and intervening when appropriate to prevent injury or accident.<sup>363</sup> Although in some respects Protective Supervision is simply another service offered by IHSS, it has its own criteria for evaluation and can be a challenging service for potentially eligible recipients to qualify for.

### 5.1 Adult Eligibility for Protective Supervision

IHSS recipients eligible for Protective Supervision are "non-self-directing, confused, mentally impaired, or mentally ill persons only."<sup>364</sup> The county must find there is a need for 24-hour supervision in order for a recipient to stay in the home.<sup>365</sup> Additionally, a health care professional must complete form SOC 821 (Social Services Form—Assessment of Need for Protective Supervision for IHSS Program)<sup>366</sup> certifying the recipient's need for 24-hour protective supervision.<sup>367</sup> The health care professional's certification is not sufficient by itself to authorize Protective Supervision.<sup>368</sup> In determining the need for Protective Supervision, the county social worker will evaluate the recipient's memory, judgment, and orientation on the three-point scale described above in section 2.4.<sup>369</sup> Recipients who are eligible for Protective Supervision always receive the maximum number of hours available: 195 for non-severely impaired and 283 for severely impaired.<sup>370</sup>

In order to be approved for Protective Supervision a recipient must have a mental impairment or illness and be non-self-directing.<sup>371</sup> Two court cases, *Marshall v. McMahon*,<sup>372</sup> and *Calderon v. Anderson*,<sup>373</sup> make clear that mental impairment or mental illness alone are not sufficient for approval of protective supervision and that additional requirements must be met before a recipient qualifies.

For the purpose of Protective Supervision eligibility, non-self-direction is defined as "who due to their cognitive impairment, mental health condition or other condition that impairs their cognitive ability to assess danger and risk of harm, are

- (A) unable to cognitively assess danger and the risk of harm, and
- (B) at risk of injury, hazard, or accident."<sup>374</sup>

Previous guidance stated that a person is unable to self-direct where a recipient is “most likely engage in potentially dangerous activities that may cause harm” due to a mental impairment. CDSS recently clarified that the recipient need only have a *risk* for harm.<sup>375</sup> It is important to note that the county cannot require that the recipient actually experience harm before approving Protective Supervision.<sup>376</sup> Indeed, a recipient who has received supervision in the past may have successfully avoided past harmful incidents.

One example of a potentially eligible recipient who has a cognitive impairment and is non-self-directing is a senior with dementia who wanders away from their home and doesn’t know how to find their way back. The purpose of approving Protective Supervision in that case would be to make sure the senior does not wander outside and get lost or harm themselves. A diagnosis of dementia alone is not sufficient.

Another example of non-self-direction would be an adult with a cognitive impairment who turns on the stove or grabs a sharp object without realizing the danger of engaging in those activities. The purpose of approving Protective Supervision in that case would be to ensure the recipient doesn’t accidentally engage in those types of harmful activities and to instead redirect the recipient to other activities. Again, a diagnosed cognitive impairment alone is not sufficient.

Additionally, the recipient must have the physical capacity to engage in self-harming behavior.<sup>377</sup> If the recipient is unable to move independently and therefore cannot self-harm, protective supervision is not available. However, a recipient who uses a wheelchair or is bedridden may still be able to self-harm and should be evaluated for Protective Supervision based on individual needs.<sup>378</sup> Moreover, modifications or restraints—such as locking the recipient in a room to prevent wandering—shall NOT be considered an appropriate modification.<sup>379</sup>

Finally, the county must determine that the recipient needs to be observed 24 hours a day in order to safely remain at home.<sup>380</sup> A recipient or the person assisting them to apply for Protective Supervision must be prepared to show how the recipient will be observed 24 hours per day. Additionally, a recipient must fill out form SOC 825 (Protective Supervision 24-Hours-A-Day Coverage Plan).<sup>381</sup> Due to the overall IHSS monthly limits on hours, Protective Supervision cannot be authorized for 24-hour-a-day care, so this need is typically met through a combination of services such as adult day health care, enrollment in a waiver program, and voluntary care during certain parts of the day.

In addition to these restrictions, Protective Supervision is not available in the following five situations:

1. For friendly visiting or social activities;
2. When the need is caused by a medical condition and the person needs medical supervision;
3. In anticipation of a medical emergency;
4. To control anti-social or aggressive behavior;
5. To guard against deliberate self-destructive behavior, such as suicide, or when an individual knowingly intended to harm themselves.<sup>382</sup>

All County Letter 15-25 provides numerous specific examples of situations where the recipient's behavior falls into one of the enumerated categories above.<sup>383</sup> While theoretically these non-eligible categories may seem easily separated from the eligible categories, more complicated situations might blur these lines. For example, if a recipient suffers from both physical and mental impairments it may be necessary to carefully document how the mental impairment, not the physical impairment, is causing the need for Protective Supervision.

The case of *Norasingh v. Lightbourne* is instructive.<sup>384</sup> In *Norasingh*, a recipient was receiving Protective Supervision until the county determined at reassessment that she was no longer eligible.<sup>385</sup> Recipient Norasingh had both epileptic seizures and psychogenic seizures which were uncontrolled and occurred frequently.<sup>386</sup> The county terminated protective supervision because (among other reasons) it believed that the service had been improperly granted in anticipation of a medical emergency, not because of a mental illness or impairment.<sup>387</sup> In remanding the case, the appeals court found that psychogenic seizures were a mental, not a physical impairment, and that Norasingh's IHSS provider was watching her to prevent injury and accident during these psychogenic seizures.<sup>388</sup> As is clear from this example, the conditions underlying a need for protective supervision can be complex, and it may be necessary to guide health care professionals through the standard for protective supervision and to show the county social worker how the recipient's mental illness or impairment impacts the recipient's functional abilities to ensure the proper outcome for a recipient.

## 5.2 Protective Supervision and Children

Both children and adults are eligible for Protective Supervision. If a child has a mental impairment or mental illness, the county must assess the recipient's needs based on the child's individual need and using the same rules for protective supervision described above.<sup>389</sup> Protective Supervision cannot be authorized as a substitute for routine childcare or supervision.<sup>390</sup>

As part of the assessment, the county will follow a four-step process to determine whether the child is eligible for protective supervision.<sup>391</sup> These steps are based on the settlement agreement in *Garrett v. Anderson* and can be found in ACL 15-25.<sup>392</sup>

1. Is the minor non-self-directing due to the mental impairment or mental illness?
  - a. If no, the minor is not eligible for Protective Supervision.
  - b. If yes, go to question 2.
2. Is the minor likely to engage in potentially dangerous activities?
  - a. If no, the minor is not eligible for Protective Supervision.
  - b. If yes, go to question 3.
3. Does the minor need more supervision than a minor of comparable age who is not mentally impaired or mentally ill? More supervision can be more time, more intensity or both.
  - a. If no, the minor is not eligible for Protective Supervision.
  - b. If yes, go to question 4.

4. Does the minor need 24-hour-a-day supervision in order to remain at home safely?
  - a. If no, the minor is not eligible for Protective Supervision.
  - b. If yes, the minor qualifies if otherwise eligible.<sup>393</sup>

Although a child's age is a reference point for the county to compare other children of a similar age's abilities and limitations, it is improper to deny a child based solely on the child's age.<sup>394</sup> Recognizing that further guidance is needed, CDSS has announced plans to release updated Protective Supervision regulations, however, no timeline for their release has been set.<sup>395</sup>

Given the complexities of Protective Supervision, Disability Rights California has another publication that may be useful entitled "In-Home Supportive Services Protective Supervision."<sup>396</sup> This publication contains additional practical information about how to qualify and detailed instructions for obtaining a sample doctor's letter.

# Chapter 4 Endnotes

- 259 Cal. Welf. & Inst. Code § 12300; [California Dept. of Social Services \(“CDSS”\) Manual of Policies & Procedures \(“MPP”\) § 30-757](#) (Provides in-depth information about each service offered through the IHSS program).
- 260 Cal. Welf. & Inst. Code § 12300(a); [MPP § 30-761.12](#).
- 261 For more information about Alternative Resources, see Chapter 2.
- 262 Cal. Welf. & Inst. Code § 12309(b).
- 263 [MPP § 30-761.13](#).
- 264 [MPP § 30-761.14](#).
- 265 [MPP § 30-761.26](#).
- 266 [MPP § 30-761.26](#).
- 267 [MPP § 30-761.211](#).
- 268 [MPP § 30-771.2](#) defines blindness as an individual who “has central visual acuity of 20/200 or less in the better eye with use of a correcting lens” or “is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.”
- 269 MPP § 30-755.11 states “a person is eligible for IHSS who is a California resident living in his/her own home, and who meets one of the following conditions: (1) currently receives SSI/SSP benefits; (2) meets all SSI/SSP eligibility criteria including income, but does not receive SSI/SSP benefits; (3) meets all SSI/SSP eligibility criteria, except for income in excess of SSI/SSP eligibility standards or immigration criteria, and meets applicable share of cost obligations; or (4) was once eligible for SSI/SSP benefits, but became ineligible because of engaging in substantial gainful activity, and meets all of the following conditions: (a) the individual was determined to be disabled in accordance with Title XVI of the Social Security Act, (b) the individual continues to have the physical or mental impairments which were the basis of the disability determination; (c) the individual requires assistance in one or more of the areas specified under the definition of “severely impaired individuals” in Section 30-753; and (d) the individual meets applicable share of cost obligations.
- 270 [MPP § 30-759.8](#).
- 271 *Id.*
- 272 [MPP § 755.12](#). The only two services that can be authorized prior to a recipient’s return home are yard hazard abatement and heavy cleaning. These two services are authorized to ensure the recipient’s home is safe for their return.
- 273 *Id.*; CDSS, [All County Letter \(“ACL”\) 02-68](#) (August 30, 2002); CDSS, [All County Information Notice \(“ACIN”\) I-43-06](#) (June 8, 2006). [ACIN I-43-06 was issued as a result of a Superior Court writ brought by Disability Rights California.](#)
- 274 *Id.*
- 275 [MPP § 30-761.2](#).
- 276 [MPP § 30-761.215](#).
- 277 *Id.*

278 [MPP § 30-761.216](#).

279 CDSS, [All County Letter \(“ACL”\) No. 24-72, \(Oct. 8, 2024\)](#); [ACL No. 25-55](#) (July 24, 2025).

280 *Id.*

281 *Id.*

282 *Id.*

283 *Id.*

284 Cal. Welf. & Inst. Code § 12301.1(a); [MPP § 30-760.2](#).

285 [MPP § 30-756.1](#).

286 *Id.*

287 [MPP § 30-756.11](#).

288 *Id.*

289 *Id.*

290 [MPP § 30-756.12](#).

291 [MPP § 30-756.13](#).

292 [MPP § 30-756.14](#).

293 [MPP § 30-756.15](#).

294 [MPP § 30-756.3](#).

295 *Id.*

296 [MPP § 30-756.2](#); [MPP § 30-780\(b\)](#).

297 [MPP § 30-756.35](#).

298 *Id.*

299 [MPP § 30-756.4](#).

300 Cal. Welf. & Inst. Code § 12301.2; [MPP § 30-757.1\(a\)](#); [ACIN I-82-17](#) (December 5, 2017); [ACL 06-34](#) (August 31, 2006); [ACIN I-06-34 Errata 2](#) (May 4, 2007).

301 [MPP § 30-757.1\(a\)](#).

302 [MPP § 30-757.1\(a\)\(1\)](#).

303 Cal. Welf. & Inst. Code § 12301.2; [MPP § 30-757.1\(a\)](#).

304 [MPP § 30-757-.131\(a\)](#).

305 [ACIN I-82-17](#) (December 5, 2017).

306 *Id.*

307 [MPP § 30-757.1\(a\)](#).

- 308 [MPP § 30-757.1\(a\)\(3\)](#).
- 309 *Id.*
- 310 [MPP § 30-757.1\(a\)\(6\)](#).
- 311 [MPP § 30-757.1\(a\)\(4\)](#).
- 312 The entire Settlement Agreement can be found at [ACIN I-18-13](#) (April 5, 2013).
- 313 The 8% reduction was codified as Welfare and Institutions Code § 12301.01. There was a 3.6% cut in effect so the Settlement Agreement added an additional 4.4% to the existing cut to make the full 8 percent reduction.
- 314 [Item 5180-111-0001\(6\) of Section 2 of SB 97](#); [ACL 15-57](#) (June 29, 2015).
- 315 [Health and Human Services Budget Summary 2016-17](#), at pg. 4.
- 316 Legislative Analyst’s Office, [“The 2021-22 California Spending Plan: Human Services,”](#) (Nov. 22, 2021).
- 317 CA Governor Gavin Newsom, [May Revision—2024-25](#), (May 2024).
- 318 CA Governor Gavin Newsom, [May Revision—2025-26](#), (May 2026).
- 319 Cal. Welf. & Inst. Code §§ 12303.4(a); 12300(h)(3); [MPP § 30-757.1\(a\)\(4\)](#).
- 320 Cal. Welf. & Inst. Code § 14132.95(g); [MPP § 30-780.2\(b\)](#).
- 321 Cal. Welf. & Inst. Code § 12304; [MPP § 30-701\(s\)\(1\)](#).
- 322 Cal. Welf. & Inst. Code § 12303.4(a).
- 323 [MPP § 30-761.271](#).
- 324 [MPP § 30-769.731](#).
- 325 Cal. Welf. & Inst. Code § 12304(a); [MPP § 30-701\(d\)\(3\)](#).
- 326 Cal. Welf. & Inst. Code § 12304(a).
- 327 Cal. Welf. & Inst. Code § 14132.95(k)(2); [MPP § 30-780.3\(4\)](#). Although this may sound like an issue, if a recipient needs advance pay he or she is directed into one of the programs that allows for it.
- 328 [ACIN I-29-18](#) (May 16, 2018).
- 329 [MPP § 30-769.737](#).
- 330 [ACIN I-29-18](#) (May 16, 2018).
- 331 [MPP § 30-768.213](#).
- 332 [MPP § 30-768.21](#); [ACIN I-27-19](#), (May 7, 2019); [ACL 24-38](#), (Jun. 6, 2024).
- 333 [MPP § 30-761.274](#), [ACL 13-66](#), (September 30, 2013).
- 334 Only non-protective supervision services in excess of the statutory maximum are considered an unmet need. Protective supervision, which requires that a recipient have a 24-hour need for care, would by its own definition always result in unmet need. See [MPP § 30-757.173](#); [ACL 13-66](#) (September 30, 2013).
- 335 *Id.*

- 336 Cal. Welf. & Inst. Code §§ 12301.01(a)(4) (8% reductions); 12301.02(a)(4) (7% reductions).
- 337 Cal. Welf. & Inst. Code § 14132.97; [ACL 03-24](#) (May 20, 2003); DHCS, [Home and Community Based Alternatives Waiver](#), (last visited Oct. 21, 2025)..
- 338 The reduction may be applied either to meet the SOC in the month in which the expense was incurred or, if the beneficiary is still financially responsible for paying the expenses and the *Hunt v. Kizer* guidelines are met, in future months. Pursuant to the *Hunt v. Kizer* court order, individuals are allowed to apply medical bills from previous months (old medical bills) toward their current month’s SOC provided these old medical bills were unpaid at the time they were submitted to the county. Individuals are allowed to use credit card or collection agency statements as evidence of medical expenses. 22 CCR § 5064. See also, CDSS, [All County Welfare Director Letter \(“ACWDL”\) 15-02](#) (January 12, 2015).
- 339 [MPP § 30-701\(s\)\(2\)](#).
- 340 [MPP § 30-763.31-.34](#).
- 341 [ACL 20-111](#), (Oct. 30, 2020); for more information see Disability Rights California, [New Rules for IHSS: Elimination of Proration of Protective Supervision Services](#), (Apr. 1, 2023).
- 342 [MPP § 30-763-.3](#).
- 343 [MPP § 30-763.31](#).
- 344 [MPP § 30-763.312](#).
- 345 [MPP § 30-763.313](#).
- 346 [MPP § 30-763.314](#).
- 347 [MPP § 30-763.321](#).
- 348 [MPP § 30-763.322](#).
- 349 *Id.*
- 350 [MPP § 30-763.352](#).
- 351 *Id.*
- 352 [MPP § 30-763.351](#).
- 353 [MPP § 30-763.4](#).
- 354 [MPP § 30-763.411](#).
- 355 [MPP § 30-763.412](#); [ACL 21-91](#), (Sep. 29, 2021).
- 356 [MPP § 30-763.413](#).
- 357 [MPP § 30-763.414](#).
- 358 [MPP § 30-763.415](#).
- 359 [MPP § 30-763.416](#).
- 360 Welf. & Inst. Code §12300(e); [ACL 23-106](#), (Dec. 21, 2023) (domestic, personal care, accompaniment for travel to health-related appointments or alternative resource sites, protective supervision and paramedical services.)
- 361 See, <https://www.disabilityrightsca.org/publications/ihss-parent-provider-eligibility-update>.

362 Cal. Welf. & Inst. Code § 12300(b).

363 [MPP § 30-757.17](#).

364 [MPP § 30-757.171](#).

365 [MPP § 30-757.173\(a\)](#).

366 CDSS, Form [SOC 821](#).

367 Cal. Welf. & Inst. Code § 12301.21; [MPP § 30-757.173\(a\)\(1\)](#).

368 [MPP § 30-757.173\(a\)\(3\)](#).

369 [MPP § 30-756.372](#).

370 Cal. Welf. & Inst. Code § 12303.4; [ACIN I-27-11](#) (May 16, 2011), Attachment B for IHSS-R, PCSP, and IPO; [ACL 14-60](#) (August 29, 2014) for CFCO.

371 [MPP § 30-757.171](#); [ACL 15-25](#) (March 19, 2015).

372 [Marshall v. McMahon](#), (1993) 17 Cal.App. 4th 1841.

373 [Calderon v. Anderson](#), (1996) 45 Cal.App. 4th 607.

374 [MPP §30-701\(n\)\(3\)](#); [ACL 15-25](#) (March 19, 2015).

375 [MPP §30-701\(n\)\(3\)](#).

376 *Id.*

377 [Calderon v. Anderson](#), 45 Cal.App. 4th 607; [ACL 15-25](#) (March 19, 2015).

378 [ACL 15-25](#) (March 19, 2015).

379 [ACL 17-95](#) (September 12, 2017).

380 [MPP § 30-757.173](#).

381 CDSS, [Form SOC 825](#).

382 [MPP § 30-757.172](#).

383 [ACL 15-25](#) (March 19, 2015).

384 [Norasingh v. Lightbourne](#), (2014) 229 Cal. App. 4th 740.

385 *Id.* at 748.

386 *Id.* at 747.

387 *Id.* at 748.

388 *Id.* at 758.

389 Cal. Welf. & Inst. Code § 12300(d)(4); [MPP § 30-763.456](#); [ACL 98-87](#) (October 30, 1998); [ACL 15-25](#) (March 19, 2015).

390 *Id.*

391 [ACL 15-25](#) (March 19, 2015).

- 392 *Id.* See also, [ACL 98-87](#) (October 30, 1998).
- 393 [ACL 15-25](#) (March 19, 2015).
- 394 [ACL 98-87](#) (October 30, 1998).
- 395 [ACL 15-25](#) (March 19, 2015).
- 396 Disability Rights California, "[In-Home Supportive Services Protective Supervision](#)," (Mar. 26, 2025).

# Chapter 5: Types of Services

This chapter will provide an in-depth look at the services available through the IHSS program.

## 1. TYPES OF SERVICES

There are nine different categories of services available through the IHSS program including: domestic, heavy cleaning, related services, personal care, accompaniment to medical appointments, yard hazard abatement, teaching and demonstration, paramedical services, and protective supervision.<sup>397</sup> State law authorizes specific types of services within the categories of personal care and domestic and related services.<sup>398</sup> A description of each category is provided below.

