

In-Home Supportive Services Quality Assurance – Desk Reviews

PP# 1902-00 IN-HOME SUPPORTIVE SERVICES QUALITY ASSURANCE - DESK REVIEWS

Disclosure: This document has been updated to include new coding ADS-PP-002-V1-IHSS
QA for reference purposes only. No revisions have been made to the policy or
procedure content.

COMPLIANCE- ADMINISTRATION	In-Home Supportive Services Quality Assurance – Desk Reviews	P&P No.	PP 1902-00
		Effective Date	5/28/2026
		Director Initials	PSL

POLICY AND PROCEDURE APPROVAL

TITLE	In-Home Supportive Services Quality Assurance - Desk Reviews		
PURPOSE	To ensure the accuracy, consistency, and integrity of In-Home Supportive Services case assessments and service authorizations through structured, off-site evaluation of case records. Quality Assurance desk reviews are designed to verify compliance with In-Home Supportive Services regulations and county policies, identify areas requiring improvement, and support ongoing quality improvement efforts.		
SCOPE	This policy is applicable to In-Home Supportive Services and Quality Assurance Program Support staff.		
APPROVED BY	TITLE	SIGNATURE	DATE
Paula S. Llanas	Director	<i>Paula S. Llanas</i>	5/28/2026
Iris Zapien	Assistant Director	<i>Iris Zapien</i>	5/28/2026
Evelyn Sanchez	Deputy Director	<i>Evelyn Sanchez</i>	5/29/2026
REVIEWED BY:			
Sonia Duran	Program Manager		
Cynthia Quinonez	Program Manager		
AUTHOR	Zoyla Leyva		
DISTRIBUTION	In-Home Supportive Services and Program Support Staff		
REASON FOR REVISION	☐ New Letter or Notice ☐ N/A ☐ Erratum to existing Letter or Notice ☐ Other: ☒ Internal Request		
POLICY AND/OR PROCEDURE DELIVERY METHOD	☒ Informative only / written communication ☐ Informative in person meeting with section/unit ☐ Classroom training		

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POLICY

It is the policy of the Imperial County Department of Social Services (ICDSS) to maintain a consistent and structured approach to Quality Assurance (QA) through the implementation of routine desk reviews of In-Home Supportive Services (IHSS) case records. These reviews are conducted to ensure compliance with applicable state and county IHSS policies, verify the integrity and accuracy of service authorizations, and support the department's commitment to continuous quality improvement, in accordance with guidance provided by the In-Home Supportive Services (IHSS) Quality Assurance/Quality Improvement (QA/QI) Policy Manual and All County Letter (ACL) No. 13-110.

ICDSS will conduct an average of 30 randomly selected desk reviews each month, totaling 323 annually, as determined by state guidelines outlined in MPP 30-702. The sample must include both approved and denied cases, with denied and approved intake cases not exceeding 10% of the total required sample. Reviews are conducted by the QA Analyst, who compares physical case file documents to data recorded in the Case Management, Information, and Payroll System II (CMIPS II). When necessary, phone interviews with the IHSS recipient or their Authorized Representative (AR) will be conducted to clarify discrepancies or gather missing information.

All findings from desk reviews must be clearly documented in the designated QA forms. Immediate action notices must be issued in cases of critical incidents or urgent compliance issues. Identified action items must be remediated within specific timeframes: 10 calendar days for immediate action items and 30 calendar days for standard findings. Contestation of findings must occur within 3 to 10 calendar days depending on the urgency. QA review outcomes are tracked to resolution, ensuring corrective actions are completed and case records are aligned with policy and service standards.

This policy ensures a transparent, accountable, and effective quality review process that protects IHSS recipients and supports high-quality service delivery in alignment with statewide QA/QI standards.

