

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, MS 19-96, Sacramento, California 95814



July 29, 2003

ALL-COUNTY INFORMATION NOTICE NO. I-46-03

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS  
ALL COUNTY WELFARE FISCAL OFFICERS

REASON FOR THIS TRANSMITTAL

- [ ] State Law Change  
 [ x ] Federal Law or Regulation Change  
 [ ] Court Order or Settlement Agreement  
 [ ] Clarification Requested by One or More Counties  
 [ ] Initiated by CDSS

**SUBJECT: CHANGE TO THE CONTRACT EXPENDITURES AND PUBLIC AUTHORITY/NONPROFIT CONSORTIUM ADMINISTRATIVE COSTS FORMS TO IMPLEMENT THE CHANGE IN FEDERAL MEDICAL ASSISTANCE PERCENTAGE**

The purpose of this letter is to provide information about revisions to the Claim for Reimbursement In-Home Supportive Services Program Contract Expenditures (SOC 432) and In-Home Supportive Services Program Public Authority Invoice Administrative Costs (SOC 448). These forms have been revised to reflect an increase in the federal financial participation for Personal Care Services Program (PCSP) costs.

The recent passage of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (H.R. 2) also provided state fiscal relief by temporarily increasing the Federal Medi-Cal Assistance Percentage (FMAP). Refer to County Fiscal Letter (CFL) 02/03-68 dated June 13, 2003. The federal sharing ratio will change retroactively according to the schedule below:

Effective Date	Through Date	Rates
April 1, 2003	September 30, 2003	54.35%
October 1, 2003	June 30, 2004	52.95%

The sharing ratios for the non-federal portion for PCSP costs (45.65 percent and 47.05 percent of the total PCSP cost, respectively) remain at 65 percent for the State and 35 percent for the county. The Non-PCSP sharing ratios for State and county remain the same (65/35). A point of clarification to counties, the increase in the FMAP percentage applies to program services only and does not apply to county administration for which the federal sharing ratio remains at 50 percent.

Also, counties are reminded of the need to forward a letter to the Adult Programs Branch at the California Department of Social Services with sample signatures of the person(s) authorized to sign the forms claiming for reimbursement in the In-Home

Supportive Services (IHSS) Program. This information allows the State to verify that the appropriate county personnel are certifying and approving the form for auditing purposes. The persons authorized to sign must be the county welfare director or the contract administrator or their representative, and the county auditor or the county controller or their representative. Counties should provide a new letter of authorized signatures whenever there is a change for the person(s) that are authorized to sign.

The SOC 448 form is available in an Excel based spreadsheet directly from the Adult Programs Branch, Fiscal and Administrative Unit. Please contact the Public Authority Fiscal Analyst at (916) 229-4584 for a working copy. This spreadsheet contains the necessary instructions and automates all the federal, State and county funding share calculations, and produces a signature ready SOC 448 with supporting monthly worksheets.

Please feel free to make copies of the forms. If counties would like a "Camera Ready" copy of the form, please contact the Department's Forms Management Unit at (916) 657-2098. For further information or clarification on the contents of this notice please contact your Adult Programs Operations Analyst at (916) 229-4000.

Sincerely,

***Original Signed (7/29/03) by  
Joseph M. Carlin for  
DONNA L. MANDELSTAM  
Deputy Director  
Disability and Adult Programs Division***

Attachment

# CLAIM FOR REIMBURSEMENT IN-HOME SUPPORTIVE SERVICES PROGRAM CONTRACT EXPENDITURES

To: Adult Programs Branch  
California Department of Social Services  
744 P Street, MS 19-96  
Sacramento, CA 95814

FROM:
COUNTY:
ADDRESS:
CONTACT PERSON:
PHONE NUMBER: (     )

CONTRACT NUMBER	CONTRACTOR NAME	SERVICE MONTH/YEAR

**CONTRACT SERVICE DELIVERY TOTALS FOR MONTH BY FUNDING SOURCE:** WARRANT DATE \_\_\_\_\_  
FISCAL YEAR/QTR. \_\_\_\_\_

FUNDING SOURCE	TOTAL CASES	TOTAL HOURS	GROSS EXP.	*ADJUSTMENTS	TOTAL NET EXP.
PCSP	_____	_____	_____	_____	_____
Non-PCSP	_____	_____	_____	_____	_____
Totals	_____	_____	_____	_____	_____

\* If the actual PCSP and Non-PCSP adjustment amounts are not known, please estimate the PCSP and Non-PCSP amounts based on the PCSP and Non-PCSP hours to total hours ratio.

### COST REIMBURSEMENT DETAIL BY FUNDING SOURCE:

FUNDING SOURCE	FEDERAL	STATE/COUNTY	STATE	COUNTY	TOTAL NET EXPENDITURE
PCSP	(54.35%) _____	(45.65%) _____	(65%) _____	(35%) _____	_____
Non-PCSP	_____	_____	(65%) _____	(35%) _____	_____
Total	_____	_____	_____	_____	_____

DO NOT  
PAY THIS  
AMOUNT

I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the Personal Care Services Program; that I have not violated any of the provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Section 1090 to 1096, inclusive of the Government Codes; that the amounts claimed herein are properly claimable as expenditures for the administration of the project as specified in accordance with all provisions of the Welfare and Institutions Codes, the rules and regulations of the State Benefits and Services Advisory Board.

I hereby certify under penalty of perjury, that I am the official responsible for the examination and settlement of accounts, that I have not violated any provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Sections 1070 to 1096, inclusive, of the Government Code; that the expenditures claimed herein have been authorized, that a clearly delineated audit trail is in place to substantiate said expenditures, and that payments therefore have been made or expenditures otherwise incurred according to law.

SIGNATURE OF COUNTY WELFARE DIRECTOR OR CONTRACT ADMINISTRATOR	DATE

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

Approved by: \_\_\_\_\_ Date \_\_\_\_\_  
(State IHSS Program Manager)

**SECTION I OVERPAYMENTS/UNDERPAYMENTS**

	PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS	
<b>A</b>	PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
<b>B</b>	CONNECTED PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
<b>C</b>	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

**SECTION II OTHER (COUNTY SPECIFIC)**

	PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS	
<b>D</b>	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
<b>E</b>	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
<b>F</b>	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

**SECTION III LIQUIDATED DAMAGES**

	PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS	
<b>G</b>	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
<b>H</b>	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
<b>I</b>	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

**SECTION IV PCSP / IHSS ADJUSTMENTS**

	PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS	
<b>J</b>	NET ADJUSTMENT C + E + H (+ / =)	(1)	(2)	(3)	(4)	(5)	(6)
<b>K</b>	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
<b>L</b>	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

**SECTION V CONTRACTOR BILLING**

	TOTAL PCSP CASES	TOTAL IHSS CASES	TOTAL PCSP HOURS	TOTAL IHSS HOURS	TOTAL PCSP GROSS	TOTAL IHSS GROSS	
<b>M</b>	SERVICE MONTH (1)						
<b>N</b>	INVOICE BILLED	(1)	(2)	(3)	(4)	(5)	(6)
<b>O</b>	NET ADJUSTMENT + / = C + E + H OR L	(1)	(2)	(3)	(4)	(5)	(6)
<b>P</b>	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)