Not every IHSS recipient receives every type of service. The State intends for specific services to be offered in a uniform manner in every county based on an individual's need.<sup>399</sup> To this end, all counties are required to use a universal needs assessment tool.<sup>400</sup> A social worker will come to the recipient's home to do an assessment using this tool.<sup>401</sup> Each applicant and recipient receives a functional ranking score, which is discussed in detail in the section titled "Hours and Need" below. The social worker's assessment will provide the basis for the types of services and the number of hours per service each recipient receives.

Each authorized service is allocated to recipients in tenths of an hour per week. This means that a recipient who is authorized for 0.8 hours per week of meal preparation is authorized for 48 minutes per week. In an effort to standardize the counties' allocation of hours to each recipient, state regulations authorize a range of hours for certain services and that range is linked to a recipient's functional ranking score.<sup>402</sup> The range of hours authorized by these Hourly Task Guidelines ("HTGs") is included with the description of each service and an explanation of how exceptions to the HTGs work. Additionally, Appendix 2 contains a chart of the specific services, functional ranks and HTGs.

### 1.1 Domestic Services

Domestic Services includes a wide variety of household chores and tasks such as: sweeping, vacuuming, and washing/waxing floors; washing kitchen counters and sinks; cleaning the bathroom; storing food and supplies; taking out garbage; dusting and picking up; cleaning oven and stove; cleaning and defrosting refrigerator; bringing in fuel for heating or cooking purposes from a fuel bin in the yard; changing bed linen; changing light bulbs, and wheelchair cleaning and changing/recharging wheelchair batteries.<sup>403</sup> Domestic services are distinct from Related Services which are described below. Domestic Services are generally authorized for 6 hours per month and assessments are not typically individualized, however, if needed, a social worker can authorize an exception.<sup>404</sup> In shared living arrangements, domestic services may be prorated.<sup>405</sup> Proration is discussed in more detail in section 5 below. Minors under the age of 18 are not eligible to receive Domestic Services.<sup>406</sup>

## 1.2 Heavy Cleaning

Heavy Cleaning includes thorough cleaning of the home to remove hazardous debris or dirt, such as throwing away large amounts of clutter into a dumpster.<sup>407</sup> Heavy Cleaning can only be authorized at the time IHSS is initially granted or if a lapse of at least 12 months occurs.<sup>408</sup> The social worker has the authority to approve this service if the recipient's living conditions present a threat to their safety or if the recipient is at risk of an eviction for failure to prepare their home for fumigation as required by statute or ordinance.<sup>409</sup>

## 1.3 Related Services

Related Services includes the following services: laundry, shopping and errands, meal preparation, and meal clean-up. Each of these services is individually assessed and allotted a specific amount of time.

### Laundry

Laundry includes tasks such as gaining access to machines, sorting laundry, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry, folding and sorting laundry, and mending and ironing.<sup>410</sup> Laundry Services can be authorized for 1.0 hour per household per week if there are laundry facilities in the home.<sup>411</sup> CDSS guidance makes clear that providers are expected to perform other tasks for the recipient while clothes are washing and drying.<sup>412</sup> If the laundry facilities are out of the home, services can be authorized for 1.5 hours per week per household.<sup>413</sup> The county can authorize exceptions over the guideline range when needed, including if a recipient is incontinent.<sup>414</sup>

### Meal Cleanup

Meal Cleanup includes tasks such as loading and unloading dishwasher; washing, rinsing, and drying dishes, pots, pans, utensils, and culinary appliances and putting them away; storing/putting away leftover foods and liquids; wiping up tables, counters, stoves, ovens, and sinks; and washing and drying hands.<sup>415</sup> Meal cleanup can be authorized for between 1.17 and 3.5 hours per week, depending on the recipient's level of need.<sup>416</sup> The county can authorize exceptions under and over the guideline range when needed.<sup>417</sup> It is important to note that Meal Cleanup does not include general cleaning of the refrigerator, stove and oven, or counters and sinks. These services are assessed under domestic services.<sup>418</sup>

### Meal Preparation

Meal Preparation includes tasks such as planning menus, removing food from refrigerator or pantry, washing and drying hands before and after meal preparation, washing, peeling, and slicing vegetables; opening packages, cans and bags, measuring and mixing ingredients, lifting pots and pans, trimming meat, reheating food, cooking and safely operating stove, setting the table, serving the meals, puréeing food, and cutting the food into bite-size pieces.<sup>419</sup> Meal preparation can be authorized for between 3.02 and 7.00 hours per week.<sup>420</sup> The county can authorize exceptions, under and over the guideline range when needed, including when a recipient needs food pureed or cut up into bite sized pieces, or when they need more frequent meals.<sup>421</sup>

## Restaurant Meal Allowance

Restaurant Meal Allowance (RMA), a direct cash benefit, may be provided when a recipient who has adequate cooking facilities at home, but whose disabilities prevent their use, chooses to receive a restaurant meal allowance in lieu of Meal Preparation, Meal Cleanup and Food Shopping.<sup>422</sup> If a recipient doesn't have adequate cooking facilities, they will be referred to the SSI/SSP program.<sup>423</sup> It is important to note that services under the PCSP do not include the RMA.<sup>424</sup> If a recipient requires this service, they will be placed in a non-PCSP program, like CFCO or IHSS Plus Option (IPO).<sup>425</sup>

If an individual recipient chooses the Restaurant Meal Allowance, they will receive \$62 per month.<sup>426</sup> A couple will receive \$124 per month.<sup>427</sup> A recipient receiving the Restaurant Meal Allowance will have the amount they receive deducted from the statutory maximum service hours per month, which is determined by multiplying the statutory maximum hours of service by the county wage, subtracting the Restaurant Meal Allowance from this product and dividing the remainder by the county hourly wage rate.<sup>428</sup> A recipient who receives a Restaurant Meal Allowance as part of their SSP grant cannot receive a Restaurant Meal Allowance from IHSS.<sup>429</sup>

## Shopping and Errands

Shopping and Errands includes such tasks as: compiling a grocery or shopping list; traveling to/from the store; bending, reaching, lifting, and managing cart or basket; identifying items needed; transferring items to home and putting items away; telephoning in and picking up prescriptions; and buying clothing.<sup>430</sup> Food shopping can be authorized for 1.0 hour per week per household<sup>431</sup> and other shopping and errands for 0.5 hours per week per household.<sup>432</sup> The county can authorize exceptions over the guideline range when needed.<sup>433</sup> The county will not authorize additional time for the recipient to accompany the provider on these errands.<sup>434</sup>

## 1.4 Personal Care Services

Personal Care Services include the following activities: ambulation, bathing, oral hygiene, grooming, routine bed bath, bowel and bladder care, dressing, repositioning, menstrual care, feeding, respiration assistance, assistance with prosthetic devices, and assistance with self-administration of medication.<sup>435</sup> Not every recipient will need or receive every type of personal care service. Each of these services is individually assessed and allotted a specific amount of time. The county should consider universal precautions, like handwashing, when assessing time for personal care services.<sup>436</sup> As with other services, exceptions over or under the HTGs can be approved if supported by the recipient's need.

### Ambulation

Ambulation includes tasks such as assisting the recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving and retrieving assistive devices, such as a cane, walker, or wheelchair; and washing and drying hands before and after performing these tasks.<sup>437</sup> Ambulation also includes assistance to and from the front door to the car (including getting in and out of the car) for medical accompaniment and/or alternative resource travel.<sup>438</sup> Ambulation services can be authorized for between 0.58 and 3.50 hours depending on the severity of the recipient's needs.<sup>439</sup>

## Bathing, Oral Hygiene, and Grooming

Bathing includes tasks such as cleaning the body in a tub or shower; obtaining water and supplies and putting them away; turning on and off faucets and adjusting water temperature; assisting with getting in and out of the tub or shower; assisting with reaching all parts of the body for washing, rinsing, drying, or applying lotion, powder, deodorant; and washing and drying hands.<sup>440</sup>

Oral Hygiene includes tasks such as applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing and drying hands.<sup>441</sup>

Grooming includes such tasks as: combing and brushing hair; hair trimming when the recipient cannot get to the barber or salon; shampooing, applying conditioner, and drying hair; shaving; fingernail and toenail care when these services are not assessed as “paramedical” services for the recipient; and washing and drying hands.<sup>442</sup>

Bathing, Oral Hygiene and Grooming Services can be authorized for between 0.5 hours and 5.1 hours depending on the severity of the recipient’s needs.<sup>443</sup> It is important to note that Bathing, Oral Hygiene, and Grooming do not include getting to and from the bathroom, which is assessed as mobility under Ambulation Services.<sup>444</sup>

## Routine Bed Bath

Routine Bed Bath includes tasks such as cleaning basin or other materials used for bed sponge baths and putting them away; obtaining water and supplies; washing, rinsing, and drying body; applying lotion, powder, and deodorant; and washing and drying hands before and after bathing.<sup>445</sup> Routine Bed Bath Services can be authorized for between 0.5 hours and 3.5 hours per week depending on the severity of the recipient’s needs.<sup>446</sup>

## Bowel and Bladder Care

Bowel and Bladder Care includes tasks such as assisting with using, emptying, and cleaning bedpans and bedside commodes, urinals, ostomy, enema, and/or catheter receptacles; application of diapers; positioning for diaper changes; managing clothing; changing disposable barrier pads; putting on/taking off disposable gloves; wiping and cleaning recipient; assisting with getting on/off commode or toilet; and washing/drying hands.<sup>447</sup> Bowel and Bladder Care Services can be authorized for between 0.58 hours and 8.00 hours depending on the severity of the recipient’s needs.<sup>448</sup> It is important to note that Bowel and Bladder Care does not include insertion of enemas, catheters, suppositories, digital stimulation as part of a bowel program, or colostomy irrigation. These tasks are assessed under Paramedical Services.<sup>449</sup>

## Care of and Assistance with Prosthetic Devices and Self-Administration of Medication

Care of and Assistance with Prosthetic Devices includes tasks such as: taking off and putting on, maintaining, and cleaning prosthetic devices, vision and hearing aids; and washing and drying hands before and after performing these tasks.<sup>450</sup>

Assistance with Self-Administration of Medication includes tasks such as: reminding the recipient to take prescribed and over-the-counter medications and setting up Medi-sets.<sup>451</sup> Direct administration of medication, including injections, is authorized under Paramedical Services.

Care of and Assistance with Prosthetic Devices and Self-Administration of Medication can each be authorized for between 0.47 hours and 1.12 hours per week.<sup>452</sup> Functional rankings do not apply for this service.<sup>453</sup> The county must consider a number of factors when determining time, including the amount and frequency of medication, special preparations required, number of prosthetic devices, the recipient's independence, and the recipient's behavior, both helpful and unhelpful.<sup>454</sup>

### **Dressing and Undressing**

Dressing and Undressing includes tasks such as washing and drying of hands; putting on and taking off, fastening and unfastening, buttoning and unbuttoning, zipping and unzipping, and tying and untying of garments, undergarments, corsets, elastic stockings, and braces; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.<sup>455</sup> Dressing and Undressing Services can be authorized for between 0.56 hours and 3.50 hours per week.<sup>456</sup>

### **Feeding Services**

Feeding services include tasks such as assisting with the consumption of food and ensuring adequate fluid intake for recipients who cannot feed themselves or who require assistance with special devices to eat or drink adequate liquids.<sup>457</sup> It includes assistance with reaching for, picking up, and grasping utensils and cup; cleaning the face and hands; and washing and drying hands.<sup>458</sup> Feeding Services can be authorized for between 0.7 hours and 9.33 hours per week.<sup>459</sup> It is important to note that Feeding Services do not include cutting food into bite-size pieces or puréeing foods, as these tasks are assessed in Meal Preparation Services.<sup>460</sup>

### **Menstrual Care Services**

Menstrual Care Services include tasks such as the external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes, using and/or disposing of barrier pads, managing clothing, wiping and cleaning, and washing and drying hands.<sup>461</sup> In assessing Menstrual Care, it may be necessary to assess additional time in other service categories such as Laundry, Dressing, Domestic, Bathing, Oral Hygiene, and Grooming.<sup>462</sup> Menstrual Care services can be authorized for between 0.28 hours and 0.80 hours per week.<sup>463</sup>

It is important to note that if a recipient wears diapers, time for menstrual care should not be necessary and any needed hours would be assessed as part of Bowel and Bladder Care.<sup>464</sup>

### **Repositioning/Rubbing Skin Services**

Repositioning/Rubbing Skin Services include tasks such as rubbing skin to promote circulation and/or prevent skin breakdown; turning in bed and other types of repositioning; and range of motion exercises when specific criteria are met.<sup>465</sup> Those criteria include general supervision

of exercises, which have been taught to the recipient and maintenance therapy when the specialized knowledge and judgment of a therapist is not needed.<sup>466</sup> Repositioning and Rubbing Skin services can be authorized for between 0.75 hours and 2.80 hours per week.<sup>467</sup>

It is important to note that Repositioning and Rubbing Skin Services do not include care of pressure sores. Skin and wound care is assessed as part of Paramedical Services and the set up and monitoring of equipment for ultraviolet treatments of the pressure sores and/or application of medicated cream to the skin is assessed as part of Care and Assistance with Prosthetic Devices.<sup>468</sup>

### Respiration Services

Respiration Services include tasks such as: assistance with self-administration of oxygen and cleaning oxygen equipment and IPBB (intermittent positive pressure breathing) machines.<sup>469</sup> All tasks approved under Respiration Services are limited to non-medical services.<sup>470</sup> There is no guideline range for Respiration services.

### Transfer Services

Transfer Services include tasks such as assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, coach, wheelchair, walker, or other assistive device generally occurring within the same room.<sup>471</sup> Transfer services can be authorized for between 0.50 hours to 3.50 hours per week.<sup>472</sup> It is important to note that Transfer Services do not include assistance on/off toilet, which is assessed as part of Bowel and Bladder Care.<sup>473</sup> Changing position to prevent breakdown and promote circulation is assessed as Repositioning/Rubbing Skin.<sup>474</sup>

## 1.5 Paramedical Services

Paramedical Services include tasks such as: administration of medication, puncturing the skin, inserting a medical device into a body orifice, activities requiring sterile procedures and other activities requiring judgment based on training given by a licensed health care professional.<sup>475</sup> The Manual of Policies and Procedures provides specific examples of tasks that can be administered as Paramedical Services, including: tracheostomy care and suctioning,<sup>476</sup> tube feeding,<sup>477</sup> skin and wound care,<sup>478</sup> catheter insertion,<sup>479</sup> and ostomy irrigation and bowel program.<sup>480</sup>

Paramedical Services are skilled tasks, which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health.<sup>481</sup> Unlike other IHSS services, Paramedical Services are only provided when ordered by the recipient's licensed health care professional<sup>482</sup> and performed under the health care professional's direction.<sup>483</sup> CDSS issued guidance in 2024 that a licensed health care professional includes a licensed Nurse Practitioner.<sup>484</sup>

The time for the needed Paramedical Services is based on the amount of time indicated by the health care professional.<sup>485</sup> In order to authorize Paramedical Services, the county must have a signed and dated order from a licensed health care professional.<sup>486</sup> The order must include a signed statement of informed consent saying that the individual has been informed of the potential risks arising from the recipient of the services.<sup>487</sup> Once the needed documentation has been submitted to the county and the Paramedical Services are part of the approved IHSS tasks, the needed services are provided by the same provider who ordinarily provides IHSS and at the same rate of pay as regular IHSS services.<sup>488</sup>

**ADVOCATE TIP:** We strongly advise recipients or their authorized representatives to contact their doctor directly and explain what they need – do not let the county take over and consult the doctor for the recipient. If the recipient has a specialist, they should be involved, rather than a primary care physician who may not understand what the specialist does for every paramedical service. It is important to confirm that the doctor has included enough time to complete an entire service, from preparation to clean-up, including record keeping – such as diabetes testing and administration of injections.

## 1.6 Protective Supervision

Protective Supervision is a distinct category of IHSS service. Unlike all the other services, which are task-based, Protective Supervision consists of observing recipient behavior and intervening as appropriate in order to safeguard the recipient against injury, hazard, or accident.<sup>489</sup> It is only available for observing the behavior of non-self-directing, confused, mentally impaired, or mentally ill persons.<sup>490</sup> Because of the complexities of the rules, regulations, and case law surrounding Protective Supervision it is discussed more fully below in Section 6.

## 1.7 Miscellaneous Services

### Teaching and Demonstration Services

Teaching and Demonstration Services are provided by IHSS providers to enable recipients to perform for themselves services which they currently receive from IHSS.<sup>491</sup> Teaching and Demonstration Services are limited to instruction in those tasks covered under the domestic, related, personal care, and yard hazard abatement services categories.<sup>492</sup> For example, if a recipient wants to learn how to do laundry and has the necessary skills to do so safely and effectively, time can be authorized for a provider to teach the recipient how to complete the task.<sup>493</sup> However, Teaching and Demonstration Services shall be authorized for no more than three months and only when there is a reasonable expectation that there will be a reduction in the need for a specified IHSS service as a result of these services.<sup>494</sup> This service is provided by a recipient's IHSS provider at the same rate of pay as all other services.<sup>495</sup> Within seven months after the completion of this task, a social worker will follow-up with the recipient to evaluate the results of the teaching and demonstration.<sup>496</sup>

## Accompaniment to Medical Appointment and Alternative Resource Sites

Accompaniment to Medical Appointments and Alternative Resource Sites is an allowable service when the recipient requires the provider's assistance with other IHSS approved tasks in transit or at the destination.<sup>497</sup> Services will not be authorized just to fill a transportation need.<sup>498</sup> Medi-Cal offers a separate transportation benefit, non-emergency medical transportation, or NEMT. If a recipient is receiving that benefit for the same appointment, they are not eligible for IHSS accompaniment services.<sup>499</sup>

When a recipient is required to travel to a medical appointment and provider assistance is needed to accomplish the travel, providers may be eligible to receive payment for wait time associated with Medical Accompaniment.<sup>500</sup> There are two types of wait time, one compensable type referred to as Wait Time—On Duty, and one non-compensable type referred to as Wait Time—Off Duty.<sup>501</sup>

**WAIT TIME—On Duty** means periods of unpredictable periods of time, usually of short duration, during which a provider is unable to use the time effectively for their own purposes.<sup>502</sup> During periods when the provider is using "Wait Time—On Duty," they may not be actively performing authorized services but cannot effectively use the time for their own purposes because they may be called on to start providing services at any time. A recipient should receive authorized hours as a part of their Medical Accompaniment hours and a provider must be paid for time they spend in "Wait Time—On Duty."<sup>503</sup> An example of time spent in "Wait Time—On Duty" is when a provider accompanies a recipient to a primary care physician's appointment and the provider doesn't know if the appointment will take 10 minutes or 30 minutes and therefore cannot leave. Instead, they must sit and wait until the recipient is finished with the appointment. The recipient should receive an allocation for that time (usually an average of how long the appointment normally takes), and the provider will be paid for that time.

**WAIT TIME—Off Duty** are periods during which the employee is completely relieved from duty and that are long enough to enable the provider to use the time effectively for their own purposes.<sup>504</sup> These waiting periods are not a part of the recipient's IHSS authorized hours. The provider must be informed in advanced that they may leave the job and will not have to return to work until a specified time. For example, if a provider takes a recipient to a dialysis appointment and the provider knows that the recipient's appointment will take three hours then the provider may leave and go home, run their own errands, etc. For this type of appointment, the recipient will not receive an IHSS allotment of time and the provider will not be paid for waiting.