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**COMPLIANCE-
ADMINISTRATION****In-Home Supportive Services
Quality Assurance – Desk Reviews**

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PURPOSE

To ensure the accuracy, consistency, and integrity of IHSS case assessments and service authorizations through structured, off-site evaluation of case records. QA desk reviews are designed to verify compliance with IHSS regulations and county policies, identify areas requiring improvement, and support ongoing quality improvement efforts.

SCOPE

This policy is applicable to IHSS and QA Program Support staff.

DEFINITIONS

Authorized Representative (AR): Is a person designated by the IHSS applicant/recipient or their legal representative, to act on their behalf for the purpose of the IHSS program. This can include helping with the application process, attending assessments, receiving notices, and handling other communications with the County or IHSS program. The AR must be 18 years or older.

Legal Representative: For the purpose of the IHSS program is a court-ordered conservator of an adult or a parent/guardian or legally authorized decisionmaker of a minor.

Case Management, Information, Payroll System II (CMIPS II): Is an information technology system that supports the IHSS program by providing functionality for case management of IHSS recipients, payroll processing for service providers, reporting, and customer support.

County Quality Assurance (QA): Refers to individuals who participate in QA activities at the county level, regardless of their official job title or the name of their unit or team.

Desk Reviews: Involve the examination of the physical case file and CMIPS II data. They may also include a phone interview conducted directly with the recipient or the recipient's AR.

Action Item Findings: Are identified issues that require follow-up or corrective action to ensure IHSS case compliance and accurate service authorization.

Recommendations: Suggested remediation steps developed in response to the findings of a QA case review.

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Resolution: Refers to the formal closure of a QA case review process, occurring when all identified findings have been addressed. This may involve corrective actions to rectify errors or disputes that have been successfully contested by program staff and subsequently rescinded by QA.

POLICY STATEMENT

It is the policy of ICDSS to maintain program integrity and compliance with state-mandated requirements through structured QA desk reviews of IHSS case records. These reviews are essential in verifying accuracy, consistency, and legality of IHSS case assessments and service authorizations. Desk reviews involve the off-site evaluation of physical files and corresponding data in CMIPS II. The goal is to identify discrepancies, ensure documentation accuracy, confirm service eligibility, and promote corrective actions to enhance service delivery and program quality.

PROCEDURES

Discovery – Desk Reviews

QA Analyst shall:

1. Email IHSS QA Accounting Technician with a list indicating the number of cases to be selected for each Social Worker and Social Services Assistant. The sample must include a minimum of two cases per case worker.
2. Select cases for review based on the following criteria:
 - a. An average of 30 cases shall be randomly selected every month.
 - b. The sample must include both denied and approved cases from intake. *Note: Denied and approved cases should not exceed 10% of the total sample required by the State.*
 - c. A total of 323 IHSS desk reviews shall be conducted annually. *Note: The exact number of cases is determined by the State on an annual basis.*

IHSS QA Accounting Technician shall:

1. Select cases using the Ad Hoc Tool, based on the criteria provided by the QA Analyst.
2. Request Office Assistant III to pull the physical case files on the second Monday of each month.
3. Ensure the files are received by the fourth Monday to allow for timely review.
4. Prepare case files for review by organizing all necessary printouts, such as SOC 293 and MEDS QX Screen printouts, and matching them with their corresponding cases.

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5. Organize selected cases by geographic location for QA Analyst to begin desk reviews.

QA Analyst shall:

1. Review all forms within the case file and compare the written information to the corresponding data in CMIPS II. This review includes:
 - a. Cases from every IHSS Social Worker and Social Services Assistant, including both denied and approved cases from IHSS Intake.
 - b. Ensuring all documentation in the file is complete and accurately filled out.
 - c. Reviewing the case narrative and cross-referencing information in CMIPS II to ensure consistency.
 - d. Verifying that the recipient is receiving appropriate and timely services.
 - e. Reviewing provider information and comparing it with data in CMIPS II.
2. Conduct telephonic interviews on a case-by-case basis to clarify discrepancies or missing information in the case file, using the Phone Interview Guide (Attachment A). Interviews should be conducted directly with the recipient or, when applicable, with the Legal Representative, or AR in cases where the client is non-self-directing, unable to communicate by phone, or is a minor. All information obtained during the interview must be documented in the Case Review Summary (Attachment B).
3. Complete the Desk Review Guide (Attachment C) for each case assigned for desk review. Ensure all required sections are thoroughly and accurately filled out to support the overall quality assurance assessment.
4. Complete the Denied Case Review Summary (Attachment D) for each case assigned for denied case review. Ensure all relevant findings and observations are clearly documented to support the review and any subsequent follow-up actions.
5. Notify the IHSS Program Manager by sending an Immediate Action Notice (Attachment E) when a QA review cannot be completed due to recipient non-cooperation or when urgent information is identified that requires immediate follow-up by IHSS Social Workers and Social Worker Assistants. Ensure all immediate action items are remediated within 10 calendar days.
6. Submit the physical case files, Case Review Summary, and if applicable, Denied Case Review Summary to the IHSS Social Worker Supervisors upon completion of the desk reviews. Submissions must be made on Mondays. *Note: If Monday is a holiday, submissions will be made the next day.*

IHSS Social Worker Supervisors shall:

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1. Distribute the case files along with the corresponding Case Review Summary to the assigned IHSS Social Workers and Social Worker Assistants for review and necessary action.

IHSS Social Workers and Social Services Assistants shall:

1. Receive notification from the IHSS Social Worker Supervisor confirming that a case review has been completed and adhere to the following response timeframes:
 - a. Identified action items must be remediated within 30 calendar days.
 - b. When contesting an action item, Social Workers and Social Services Assistants have 10 calendar days to contest and return the Case Review Summary to the QA Analyst, providing an explanation for the disagreement. *Note: The 10 calendar days begin on the day the Case Review Summary form is submitted to the IHSS Office Assistant Supervisor.*
 - c. Immediate action item findings include the following:
 - i. Critical incident
 - ii. IHSS services ineligibility
 - iii. Recipient moved out of County or State
 - iv. Recipient is unwilling to give information or complete a home visit
 - d. Identified immediate action items must be remediated within 10 calendar days.
 - e. When contesting immediate action items, Social Workers have three calendar days to contest and return the Immediate Action Notice (Attachment E) to the QA Analyst, providing an explanation for the disagreement. *Note: The three calendar days begin on the day the Immediate Action Notice is submitted to IHSS.*
2. Submit the Case Review Summary Guides, including all remediations, to the IHSS Social Worker Supervisor for approval.

IHSS Social Workers Supervisors shall:

1. Review Case Review Summary remediations:
 - a. If approved, email the QA Analyst to indicate that the Case Review Summary has been delivered to the QA Analyst Inbox.
 - b. If denied, return the guide to the Social Worker or Social Services Assistant for corrections. Once corrections are made, email the QA Analyst to confirm that the Case Review Summary has been delivered to the QA Analyst Inbox.

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ATTACHMENTS

- Attachment A Phone Interview Guide (Attachment B in QA Plan)
- Attachment B Case Review Summary (Attachment F in QA Plan)
- Attachment C Desk Review Guide (Attachment A in QA Plan)
- Attachment D Denied Case Review Summary (Attachment G in QA Plan)
- Attachment E Immediate Action Notice (Attachment H in QA Plan)
- Attachment F Case Review Findings Decision (Attachment I in QA)

REFERENCES

ACL No. 13-110 – Release of California Department of Social Services (CDSS) In-Home Supportive Services (IHSS) Quality Assurance/Quality Improvement (QA/QI) Policy Manual

In-Home Supportive Services (IHSS) Quality Assurance/Quality Improvement (QA/QI) Policy Manual

