



# 20% IHSS Cuts Fact Sheet

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**Here is what you need to know about the IHSS cuts:**

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- 1) The state plans to cut IHSS hours by 20% on January 1, 2012.
- 2) Your hours will not be cut if you ask for an IHSS Care Supplement no later than January 3, 2012. The sooner you get your application to the county the better.
- 3) The state will mail reduction notices and the application for the IHSS Care Supplement on or before December 15, 2011. So, check your mail!
- 4) Read our publication so you know how to get the IHSS Care Supplement.

# In-Home Supportive Services (IHSS) Program 20% Cut in Services

## **BUDGET CUTS**

The 2011-2012 California budget was based on how much money the state thought it would receive. By December 15, 2011, state officials will say how much money the state thinks it will actually take in. If the state does not have enough money, state law says that IHSS service hours must be cut by 20%. The cut in IHSS hours will take place as of January 1, 2012.

The IHSS 20% cut in service hours will be based on the most recent IHSS assessment of need. For example, a consumer who has 100 hours per month of IHSS already had hours cut by 3.6%, or 3.6 hours. This consumer will be cut by an additional 20%, or 20 hours. This consumer will be left with a total of 76.4 hours per month. This is a total cut of 23.6%, or 23.6 in total authorized hours.

## **IHSS 20% CUT IN SERVICES NOTICE**

The state will send IHSS consumers a notice about the 20% cuts by December 15, 2011. The notice will include the consumer's total authorized IHSS service hours now, and total IHSS service hours after the 20% cut. The state will also add a message on providers' time sheets, telling them about the 20% cut.

The 20% cut in services notice will also tell IHSS consumers about how to apply for an IHSS Care Supplement. **If you mail or bring in to the county your application for the IHSS Care Supplement by January 3, 2012, your IHSS hours will be restored until the county takes action on your application.** If you bring in your application be sure to get a receipt.

## **HOW TO APPLY FOR THE IHSS CARE SUPPLEMENT**

Everyone who gets a notice about the 20% cuts in December can apply for the IHSS Care Supplement. If you are approved for the IHSS Care Supplement, you will get some or all of your IHSS hours back.

State law says that you are eligible for the IHSS Care Supplement if the 20% cut in IHSS service hours will put you at serious risk of out-of-home placement. “Out-of-home placement” means that you would have to leave your current home and live somewhere else such as a board and care home or a nursing home.

In your application for an IHSS Care Supplement, you should explain to the county why you need to get back all or some of your authorized IHSS hours. For example:

- If you do not get daily meal clean-up, you will be at risk of a pest infestation or you might fall if you try to clean up after meals by yourself, or
- You have a lot of medical appointments and your health will get worse if your IHSS provider does not have enough time to take you to and from medical appointments, or
- You will not remember to eat, or will not finish your meals without prompting from your IHSS provider, or
- You have been threatened with eviction because you have a problem with hoarding and cluttering and need all of the IHSS hours to avoid eviction, or
- Your IHSS provider will not have enough hours to keep working and if your IHSS provider quits, you will not be able to find anyone else who will do the work.

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

## **FUNCTIONAL INDEX RANKS**

In deciding if you are eligible to receive an IHSS Care Supplement, the county will look at something called “Functional Index Ranks.” Functional Index Ranks are measures of your functional limitations. Functional Index Ranks measure the kind of help you need in order to do various IHSS tasks.

You can help the county get up-to-date information about your functional limitations by asking your doctor to fill out the attached survey. This survey explains what your Functional Index Ranks really are and what help you need performing IHSS tasks.

You can mail the survey with your application for the IHSS Care Supplement if your doctor completes it in time. **The survey is not required but it may be helpful.** You can also mail in or drop off the survey if it is completed later.

Whatever you do, **do not delay sending in your IHSS Care Supplement application for any reason!** Be sure to mail it in by January 3, 2012.

### **SOME IHSS CONSUMERS ARE EXEMPT FROM THE 20% CUTS**

IHSS Consumers are exempt from the 20% cuts if they also get services under one of the state's Home and Community Based Services Waivers, which include:

- AIDS Waiver,
- DD Waiver for Regional Center consumers,
- Multipurpose Senior Services Program (MSSP),
- Nursing Facility/Acute Hospital (NF/AH) Waiver, and
- In-Home Operations (IHO) Waiver.

If you are on a waiver, you should not get a reduction notice. If you DO get a reduction notice, the State has made a mistake and you should file an appeal and request a state hearing right away. You should also call your Regional Center worker, MSSP case manager or IHO case manager to ask for help.

### **APPEAL RIGHTS**

Consumers who are denied an IHSS Care Supplement have the right to request a hearing. At this time, we do not know whether consumers will get aid paid pending if they appeal the denial of the IHSS Care Supplement, or if they appeal the 20% reduction.