The county social workers are directed to assess recipients for wait time by phone or in person by asking how frequently they have medical or other health-related appointments, the purpose of the appointments, and if accompaniment by an IHSS provider is needed during travel to and from the facility.<sup>505</sup>

## Yard Hazard Abatement

Yard Hazard Abatement is light work in the yard which may be authorized for removal of high grass or weeds, and rubbish when this constitutes a fire hazard.<sup>506</sup> This service is also available for the removal of ice, snow, or other hazardous substances from entrances and essential walkways when access to the home is hazardous.<sup>507</sup>

# Chapter 5 Endnotes

- 397 Cal. Welf. & Inst. Code § 12300; [California Dept. of Social Services \(“CDSS”\) Manual of Policies & Procedures \(“MPP”\) § 30-757](#) (Provides in-depth information about each service offered through the IHSS program).
- 398 *Id.*
- 399 Cal. Welf. & Inst. Code § 12301.
- 400 Cal. Welf. & Inst. Code § 12309. See CDSS’s [“IHSS Training Academy”](#) for additional assessment tools.
- 401 [MPP § 30-761.13](#).
- 402 Cal. Welf. & Inst. Code § 12301.2; [MPP § 30-757.1\(a\)](#); [MPP § 30-756.11-.115](#) provides the definitions for Rank 1 through Rank 5. Rank 1 is defined as “Independent: able to perform function without human assistance, although the recipient 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 recipient who ranks a “1” in any function shall be authorized the correlated service activity.” Rank 2 is defined as “Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement.” Rank 3 is defined as “Can perform the function with some human assistance, including but not limited to, direct physical assistance from a provider.” Rank 4 is defined as “Can perform a function but only with substantial human assistance.” Rank 5 is defined as “Cannot perform the function, with or without human assistance.” See also *V.L. v. Wagner*, 669 F.Supp.2d 1106 (N.D. Cal. 2009) (the ranks “have never before been used to determine IHSS eligibility.” Rather, “the purpose of the ranks was to help social workers determine with uniformity the number of hours of a particular service elderly and disabled individuals needed.”).
- 403 [MPP § 30-757.11](#); 22 Cal. Code of Regs., tit. 22, § 51183(b)(1), also listed as [MPP § 30-780.1\(b\)\(1\)](#).
- 404 [MPP § 30-757.11\(k\)\(1\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(b), also listed as [MPP § 30-780.1\(b\)](#).
- 405 [MPP § 30-763.31](#).
- 406 [MPP § 30-763.456](#).
- 407 [MPP § 30-757.12](#); 22 Cal. Code of Regs, tit. 22, § 51183(b)(6), also listed as [MPP § 30-780.1\(b\)\(6\)](#).
- 408 [MPP § 30-757.121](#).
- 409 *Id.*
- 410 [MPP § 30-757.134](#); 22 Cal. Code of Regs., tit. 22, § 51183(b)(2), also listed as [MPP § 30-780.1\(b\)\(2\)](#).
- 411 [MPP § 30-757.134\(c\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(b), also listed as [MPP § 30-780.1\(b\)](#).
- 412 [MPP § 30-757.134\(c\)\(1\)](#).
- 413 [MPP § 30-757.134\(d\)](#).
- 414 [MPP § 30-757.134\(e\)](#).
- 415 [MPP § 30-757.132](#); 22 Cal. Code of Regs., tit. 22, § 51183(b)(4), also listed as [MPP § 30-780.1\(b\)\(4\)](#).
- 416 [MPP § 30-757.132\(b\)](#).
- 417 [MPP § 30-757.132\(d\)](#).
- 418 [MPP § 30-757.132\(a\)](#).

- 419 [MPP § 30-757.131](#); 22 Cal. Code of Regs., tit. 22, § 51183(b)(4), also listed as [MPP § 30-780.1\(b\)\(4\)](#).
- 420 [MPP § 30-757-131\(a\)](#).
- 421 [MPP § 30-757.131\(c\)](#).
- 422 Cal. Welf. & Inst. Code § 12303.7; [MPP § 30-757.133](#).
- 423 [MPP § 30-757.133\(a\)\(3\)](#).
- 424 CDSS, [All County Letter \(“ACL”\) 93-21](#) (March 16, 1993), at pg. 2.
- 425 *Id.*; For more information on specific IHSS programs, see Chapter 1.
- 426 Cal. Welf. & Inst. Code § 123303.7; [MPP § 30-757.133\(1\)\(A\)](#).
- 427 *Id.*
- 428 [MPP § 30-765.133](#).
- 429 [MPP § 30-765.133\(a\)\(3\)](#).
- 430 [MPP § 30-757.135\(c\)](#).
- 431 [MPP § 30-757.135\(b\)\(1\)](#).
- 432 [MPP § 30-757.135\(c\)\(1\)](#).
- 433 [MPP § 30-757.135\(d\)](#).
- 434 [MPP § 30-757.135\(a\)](#).
- 435 Cal. Welf. & Inst. Code § 12300(c); [MPP § 30-757.14](#).
- 436 [MPP § 30-757.1\(a\)\(1\)\(A\)](#).
- 437 Cal. Welf. & Inst. Code § 12300(c)(1); [MPP § 30-757.14\(k\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(1), also listed as [MPP § 30-780.1\(a\)\(1\)](#).
- 438 *Id.* Alternative resource travel may be authorized when accompaniment is needed during necessary travel to alternative resource sites such as an adult day care or community resource center.
- 439 [MPP § 30-757.14\(k\)\(1\)](#).
- 440 [MPP § 30-757.14\(e\)\(1\)](#); [MPP § 30-780.1\(a\)\(2\)](#).
- 441 [MPP § 30-757.14\(e\)\(2\)](#).
- 442 [MPP § 30-757.14\(e\)\(3\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(2), also listed as [MPP § 30-780.1\(a\)\(2\)](#).
- 443 [MPP § 30-757.14\(e\)\(5\)](#).
- 444 [MPP § 30-757.14\(e\)\(4\)](#).
- 445 [MPP § 30-757.14\(d\)](#).
- 446 [MPP § 30-757.14\(d\)\(1\)](#).
- 447 [MPP § 30-757.14\(a\)](#); [MPP § 30-780.1\(a\)\(4\)](#).
- 448 [MPP § 30-757.14\(a\)\(2\)](#).
- 449 [MPP § 30-757.14\(a\)\(1\)](#).

450 [MPP § 30-757.14\(i\)](#).

451 [MPP § 30-757.14\(i\)\(1\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(7), also listed as [MPP § 30-780.1\(a\)\(7\)](#).

452 [MPP § 30-757.14\(i\)\(2\)](#).

453 [MPP § 30-757.1\(i\)\(2\)](#).

454 [MPP § 30-757.1\(i\)\(3\) and \(4\)](#).

455 [MPP § 30-757.14\(f\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(3), also listed as [MPP § 30-780.1\(a\)\(3\)](#).

456 [MPP § 30-757.14\(f\)\(1\)](#).

457 [MPP § 30-757.14\(c\)](#).

458 [MPP § 30-757.14\(c\)\(1\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(6), also listed as [MPP § 30-780\(a\)\(6\)](#).

459 [MPP § 30-757.14\(c\)\(3\)](#).

460 [MPP § 30-757.14\(c\)\(2\)](#).

461 [MPP § 30-757.14\(j\)](#); 22 Cal. Code of Regs. tit. 22, § 51183(a)(4), also listed as [MPP § 30-780.1\(a\)\(4\)](#).

462 [MPP § 30-757.14\(j\)\(1\)](#).

463 [MPP § 30-757.14\(j\)\(3\)](#).

464 [MPP § 30-757.14\(j\)\(2\)](#).

465 [MPP § 30-757.14\(g\)](#).

466 [MPP § 30-757.14\(g\)\(1\)\(2\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(5), also listed as [MPP § 30-780.1\(a\)\(5\)](#).

467 [MPP § 30-757.14\(g\)\(4\)](#).

468 [MPP § 30-757.14\(g\)\(3\)](#).

469 [MPP § 30-757.14\(b\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(8), also listed as [MPP § 30-780.1\(a\)\(8\)](#).

470 *Id.*

471 [MPP § 30-757.14\(h\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(5), also listed as [MPP § 30-780.1\(a\)\(5\)](#).

472 [MPP § 30-757.14\(h\)\(2\)](#).

473 [MPP § 30-757.14\(h\)\(1\)\(A\)](#).

474 [MPP § 30-757.14\(h\)\(1\)\(B\)](#).

475 Cal. Welf. & Inst. Code § 12300.1; [MPP § 30-757.191\(c\)](#); 22 Cal. Code of Regs., tit. 22, § 51183(a)(9), also listed as [MPP 30-780.1\(a\)\(9\)](#).

476 [MPP § 30-756.42](#).

477 [MPP § 30-756.41](#).

478 [MPP § 30-780.1\(a\)\(5\)](#).

479 [MPP § 30-757.14\(a\)\(1\)](#); [MPP § 30-780.2\(g\)](#).

480 *Id.*

481 [MPP § 30-757.191](#).

482 Cal. Welf. & Inst. Code § 12300.1; [MPP § 30-757.192](#).

483 [MPP § 30-757.193](#).

484 [ACL 24-89](#), (Nov. 26, 2024).

485 [MPP § 30-757.194](#).

486 [MPP § 30-757.196](#); [MPP § 30-780.2\(e\)](#); CDSS, [FORM SOC 321 Request for Order and Consent – Paramedical Services](#).

487 *Id.*

488 [MPP § 30-757.195](#).

489 [MPP § 30-757.17](#).

490 [MPP § 30-757.171](#).

491 Cal. Welf. & Inst. Code § 12300(b); [MPP § 30-757.18](#).

492 [MPP § 30-757.18](#).

493 See [MPP § 30-757.182](#).

494 [MPP §§ 30-757.183](#); [30-757.184](#). The reduction in cost must be at least equivalent to the cost of services provided for Teaching and Demonstration. The reduction in cost is equivalent if the full cost of service authorized under this category is recovered within six months after the conclusion of the training period.

495 [MPP § 30-757.181](#).

496 [MPP § 30-757.185](#).

497 Cal. Welf. & Inst. Code § 12300(b); [MPP § 30-757.15](#); [ACL 17-42](#) (June 23, 2017).

498 [ACL 17-42](#) (June 23, 2017).

499 *Id.*

500 Cal. Welf. & Inst. Code § 12300(b); [MPP § 30-757.15](#); 22 Cal. Code of Regs., tit. 22, § 51183(b)(5) also listed as [MPP § 30-780.1\(b\)\(5\)](#).

501 See 29 C.F.R. §§ 785.15-.16 (Federal regulations define two different types of wait time: “engaged to wait” and “waiting to be engaged.”); [ACL 16-01](#) (January 7, 2016).

502 29 C.F.R. § 785.15.

503 [ACL 16-01](#) (January 7, 2016) at 14.

504 See 29 C.F.R. § 785.16.

505 [ACL 14-82](#) (November 25, 2014).

506 Cal. Welf. & Inst. Code § 12300(b); [MPP § 30-757.16](#); 22 Cal. Code of Regs., tit. 22, § 51183(b)(7) also listed as [MPP § 30-780.1\(b\)\(7\)](#).

507 [MPP § 30-757.16](#); 22 Cal. Code of Regs., tit. 22, § 51183(b)(7) also listed as [MPP § 30-780.1\(b\)\(7\)](#).

# Chapter 6: IHSS Providers

There are approximately 799,379 individuals working as IHSS providers as of the publication of this guide.<sup>508</sup> These providers serve more than 892,752 IHSS recipients across California. About 73% of IHSS providers are family members.<sup>509</sup> Provider turnover is high in the IHSS program, with the Legislative Analyst's Office estimating it may be as high as 33%.<sup>510</sup> The overwhelming majority of homecare workers in California, which include IHSS providers, are women and people of color.<sup>511</sup>

As the IHSS program has become more administratively complex, so have rules surrounding provider employment. This chapter contains important information about the IHSS program for providers. There are five sections: (1) IHSS Provider Eligibility Criteria; (2) Selection, Hiring, and Termination; (3) Payment Issues, Including Share-Of-Cost; (4) Timesheets and Workweeks; and (5) Overtime, Exemptions, Travel Time, Wait Time and Violations.

## 1. IHSS PROVIDER ELIGIBILITY CRITERIA

An IHSS provider is someone who is paid to provide services to an IHSS recipient. IHSS recipients have the right to choose their provider. There are only two restrictions on who a recipient can choose to be a paid IHSS provider: (1) the individual must be eligible to work in the United States; and (2) the individual must pass a criminal background check conducted by the Department of Justice.<sup>512</sup>

Minors can work as IHSS providers subject to restrictions under California labor law.<sup>513</sup> Even minors need to pass a background check in order to be eligible to work as an IHSS provider.<sup>514</sup>

### 1.1 Provider Enrollment Process and Timeline

A provider must complete the following four-steps within 90 calendar days of initiating the enrollment process.<sup>515</sup>

1. Complete and sign the IHSS Program Provider Enrollment Form (SOC 426) and return it in-person to the County IHSS office or IHSS Public Authority.<sup>516</sup> Applicants must report if they have been convicted of any Tier 1 or Tier 2 disqualifying crime(s) within the last ten years.<sup>517</sup> Tier 1 and Tier 2 disqualifying crimes are described below. The information provided in SOC 426 will be verified by a criminal background check by the Department of Justice.<sup>518</sup> When returning a completed form, the applicant provider must bring and allow the county to photocopy the following original documents:<sup>519</sup>
  - » A valid (unexpired) photo ID issued by a U.S. federal or state government agency or by a federally-recognized Native American or Alaskan Native tribal organization.<sup>520</sup>
  - » An original Social Security card or a replacement card issued by the Social Security Administration (SSA).<sup>521</sup> Official correspondence from the SSA demonstrating that the individual's Social Security number may be accepted in lieu of the Social Security card.<sup>522</sup>

2. Be fingerprinted and undergo a criminal background check by the Department of Justice that will establish whether a prospective provider has been convicted of, or incarcerated following a conviction for, any Tier 1 or Tier 2 disqualifying crime(s) within the last ten years.<sup>523</sup> The county will provide the form(s) and instructions for having fingerprints scanned and transmitted to the Department of Justice.<sup>524</sup> The applicant provider bears the expense of the criminal background check.<sup>525</sup>
3. Attend an in-person IHSS Program Provider Orientation given by the county.<sup>526</sup>
4. Sign an IHSS Program Provider Enrollment Agreement (SOC 846) acknowledging that they understand and agree to the rules and requirements for being an IHSS provider.<sup>527</sup>

### Tier 1 and Tier 2 Disqualifying Crimes

The criminal background check is used to determine whether an individual has been “convicted of, or incarcerated following a conviction for, any Tier 1 or Tier 2 disqualifying crime(s) within the last 10 years.”<sup>528</sup> Tier 1 disqualifying crimes include fraud against a government health care or supportive services program,<sup>529</sup> specified child abuse,<sup>530</sup> and abuse of an elder or dependent adult.<sup>531</sup> Anyone who has been convicted for a Tier 1 crime in the past ten years is not eligible to be a provider, even if the Tier 1 crime was expunged from their record.<sup>532</sup>

A complete list of Tier 2 crimes is available at all county IHSS offices and online.<sup>533</sup> In general, Tier 2 disqualifying crimes include violent or serious felonies,<sup>534</sup> sex crimes,<sup>535</sup> and felony offenses for fraud against a public social services program.<sup>536</sup> The Department of Social Services (CDSS) recently published All County Letter 19-14 further explaining Tier 2 crimes and when they are disqualifying.<sup>537</sup> Under certain circumstances, applicants with a Tier 2 conviction may still be eligible.<sup>538</sup> First, an individual recipient can grant a waiver to the prospective provider, which allows that provider to work for that one recipient. Alternatively, a prospective provider can apply directly to CDSS for a general exception. CDSS published guidance explaining the general exception process for waiving Tier 2 crimes in All County Letter 19-64. Additionally, SOC 847 contains additional information on exceptions to a Tier 2 conviction.<sup>539</sup>

## **2. SELECTION, HIRING, AND TERMINATION**

### **2.1 Finding a Provider**

IHSS recipients are responsible for interviewing, hiring, and, if needed, firing their IHSS provider. Recipients may hire anyone who meets the IHSS provider enrollment requirements and can meet their needs. This can be a family member, friend, or someone referred from the Public Authority Registry. Each county maintains a database registry made up of IHSS providers who have already completed the program enrollment process. The contact information for the Public Authority in each county is available online.<sup>540</sup> Recipients who cannot find a provider should contact the county IHSS office or Public Authority for assistance.

## 2.2 Interviewing a Provider

Before interviewing a provider, recipients should review their authorized services and know the hours they have been awarded for each service. If one provider cannot provide all of the services the recipient needs or is unavailable to work all of the authorized hours, the recipient may need to hire more than one provider. Recipients with specific needs, such as a special diet or assistance with transfers, should mention this during the interview. CDSS recommends first screening applicants through a telephone interview, meeting in person with the strongest candidates, and checking their references to get an idea of the kind of work they used to do, how long they were employed, their reliability, and their strengths and weaknesses.

There is a section on the CDSS website devoted to finding, hiring, and working with providers. Recipients can find fact sheets on a variety of topics, from selection and hiring to setting and maintaining boundaries with a provider. These fact sheets are available online.<sup>541</sup>

## 2.3 Terminating a Provider

A recipient has the right to fire their provider for any reason as long as it is not discriminatory. In determining to fire a provider, a recipient should consider the severity of the problem or disagreement, whether it can be fixed, and the time it will take to find a new provider. For more information on deciding when to fire a provider is available at the CDSS website.<sup>542</sup>

## 2.4 Back-Up Providers

In 2022, CDSS mandated that all counties create a back-up provider registry that IHSS recipients can access during emergencies to fill gaps in care.<sup>543</sup> Individuals providing IHSS services through the back-up registry receive a two-dollar wage differential above the locally negotiated county IHSS wage. In situations in which two or more providers work for the same recipient, the available provider can receive an overtime exemption in order to provide back-up care in place of a temporarily unavailable provider.<sup>544</sup> IHSS recipients with urgent personal care needs<sup>545</sup> that cannot be met by a current provider, or recipients who are transitioning from institutional care to community settings and have not yet identified a provider can access their county's back-up provider registry. Recipients with non-severe impairments can receive up to 80 hours a year of back-up care, while individuals with severe impairments can receive up to 160 hours.

# **3. PAYMENT ISSUES, INCLUDING SHARE-OF-COST**

## 3.1 IHSS and Medi-Cal Share of Cost

IHSS is a covered Medi-Cal benefit; therefore, financial eligibility for IHSS is established through the Medi-Cal determination process. IHSS recipients who are on a free Medi-Cal program have all IHSS hours paid for by the State. For more information on Medi-Cal programs, see Chapter 3.

IHSS recipients enrolled in Medi-Cal with a Share of Cost (SOC) must incur the amount of their SOC before Medi-Cal will pay for any services. This means that the state, before paying for IHSS, will apply any owed IHSS wages, to the recipient's SOC. This results in recipients with an SOC owing wages to their providers. Depending on how many IHSS hours the recipient is authorized, sometimes they owe the entire share of cost amount to the provider, and sometimes they owe less. Recipients may also pay down their share of cost by utilizing and paying for other Medi-Cal covered services unconnected to IHSS during the pay period.

#### Example 1—IHSS with a Share of Cost (SOC)

Juanita receives \$2,000 in monthly retirement income and has an **\$1,400 SOC per month**. Juanita is authorized for 180 hours of IHSS per month and her county pays \$16.50/hour. This means if her provider, Monica, works all her authorized hours, she will earn \$2,970/month. There are two pay periods per month so if Monica works 75 hours per pay period, she will earn \$1,485 for each pay period.