MPP 30-702 – County Quality Assurance and Quality Improvement

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REVISION RECORD

REVISION NUMBER	DESCRIPTION OF CHANGE	REVISION COMPLETED BY	DATE
0	Initial Release		
1	Added new coding ADS-PP-002-V1-IHSS QA. No changes were made to the policy or procedure content.		7/27/2026
2			
3			
4			
5			

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Attachment A

Imperial County Dept. of Social Services-IHSS-Quality Assurance | Attachment B

PHONE INTERVIEW GUIDE

Recipient's Name:

Case Number:

Case Worker:

Date:

If client is not able to answer due to a condition, document condition and name/relationship of person answering questions:

Name/Relationship:

Reason:

I am _____ from IHSS Quality Assurance. Your case has been selected randomly to be reviewed. May I ask you a few questions to confirm that the information that is in your case is correct? This will take 5-10 minutes (if now is not a good time, when may I call you back?)

QUESTIONS	CORRECT?	COMMENTS
Your full name	☐ Yes ☐ No	
Your date of birth	☐ Yes ☐ No	
Your address	☐ Yes ☐ No	
Current address and date of move	☐ Yes ☐ No	
Primary Language	☐ Yes ☐ No	
Ethnicity	☐ Yes ☐ No	
Are you related to someone that works for IHSS (County section)?	☐ Yes ☐ No	
If yes, what is the employee name?		
Living arrangements-how many people live in the home? If different, who moved in/out the home?	☐ Yes ☐ No	
Does anyone else in your home receive IHSS?	☐ Yes ☐ No	
If so, who?		
Is your home a? ☐ House ☐ Apt. ☐ Mobile Home ☐ Other	☐ Yes ☐ No	
Do you have a? ☐ Washer ☐ Dryer	☐ Yes ☐ No	
How many providers do you have?	☐ Yes ☐ No	
The name of your provider is?	☐ Yes ☐ No	
Your relationship to your provider is?	☐ Yes ☐ No	
How many hours a day does your provider work?	☐ Yes ☐ No	
How many days a week?	☐ Yes ☐ No	
What days of the week? ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S ☐ SU	☐ Yes ☐ No	
Who authorizes the timesheets? If client has an AR, verify AR form was completed and filed in recipient's file	☐ Yes ☐ No	
Does provider work all the hours reported on the timesheet? If not, why?	☐ Yes ☐ No	
Have you been hospitalized since last renewal?	☐ Yes ☐ No	
If yes, what dates/Hospital?		
Did provider claim hours?	☐ Yes ☐ No	

Thank you for your time. I will report the changes we discussed to your Social Worker. This concludes my review.

RECORD OF CALLS	DATE	TIME	OUTCOME
1 st attempt:			
2 nd attempt:			
3 rd attempt:			

Attachment B

Imperial County Dept. of Social Services-IHSS-Quality Assurance | Attachment F

CASE REVIEW SUMMARY			
Case Sample (Month/Year):		☐ Desk Visit	☐ Phone
		☐ Home	
Case Name: Click or tap here to enter text.	Case Number: Click or tap here to enter text.	Case Worker: Click or tap here to enter text.	
Review Date: Click or tap here to enter text.	Response Due Date: Click or tap here to enter text.	Reviewed By: Click or tap here to enter text.	
TYPE OF ELIGIBILITY			
☐ Status	☐ Income Eligible	☐ PCSP	
☐ IHSS-R	☐ IPO	☐ CFCO	
TYPE OF FINDING			
☐ No Finding	☐ Action Item	☐ Informational Item	
☐ Procedural	☐ Underpayment	☐ Overpayment	

During the Desk/Phone Review, QA found the following Action/Info items:

Action Items:

Informational Items:

RESPONSE REQUIRED			
☐ YES	☐ NO	☐ OST	☐ CASEWORKER
TO BE COMPLETED BY IHSS STAFF			
☐ I agree with findings and corrective action has been taken		☐ I disagree with findings.	

