State of California - Health & Welfare Agency - Department of Social Services REASSESSMENT - CHANGE

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION-

Note: This notice relates ONLY to your Social Services.
It does NOT affect your receipt of SSI/SSP or Social Security.
KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

YOUR IHSS OFFICE

SAN LUIS OBISPO COUNTY
DEPARTMENT OF SOCIAL SERVICES
P.O. BOX 8119
SAN LUIS OBISPO, CA 93403-8119

IF REQUESTING A STATE HEARING, PLEASE SEND TO:

SAN LUIS OBISPO COUNTY
DEPT. OF SOCIAL SERVICES
P.O. BOX 8119
SAN LUIS OBISPO, CA 93403-8119

BEAL, ARTHUR
881 HILLCREST
CAMBRIA, CA 93428

Case Number: 4001606278

Date Mailed: 10-24-90

YOUR AUTHORIZATION FOR IN-HOME SUPPORTIVE SERVICES HAS BEEN CHANGED EFFECTIVE 10/16/90.

	NOW	WAS
Your Countable Income:	$	$
Minus SSI/SSP Benefit Level:	$	$
Your Share of Cost:	$	$
Minus Assessed IHSS Cost:	$	$
Income in Excess of Assessed Cost:	$	$

SERVICES	HOURS NOW	PREVIOUS HOURS	(+) INCREASE OR (-) DECREASE
DOMESTIC SERVICES per month:	6.00	6.00	
Clean floors, wash kitchen counters, stoves, refrigerators, bathroom; store food, supplies; take out garbage; dust, pick up; bring in fuel; change and make bed.			
HEAVY CLEANING (one month only):			
RELATED SERVICES per week:			
* Prepare Meals:	7.00	7.00	
** Meal Cleanup:	2.00	2.00	
Routine Laundry:	1.50	1.50	
Shopping for Food:	1.00	1.00	
Other Shopping Errands:	.50	.50	
NON-MEDICAL PERSONAL SERVICES per week:			
* Respiration Assistance:			
* Bowel, Bladder Care:	2.50	1.50 +	1.00
* Feeding:			
* Routine Bed Baths:	5.00	2.00 +	3.00
* Dressing:			
* Menstrual Care:			
* Ambulation:	1.25	.50 +	.75
* Move In/Out of Bed:			
* Bathe, Oral Hygiene/Grooming:			
* Rub Skin, Repositioning, Help On/Off Seats, In/Out of Vehicle:			
* Care/Assistance with Prosthesis:			

SERVICES	HOURS NOW	PREVIOUS HOURS	(+) INCREASE OR (-) DECREASE
TRANSPORTATION SERVICES per week:			
Medical Appointment:	.50	.50	
To Alternative Resources:			
YARD HAZARD ABATEMENT:			
Remove Grass, or Weeds, Rubbish (one month only):			
Remove Ice, Snow, per week:			
PROTECTIVE SUPERVISION per week:			
TEACHING/DEMONSTRATION per week: (no more than three months duration)			
* PARAMEDICAL SERVICE per week:			
TOTAL WEEKLY HOURS X 4.33:	92.01	71.44 +	20.57
ADD DOMESTIC SERVICE HOURS:	6.00	6.00	
ADD HEAVY CLEANING:			
ADD REMOVE GRASS, ETC.:			
TOTAL MONTHLY HOURS (rounded to the nearest tenth)	98.0	77.4 +	20.6

	NOW	WAS
Restaurant Meal Allowance:	$	$

☐ "Since you meet the criteria for 20 hours or more in starred (*) services you can get an advance payment to pay your own provider. If you want to get advance payment, contact your service worker. The double starred (**) service is included in the 20 hours only when assistance with feeding, preparation of meals and meal cleanup are all required."