Because of Juanita's share of cost, however, Monica's first check may have as much as \$1,400 deducted from it. This means that the state would pay Monica \$85 and it will expect Juanita to pay the remaining \$1,400 of owed wages to Monica. At this point, Juanita has met her SOC for the month so all other medical expenses will be paid for and Monica's second check will be paid in full. This cycle will repeat every month because share of cost is a per month cost.

Recipients who have a Medi-Cal SOC and their providers will receive an "Explanation of Share-of-Cost" letter that identifies the SOC amount to be paid that pay period. The SOC amount will also appear on their provider's timesheet under "Share-of-Cost Liability." The SOC amount may change each pay period, depending on whether the recipient has incurred their SOC for other medical expenses before the timesheet is processed each pay period. Additionally, recipients with more than one IHSS provider cannot choose to which provider the SOC amount will be incurred. Any unpaid SOC will be subtracted from the first IHSS provider's timesheet that is processed by the county.

#### Example 2—IHSS with a Share of Cost (SOC) and Two Providers

Juanita has hired a second provider, Felix, because Monica only wants to work 100 hours per month. Felix agrees to work 80 hours per month. As in Example 1, a total of \$2,970 per month will be paid in IHSS wages between the two providers.

In January, Monica works 50 hours during the first pay period and Felix works 40 hours. Felix submits his timesheet first. Because of Juanita's \$1,400 SOC, Felix will not be paid anything by the state for those 50 hours of work. Instead, Juanita will owe him \$660 ( $\$16.50 \times 40$ ). When Monica submits her timesheet for 50 hours, she will receive a check for \$85 from the state. Juanita will owe Monica \$740 ( $\$1,400 - \$660$ ) in wages. Both Monica and Felix will be paid by the state for all their hours for their second pay period.

In February, Monica works 50 hours during the first pay period and Felix works 40 hours. Monica submits her timesheet first. Because of Juanita's \$1,400 SOC, Monica will not be paid anything by the state for those 50 hours of work. Instead, Juanita will owe her \$825 (50 x \$16.50). When Felix submits his timesheet for 40 hours, he will receive \$85 from the state. Juanita will owe Felix \$490 (\$575-\$85) in wages.

**Because a recipient's SOC can result in unpaid wages to the provider for which the recipient is responsible, a recipient who has a SOC may have a difficult time keeping a provider.** It is worthwhile to determine if the IHSS recipient is eligible or can make themselves eligible for a free Medi-Cal program. For more information about IHSS and Medi-Cal SOC is available in Chapter 3. There are also explanatory handouts on CDSS's website.<sup>546</sup>

### 3.2 Advance Pay

The overwhelming majority of IHSS providers are paid in arrears from the State after they have worked their hours. However, there is an alternative. Advance Pay allows severely impaired IHSS recipients to receive an advanced payment for their monthly IHSS services to pay the provider(s) directly for their service.<sup>547</sup> Advance pay is optional and only available in the IHSS Residual (IHSS-R), IHSS Plus Option (IPO), and Community First Choice Option (CFCO) programs.<sup>548</sup>

To be eligible for Advance Pay, the IHSS recipient must meet all of the following conditions:

1. Qualify as a "severely impaired individual" which means the recipient is authorized for 20 or more hours per week in one or more of the following areas: personal care services; preparation of meals; meal cleanup when preparation of meals and consumption of food are required; and paramedical services;<sup>549</sup> and
2. Are capable of handling their own financial and legal affairs;<sup>550</sup> and
3. Agree that the amount advanced cannot exceed the amount needed to pay for authorized IHSS service hours.<sup>551</sup>

The Advance Pay recipient, or their legal guardian or conservator, must submit their provider's semi-monthly timesheets to the appropriate county social services office.<sup>552</sup> If the Advance Pay recipient does not submit the provider's timesheets within 90 days from the date of payment, counties can remove the Advance Pay and change the recipient's payment delivery method.<sup>553</sup> When a recipient does not submit a timesheet within 45 days, the payment made to the recipient without a corresponding timesheet is treated as an overpayment and can be recouped by the county.<sup>554</sup>

### 3.3 Paper Checks

Timesheets are processed at the CDSS timesheet processing facility in Chico, CA. After the timesheet is checked for accuracy, it is sent for further processing to a second facility in Roseville, CA. The Roseville facility sends a request to the State Controller, who then issues the paper check within two business days. Providers should receive their next timesheet around the same time as their paycheck.<sup>555</sup> For more information on submitting paper timesheets, see section 5.1.A of this chapter below.

### 3.4 Direct Deposit

As of July 1, 2022 providers must receive their IHSS paychecks through Direct Deposit. With Direct Deposit, paychecks are deposited directly into the provider's account at a bank, savings and loan, or credit union. Direct Deposit is mandatory, has advantages over paper checks because it eliminates the possibility of checks being lost or stolen, and allows providers to be paid more quickly.<sup>556</sup>

To enroll in direct deposit, providers must enroll online using the Electronic Services Portal or complete form SOC 829 (Direct Deposit Enrollment/Change/Cancellation Form).<sup>557</sup> They can also call the Direct Deposit Help Desk toll free at (866) 376-7066. If a provider works for more than one recipient, they must enroll separately for each recipient for whom they work and want their wages directly deposited.

### 3.5 IHSS Payments and Federal Taxes for Certain Providers

On March 1, 2016, CDSS received a ruling from the IRS that IHSS wages received by IHSS providers who live in the same home with the recipient of those services are excluded from gross income for purposes of federal and state income tax.<sup>558</sup> A live-in provider must fill out an SOC 2298 (In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) Live-In Self-Certification Form for Federal and State Tax Wage Exclusion in order to receive this benefit.<sup>559</sup> If the provider prefers to pay taxes out of their check, they do not have to file the self-certification form.

## 4. TIMESHEETS AND WORKSHEETS

### 4.1 Timesheets

Timesheets must be submitted two times per month in order to receive payment for providing IHSS services. The counties are required to train providers on how to properly complete timesheets as a part of their orientation.<sup>560</sup>

For payroll purposes, each month is divided into two payment periods.<sup>561</sup> The first pay period (also known as Part A) is for hours worked from the 1<sup>st</sup> to 15<sup>th</sup> of the month.<sup>562</sup> The second pay period (also known as Part B) is for hours worked from the 16<sup>th</sup> until the end of the month.<sup>563</sup>

**PRACTICE TIP:** It is strongly recommended that both the recipient and their provider use a calendar to track hours and minutes worked each day. Because of the complexities of calculating hours in the IHSS program, using a calendar to track time worked makes it easier to add up workweek hours, calculate overtime hours correctly, and ensure hours are billed to the proper pay period.<sup>564</sup>

## 4.2 Electronic Services Portal and Electronic Visit Verification

IHSS providers and recipients in all California counties must submit and approve timesheets online using the Electronic Timesheet Service (ETS) or through the Telephonic Timesheet Service (TTS).<sup>565</sup> Paper timesheets were phased out by the end of 2020.<sup>566</sup> ETS allows IHSS providers and recipients to do the following:

- Register and enroll to electronically submit and approve timesheets
- Enter time worked and submit timesheets
- Approve and/or reject electronically submitted timesheets
- View the previous three (3) months of timesheet history
- Check-in and check-out time and location for EVV compliance (explained below).<sup>567</sup>

To register and begin using electronic timesheets, providers must create an account as a new user. Recipients must enroll in order to approve electronic timesheets for their providers. If the recipient does not enroll, the provider cannot use ETS to submit timesheets, but can still use the service to view timesheet history.<sup>568</sup>

### Electronic Visit Verification

In compliance with federal requirements California implemented the Electronic Visit Verification system as of December 31, 2020.<sup>569</sup> The EVV system requires all providers who do not live with the IHSS recipient to check in and out using geo-location at the beginning and end of each work day.<sup>570</sup> Providers can use the EVV app on their mobile phone or other device, or use the EVS or TTS system to input the provider location when checking in or out of the recipient's home.<sup>571</sup> Live-in providers are exempt from having to report their location and do not have to check in or out.<sup>572</sup>

Providers who live in the same home as the IHSS recipient they work for should self-certify their living arrangement using the [SOC 2298](#) form.

The CDSS website has a more complete overview of ETS, EVV, self-certification as well as information regarding registration for providers and recipients, time entry, and approving timesheets.<sup>573</sup>

## 5. OVERTIME, EXEMPTIONS, WAIT TIME, TRAVEL TIME, AND VIOLATIONS

### 5.1 Overtime

In response to federal Department of Labor regulations, the state of California agreed to pay overtime for in-home care workers in the IHSS and Waiver Personal Care Services (WPCS) programs. As of February 1, 2016, IHSS providers will be paid overtime at a rate equal to one and one-half times the regular rate of hourly pay, when their time exceeds 40 hours per workweek.<sup>574</sup>

### Example 1:

If the IHSS wage is \$16/hour and the provider works 50 hours in one workweek, they will receive \$16/hour for 40 of those hours and \$24/hour for 10 hours.

If a provider works for more than one consumer, the combined total hours worked for all consumers will be used to calculate overtime.

### Example 2:

Provider works 25 hours for IHSS recipient #1 and 33 hours for IHSS recipient #2. Provider's total weekly hours are 58. Provider gets 18 hours per week of overtime.

The State has limited the amount of overtime a provider can work within a workweek. Providers who work for one consumer cannot work more than 70 hours and 45 minutes per workweek for IHSS and/or WPCS combined.<sup>575</sup> Providers who work for multiple consumers cannot work more than 66 hours per workweek for IHSS and/or WPCS combined, unless they are approved for IHSS Exemption 1 or 2 (discussed further below).<sup>576</sup>

## 5.2 Overtime Exemptions

As of July 1, 2017, there are two IHSS overtime exemptions codified in California state law.<sup>577</sup> The goal of these exemptions is to maintain continuity of care and ensure that IHSS recipients who are at risk of out-of-home placement can remain safely in their own homes. When granted, either exemption allows IHSS providers to work above the 66-hour workweek limit up to a maximum of 360 hours per month combined for all IHSS recipients they serve.<sup>578</sup>

During the assessment or reassessment, the county IHSS program will evaluate recipients and determine if circumstances indicate that their provider may be eligible for Exemption 1 or 2. The county will inform potentially qualifying recipients about the exemption(s) and the process by which a recipient or their provider may apply.<sup>579</sup>

Please note that even with an overtime exemption, the state will not pay a provider for more than 360 hours per month. This means that a provider cannot work more than 360 hours per month regardless of how many hours their recipient or recipients are approved for. If a recipient has a provider who cannot fulfill all their authorized hours because it would exceed 360 hours per month, that recipient must hire an additional IHSS provider to work the remaining hours.

Exemption 1 is available to providers who met all of the following conditions on or before January 31, 2016:

- » Provide services to two or more IHSS recipients; and
- » Live in the same home as all of the recipients for whom they provide services; and
- » Are related biologically, by adoption, or as a foster caregiver, legal guardian, or conservator, to all of the recipients for whom they provide services as the recipients' parent, stepparent, foster or adoptive parent, grandparent, legal guardian, or conservator.<sup>580</sup>

Before Exemption 1 was codified in statute, CDSS sent a letter and form to providers who were identified as meeting the criteria so many eligible providers have received an exemption. However, if a provider meets all of the criteria above, they are still eligible to apply for an exemption. The application (SOC 2279 is available at CDSS's website.<sup>581</sup> Providers can mail completed applications to:



California Department of Social Services  
744 P Street, M.S. 9-11-96  
Sacramento, CA 95814

Exemption 2 is available to providers who work for two or more recipients who each meet at least ONE of the following conditions that puts the recipient at serious risk of out-of-home placement, if the services are not provided by that provider:

- » Has complex medical and/or behavioral needs that must be met by a provider who lives in the same home as the recipient; OR
- » Lives in a rural or remote area where available providers are limited, and as a result, the recipient is unable to hire another provider; OR
- » Is unable to hire another provider who speaks the same language as the recipient, and as a result, the recipient is unable to direct his or her own care.<sup>582</sup>

To determine whether an exemption is warranted, the county must consider any of the circumstances listed in 1-3 above that put the recipient at risk of out-of-home placement without an exemption.<sup>583</sup> The recipient must still explore available options for hiring an additional provider, but the county must help the recipient, if needed, and must consider prior documented attempts to find or utilize other providers.<sup>584</sup> For more information, see Disability Rights California's "Recent Changes to In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) Workweek Exemptions for Providers (March 1, 2019)."<sup>585</sup>

The county is required to review all Exemption 2 applications and mail a written decision to the provider and recipients stating whether their application has been approved or denied within 30 days.<sup>586</sup> If an Exemption 2 request is denied, the notification letter must state the reason for the denial and provide information on how to request an independent review by CDSS.<sup>587</sup>

When a request for Exemption 2 is denied, the provider or recipient can request an administrative review through the Exemption State Administrative Review (ESAR) process.<sup>588</sup> Anyone seeking a review of an Exemption 2 denial must fill out and mail form [SOC 2313](#) (Workweek Limits for Extraordinary Circumstances (Exemption 2) State Administrative Review Request Form). An ESAR may not be requested by telephone.<sup>589</sup>

SOC 2313 must be postmarked within 45 calendar days of the date of the Notice to Provider of Ineligibility for Exemption from the IHSS Program Workweek Limits for Extraordinary Circumstances (SOC 22123) and mailed to:



California Department of Social Services  
Appeals, Administrative Review and Reimbursement Bureau  
Attention: Exemption 2 State Administrative Review Unit  
744 P Street, MS 9-11-04  
Sacramento, CA 95814

Failure to submit a complete ESAR or submitting an untimely request (i.e. more than 45 calendar days from the denial notice), may be denied by the ESAR unit and cause an ESAR unit denial.<sup>590</sup>

During the ESAR process, overtime violations will be suppressed regardless of the outcome of the ESAR review.<sup>591</sup> This means a provider cannot accrue another violation during the ESAR process. For more information about overtime violations, see section 5.6 below. The ESAR Unit will send written notice to the provider and the recipients stating the telephone conference date and time, within ten (10) business days of the date the ESAR request was received, and confirm the telephone number that the ESAR Unit will use to contact the provider.<sup>592</sup>

**PRACTICE TIP:** Providers and recipients have a right to present additional information at or prior to the conference that substantiates their qualifications for an exemption. It is helpful to include letters from healthcare providers, family members, or friends explaining their observations or experience with how the recipients' health and/or safety is negatively impacted by the introduction of a different provider. If applicable, the additional information should also include documentation about past incidents where the recipient was harmed when their services could not be provided by their live-in caregiver.

Individuals who have submitted an ESAR can request more time to submit additional written documentation.<sup>593</sup> The ESAR Unit will allow ten business days from the date of the review for the information to be sent via facsimile or mail (postmarked).<sup>594</sup> If additional information is not submitted within ten business days, the ESAR Unit will make a decision based solely on the information it has obtained through the SOC 2313 (and any accompanying documentation), the telephone conference, and the county's documentation.

The ESAR Unit will make a final decision to either uphold or overturn the county's ineligibility determination, and will mail written notice to the provider, recipients, and the county within 20 business days of the telephone conference, unless additional time to submit information has been requested. If the county's decision is overturned (i.e. approved for Exemption 2), the ESAR Unit will process and approve the Exemption 2 request and the provider will be required to complete the Exemption from Workweek Limits for Extraordinary Circumstances Approved Exemption Provider Agreement (SOC 2308) to the county IHSS office. If the county's decision is upheld (i.e. denial of Exemption 2), providers will be informed that they must adhere to existing workweek limits and recipients will need to hire additional provider(s) to work additional authorized IHSS hours.<sup>595</sup>

### 5.3 Travel Time

Providers with multiple recipients may be eligible to be paid for travel time between two recipients on the same day. Travel time means the "time spent traveling directly from a location where authorized services...are provided to one recipient to another location where authorized services are to be provided to another recipient."<sup>596</sup> Providers may not be paid for travel of more than 7 hours per week,<sup>597</sup> and travel time will not be deducted from the consumer's service hours.<sup>598</sup> A provider cannot get paid for the travel time to and from his or her own home to any IHSS recipient's location.<sup>599</sup> Providers of multiple recipients can claim travel time electronically through the ESP. If preferred, providers can instead complete form SOC 2255 (IHSS Program Provider Workweek & Travel Time Agreement) and submit it to the local IHSS office. To be compensated for their travel time, providers must either submit their travel time electronically or via the paper form.<sup>600</sup>

### 5.4 Medical Accompaniment and Wait Time

Providers can be paid for transportation when the IHSS recipient needs the assistance for travel to access health-related appointments or an alternative care site. Transportation is generally not covered unless the recipient requires assistance with an authorized IHSS task during travel or at the destination.<sup>601</sup> However, when the presence of the provider is needed to allow the recipient to accomplish the travel because the recipient has documented disability that prevents them from entering public spaces alone, accompaniment will be covered even if the travel is not needed to access a separate IHSS service.<sup>602</sup>

Providers can also be paid for time spent waiting at medical appointments.<sup>603</sup> This change went into effect on February 1, 2016, after the United States Department of Labor published its final rule related to the Fair Labor Standards Act for Domestic Services.<sup>604</sup> In order to be paid for wait time, the provider must demonstrate that, while they are at a recipient's medical appointment, they are unable to leave because they cannot predict how long the recipient's appointment will take.<sup>605</sup> This time is called "engaged to wait" or "Wait Time—On Duty." The provider will also be paid if their presence is required for the recipient to remain at the appointment.<sup>606</sup>

Providers cannot otherwise be paid for time spent “waiting to be engaged,” otherwise known as “Wait Time—Off Duty.”<sup>607</sup> Off-duty wait time occurs when a provider does not have to perform work duties and may use the set time for their own purposes.<sup>608</sup> Providers must be told in advance that they may leave the location and will not have to resume work until a specific time. For example, if a provider accompanies their recipient to a treatment that is scheduled to last for three hours, the provider must be told that they do not have to wait, but must return in three hours to pick up the recipient. In this example, the provider is able to use that time for their own personal business and therefore would not be paid for that time.

If a recipient is authorized for medical accompaniment, the provider will be considered “off-duty” and will not be paid for any time spent waiting for the recipient, if all of the following conditions are met:

1. The amount of time the appointment will take is known in advance, which would allow the provider plenty of notice that they will not be needed to provide services during that time and which can then be used for their own purposes; and
2. The appointment is scheduled to last enough time for the provider to conduct personal business; and
3. The provider is not required to perform any other authorized service such as food shopping or other shopping/errands during the appointment time.<sup>609</sup>

If all of the above conditions are met, then the provider must be informed by the recipient that they do not have to work until a specified time when they must return to accompany the recipient home and will not be compensated for this time. If all of the above conditions are NOT met, the provider is considered “on-duty,” and must be paid for the time spent waiting for the recipient.<sup>610</sup>

## 5.5 Medical Accompaniment and Wait Time for Minors

While CDSS considers taking a child to a medical appointment part of the parent or parents’ “typical” responsibilities, in some circumstances, parents can be paid for time required to take their minor child to a medical appointment, and for wait time. Specifically, CDSS evaluates three criteria to determine whether accompaniment for a minor recipient is reimbursable: (1) the minor has an extraordinary assessment need; (2) the appointment must be with a licensed health care professional in a specialty care field; and (3) the minor must require IHSS services to or from the medical appointment. For more detailed information, see All County Letter 17-42.<sup>611</sup>

## 5.6 Overtime and Travel Time Violations

Providers can be penalized for failing to adhere to the overtime and travel time rules.<sup>612</sup> If a provider submits a timesheet that reports hours above the workweek overtime limits or the travel time limits, the provider will incur a violation.<sup>613</sup> There are escalating consequences for each violation. First and second violations result in a written warning. A third violation in a three-month suspension from work in the IHSS program and a fourth violation results in a one-year suspension from the IHSS program.<sup>614</sup> Providers are given an opportunity to cure one violation by reading training materials after the second violation. A provider can only accrue one violation per month even though there are two pay periods each month.