*Explanation must state the specific corrective action(s) taken or reason for disagreement; please include applicable regulation(s) (ACL, ACIN, MPP, WIC).

*Disagreement response must be submitted within 10 calendar days of Review Date.

Imperial County Dept. of Social Services-IHSS-Quality Assurance | Attachment F

Response to Action Item:

Effective Date:_____Hrs. Changed
from_____to_____

Disagreement:

FOR IHSS USE AND PURPOSE ONLY:							
Received by IHSS PM on:		Assigned to:		Date Assigned:			
Completed by:		Completion Date:		Verified by:		Verification Date:	

Attachment C

Imperial County Dept. of Social Services-IHSS-Quality Assurance | Attachment A

DESK REVIEW GUIDE				
Case Name:	Case Number:		Case Worker:	
Review Date:		Reviewed by:		
HOME & PERSON SCREEN & SOC 295	Y	N	NA	COMMENTS
Is case status eligible?	☐	☐	☐	
Is information from SOC 295 complete?	☐	☐	☐	
If blind or visually impaired, is the SOC 295 marked appropriately?	☐	☐	☐	
Is language coded as noted on SOC 295? (Person Home page)	☐	☐	☐	
Does the application date on SOC 295 match the application date in Authorization Summary page in CMIPS?	☐	☐	☐	
If there is a companion case, is it documented in CMIPS? (Homescreen)	☐	☐	☐	
Updated SOC 873 on file properly completed and signed by LHCP and recipient?	☐	☐	☐	
If no SOC 873, was Exception Granted and Alternative Documentation (SOC 876) provided?	☐	☐	☐	
Was SOGI section completed on SOC 295 form?	☐	☐	☐	
Is SOGI info. entered correctly in CMIPS? (ACL 18-77 eff 7/1/18)	☐	☐	☐	
MEDICAL ELIGIBILITY INFORMATION	Y	N	NA	COMMENTS
Is Medi-Cal eligibility active?	☐	☐	☐	
CONTACTS SCREEN	Y	N	NA	COMMENTS
Are contacts correctly entered?	☐	☐	☐	
If the client has an AR/TPRD and/or Legal Representative (i.e. Guardian, Conservator) is the information entered correctly?	☐	☐	☐	
BLIND OR VISUALLY IMPAIRED	Y	N	NA	COMMENTS
Are fields completed correctly if applicable? (I-25-15)	☐	☐	☐	
NOTICE OF ACTION	Y	N	NA	COMMENTS
Is there a NOA in the case for the current assessment period?	☐	☐	☐	
If Intake, was NOA sent timely? (Should be in case notes eff. 2/20/2016)	☐	☐	☐	
If negative action, did client receive a 10-day notice?	☐	☐	☐	
HOUSEHOLD EVIDENCE SCREEN	Y	N	NA	COMMENTS
Are the living arrangements correctly documented, and entered into CMIPS?	☐	☐	☐	
Spouse identified correctly and role documented (e.g. able and available spouse info).	☐	☐	☐	
Minor Recipients: Parent identified correctly and the role is documented (e.g. paid parent provider).	☐	☐	☐	
SERVICE EVIDENCE SCREEN	Y	N	NA	COMMENTS
Is there documentation of recipient's abilities and limitations to justify the Functional Index rank for each service category?	☐	☐	☐	

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Does the diagnosis documented justify the need for service?	☐	☐	☐	
Are computations correct in applicable services?	☐	☐	☐	
Are pro rations correctly entered in CMIPS? Hours authorized need to be within HTG, if not an exception MUST be documented.	☐	☐	☐	