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

## **Physician's Survey Regarding Functional Limitations**

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

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

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

PLEASE COMPLETE THIS SURVEY

Patient Name:

DOB:

Diagnosis:

Prognosis:

Date Patient Last Seen By You:

INSTRUCTIONS

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

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

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

- Independent: Requires no physical assistance though consumer may experience some difficulty or discomfort. Completion of the task poses no risk to his/her safety.
- Can move independently with only reminding or encouragement. For example, needs reminding to lock a brace, unlock a wheelchair or to use a cane or walker.
- Requires physical assistance from another person for specific maneuvers; e.g., pushing wheelchair around sharp corner, negotiating stairs or moving on certain surfaces.
- Requires assistance from another person most of the time. At risk if unassisted.
- Totally dependent upon others for movement. Must be carried, lifted or pushed in a wheelchair or gurney at all times.

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

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**BATHING, ORAL HYGIENE AND GROOMING, ROUTINE BED BATHS:  
MPP §§ 30-757.14 (D) & 30-757.14 (E)**

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Bathing means cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of a tub, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care (unless toenail care is medically contraindicated and therefore is evaluated as a Paramedical Service). NOTE: Getting to and from the bathroom is evaluated as Mobility Inside.

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- Independent: Able to bathe and groom self safely without help from another person.

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  - Able to bathe and groom self with direction or intermittent monitoring. May need reminding to maintain personal hygiene.

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  - Generally able to bathe and groom self, but needs assistance with some areas of body care; e.g., getting in and out of shower or tub, shampooing hair, or can sponge bathe but another person must bring water, soap, towel, etc.

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  - Requires direct assistance with most aspects of bathing and grooming. Would be at risk left alone.

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  - Totally dependent on others for bathing and grooming.
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Please briefly describe how your patient's functional limitations limit your patient's ability to bathe, maintain oral hygiene and grooming and the potential consequences if the patient does not get help:

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**DRESSING: MPP § 30-757.14 (F)**

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Putting on and taking off, fastening and unfastening garments and undergarments, special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

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- Independent: Able to put on, fasten and remove all clothing and devices without assistance. Clothes self appropriately for health and safety.

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  - Able to dress self, but requires reminding or direction with clothing selection.

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  - Unable to dress self completely, without the help of another person; e.g., tying shoes, buttoning, zipping, putting on hose or brace, etc.

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  - Unable to put on most clothing items by self. Without assistance would be inappropriate or inadequate clothed.

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

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

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

- Independent: Able to manage bowel, bladder and menstrual care with no assistance from another person.
- Requires reminding or direction only.
- Requires minimal assistance with some activities but the constant presence of the provider is not necessary.
- Unable to carry out most activities without assistance.
- Requires physical assistance in all areas of care.

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Please briefly describe how your patient's functional limitations limit your patient's ability manage bowel, bladder and menstrual care and the potential consequences if the patient does not get help:

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**TRANSFER: MPP § 30-757.14(H)**

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

- Independent: Able to do all transfers safely without assistance from another person.
- Able to transfer but needs encouragement or direction.
- Requires some help from another person; e.g., routinely requires a boost or assistance with positioning.
- Unable to complete most transfers without physical assistance. Would be at risk if unassisted.

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- Totally dependent upon another person for all transfers. Must be lifted or mechanically transferred.
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Please briefly describe how your patient's functional limitations limit your patient's ability to transfer and the potential consequences if the patient does not get help:

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**FEEDING: MPP § 30-757.14(c)**

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

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

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**RESPIRATION: MPP § 30-757.14(B)**

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

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- Does not use respirator or other oxygen equipment or able to use and clean independently.
  - Needs help with self-administration and/or cleaning.
  - Needs Paramedical Service such as suctioning.\*
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Please briefly describe how your patient's functional limitations limit your patient's ability to respire and the potential consequences if the patient does not get help:

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### MENTAL FUNCTIONING ASSESSMENT

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Please check appropriate box

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

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

- No problem: Memory is clear; consumer is able to give you accurate information about his/her medical history; is able to talk appropriately about comments made earlier in the conversation; has good recall of past events.
- Memory loss is moderate or intermittent: Consumer shows evidence of some memory impairment, but not to the extent where (s)he is at risk; consumer needs occasional reminding to do routine tasks or help recalling past events.
- Severe memory deficit: Consumer forgets to start or finish activities of daily living which are important to his/her health and/or safety. Cannot maintain much continuity of thought in conversation with you.

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

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

- No problem: Orientation is clear. Consumer is aware of where (s)he is and can give you reliable information when questioned about activities of daily living, family, etc.; is aware of passage of time during the day.
- Occasional disorientation and confusion apparent but does not put self at risk: Consumer has general awareness of time of day; is able to provide limited information about family, friends, daily routine, etc.
- Severe disorientation which puts consumer at risk: wanders off; lacks awareness or concern for safety or well-being; unable to identify significant others or relate safely to environment or situation; no sense of time of day.

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

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

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Judgment unimpaired: Able to evaluate environmental cues and respond appropriately.

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Judgment mildly impaired: shows lack of ability to plan for self; has difficulty deciding between alternatives but is amenable to advice; social judgment is poor.

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Judgment severely impaired: fails to make decisions or makes decisions without regard to safety or well-being.

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

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**Other Functional Limitations**

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

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

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

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

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

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Please explain:

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

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