A violation accrues each time any of the following occurs:

- » A provider works more than 40 hours in a workweek for a recipient without the recipient getting approval from the county when that recipient is authorized less than 40 hours in a workweek;
- » A provider works more hours for his/her recipient than he/she is authorized for in a workweek, which causes the provider to work more overtime hours than normal that month;
- » A provider works for multiple recipients and claims more than 66 hours in a workweek;
- » More than seven (7) hours of travel time is claimed in a workweek.<sup>615</sup>

Given the seriousness of the penalties for violating the overtime and/or travel time rules, CDSS has created processes for counties to ensure violations are correctly determined.<sup>616</sup> CDSS has created processes for county reviews of decisions and providers seeking to challenge a violation decision at the county level should use form SOC 2272 (IHSS Program Notice to Provider of Right to Dispute Violation for Exceeding Workweek and/or Travel Time Limits).<sup>617</sup>

Additionally, if a provider disagrees with a county's decision to uphold a third or fourth violation, the provider has the right to appeal the decision to CDSS Adult Programs Division's Appeals Unit.<sup>618</sup> To appeal a third or fourth level violation to the Appeals Unit, a provider must submit form SOC 2273 (IHSS Program State Administration Review Request of Third or Fourth Violation for Exceeding Workweek and/or Travel Time Limits).<sup>619</sup> The appeal must be postmarked within 10 calendar days from the date on the SOC 2282 or 2284.<sup>620</sup> CDSS Appeals Unit has 15 days to make its decision.<sup>621</sup>

For more information about the consequences for each violation, and tips on how to avoid them, CDSS has created timesheet violation learning modules.<sup>622</sup>

# Chapter 6 Endnotes

- 508 California Department of Social Services (“CDSS”), [“Local Assistance Estimate Methodologies, 2019-20 Governor’s Budget”](#), at pg. 224.
- 509 Laurel Beck, [“Just the Facts: California’s In-Home Support Program”](#), Public Policy Institute of California (November 2015).
- 510 Sarah Thomason & Annette Bernhardt, [“California’s Homecare Crisis: Raising Wages is Key to the Solution”](#), UC Berkeley Labor Center, (November 2017), at pg. 3.
- 511 *Id.* at pg. 6.
- 512 See [CDSS Manual of Policies and Procedures \(“MPP”\) § 30-776.4](#).
- 513 CDSS, [All County Letter \(“ACL”\) 19-14](#) (February 7, 2019).
- 514 *Id.*
- 515 [MPP § 30-776.2](#). A complete copy of the four-step process is available online at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC847.pdf>.
- 516 [MPP § 30-776.413](#). Blank copies of Form [SOC 426](#) are available at the County IHSS Office, Public Authority, or online [here](#).
- 517 [MPP § 30-776.411\(a\)](#).
- 518 [MPP § 30-776.411\(6\)](#); see also, [MPP § 30-776.411\(l\)\(4\)](#).
- 519 [MPP § 30-776.414](#).
- 520 [MPP § 30-776.414\(a\),\(b\)](#). Examples of acceptable identification include: a driver license or identification card issued by a state department of motor vehicles, U.S. passport, U.S. military identification card, or a Native American or Alaskan Native tribal identification card.
- 521 [MPP § 30-776.414\(b\)](#).
- 522 [MPP § 30-776.414\(b\)\(1\)](#).
- 523 [MPP § 30-776.441](#); .44.
- 524 [MPP § 30-776.53](#).
- 525 [MPP § 30-776.442](#).
- 526 [MPP § 30-776.42](#).
- 527 [MPP § 30-776.43](#).
- 528 [MPP § 30-776.441](#).
- 529 [MPP § 30-701\(t\)\(1\)\(A\)](#).
- 530 [MPP § 30-701\(t\)\(1\)\(B\)](#). Penal Code § 273a(a) includes “any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of that child to be injured, or willfully causes or permits that child to be placed in a situation where his or her person or health is endangered...”

- 531 [MPP § 30-701\(t\)\(1\)\(C\)](#). Penal Code § 368 includes “any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered...”
- 532 See [MPP § 30-776.411\(l\)\(5\)\(A\)](#).
- 533 CDSS, “[Tier 2 Exclusionary Crimes](#)”, (last visited Aug. 6, 2025).
- 534 [MPP § 30-701\(t\)\(2\)\(A\)](#).
- 535 [MPP § 30-701\(t\)\(2\)\(B\)](#).
- 536 [MPP § 30-701\(t\)\(2\)\(C\)](#). Felony offense for fraud is defined in WIC § 10980(c)(2) and 10980(g)(2).
- 537 [ACL 19-14](#) (February 7, 2019).
- 538 *Id.*
- 539 CDSS, Form [SOC 847](#).
- 540 See California Association of Public Authorities for In-Home Supportive Services (CAPA), [County Public Authorities](#), (last visited 10/23/2025).
- 541 CDSS, “[In-Home Supportive Services \(IHSS\) Fact Sheets](#)” (last visited Aug 6, 2025).
- 542 CDSS, IHSS Training Academy, “Deciding When to Fire a Provider”.
- 543 Welf. & Inst. Code §123005 and §12300.6; [ACL No. 22-65](#), (Aug. 2, 2022).
- 544 *Id.*
- 545 Urgent need is defined as one that is “immediate and cannot be postponed until the provider is available to provide the need,” and “has a direct impact upon the IHSS recipient and delaying the need would potentially jeopardize the health and/or safety of the IHSS recipient and may result in the need for emergency services and/or out-of-home placement.” [ACL No. 22-65](#); [ACL No. 16-01](#).
- 546 See CDSS, [IHSS Share-of-Cost](#); CDSS, IHSS Training Academy “[Share-of-Cost](#)”.
- 547 Welf. & Inst. Code § 12304; [MPP § 30-767.133](#).
- 548 42 C.F.R. § 441.545(b)(2) allows for advance payment of direct cash to individuals in the CFCO program. The CFCO program allows the Advance Pay recipient to further exercise their self-discretion by making a direct payment to their provider. CFCO also allows these recipients to exercise as much control as desired to select, train, supervise, schedule, determine duties, and fire an attendant care provider.
- 549 Welf. & Inst. Code § 12304(d); [MPP § 30-701\(s\)\(1\)](#).
- 550 Welf. & Inst. Code § 12304(a).
- 551 Welf. & Inst. Code § 12304(b).
- 552 [MPP § 30-769.737](#).
- 553 [MPP § 30-767.133](#).

- 554 ACL 24-38, (Jun. 6, 2024).
- 555 See UDW, "[How do I get my IHSS timesheet and paycheck](#)".  
CDSS, "[Online Direct Deposit Service](#)" (last visited Feb 19, 2026).
- 556 CDSS, Form [SOC 831](#).
- 557 CDSS, Form [SOC 829 IHSS Direct Deposit Enrollment/Change/Cancellation Form](#).
- 558 Internal Revenue Code § 131; [IRS Notice 2014-7](#). See also [Franchise Tax Board, In-Home Supportive Services: Personal Income Types](#), (last visited Oct. 23, 2025); CDSS, "Live-In Provider Self-Certification Information" (last visited Aug. 6, 2025).
- 559 CDSS, Form [SOC 2298](#).
- 560 [MPP § 30-776.431\(c\)](#).
- 561 [MPP § 30-701\(p\)\(2\)](#).
- 562 *Id.*
- 563 *Id.*
- 564 A provider should use the information provided by Form [SOC 2271](#), which explains the total number of authorized hours for their recipient and the maximum weekly hours to fill out a blank calendar to ensure they understand how many hours they may work each week. The provider can use this information to discuss their schedule with their recipient.
- 565 [ACL 17-76](#) (July 14, 2017).
- 566 [ACL 20-04](#), (Jan 6, 2020).
- 567 [ACL 17-76](#) at 2.
- 568 *Id.*
- 569 [ACL 20-04](#), (Jan. 6, 2020); [ACIN I-03-21](#), (Jan. 11, 2021); ACIN [I-34-23](#), (Jun 28, 2023).
- 570 *Id.*
- 571 *Id.*
- 572 *Id.*
- 573 [CDSS, Electronic Services Portal](#) (last visited Aug. 6, 2025); [Electronic Visit Verification](#), (last visited Oct. 28, 2025); [Live-In Provider Self-Certification Information](#), (last visited Oct. 28, 2025).
- 574 [ACL 16-01](#) (January 7, 2016).
- 575 Welf. & Inst. Code § 12300.4.
- 576 Welf. & Inst. Code §§ 12300.4(d)(3); 14132.99(d)(1)(B)(2).
- 577 Welf. & Inst. Code § 12300.4(d)(3).
- 578 *Id.*
- 579 Welf. & Inst. Code § 12300.4(d)(3)(C)

580 Welf. & Inst. Code § 12300.4(d)(3)(A).

581 CDSS, Form SOC 2279.

582 Welf. & Inst. Code § 12300.4(d)(3)(B); [ACL 18-31](#) (March 22, 2018).

583 Welf. & Inst. Code §12300.4(d)(3)(E)(i).

584 [ACL 18-31](#) (March 22, 2018).

585 Disability Rights California (“DRC”), “[Recent Changes to In-Home Supportive Services and Waiver Personal Care Services Workweek Exemptions for Providers](#)” (Mar. 1, 2019).

586 Welf. & Inst. Code §12300.4(d)(3)(E).

587 Welf. & Inst. Code §12300.4(d)(3)(E)(iii)(I).

588 [ACL 18-58](#) (May 31, 2018).

589 *Id.*

590 *Id.* at 4.

591 *Id.*

592 *Id.*

593 *Id.* at 5.

594 *Id.*

595 *Id.*

596 Welf. & Inst. Code §12300.4(f)(1); *See also* [ACL 16-01](#) (January 7, 2016).

597 *Id.*

598 Welf. & Inst. Code §12300.4(f)(4); [ACL 16-01](#).

599 [ACL 16-01](#) at 13.

600 *Id.* at 14.

601 [ACL 17-42](#), (June 23, 2017).

602 [ACL 20-35](#), (May 8, 2020).

603 Welf. & Inst. Code § 12301.24(a)(6); [ACL 16-01](#) at 14.

604 *Id.*; [ACL 16-01](#) at 2.

605 [ACL 16-01](#) at 14-15.

606 [ACL 20-35](#), (May 8, 2020).

607 *Id.* at 15.

608 *Id.*

609 *Id.*

- 610 *Id.*
- 611 [ACL 17-42](#) (June 23, 2017).
- 612 Welf. & Inst. Code § 12300.4(b)(5); [ACL 16-01](#); [ACL 16-36](#) (April 21, 2016).
- 613 *Id.*
- 614 See Form [SOC 846 \(11/15\)](#), pg. 4 for an explanation of consequences of each violation.
- 615 [ACL 16-01](#).
- 616 [ACL 16-44](#) (May 10, 2016)
- 617 Form [SOC 2272 \(5/16\)](#).
- 618 *Id.*; [ACL 16-46](#) (May 16, 2016).
- 619 Form [SOC 2273](#).
- 620 [ACL 16-46](#) at 9.
- 621 *Id.*
- 622 CDSS, "[IHSS Timesheet Training Series](#)" (last visited Aug. 6, 2025); see also ACIN [I-16-23](#), (May 23, 2023).

# Chapter 7: Post-Eligibility Issues

This chapter will provide an overview of post-eligibility IHSS issues. There are eight sections: (1) Annual Reassessments (2) Change of Circumstance Reassessments; (3) Inter-County Transfers; (4) Overpayments; (5) Institutional Placement and its Effect on IHSS; (6) County Social Worker Issues; (7) Third Party Liability; and (8) Estate Recovery.

## 1. ANNUAL REASSESSMENTS

The county welfare department must generally conduct a reassessment of a recipient's need "prior to the end of the twelfth calendar month from the last face-to-face assessment."<sup>623</sup> The county may extend this reassessment to 18-months and must offer telehealth reassessments if the recipient meets specific criteria, which focuses on the stability of the recipient's circumstances.<sup>624</sup> This provision can be used to lessen the frequency of reassessments for some IHSS recipients. Conversely, the county may shorten the length of time between assessments if it has information that the recipient's need for IHSS is likely to decrease in less than 12 months.<sup>625</sup> Recipients with disabilities or conditions that are expected to improve or decline within a year may find the county conducting more frequent assessments.

A recipient is not required to provide a new health care certification form (SOC 873) at each subsequent reassessment.<sup>626</sup> However, if determined necessary, the county can request a new SOC 821 form (Assessment of Need for Protective Supervision for IHSS) from a recipient who receives protective supervision.<sup>627</sup> The county may also request a new SOC 321 (Request for Order and Consent-Paramedical Services) if a recipient needs additional paramedical services that were not authorized by the previous form.<sup>628</sup>

If the county performs a reassessment before the twelfth calendar month, the time for the next reassessment shall be adjusted to the 12-month requirement.<sup>629</sup> This means that if a recipient is normally assessed in January, but has a reassessment in April, the next annual reassessment should happen in April of the following year. This helps ensure that recipients are not constantly being reassessed especially after a change of circumstances reassessment or a reassessment ordered as part of a hearing decision or conditional withdrawal.

## 2. CHANGE OF CIRCUMSTANCE REASSESSMENTS

As discussed above, an IHSS recipient's eligibility for services is typically reassessed annually. However, when a recipient experiences a change of circumstances that requires an adjustment in their IHSS services, they have the right to request a reassessment at any time.<sup>630</sup> A change of circumstances can relate to a change in a recipient's functional needs, living arrangement, or the severity of their condition or disability. A recipient is not required to submit a new health care certification form to show or verify a change of circumstances.<sup>631</sup>

Unfortunately, although the county is required to perform a reassessment, there is no fixed mandated timeline. However, if a recipient has requested a reassessment due to a change of circumstances and the county has failed to set a date for the in-home assessment or has delayed issuing the new Notice of Action, the recipient has the right to file for an administrative law judge hearing at any time.<sup>632</sup> See Chapter 8 for more information about Hearings and Appeals.

It should be noted that a reassessment based on a change in circumstances does not guarantee additional hours. The social worker could find the recipient's needs have not changed in a way that affects their IHSS hours or could find that a decrease in hours is appropriate. If the reassessment does not result in an appropriate number of hours to ensure the recipient can remain safely at home, the recipient has the right to file for an administrative law judge hearing to challenge the reassessment.<sup>633</sup>

### **3. INTER-COUNTY TRANSFERS**

If a recipient moves from one county into another county, while enrolled in the IHSS program, their IHSS case will need to be transferred from the "transferring county" to the "receiving county."<sup>634</sup> The transferring county (i.e. the county of origin) is responsible for initiating the intercounty transfer once they have been informed of the recipient's move to a new county.<sup>635</sup> The transferring county must send to the receiving county a notice of transfer<sup>636</sup> and additional documents within 10 days of notification of the move.<sup>637</sup>

The receiving county is responsible for completing and returning the notification of transfer form within 30 days of receipt.<sup>638</sup> The transferring county is responsible for following up if they have not received the form from the receiving county.<sup>639</sup> This transition time is known as the transfer period.<sup>640</sup> The transferring county is responsible for authorizing and funding services until the transfer period expires.<sup>641</sup> The transfer period "shall end as soon as administratively possible but no later than the first day of the month following 30 calendar days after the notification of transfer form is sent to the receiving county or as allowed in Section 30-759.96."<sup>642</sup>

The intercounty transfer shall not interrupt or cause an overlap of recipient's IHSS services.<sup>643</sup> A recipient should continue to use their IHSS hours throughout the transfer period and their provider should continue to submit their timesheets for any work performed.

The receiving county is required to complete a face-to-face assessment with the recipient during the transfer period.<sup>644</sup> This assessment can result in a change of hours for the recipient. The most likely reason for a change in the recipient's hours is the change in the living arrangement. For example, if a recipient lived alone in the transferring county, but is moving in with a roommate in the receiving county that could have an effect on their IHSS hours. Additionally, and sometimes more problematically, the receiving county can disagree with the transferring county's assessment of the recipient's needs.

**PRACTICE TIP:** It is important to scrutinize any decrease in hours to determine if the receiving county is inappropriately disregarding the assessments of the transferring county. The receiving county should not determine the recipient's hours as if they are a new applicant, but instead should only change hours if there has been a change in circumstances or a medical improvement.<sup>645</sup>

## **4. OVERPAYMENTS**

The state requires counties to respond to and resolve potential IHSS overpayments.<sup>646</sup> An IHSS overpayment is defined as the amount of aid paid by the Department of Social Services or the Department of Health Care Services to a provider or recipient that exceeds the amount of services authorized or furnished.<sup>647</sup> Overpayments may be collected from either the recipient or the provider depending on who received the IHSS funds.<sup>648</sup>

The specific rules governing overpayments are dependent on whether the IHSS program is funded through federal Medicaid dollars or through state and county only dollars. Approximately 99% of IHSS recipients receive IHSS linked to federal financial participation Medicaid. The state Medi-Cal regulations governing overpayments state that a potential overpayment occurs when:

- A beneficiary has been informed verbally and in writing about their responsibility to completely and accurately report changes that would affect eligibility or share of cost within 10 days;
- A beneficiary has completed and signed the appropriate paperwork and has, within their competence, done any of the following, which when considered in conjunction with other information available on the beneficiary's circumstances would result in ineligibility or an increased share of cost:
  - » Provided incorrect written or oral information;
  - » Failed to provide required information that affects eligibility or share of cost;
  - » Failed to report changes in circumstances that affect eligibility or share of cost.<sup>649</sup>

In the IHSS program, an overpayment can occur because of an underlying issue with the beneficiary's Medi-Cal eligibility or because of an issue directly related to IHSS eligibility. In either situation, overpayments cannot be assessed if the beneficiary informed the county about a change in circumstances, but the county failed to make the change.<sup>650</sup>

Overpayments in the IHSS-Residual (IHSS-R) program are not governed by Medicaid rules. Instead, the Department of Social Services has promulgated specific overpayment regulations.<sup>651</sup> An IHSS-R overpayment is defined as a "cash payment [that] was made for the purchase of IHSS or services were delivered in an amount to which the recipient was not entitled."<sup>652</sup>

Under no IHSS program will a payment made while a beneficiary is receiving aid paid pending an administrative law judge hearing be considered an overpayment.<sup>653</sup> This means a beneficiary can continue to use their IHSS services while waiting for their hearing without fear of having to repay those costs if they lose. Once an administrative law judge has issued a decision, however, the recipient must abide by that decision unless it is overturned at a rehearing or by writ.

## **5. INSTITUTIONAL PLACEMENT AND ITS EFFECT ON IHSS**

An individual cannot receive IHSS while in an out-of-home setting.<sup>654</sup> Out-of-home settings include acute care hospitals, skilled nursing facilities, intermediate care facilities, community care facilities, and board and care facilities.<sup>655</sup>

If an individual who is authorized to receive IHSS goes into an institutional setting, their overall eligibility for IHSS is not immediately affected. They should not, however, use services or sign a timesheet that authorizes payment for the days they stayed in the out-of-home setting. This is true even if the individual or the provider do not think the individual is receiving the necessary assistance with their personal care needs at the out-of-home setting.

Individuals who enter an out-of-home setting must inform the county welfare department of this change of circumstance within 10 days if it is material to their eligibility and level of need.<sup>656</sup> The longer the stay in the out-of-home setting, the more likely it will affect an individual's eligibility for IHSS. For example, it is not necessary to inform the county welfare department about a three-day stay in the hospital, but becomes necessary if that three-day stay is followed by a month in a skilled nursing facility.