SERVICES	RANKING	TOTAL NEED	WITHIN HTG?		EXCEPTION	
Domestic			☐ Over	☐ Under	☐ Yes	☐ No
Meal Preparation			☐ Over	☐ Under	☐ Yes	☐ No
Meal Cleanup			☐ Over	☐ Under	☐ Yes	☐ No
Laundry			☐ Over	☐ Under	☐ Yes	☐ No
Shopping for food			☐ Over	☐ Under	☐ Yes	☐ No
Other Shopping & Errands			☐ Over	☐ Under	☐ Yes	☐ No
Respiration			☐ Over	☐ Under	☐ Yes	☐ No
B & B Care			☐ Over	☐ Under	☐ Yes	☐ No
Feeding			☐ Over	☐ Under	☐ Yes	☐ No
Bed Baths			☐ Over	☐ Under	☐ Yes	☐ No
Dressing			☐ Over	☐ Under	☐ Yes	☐ No
Menstrual			☐ Over	☐ Under	☐ Yes	☐ No
Ambulation			☐ Over	☐ Under	☐ Yes	☐ No
Transfer			☐ Over	☐ Under	☐ Yes	☐ No
Bathing/Oral			☐ Over	☐ Under	☐ Yes	☐ No
Rub. Skin/Resp.			☐ Over	☐ Under	☐ Yes	☐ No
Prosthetic Assistance			☐ Over	☐ Under	☐ Yes	☐ No
Acc. to Medical Appt			☐ Over	☐ Under	☐ Yes	☐ No
Acc. to Alt. Resources			☐ Over	☐ Under	☐ Yes	☐ No
Protective Supervision			☐ Over	☐ Under	☐ Yes	☐ No
Paramedical Services			☐ Over	☐ Under	☐ Yes	☐ No

PROGRAM EVIDENCE SCREEN	Y	N	NA	COMMENTS
Were services authorized according to SSI/SSP living arrangement?	☐	☐	☐	
Was the application processed timely (i.e. Intake/ICT 90 days or renewal 12 months)?	☐	☐	☐	
Variable Assessment (18 months) criteria met?	☐	☐	☐	
DISASTER PREPAREDNESS SCREEN	Y	N	NA	COMMENTS
IC-CDP-I form completed and consistent with SOC 864, documentation, and CMIPS Disaster Preparedness screen?	☐	☐	☐	
AUTHORIZATION	Y	N	NA	COMMENTS
Does the narrative meet the key elements identified in QA guide? (I-20-15)	☐	☐	☐	
Are services authorized (SOC 293) described in the narrative?	☐	☐	☐	

Imperial County Dept. of Social Services-IHSS-Quality Assurance | Attachment A

Are alternate resources identified and inquiry documented?	☐	☐	☐	
Was Motor Voter offered?	☐	☐	☐	
Was SOC 450 completed for voluntary services? (if applicable)	☐	☐	☐	
If applicable, is there a medical verification on file of the spouse's inability to perform domestic and related services?	☐	☐	☐	
If applicable, is there documentation of spouse's unavailability due to employment, health, or other unavoidable reasons to justify authorization of domestic/related services, medical accompaniment, and protective supervision? (ACL 21-91)	☐	☐	☐	
Are guidelines correctly applied to the case if client is under age 18? (ACL 15-45)	☐	☐	☐	