The above action(s) is supported by Federal Law (Social Security Act), State Law (Welfare and Institutions Code), Federal Regulations (Code of Federal Regulations), State Regulations (California Administrative Code and State Department of Social Services Manual of Policies and Procedures):

ALTERNATIVE RESOURCES AVAILABLE TO YOU FOR BWL/BLDR CARE, BED BATH, AMB HAVE BEEN REDUCED . MPP 30-763.3
DUE TO A MID-MONTH REASSESSMENT YOUR TOTAL SERVICES FOR 10/90 ARE PRORATED IN THE AMOUNT OF 88.0 AUTHORIZED HOURS. BEGINNING THE NEXT MONTH YOU ARE AUTHORIZED TO RECEIVE THE SERVICE HOURS LISTED ABOVE . MPP 30-759.4 & .5
YOU HAVE BEEN FOUND IN NEED OF ADDITIONAL HOURS OF SERVICE. MPP 30-763.2

You must report immediately any changes that might affect your eligibility or need for In-Home Supportive Services such as change in income, property, living arrangement, medical condition or ability to work. If you have any questions or think additional facts should be considered contact:

District Office: 1 Service Worker: BILL RICHARDSON SW#: 5233 Telephone: 805 549-4110

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING. PLEASE SEND YOUR WRITTEN REQUEST TO THE COUNTY ADDRESS ON THE TOP RIGHT HAND CORNER OF THIS FORM.

099C
A 690 (1-88)
VA 690 (1-88)

PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

RIGHT TO REQUEST A STATE HEARING

1. You have the right to a conference with representatives of the County Welfare Department to talk about this intended action. At such a conference, you may speak for yourself or be represented by a lawyer, a friend or other spokesperson. If you want a conference, contact your county department.

2. Whether you request a conference or not, you also have the right to request a State Hearing and decision by the Director of the State Department of Social Services (see form below). Your request may be written or oral but it must state that you want a hearing and why you are dissatisfied. YOUR REQUEST FOR A HEARING MUST BE MADE WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

3. IF YOU REQUEST A STATE HEARING ANYTIME BEFORE THE EFFECTIVE DATE OF THE COUNTY'S PROPOSED ACTION, YOUR SERVICES MAY CONTINUE UNTIL THE HEARING. You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request is made in good faith.

4. You may request a State Hearing on your own, or you may ask your county department for assistance. In either case, however, be sure to inform your county department worker as soon as possible.

5. At a State Hearing you have the right to be represented by an attorney or any other person (a friend, relative, or other spokesperson), of your choice. You may obtain free legal advice and the services of a lawyer. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response. You may also contact the nearest social service rights organization for assistance in presenting your claim.

6. State regulations governing State Hearings for social services are available at the office of the County Welfare Department.

7. Information Practices - The information you are requested to provide is mandatory in order to process your request for a State Hearing pursuant to W&IC 10950. A case file will be established by the Office of the Chief Referee. You have the right to examine the materials that constitute the record for decision. Any information you provide may be shared with the County Welfare Department or the United States Department of Health and Human Services.

If you wish to make a written request for a State Hearing, please send this page to the County Welfare Department. The address is found on the front side of this notice on the top right hand corner.

To make an oral request for a State Hearing, or obtain further information about your State Hearing rights or files, you may contact;

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, Ca. 95814
(800) 952-5253 (toll-free number)*
TDD (800) 952-8349* For Hearing and Speech Impaired

*You may have to dial "1" first.

REQUEST FOR STATE HEARING

Name (Last, First, Middle Initial) _____ Phone No. _____ Social Security No. _____

Address _____ City _____ State _____ Zip Code _____

I hereby request a State Hearing before the State Department of Social Services on the action taken by the County regarding my social services. The reasons for my request are as follows:

I have trouble understanding English, therefore I request an interpreter for my hearing in the following: Language _____ Dialect _____

Signature _____ Date Signed _____

AUTHORIZED REPRESENTATIVE

I have authorized the following person to act on my behalf in my appeal. I authorize the Department to release any or all information about my case to that person.

Name of Authorized Representative _____

Address of Authorized Representative _____

Signature of State Hearing Applicant _____ Date Signed _____