If an individual is moving out of their own home and into an out-of-home setting permanently, they will no longer be eligible for IHSS.<sup>657</sup> However, if circumstances change and the individual can live safely at home again, the county must assess the individual's IHSS eligibility pursuant to the discharge rules.<sup>658</sup> For more information on these rules, see Chapter 2.

## **6. COUNTY SOCIAL WORKER ISSUES**

The IHSS program refers to its eligibility workers as county social workers. A county social worker is responsible for assessing an applicant's initial need for IHSS and for conducting reassessments for current recipients. There are times when an applicant or recipient may run into a problem or disagreement with their county social worker. Complaints about social worker behavior may not be adjudicated through the state hearing process.<sup>659</sup>

### **6.1 Discrimination Complaints**

If a recipient believes they are being illegally discriminated against by their county social worker, they have three administrative complaint options:

1. The recipient can talk to their county welfare department’s civil rights representative.<sup>660</sup> The complainant must contact their county civil rights representative within 180 days from the date of the alleged discrimination and provide information about what type of discrimination occurred, the name of the social worker, and the facts surrounding the incident(s). If the representative fails to resolve the complaint in a satisfactory manner, the complainant can request an investigation. The county is required to investigate and provide the complainant with information about the resolution of the case.
2. The recipient can file a discrimination complaint through the California Department of Social Services by mail, email, fax, or phone.<sup>661</sup> The CDSS website also provides links in 15 languages to ensure broad access to the complaint process.<sup>662</sup>
3. The recipient can file a federal discrimination complaint through the U.S. Department of Health and Human Services by sending a letter to:



Centralized Case Management Operations  
 U.S. Department of Health and Human Services  
 200 Independence Avenue, S.W> Room 509F HHH Bldg.  
 Washington, D.C. 20201  
 Or by email to [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov).<sup>663</sup>

## 6.2 Customer Service Issues and Requesting a new IHSS Social Worker

If you believe that your IHSS social worker has behaved in an unprofessional or inappropriate way, you can contact your IHSS social worker’s supervisor for assistance or to file a complaint. You may also request a new IHSS social worker. If the county does not have another IHSS social worker available it can assign to you, the county may deny your request. If the county has an IHSS social worker available, it may assign you a new IHSS social worker. If the county refuses to assign you a new IHSS social worker, you can contact the [California Department of Social Services, Adult Programs](#) at: 916-651-8848. You may also contact your local board of supervisors for help with obtaining a new IHSS social worker.<sup>664</sup>

## 7. THIRD PARTY LIABILITY

County welfare departments are required to identify any third parties that have obligations to pay for supportive services similar to IHSS.<sup>665</sup> These third parties include but are not limited to: long-term care insurance, worker’s compensation insurance, victim compensation program payments, and civil judgment/pending litigation.<sup>666</sup> If the county determines that there is a potential source of third-party liability, the county must make the appropriate referrals.<sup>667</sup>

## **8. ESTATE RECOVERY**

California is required by federal law to seek estate recovery from certain Medi-Cal beneficiaries if they used specific Medi-Cal services.<sup>668</sup> Prior to 2017, California's estate recovery law extended estate recovery to a wider array of Medi-Cal services than is required under federal law. However, this changed with the passage of SB 833 in 2016—for deaths that occur on or after January 1, 2017, California conformed its estate recovery law to the minimum required by federal law.<sup>669</sup>

As a part of this change, receipt of IHSS services was exempted from estate recovery.<sup>670</sup> This means that the State cannot seek to collect reimbursement for IHSS services provided during a person's life.<sup>671</sup> Institutional long-term care and certain other home and community-based services are subject to estate recovery.<sup>672</sup>

An exploration of all the estate recovery rules is beyond the scope of this manual, however, CANHR (California Advocates for Nursing Home Reform) has created two helpful FAQs explaining the estate recovery rules in detail for those who died before January 1, 2017 and those who died on or after January 1, 2017.<sup>673</sup>

# Chapter 7 Endnotes

- 623 Cal. Welf. and Inst. Code § 12301.1(b)(1); [MPP § 30-761.212](#).
- 624 Cal. Welf. and Inst. Code § 12301.1(c) ; § 12300.2; [MPP § 30-761.215\(a\)-\(h\)](#); see also [MPP §§ 30-761.216-17](#); [ACL 24-72](#), (Oct. 8, 2024).
- 625 Cal. Welf. and Inst. Code § 12301.1(c)(3); [MPP § 30-761.218](#).
- 626 [MPP § 30-754.13](#).
- 627 Cal. Welf. and Inst. Code § 12301.21(c); [MPP § 30-757.173\(b\)](#); California Dept. of Social Services (“CDSS”), Form.
- 628 CDSS, Form SOC 321.
- 629 [MPP § 30-761.212\(a\)](#).
- 630 Cal. Welf. and Inst. Code § 12301.1(d); [MPP § 30-761.219\(a\)](#).
- 631 [MPP § 30-754.13](#).
- 632 Cal. Welf. and Inst. Code § 10950; [MPP § 22-003.1](#).
- 633 *Id.*
- 634 [MPP § 30-701\(i\)](#).
- 635 [MPP § 30-759.9](#).
- 636 The California Welfare Director’s Association’s website has an [Intercounty Transfer form](#) that transferring counties can use.
- 637 [MPP § 30-759.91](#). [MPP § 30-759.911](#) specifies that the documents required in section 30-759.1 “include, but are not limited to, an application for In-Home Supportive Services ([SOC 295, 10/90](#)); the most recent IHSS assessment, an IHSS provider eligibility update, a personal care services program provider enrollment form (SOC 428, 5/90), if applicable; a paramedical authorization form ([SOC 321, 10/88](#)), if applicable; current NOAs, and any information pertaining to overpayments and fraud investigations, if applicable.” Please note that all the specific forms cited have more recent versions that must be used.
- 638 [MPP § 30-759.93](#).
- 639 [MPP § 30-759.931](#).
- 640 [MPP § 30-701\(i\)\(1\)\(C\)](#).
- 641 [MPP § 30-759.921](#).
- 642 [MPP § 30-701\(i\)\(1\)\(D\)](#); Section [30-759.96](#) provides that the transferring county shall retain responsibility for a recipient’s IHSS case if they are actively appealing an adverse action by the transferring county.
- 643 [MPP § 30-759.92](#).
- 644 [MPP § 30-759.94](#).
- 645 [MPP § 30-759.5](#).
- 646 Cal. Welf. & Inst. Code § 12305.71(c); [MPP § 30-702.16](#).

- 647 Cal. Welf. & Inst. Code § 12305.8(b).
- 648 See *Id.*; Cal. Welf. & Inst. Code § 12305.83.
- 649 Cal. Code Regs., tit. 22, § 50781.
- 650 *Id.*
- 651 [MPP § 30-768](#).
- 652 [MPP § 30-768.11](#).
- 653 For IHSS-R, see [MPP § 30-768.111](#); for all other IHSS programs, see [MPP §§ 22-072; 22-073](#).
- 654 [MPP § 30-701\(o\)\(2\)](#).
- 655 [MPP § 30-701\(o\)\(1\)](#).
- 656 [MPP § 30-760.14,.15](#).
- 657 [MPP § 30-755.1](#).
- 658 [MPP § 30-755.12](#); [ACIN I-67-23](#), (Dec. 7, 2023).
- 659 [MPP § 22-003.13](#).
- 660 CDSS, "[Discrimination and Retaliation Complaints](#)" (last visited Aug. 6, 2025).
- 661 *Id.*
- 662 *Id.*; CDSS has links to English, Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Lao, Portuguese, Russian, Spanish, Tagalog, Ukrainian, and Vietnamese.
- 663 *Id.*
- 664 For more, see DRC, [IHSS, Disagreements, Complaints and Requesting a New IHSS Social Worker](#), (Oct. 1, 2020).
- 665 Cal. Welf. & Inst. Code §§ 12300(d)(1)(employer responsibilities when IHSS is provided at places of employment); 12305.71(c)(1),(2)(general quality assurance responsibility to identify sources of third party liability).
- 666 [MPP § 30-702.17](#).
- 667 *Id.*
- 668 42 U.S.C. § 1396p(b)(1).
- 669 Cal. Welf. & Inst. Code § 14009.5; See also DHCS, "[Changes to Estate Recovery effective January 1, 2017 due to legislation SB 833](#)".
- 670 *Id.*
- 671 *Id.*
- 672 42 U.S.C. § 1396p(b)(1); Cal. Welf. & Inst. Code § 14009.5.
- 673 CANHR, "[California's Medi-Cal Recovery Program - Frequently Asked Questions](#)" (last updated June 23, 2025).

# Chapter 8: Appeals and Hearings

IHSS recipients and applicants have the right to challenge a county's decision to deny, change, or terminate their IHSS benefits by filing an administrative appeal. This chapter provides information about IHSS administrative appeals and hearings. There are nine sections: (1) Appeals Basics; (2) Adequate Notice; (3) Deadlines; (4) Requesting a Hearing; (5) Authorized Representatives; (6) Before the Hearing; (7) Preparing for the Hearing; (8) At the Hearing; and (9) Decisions, Rehearings and Administrative Writs.

## 1. APPEALS BASICS

An individual has the right to an impartial hearing if they disagree with any action by the county relating to their IHSS benefits, including: a denial, reduction, or termination of services; if their application is not acted upon with reasonable promptness; if they were not awarded all of the hours they think they need; and if needed services, such as protective supervision, are not awarded.<sup>674</sup> An appeal is a formal request by an applicant or recipient for a third party adjudicator, specifically an Administrative Law Judge (ALJ), to determine whether the county made the correct determination. If the county later agrees it made a mistake, or the ALJ finds that the county made the wrong decision, the county must correct its mistake.

An individual can appeal by phone, in person, or in writing. It is helpful to make the appeal in writing and keep a copy of the request.

The Department of Health Care Services has contracted with the California Department of Social Services to provide for state fair hearings.<sup>675</sup> The state Hearings Division (SHD) is responsible for the overall administration of the hearing process, including processing hearing requests and providing support.<sup>676</sup> The SHD is a state agency overseen by the California Department of Social Services (CDSS).

Once an applicant or recipient requests a hearing, they are called a "claimant." The county social services agency (also known as the county welfare department or CWD) then assigns an Appeals Specialist from the county's appeals unit, which is a department within the CWD to the matter.<sup>677</sup> Appeals Specialists are sometimes called Appeals Workers or county representatives. The Appeals Specialist represents the county and gathers information to prepare for the hearing, and should attempt to resolve the issue prior to a hearing.

If the Appeals Specialist is unable to resolve the issue with the claimant, then the claimant attends a hearing and presents their issues to the ALJ. The ALJ then issues a decision either agreeing with the claimant in whole, or in part, or upholding the county action. However, the Director of CDSS has the authority to set aside, or overturn, the ALJ's ruling.<sup>678</sup> If the recipient is unhappy with the ALJ or the Director's decision, they can file for a rehearing,<sup>679</sup> or file an Administrative Writ in Superior Court.<sup>680</sup> Both rehearing's and writs are discussed in more detail in section 9 of this chapter.

## 2. ADEQUATE NOTICE

The County must send adequate notice in the form of a Notice of Action (NOA) to tell a recipient when there is a change in their IHSS services.<sup>681</sup> The notice must include the following:

- » The action the county intends to take,
- » The reasons for that action,
- » The specific regulations supporting the action,
- » An explanation of the right to request a hearing, and, if appropriate,
- » The circumstances under which aid will be continued if a hearing is requested (this is also called "Aid Paid Pending," which is discussed later in section 3).<sup>682</sup>

In addition, the notice must also tell the recipient what, if any, information the county still needs, and what the claimant must do to reestablish eligibility for IHSS or to determine the correct number of IHSS hours for a claimant.<sup>683</sup>

The NOA must also be written in the primary language of the recipient, if the language is listed in the translated forms on the CDSS website.<sup>684</sup> This is known as a "language compliant" notice. If CDSS cannot provide a NOA written in the claimant's primary language, the county must offer and provide interpretive services for the NOA if: (1) the claimant tells the county that they need an interpreter within 90 days of the date on the NOA, or (2) the claimant already told the county that they wanted notices in their primary language and tells the county within 90 days of the date on the NOA.<sup>685</sup>

A NOA is considered "timely," if it is mailed at least 10 days before the effective date of the action.<sup>686</sup> The 10 days does not include the date of mailing or the date that the action is to take effect.<sup>687</sup> The "effective date" is the date that the changes in IHSS services will take effect. For example, if an action will be effective on November 1, then a timely notice must be sent by October 20.

If the county does not send adequate notice, the recipient can still file an appeal. Once an appeal is filed, the claimant can explain the NOA's deficiency to the Appeals Specialist and, if necessary, the ALJ at the hearing.<sup>688</sup> The Appeals Specialist and the ALJ will then look at the NOA and determine whether it meets the requirements for adequate notice. If the ALJ finds that adequate notice was required but not provided, and the case involves a termination, or reduction, of IHSS hours, then the county must restore the services back to the effective date on the NOA pending a hearing decision.<sup>689</sup> If the notice is defective, the claimant can agree either to postpone the hearing until the county sends a proper NOA, or go ahead with the hearing without requesting proper notice.<sup>690</sup> If the ALJ determines that adequate and language compliant notice was provided, then the claimant must go ahead with the hearing, or the case will be dismissed.<sup>691</sup>

**PRACTICE TIP:** Inadequate notice should be raised as a violation of the claimant’s due process rights, although practically speaking, it will most likely not have any effect on the substantive decision. However, claimants may also raise the issue of inadequate notice to prevent the county from raising issues at the hearing that were not contained in the notice. In addition, if it is determined that adequate notice was not provided, the county must rescind the notice and send a new one, and the claimant’s deadline for aid paid pending will be extended.

### **3. APPEALS DEADLINES**

Generally an appeal, also called a hearing request, must be filed within 90 calendar days after an adequate and language-compliant NOA was mailed by the county or given to the claimant.<sup>692</sup> If adequate notice or language-compliant notice was not provided, any hearing request will be accepted, even if it is made later than 90 days after the date the NOA was mailed by the county or given to the claimant.<sup>693</sup> Recipients should consider saving the envelope that the notice was mailed in because sometimes there is a significant difference between the date on the notice and the postmarked date.<sup>694</sup>

A recipient can request a hearing after the 90-day deadline has expired if good cause exists.<sup>695</sup> Good cause means “a substantial and compelling reason beyond the claimant’s control,” and considers the length of the delay, the diligence of the claimant making the request, and the potential prejudice to the other party.<sup>696</sup> The recipient or applicant’s inability to understand an adequate and language-compliant notice, in and of itself, does not constitute good cause.<sup>697</sup> However, it is important to determine whether an individual’s disability affected their ability to understand the notice and raise that issue, if relevant. A claimant filing a hearing request after the 90-day deadline with good cause must request the hearing within 180 days after the NOA was mailed by the county or given to the claimant.<sup>698</sup>

If the claimant is already receiving IHSS services, the request for appeal must be filed before the Notice of Action is effective to maintain their benefits while waiting for a hearing. If the request is filed within this period, their benefits will not change until there is a hearing and a decision is issued.<sup>699</sup> This is known as “aid paid pending.” If the hearing request is filed after the effective date, then the claimant will not continue receiving the same benefits while they wait for a hearing and decision. If the claimant withdraws or abandons<sup>700</sup> their hearing request, then aid paid pending ends.

If the recipient believes they have not been granted enough IHSS hours, they may challenge the county’s decision at any time. This can be useful if a recipient didn’t file an appeal at the time of a notice.<sup>701</sup> However, the ALJ may only review the 90-day period prior to the hearing request.<sup>702</sup> For example, if a claimant’s hours are reduced on January 1 and they file a hearing request on June 1 challenging that county decision, the ALJ may only consider retroactive restoration of the hours for March, April, and May. The claimant would not be able to restore hours for January and February.

## 4. REQUESTING A HEARING

A claimant can make a hearing request [on-line](#), over the phone, in person, or in writing.<sup>703</sup> If requesting a hearing in writing, the request can take any form, including completing the form on the back of the NOA, submitting a request online, or writing a letter.<sup>704</sup> The claimant can request assistance from the county in filling out the hearing request.<sup>705</sup> Although some counties accept hearing requests, it is generally best practice to send a hearing request directly to the state Hearing Division.<sup>706</sup> Written hearing requests can be faxed to **(833) 281-0905**, or mailed to the following address:



California Department of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, California 94244-2430

Written hearing requests should include the claimant's full name, address, telephone number, the name of the county involved, and an explanation of why a hearing is being requested. If a claimant requires a hearing over the phone or in their home,<sup>707</sup> or needs an interpreter at the hearing, they can include that information in their written request.<sup>708</sup> If asked, the county must provide a duplicate copy of the NOA if the back of that form is used to request a hearing.<sup>709</sup> A copy of the hearing request should be kept for the claimant's records.

If requesting a hearing by phone, the claimant can call (855) 743-8525 or (855) 795-0634.<sup>710</sup> For claimants with hearing impairments, the TDD number is (800) 952-8349. To request a hearing online, use [this website](#).<sup>711</sup>

After submitting a hearing request, claimants will receive two notices from the SHD. The first notice is a confirmation of the request for a hearing. The second notice will be mailed to both the claimant and the county and will contain the date, time, and place of the hearing and must be sent at least 10 days prior to the hearing.<sup>712</sup> However, both parties can agree to a shorter time period for notice.<sup>713</sup> If either the claimant or the county does not receive notice of the hearing at least 10 days prior to the hearing date, the hearing can be postponed if the claimant requests a postponement.<sup>714</sup>

**PRACTICE TIP:** Claimants sometimes receive notices of action reinstating benefits, which essentially reflect that they are receiving aid paid pending a hearing. Claimants should not assume that this notice means the appeal has been resolved. If a claimant is unsure why their benefits have been restored, they should call the county appeals specialist working on their case and inquire.

Claimants may also request an expedited hearing for urgent issues. Expedited hearings are scheduled 10 working days from the date the claimant's request for expedited hearing is received when the Presiding Judge finds it necessary to have an expedited hearing.<sup>715</sup> For expedited hearings, the ALJ must issue a decision within five working days from the date the record is closed.<sup>716</sup>

## **5. AUTHORIZED REPRESENTATIVES**

The claimant may authorize a person or organization to communicate with the Appeals Specialist and to represent them at the hearing.<sup>717</sup> The claimant can choose to authorize a lawyer, a friend, an advocate, or a family member. To do so, the claimant must sign and date an authorized representative form or a statement saying they are authorizing someone to act on their behalf.<sup>718</sup>

If a claimant has a conservator or has appointed an attorney-in-fact or agent through a durable power of attorney that individual can act as the authorized representative or appoint someone else to act on the claimant's behalf.<sup>719</sup>

A claimant may also appoint an authorized representative at their hearing by telling the ALJ that the person is authorized to represent them.<sup>720</sup> An authorized representative may represent the claimant at a hearing even if the claimant is not at the hearing and they do not have a signed authorization, as long as the ALJ determines that the claimant wishes to proceed with the hearing and an amended authorization is submitted after the hearing.<sup>721</sup>

If the claimant has not authorized a representative in writing and is not present at the hearing, an individual may still act as the authorized representative if: (1) the person is an attorney, and (2) the attorney states on the hearing record that the claimant is mentally competent and has authorized the attorney to act as the authorized representative regarding the issues at the hearing.<sup>722</sup> If the person is not an attorney, they may still act as an authorized representative if they affirm that (1) the claimant is mentally competent, and (2) the claimant has authorized them to act as the claimant's authorized representative.<sup>723</sup> If the proposed representative cannot affirm on the record that the claimant is mentally competent, or that the claimant has authorized them to act on the claimant's behalf, then the case will be dismissed.<sup>724</sup>

If the claimant is incompetent, and does not have a conservator or attorney-in-fact appointed through a durable power of attorney, the hearing may proceed at the ALJ's discretion if the person is a relative, or a person who has knowledge of the claimant's circumstances and who completed and signed the Statement of Facts on the claimant's behalf.<sup>725</sup>

## **6. BEFORE THE HEARING**

After the hearing request is filed, SHD sends the claimant information about their hearing rights, and the name, address, and phone number of the Appeals Specialist assigned to the case. The Appeals Specialist is required to resolve the issue without the need for a hearing and at the lowest level possible.<sup>726</sup>

The Appeals Specialist must provide claimants with information regarding the administrative process, including preparing a Statement of Position, which provides information regarding the action(s) taken by the county.<sup>727</sup> Information about the Statement of Position can be found later in this chapter, at Section 7(B).

## 6.1 Conditional Withdrawals

The Appeals Specialist may offer a “conditional withdrawal” of the claimant’s hearing request. This means that the claimant withdraws their hearing request on the condition that the county do something to fix the problem, such as conducting a reassessment to determine the claimant’s IHSS hours of need. Conditional withdrawals must be accompanied by an agreement signed by the claimant and the county.<sup>728</sup>

**PRACTICE TIP:** Although an Appeals Specialist may offer to remedy the issue without the need for a hearing, they might only authorize benefits from the date of the conditional withdrawal, and not the date of action the claimant is disputing. When agreeing to a conditional withdrawal, remember to request benefits retroactive to the date of action. Get this assurance in writing as part of the conditional withdrawal.

The conditional withdrawal must provide that the actions of both parties will be completed within 30 days from the date the conditional withdrawal is signed by both parties and received by the county.<sup>729</sup> The county then issues a new NOA for the redetermination. The claimant has the right to have their hearing rescheduled if they disagree with the new assessment or a decision not to authorize retroactive benefits. The claimant can reinstate the hearing request based on the new NOA, but the request for reinstatement must be made within 90 days.<sup>730</sup>

## 6.2 Postponements

Claimants may also request a postponement of the hearing. However, a claimant must show good cause for postponing the hearing and waive their right to a decision within 90 days if they receive a postponement.<sup>731</sup> Good cause includes, but is not limited to:

- » A death in the family.
- » Personal illness or injury.
- » Sudden and unexpected emergencies that prevent the claimant or the claimant’s authorized representative from appearing.
- » A conflicting court appearance that cannot be postponed.
- » The claimant contends that they are not adequately prepared to discuss the issues because they did not receive an adequate and/or language-compliant notice, and the ALJ determines that the required notice was not received.
- » The county does not make a position statement available to the claimant at least two working days prior to the date of the scheduled hearing, or the county has modified the position statement, and the claimant agrees that the ALJ can issue a decision at a later date.<sup>732</sup>

If a postponement is granted for good cause, then aid paid pending will continue until the next scheduled hearing date.<sup>733</sup> The county also has the right to request a postponement.<sup>734</sup> In addition, a hearing shall be postponed if either party has not received notice of the time and place of the hearing at least 10 days prior to the hearing and that party requests a postponement.<sup>735</sup> Any requests for postponements may not exceed 30 days.<sup>736</sup>

## **7. PREPARING FOR THE HEARING**

### **7.1 Requesting the IHSS File**

Upon request, the county must allow the claimant to examine their case file during regular working hours.<sup>737</sup> Prior to the hearing, the claimant should request to see their entire IHSS file. In addition, the claimant has the right to examine the information used by the county in making its decision to change, deny, or terminate the claimant's IHSS hours, including any policy materials and regulations.<sup>738</sup> If the claimant's IHSS hours were reduced, they should ask their IHSS worker for copies of the regulations listed on the NOA. These materials can help to determine whether a hearing should be requested, and to prepare for a scheduled hearing.

**PRACTICE TIP:** After a hearing request is made, request the IHSS case file from the claimant's IHSS social worker, and once it has been provided, request a postponement so the claimant has the opportunity to review the case file and gather necessary information.

### **7.2 Gathering Information**

In addition to requesting the claimant's IHSS case file, it is important to gather information about how the county IHSS social worker determined the hours for which the claimant was authorized.

1. Ask the claimant's social worker for a copy of the latest needs assessment forms. These county forms will include notes about why hours were or were not authorized or reduced. Also ask for a copy of the most recent SOC 293 needs assessment form. The SOC 293 form is on the IHSS case management system (CMIIPS) and includes information on the functional ranking of what the social worker believes the claimant can and cannot do. If the claimant is challenging a reduction in hours, ask for copies of both new and old county assessment forms and new and old SOC 293 forms.
2. Ask for a copy of the sheets in the file where notes were made about contacts and visits with the claimant over the last year.
3. Ask the claimant's social worker for copies of any doctor or medical reports in their file and for copies of any paramedical forms.

It is also helpful to have a letter or declaration from the claimant's physician or other treating professional explaining why the claimant requires IHSS services, and what services they need. The letter should outline the claimant's functional limitations, such as not being able to lift heavy items or bend over, or that the claimant requires assistance in remembering to take medications. The claimant should have the physician review any information provided to the county, check for accuracy and correct mistakes by obtaining current information about functional limitations. The claimant's physician should also explain any changes in the claimant's condition. If the condition varies on a day-to-day basis, the physician should determine the claimant's ranks based on the bad days. A supporting letter or declaration can also help establish the claimant's need for paramedical services. The claimant should tell the physician about what services IHSS provides so that the letter can explain what services the claimant needs in relation to their functional limitations.

If the claimant is contesting the denial or termination of protective supervision, the letter or declaration from their treating physician or mental health provider should explain that the claimant is non-self-directing and provide reasons and examples for that determination. The treating provider should also explain how the claimant's impaired memory or judgment, and confusion cause the claimant to engage in potentially dangerous activities or behaviors. Claimants contesting the denial or termination of protective supervision should also get an updated SOC 821 form, with as much detail as possible, from the treating provider. Although the SOC 821 provides supporting evidence of a claimant's need for protective supervision, it is not determinative and the county may use the SOC 821 in conjunction with other information about the claimant's needs.<sup>739</sup>

**PRACTICE TIP:** Physicians are often very busy and hard to reach. Drafting a letter on the physician's behalf, as outlined above, can be helpful. Be sure that everything is completely accurate, and provide the physician with time to review.

### 7.3 Self-Assessments

If the claimant is challenging a reduction in their IHSS hours, or disagrees with the social worker's assessment of the need for IHSS hours, it is helpful for the claimant to do a self-assessment. This will help the claimant figure out how many minutes/hours are needed in the respective categories, and will help rebut the county's determination. You can find a copy of a [self-assessment worksheet](#) on Disability Rights California's website, called "Fair Hearings Guide: How to Prepare for IHSS Terminations or Reductions in Hours."<sup>740</sup>

### 7.4 County's Statement of Position

The county must provide a copy of its Statement of Position at least two business days before the hearing.<sup>741</sup> The position statement is a document written by the Appeals Specialist that supports the county's decision to change or deny IHSS services. It should summarize all the facts of the case, including facts that are helpful to the claimant, and the regulatory justification for the county action.<sup>742</sup> It must include copies of documentary evidence and a list of witnesses whom

the county intends to use during the hearing.<sup>743</sup> The position statement can help the claimant identify other witnesses and evidence they might need to support their claims. If the county welfare department does not make the position statement available to the claimant at least two business days before the hearing, or if the county welfare department decides to modify the position statement after providing it to the claimant, the claimant will have good cause to postpone the hearing.<sup>744</sup> If the claimant requests a postponement on this basis, then aid paid pending will continue.<sup>745</sup>

The claimant can authorize the county to send them a copy of the position statement electronically or by mail.<sup>746</sup> However, in order to receive a copy of the position statement electronically, the claimant must authorize electronic transmission, and the county agency must be able to comply with all state and federal privacy laws in transmitting the document electronically.<sup>747</sup> If those two requirements are met, then the county welfare department must send the claimant the position statement at least two business days before the hearing.<sup>748</sup> Otherwise, the county welfare department can “choose whether to mail the position statement or make it available at the appropriate county welfare department.”<sup>749</sup> However, CDSS policy “encourages” counties to discuss with claimants how they prefer to receive the position statement.<sup>750</sup>

## **8. AT THE HEARING**

IHSS hearings are administrative hearings conducted by an ALJ in an impartial manner “in order to encourage free and open discussion by participants.”<sup>751</sup> An IHSS hearing is considered informal because the rules of evidence and civil procedure, are not strictly enforced.<sup>752</sup> However, all testimony, whether from the claimant, the county, or the claimant’s authorized representative, is still submitted under oath.<sup>753</sup>

When the hearing begins, the ALJ will ask the Appeals Specialist, to testify first and explain why the claimant’s hours were reduced or terminated, or why the claimant does not need additional hours. The Appeals Specialist may present evidence from the county, or have someone from the county testify, such as the social worker who conducted the assessment, the claimant’s IHSS case worker, or a supervisor. When the Appeals Specialist has finished their explanation, the ALJ will have the claimant explain why they believe the county made the wrong decision. The claimant can submit documents to the ALJ as evidence, ask the county questions or have someone testify on their behalf.

The hearing will involve the presentation of evidence (testimony by witnesses, letters, diary log, medical reports) about the claimant’s needs in the service category areas where the claimant and the county disagree. The evidence should explain what the claimant needs, how long it takes to provide the service, the reason the claimant needs more time than that set out in the assessment or the county guidelines, and what risks the claimant may be exposed to if they do not receive the level of services requested. Witnesses may include — in addition to the IHSS recipient — past and present IHSS providers, regional center case managers, friends and family, etc.

The hearing will be recorded.<sup>754</sup> Speak clearly and loudly to ensure everything is recorded. The transcript can be important when there is an unfavorable decision and the claimant files an Administrative Writ in Superior Court, discussed below.

## **9. DECISIONS, REHEARINGS, AND ADMINISTRATIVE WRITS**

The ALJ will issue a decision within 90 days of the conclusion of the hearing, unless a claimant waives their right to have a decision within the 90-day timeframe.<sup>755</sup> The Director of CDSS can adopt the decision of the ALJ as final, or can overturn the decision and issue a new one. If either the claimant or the county is unhappy with the decision, they can either (1) file for a rehearing, or (2) file an Administrative Writ in Superior Court.

### **9.1 Rehearing**

If a claimant disagrees with the hearing decision, they must request a rehearing within 30 days of receiving the final decision.<sup>756</sup> However, if a claimant is able to show good cause, a request for rehearing may be filed more than 30 days from the date of the decision. The Director must agree that good cause exists, and any late rehearing request must be filed within 180 days of the decision.<sup>757</sup> The Director of CDSS then serves the request for rehearing on the other party, and the other party has five days to file a statement supporting or objecting to the request.<sup>758</sup> The Director must grant or deny the rehearing request within 35 working days after the request for rehearing is made, although rehearsings in practice are often granted or denied many months past this deadline.<sup>759</sup>

The grounds for requesting a rehearing are:

- » The adopted decision is inconsistent with the law.
- » The adopted decision is not supported by the evidence in the record.
- » The adopted decision is not supported by the findings.
- » The adopted decision does not address all of the claims or issues raised by the parties.
- » The adopted decision does not address all of the claims or issues supported by the record or evidence.
- » The adopted decision does not set forth sufficient information to determine the basis for its legal conclusion.
- » Newly discovered evidence, that was not in custody or available to the party requesting rehearing at the time of the hearing, is now available and the new evidence, had it been introduced, could have changed the hearing decision.
- » For any other reason necessary to prevent the abuse of discretion or an error of law, or for any other reason consistent with Section 1094.5 of the Code of Civil Procedure.<sup>760</sup>

**PRACTICE TIP:** It can take many months for CDSS to issue a decision granting or denying the request for a rehearing. If the claimant receives an unfavorable hearing decision, the best thing to do is to request a rehearing, and include any relevant evidence that was not presented at the hearing. Claimants can also file an Administrative Writ, as discussed below. Note that you do not have to file for a rehearing before filing a writ. A writ must be filed in state superior court within one year of the decision whether or not a rehearing is pending.<sup>761</sup>

## 9.2 Petition for Writ of Administrative Mandate

A claimant may also choose to file a Writ of Administrative Mandate in Superior Court. A writ asks a Superior Court judge to review the hearing decision and to set aside that decision and issue a new one. Petitions for Writ of Administrative Mandate must be filed within one year after receiving the decision.<sup>762</sup>

An Administrative Writ challenging a decision by CDSS is brought under California Code of Civil Procedure § 1094.5. The court reviews the underlying administrative proceedings to ensure that CDSS proceeded in accordance with the law, that the claimant received a fair trial, and that CDSS' decision is supported by the findings, or that the findings are supported by the evidence.<sup>763</sup> The party filing the writ is called a "Petitioner," and CDSS is the "Respondent." Evidence in Administrative Mandate proceedings is limited to the underlying hearing record, including anything submitted at the time of the hearing, the hearing transcript, and rehearing. This is why it is important to prepare for the hearing by submitting evidence of the claimant's need for IHSS services, and to speak clearly at the hearing so that the proceedings can be properly recorded. It is also important to include additional evidence (if it exists) in the rehearing request because that will become part of the record whether or not a rehearing is granted.

For more information on filing Administrative Writs, claimants and advocates should review practice guides and online resources.<sup>764</sup> Keep in mind that each Superior Court has different filing procedures and rules, and some have special rules for filing Administrative Writs.

**PRACTICE TIP:** Petitioners who file for an administrative writ under Welfare and Institutions Code section 1094.5 are not required to pay a filing fee.<sup>765</sup> In addition, successful Petitioners are entitled to reasonable attorney's fees and costs.<sup>766</sup>

# Chapter 8 Endnotes

- 674 Cal. Welf. & Inst. Code § 10950(a); California Dept. of Social Services (“CDSS”) [Manual of Policies & Procedures \(“MPP”\) § 22-003.1](#); see also 45 C.F.R. § 205.10. For instances of when an individual does not have a right to a hearing, see Cal. Welf. & Inst. Code § 10950(d) and [MPP §§ 22-003.11-.15](#).
- 675 Cal. Welf. & Inst. Code § 10950(f); MPP § 22-000.11.
- 676 Cal. Welf. & Inst. Code § 10950(f); MPP § 22-000.11.
- 677 For contact information for each county’s appeals unit, including names of supervisors, visit [CDSS, County Roster](#).
- 678 [MPP § 22-001\(d\)\(2\)](#).
- 679 Cal. Welf. & Inst. Code § 10960.
- 680 See Cal. Welf. & Inst. Code § 1094.5.
- 681 [MPP § 22-071.1](#). Notice is required for IHSS recipients and applicants in the following instances: when services are granted or increased; when services are denied, decreased, suspended, cancelled, discontinued, or terminated; when the county does something after a claimant has conditionally withdrawn their request for a hearing; when the county determines that immediate need does not exist; when the county does something after a hearing; and when the county makes changes to the payment of services.
- 682 [MPP § 22-001\(a\)\(1\)](#); MPP § 10-116.4; 22 C.C.R. § 51014.1(c)(1)-(3); 42 C.F.R. § 431.210(a)-(c).
- 683 [MPP § 22-071.6](#).
- 684 [MPP § 21-115.2](#); CDSS, [Translated Forms and Publications](#), (last visited Aug. 6, 2025).
- 685 [MPP §22-071\(L\)\(1\)\(b\)](#).
- 686 [MPP § 22-001\(t\)\(1\)](#).
- 687 [MPP § 22-072.4](#).
- 688 Cal. Welf. & Inst. Code § 10967.
- 689 [MPP § 22-049.523](#); Welfare and Institutions Code § 10967 (“If the notice was not adequate and involved termination or reduction of aid, retroactive action shall be taken by the county to reinstate aid pending.”).
- 690 [MPP § 22-049.52](#); Cal. Welf. & Inst. Code § 10967.
- 691 *Id.*
- 692 Cal. Welf. & Inst. Code § 10951(a)(1); [MPP § 22-009.1](#).
- 693 [MPP § 22-009.11](#).
- 694 Bet Tzedek, [“Chapter 7: In-Home Support Services \(IHSS\)”](#)
- 695 Cal. Welf. & Inst. Code § 10951(a)(1).
- 696 Cal. Welf. & Inst. Code § 10951(a)(2); see also [All County Information Notice \(“ACIN”\) No. I-66-08](#) (November 19, 2008).
- 697 *Id.*

698 *Id.*

699 [MPP § 22-072.5](#).

700 If the claimant fails to appear personally or by authorized representative at the scheduled hearing, the request for hearing shall be considered abandoned and a written decision shall be issued dismissing the claim. [MPP § 22-054.221](#).

701 *Id.*

702 [MPP § 22-009.2](#).

703 [MPP § 22-004.1](#).

704 [MPP § 22-004.21](#). A hearing request can be made online at [CDSS, State Hearing Requests](#).

705 [MPP § 22-004.211](#).

706 [MPP § 22-004.22](#).

707 [MPP §§ 22-045.11, 22-045.13](#).

708 [MPP § 22-004.211](#).

709 [MPP § 22-071.5](#).

710 For more information on state hearing requests, see CDSS, *supra* note 31.

711 CDSS, [Hearing Requests](#), (last visited Oct. 29, 2025).

712 [MPP § 22-045.3](#).

713 [MPP § 22-045.31](#).

714 [MPP § 22-045.33](#).

715 [All County Appeals Letter](#) (January 19, 2004).

716 *Id.*

717 [MPP § 22-001\(a\)\(6\)](#); [MPP § 22-085.1](#).

718 [MPP § 22-085.1](#). For state hearings, use [DPA 19 \(12/2010\)](#) to authorize a representative. Individuals can also appoint a representative using the [NA Back 9 \(4/2013\)](#).

719 See Probate Code § 4120 et seq.; [All County Welfare Directors Letter \(“ACWDL”\) 94-70](#) (August 23, 1994).

720 [MPP § 22-085.11](#).

721 [MPP § 22-085.12](#).

722 [MPP § 22-085.21](#).

723 [MPP § 22-085.22](#). In addition, the representative must submit a written authorization within 10 days of the hearing, or the case will be dismissed. [MPP § 22-085.221-222](#).

724 [MPP § 22-085.24](#).

725 [MPP § 22-085.23](#).

726 [MPP § 22-073.23](#).

- 727 [MPP §§ 22-073.232 and .25](#); [All County Letter \(“ACL”\) 17-102](#) (September 29, 2017).
- 728 [MPP § 22-054.211\(b\)\(3\)](#).
- 729 [MPP § 22-054.211\(b\)\(3\)\(B\)](#).
- 730 [MPP § 22-054.211\(b\)\(3\)\(C\)](#).
- 731 [MPP § 22-053.112](#).
- 732 [MPP § 22-053.113](#). See CDSS, “[CDSS State Hearings Division Postponement Procedures](#)” for a detailed description of CDSS’ State Hearings Division Postponement Procedures.
- 733 [MPP § 22-053.43](#).
- 734 [MPP § 22-053.121](#).
- 735 [MPP § 22-053.141](#).
- 736 [MPP § 22-053.3](#).
- 737 [MPP § 22-051.1](#). Cal. Welf. & Inst. Code § 10850(c) authorizes CDSS to issue regulations concerning access to case files, including access to case files by applicants and recipients. MPP § 19-005.1 says any recipient or applicant, or their authorized representative, may review the file “made or kept by the county welfare department in connection with the administration of the public assistance program.” A claimant can review medical records in their file. (MPP § 19-006 note). The only records a claimant cannot see are those covered by a specific “privilege” such as the lawyer-client privilege (and the claimant does not own the privilege). (MPP § 19-006; see, also, the state hearing regulations at MPP § 22-051).
- 738 [MPP § 22-051.3](#).
- 739 [MPP § 30-757.173\(a\)\(2\)-\(3\)](#).
- 740 See also DRC, “[IHSS Fair Hearings Guide: How to Prepare for IHSS Terminations or Reductions in Hours](#)” (Mar. 1, 2025).
- 741 Cal. Welf. & Inst. Code § 10952.5(a); [ACL 17-21](#) (February 16, 2017); [ACL 17-102](#) (September 29, 2017).
- 742 [ACL 17-21](#) (February 16, 2017).
- 743 *Id.*
- 744 Cal. Welf. & Inst. Code § 10952.5(b); [ACL 17-21](#) (February 16, 2017).
- 745 *Id.*
- 746 Cal. Welf. & Inst. Code § 10952.5(a); [ACL 17-21](#) (February 16, 2017).
- 747 *Id.*
- 748 *Id.*
- 749 *Id.*
- 750 *Id.*
- 751 Welfare and Institutions Code § 10955.
- 752 *Id.*

- 753 *Id.*
- 754 Cal. Welf. & Inst. Code § 10956; [MPP § 22-049.4](#).
- 755 [MPP § 22-060.1](#).
- 756 Cal. Welf. & Inst. Code § 10960(a); [ACIN I-66-08](#) (November 19, 2008).
- 757 Cal. Welf. & Inst. Code § 10960(f)(2).
- 758 Cal. Welf. & Inst. Code § 10960(a).
- 759 *Id.*
- 760 Cal. Welf. & Inst. Code § 10960(b).
- 761 Cal. Welf. & Inst. Code § 10962.
- 762 *Id.*
- 763 Cal. Civ. Proc. Code § 1094.5(b). “The inquiry in such a case shall extend to the questions whether the respondent has proceeded without, or in excess of, jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion. Abuse of discretion is established if the respondent has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.”
- 764 Claimants and advocates may want to review the “[Writ of Mandate Outline](#)” by Richard Rothschild.
- 765 Cal. Welf. & Inst. Code § 10962.
- 766 *Id.*

# Appendix A

## IHSS Program Chart

| AUTHORITY?              | IHSS COMMUNITY FIRST CHOICE OPTION (CFCO), PUBLIC LAW 111-148 (2010); 42 U.S.C. § 18001 ET SEQ  | IHSS MEDI-CAL PERSONAL CARE SERVICES PROGRAM (PCSP), WELF. & INST. CODE § 14132.95  | IHSS PLUS OPTION (IPO), WELF. & INST. CODE § 14132.952   | IHSS RESIDUAL (IHSS-R) PROGRAM, WELF. & INST. CODE § 12300 ET SEQ.  |
|-------------------------|---|---|--|---|
| ELIGIBILITY?            | Beneficiary receives full-scope Medi-Cal with federal financial participation (FFP), and meets CFCO Nursing Facility Level of Care eligibility. <sup>767</sup>                                | Beneficiary receives full-scope Medi-Cal with FFP. Includes SSI beneficiaries; 1619 SSI beneficiaries (people who work even though disabled); Pickles; other Medi-Cal programs including A&D FPL; or Working Disabled; DD Waiver & HCBA Waiver people. <sup>768</sup> | Beneficiary receives full-scope Medi-Cal with FFP. Includes SSI beneficiaries; 1619 SSI beneficiaries (people who work even though disabled); Pickles; other Medi-Cal programs including A&D FPL; or Working Disabled; DD Waiver & HCBA Waiver people. Does not require a disability determination. <sup>769</sup> | Recipient does not receive (1) full scope Medi-Cal or (2) Medi-Cal with FFP. Includes individuals with state-only Medi-Cal, primarily lawful permanent residents and persons residing in the United States under color of law (PRUCOL) who are not eligible for full-scope Medi-Cal with FFP, <sup>770</sup> and undocumented individuals who enrolled in Medi-Cal prior to Jan. 1, 2026. |
| FUNDING?                | Federal Medicaid 50% + 6%; State and County contribute remaining 44%  | Federal Medicaid 50%, 32.5% State, and 17.5% County <sup>771</sup>  | Federal Medicaid 50%; of remaining 50%, County pays 35% and State pays 65% <sup>772</sup>  | County pays 35% & State 65% of total cost <sup>773</sup>  |
| SERVICES AND PROVIDERS? | <ul style="list-style-type: none"> <li>• All services, including Restaurant Meal allowance</li> <li>• All providers, including spouses and parents of minor children<sup>774</sup></li> </ul> | <ul style="list-style-type: none"> <li>• All Services except Restaurant Meal Allowance</li> <li>• All providers except spouses and parents of minor children.</li> <li>• No Advance Pay<sup>775</sup></li> </ul>  | <ul style="list-style-type: none"> <li>• All services, including restaurant meal allowance</li> <li>• All providers, including spouses and parents of minor children<sup>776</sup></li> </ul>  | <ul style="list-style-type: none"> <li>• All Services including Restaurant Meal Allowance</li> <li>• All providers including spouses and parents of minor children.</li> <li>• Advance Pay<sup>777</sup></li> </ul>   |

## IHSS Program Chart

| AUTHORITY?                             | IHSS COMMUNITY FIRST CHOICE OPTION (CFCO), PUBLIC LAW 111-148 (2010); 42 U.S.C. § 18001 ET SEQ  | IHSS MEDI-CAL PERSONAL CARE SERVICES PROGRAM (PCSP), WELF. & INST. CODE § 14132.95  | IHSS PLUS OPTION (IPO), WELF. & INST. CODE § 14132.952  | IHSS RESIDUAL (IHSS-R) PROGRAM, WELF. & INST. CODE § 12300 ET SEQ.   |
|--|---|---|---|--|
| SEVERELY/<br>NON-SEVERELY<br>IMPAIRED? | Maximum 283 hours/month (including protective supervision: 195 hours for non-severely impaired, 283 hours for severely impaired) <sup>778</sup> | Maximum 283 hours/month <sup>779</sup> (except for Protective Supervision: 195 hours for non-severely impaired, 283 hours for severely impaired) <sup>780</sup> | Maximum 283 hours/month for severely impaired, 195 hours/month for non-severely impaired <sup>781</sup> | Maximum 283 hours/month for severely impaired (needs 20 or more hours/week for personal care, paramedical and meal prep) or 195 hours/month for non-severely impaired <sup>782</sup> |
| CAN SOMEONE ELSE SUPPLEMENT PAY?       | No  | No, but can pay for hours not covered such as time in between tasks if pay provider directly; others can pay provider directly for share of cost.               | No  | Yes, if given directly to provider.  |
| SPOUSE PROVIDER?                       | Covered <sup>783</sup>  | Not covered because relative provider. <sup>784</sup>   | Covered <sup>785</sup>  | Covered for nonmedical personal care services, paramedical services and, if prevented from working, protective supervision & transportation. <sup>786</sup>                          |
| PARENT PROVIDER FOR MINOR?             | Covered <sup>787</sup>  | Not covered because relative provider. <sup>788</sup>   | Covered <sup>789</sup>  | Covered <sup>790</sup>   |

# Appendix A Endnotes

- 767 ACL 14-60
- 768 See, generally, Welfare and Institutions Code 14132.95; ACWDL 05-21; ACIN I-18-08
- 769 ACL 11-19
- 770 MPP §30-755.113; ACIN I-18-08; ACIN I-28-06
- 771 <http://www.cdss.ca.gov/inforesources/IHSS>
- 772 [http://www.cicaihss.org/sites/default/files/ihss\\_overview\\_for\\_senate\\_budget\\_sub\\_3\\_hearing\\_3-2-2017\\_v2.pdf](http://www.cicaihss.org/sites/default/files/ihss_overview_for_senate_budget_sub_3_hearing_3-2-2017_v2.pdf) at p. 5 (50% federal funds); Welf. & Inst. Code § 14132.952(g) (To the extent permitted by federal law, reimbursement rates for services under the IHSS Plus option shall be equal to the rates in each county for the same mode of services in the In-Home Supportive Services program pursuant to Article 7 (commencing with [Section 12300](#)) of Chapter 3).
- 773 [http://www.cicaihss.org/sites/default/files/ihss\\_overview\\_for\\_senate\\_budget\\_sub\\_3\\_hearing\\_3-2-2017\\_v2.pdf](http://www.cicaihss.org/sites/default/files/ihss_overview_for_senate_budget_sub_3_hearing_3-2-2017_v2.pdf) at p. 23; ACL 14-60
- 774 ACL 14-60
- 775 ACWDL 05-21
- 776 ACL 11-19
- 777 Welfare and Institutions Code § 12300
- 778 ACL14-60
- 779 WIC § 51350
- 780 ACIN I-28-06
- 781 ACL 11-19
- 782 Welfare and Institutions Code § 12303.4(a); MPP § 30-765.12; ACIN I-28-06
- 783 ACL 14-60
- 784 ACWDL 05-21; Welfare and Institutions Code §§ 14132.95(c) (Services provided), 14132.95(f) (prohibition on spouse or parent providers in PCSP)
- 785 ACL 11-19
- 786 ACIN I-28-06
- 787 ACL 14-60
- 788 ACWDL 05-21; Welfare and Institutions Code §§ 14132.95(c) (Services provided), 14132.95(f) (prohibition on spouse or parent providers in PCSP)
- 789 ACL 11-19
- 790 ACIN I-28-06

# Appendix B: Form Library<sup>1</sup>

| TOPIC               | DESCRIPTION   | FORM  |
|---------------------|---|---|
| IHSS Application    | Health care certification of need for IHSS  | <a href="#">SOC 873</a>                       |
| IHSS Application    | Statement of Facts form   | <a href="#">SOC 310</a>                       |
| IHSS Application    | Application for IHSS Services   | <a href="#">SOC 295</a>                       |
| IHSS Application    | Health care certification requirement   | <a href="#">SOC 874</a>                       |
| IHSS Application    | Doctor's verification of need for spousal impoverishment protection due to HCBS needs | <a href="#">MC 604</a><br><a href="#">MDV</a> |
| IHSS Application    | Direct Deposit information  | <a href="#">SOC 831</a>                       |
| IHSS Application    | Direct Deposit enrollment/change/cancellation form                                    | <a href="#">SOC 829</a>                       |
| Provider Enrollment | Voluntary services certification  | <a href="#">SOC 450</a>                       |
| Provider Enrollment | Recipient designation of provider   | <a href="#">SOC 426A</a>                      |
| Provider Enrollment | Provider enrollment form  | <a href="#">SOC 426</a>                       |
| Provider Enrollment | Provider enrollment agreement   | <a href="#">SOC 846</a>                       |
| Provider Enrollment | Information on the provider enrollment process  | <a href="#">SOC 847</a>                       |
| Provider Enrollment | IHSS/WPCS Provider live-in certification form for tax wage exclusion                  | <a href="#">SOC 2298</a>                      |
| Provider Enrollment | Notification of recipient hours and maximum weekly hours                              | <a href="#">SOC 2271</a>                      |
| Provider Enrollment | Live-in care provider overtime exemption form   | <a href="#">SOC 2279</a>                      |
| State Fair Hearings | Authorized Representative Form  | <a href="#">DPA 19</a>                        |
| State Fair Hearings | Request a Hearing and Hearing Rights Form   | <a href="#">NA Back 9</a>                     |

<sup>1</sup> These is an incomplete list that is comprised of frequently used forms. For a complete list of IHSS and other forms, see CDSS, [Forms/Brochures](#), (last visited 11/17/2025).

# Appendix C

## IHSS Hourly Tasks Chart<sup>1</sup>

| #  | TASK  | HTG RANGE PER FUNCTIONAL RANK |             |             |             |
|----|---|-------------------------------|-------------|-------------|-------------|
|    |   | RANK 2                        | RANK 3      | RANK 4      | RANK 5      |
| 1  | Meal Preparation (see MPP 30-757.131(a))                            | 3.02 - 7.00                   | 3.50 - 7.00 | 5.25 - 7.00 | 7.00 - 7.00 |
| 2  | Meal Cleanup (see MPP 30-757.132(b))                                | 1.17 - 3.50                   | 1.75 - 3.50 | 1.75 - 3.50 | 2.33 - 3.50 |
| 3  | Bowel and Bladder Care (see MPP 30-757.14(a)(2))                    | 0.58 - 2.00                   | 1.17 - 3.33 | 2.91 - 5.83 | 4.08 - 8.00 |
| 4  | Feeding (see MPP 30-757.14(c)(3))                                   | 0.70 - 2.30                   | 1.17 - 3.50 | 3.50 - 7.00 | 5.25 - 9.33 |
| 5  | Bed Baths (see MPP 30-757.14(d)(1))                                 | 0.50 - 1.75                   | 1.00 - 2.33 | 1.17 - 3.50 | 1.75 - 3.50 |
| 6  | "Bathing, Oral Hygiene, and Grooming (see MPP 30-757.14(e)(5))"     | 0.50 - 1.92                   | 1.27 - 3.15 | 2.35 - 4.08 | 3.00 - 5.10 |
| 7  | Dressing (MPP 30-757.14(f))   | 0.56 - 1.20                   | 1.00 - 1.86 | 1.50 - 2.33 | 1.90 - 3.50 |
| 8  | Repositioning or Rubbing Skin (MPP 30-757.14(g)(4))                 | 0.75 - 2.80                   |             |             |             |
| 9  | Transfer (MPP 30-757.14(h)(2))                                      | 0.50 - 1.17                   | 0.58 - 1.40 | 1.10 - 2.33 | 1.17 - 3.50 |
| 10 | "Care and Assistance with Prosthetic Devices (MPP 30-757.14(i)(2))" | 0.47 - 1.12                   |             |             |             |
| 11 | Menstrual Care (MPP 30-757.14(j)(3))                                | 0.28 - 0.80                   |             |             |             |
| 12 | Ambulation (MPP 30-757.14(k)(1))                                    | 0.58 - 1.75                   | 1.00 - 2.10 | 1.75 - 3.50 | 1/75 - 3.50 |

<sup>1</sup> CDSS, MPP Section 30-757.11-S2ction 30-757.14(k). For time allocations in hours:minutes format, see CDSS, [Functional Index Rankings and Hourly Task Guidelines](#).

# Appendix D

**NOTICE OF ACTION  
IN-HOME SUPPORTIVE SERVICES (IHSS)  
CHANGE**

COUNTY OF \_\_\_\_\_

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

Notice Date : \_\_\_\_\_

Case Name : \_\_\_\_\_

Case Number : \_\_\_\_\_

Social Worker Name : \_\_\_\_\_

Social Worker Number : \_\_\_\_\_

Social Worker Telephone : \_\_\_\_\_

Social Worker Address : \_\_\_\_\_

**NOTE:** This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

(ADDRESSEE)

As of \_\_\_\_\_ the services you can get and/or the amount of time you can get for services has changed.  
Here why: MMDDYYYY  
Total Hours:Minutes of IHSS you can get each month is now: \_\_\_\_\_. This is a/an increase/decrease of \_\_\_\_\_.  
You will now get the services shown below for amount of time shown in the column "Authorized Amount of Service You can Get." That column shows the hours/minutes you got before, the hours/minutes you will get from now on, and the difference. If you are getting less time for a service, the reason(s) is shown on the next page.  
1) If there is a zero in the "Authorized Amount of Service You Can Get" column or the amount is less than the "Total Amount of Service Needed" column, the reason is explained on the next page(s).  
2) "Not Needed" means that your social worker found that you do not require assistance with this task. (MPP 30-756.11)  
3) "Pending" means the county is waiting for more information to see if you need that service. See the next page(s) for more information.

| SERVICES<br><br><i>Note: See the back of the next page for a short description of each service.</i> | TOTAL AMOUNT OF SERVICE NEEDED | ADJUSTMENT FOR OTHERS WHO SHARE THE HOME (PRORATION) | AMOUNT OF SERVICE YOU NEED | SERVICES YOU REFUSED OR YOU GET FROM OTHERS | AUTHORIZED AMOUNT OF SERVICE YOU CAN GET |      |         |
|---|--------------------------------|--|----------------------------|---|--|------|---------|
|   | HOURS: MINUTES                 |  | HOURS: MINUTES             |   | HOURS:MINUTES                            | NOW  | WAS +/- |
| <b>DOMESTIC SERVICES (per MONTH):</b>   |                                |  |                            |   |  |      |         |
| <b>RELATED SERVICES (per WEEK):</b>   |                                |  |                            |   |  |      |         |
| Prepare Meals   |                                |  |                            |   |  |      |         |
| Meal Clean-up   |                                |  |                            |   |  |      |         |
| Routine Laundry   |                                |  |                            |   |  |      |         |
| Shopping for Food   |                                |  |                            |   |  |      |         |
| Other Shopping/Errands  |                                |  |                            |   |  |      |         |
| <b>NON-MEDICAL PERSONAL SERVICES (per WEEK):</b>  |                                |  |                            |   |  |      |         |
| Respiration Assistance (Help with Breathing)  |                                |  |                            |   |  |      |         |
| Bowel, Bladder Care   |                                |  |                            |   |  |      |         |
| Feeding   |                                |  |                            |   |  |      |         |
| Routine Bed Bath  |                                |  |                            |   |  |      |         |
| Dressing  |                                |  |                            |   |  |      |         |
| Menstrual Care  |                                |  |                            |   |  |      |         |
| Ambulation (Help with Walking, including Getting In/Out of Vehicles)                                |                                |  |                            |   |  |      |         |
| Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)  |                                |  |                            |   |  |      |         |
| Bathing, Oral Hygiene, Grooming   |                                |  |                            |   |  |      |         |
| Rubbing Skin, Repositioning   |                                |  |                            |   |  |      |         |
| Help with Prosthesis (Artificial Limb, Visual/Hearing Aid) and/or Setting up Medications            |                                |  |                            |   |  |      |         |
| <b>ACCOMPANIMENT (per WEEK):</b>  |                                |  |                            |   |  |      |         |
| To/From Medical Appointments  |                                |  |                            |   |  |      |         |
| To/From Places You Get Services in Place of IHSS  |                                |  |                            |   |  |      |         |
| <b>PROTECTIVE SUPERVISION (per WEEK):</b>   |                                |  |                            |   |  |      |         |
| <b>PARAMEDICAL SERVICES (per WEEK):</b>   |                                |  |                            |   |  |      |         |
| TOTAL WEEKLY HOURS:MINUTES OF SERVICE YOU CAN GET:  |                                |  |                            |   |  |      |         |
| MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS:MINUTES:                |                                |  |                            |   | x  | 4.33 | =       |
| SUBTOTAL MONTHLY HOURS:MINUTES OF SERVICE YOU CAN GET:  |                                |  |                            |   |  |      |         |
| ADD MONTHLY DOMESTIC HOURS:MINUTES OF SERVICE YOU CAN GET (from above):                             |                                |  |                            |   |  |      |         |
| <b>TOTAL HOURS:MINUTES OF SERVICE YOU CAN GET PER MONTH:</b>  |                                |  |                            |   |  |      |         |
| <b>TIME LIMITED SERVICES (per MONTH):</b>   |                                |  |                            |   |  |      |         |
| Heavy Cleaning:   |                                |  |                            |   |  |      |         |
| Yard Hazard Abatement   |                                |  |                            |   |  |      |         |
| Remove Ice, Snow  |                                |  |                            |   |  |      |         |
| Teaching and Demonstration  |                                |  |                            |   |  |      |         |
| <b>TOTAL HOURS:MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:</b>                          |                                |  |                            |   |  |      |         |

**Questions?:** Please contact your IHSS social worker. See top of page for phone number.  
**State Hearing:** If you think this action is wrong, you can ask for a hearing. The back of this page tells how.