****FORMS****

SOC 864-INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT	Y	N	NA	COMMENTS
Was a new SOC 864 form completed and properly signed during the home visit?	☐	☐	☐	
SOC 332-RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST	Y	N	NA	COMMENTS
Is there a new SOC 332 form completed and containing appropriate signatures?	☐	☐	☐	
IC-NRPR-NOTIFICATION TO RECIPIENT ABOUT PROVIDER RESPONSIBILITIES				
Is there a new IC-NRPR form completed and containing appropriate signatures?	☐	☐	☐	
SOC 426A-RECIPIENT DESIGNATION OF PROVIDER	Y	N	NA	COMMENTS
Is there a SOC 426A form for each provider currently working for the recipient?	☐	☐	☐	
SOC 2256-RECIPIENT & PROVIDER WORKWEEK AGREEMENT	Y	N	NA	COMMENTS
Does client have more than one provider?	☐	☐	☐	
Is form complete (if more than one provider)? (optional)	☐	☐	☐	
Are client's hours distributed correctly amongst active IPs?	☐	☐	☐	
SOC 2305-REQUEST FOR EXEMPTION FROM WORKWEEK LIMITS FOR EXTRAORDINARY CIRCUMSTANCES (EXEMPTION 2)	Y	N	NA	COMMENTS
If IP has 2 or more recipients and hours exceed 66 hours per week, was applicable form used? (ACL 18-31)	☐	☐	☐	
SOC 321-REQUEST FOR ORDER AND CONSENT - PARAMEDICAL SERVICES	Y	N	NA	COMMENTS
If paramedical services are authorized, is there a current SOC 321 form on file?	☐	☐	☐	
Is SOC 321 form consistent with authorized services?	☐	☐	☐	

Imperial County Dept. of Social Services-IHSS-Quality Assurance | Attachment A

Was the SOC 321 form received & signed by the physician prior to service authorization?	☐	☐	☐	
SOC 821-ASSESSMENT OF NEEDS FOR PROTECTIVE SUPERVISION FOR IHSS	Y	N	NA	COMMENTS
If protective supervision services are authorized, is there a signed and dated form from the client's physician on file?	☐	☐	☐	
If protective supervision was authorized, is it described in the narrative?	☐	☐	☐	
Was the need of protective supervision confirmed by client's physician?	☐	☐	☐	
Are calculations on SOC 293 form for protective supervision correct?	☐	☐	☐	
Is the continued need for protective supervision documented during the Reassessment?	☐	☐	☐	
Is there a completed SOC 825 form on file?	☐	☐	☐	
SOC 839-DESIGNATION OF AUTHORIZED REPRESENTATIVE	Y	N	NA	COMMENTS
If interview was conducted with other than client, was SOC 839/AR form completed?	☐	☐	☐	
If client is unable to verify/approve Timesheets and/or Provider Related Documents (TPRD), is there an SOC 839 and/or SOC 839A form completed?	☐	☐	☐	
If applicable, is there a SOC 839B/Cancellation of AR/TPRD Signatory form completed?	☐	☐	☐	
LANGUAGE	Y	N	NA	COMMENTS
Is the Civil Rights form (IC-CR) properly completed?	☐	☐	☐	
If non-English speaking, was case properly assigned?	☐	☐	☐	
If not, was the use of an interpreter documented?	☐	☐	☐	
TASKS SCREEN	Y	N	NA	COMMENTS
Were there any tasks generated in the last 12 months?	☐	☐	☐	
If yes, were tasks completed in a timely manner?	☐	☐	☐	
If no, what happened to the tasks?	☐	☐	☐	
MISCELLANEOUS	Y	N	NA	COMMENTS
Are documents properly filed in case folder?	☐	☐	☐	

****CHORE PROVIDER DATA****

CASE PROVIDER SCREEN	Y	N	NA	COMMENTS
Is there an active provider?	☐	☐	☐	
If there is no active provider, did the caseworker follow up with the recipient (i.e. referral to Public Authority or provide info for IP enrollment process)	☐	☐	☐	
Is provider's information complete and accurate?	☐	☐	☐	
Do total hours on all active providers match SOC 293?	☐	☐	☐	
Are payment current in the Timesheets Screen?	☐	☐	☐	
PROVIDER FORMS	Y	N	NA	COMMENTS
Is there a signed and dated SOC 426 in provider(s) file?	☐	☐	☐	

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Is there an SOC 846 form in provider file (version 8/2015)?

☐	☐	☐
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Is SOC 2255 filed in provider's file (if IP has more than one recipient)?

☐	☐	☐
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Is there a signed and dated IC-PR/Provider Responsibilities form in provider's file?

☐	☐	☐
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Attachment D

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DENIED CASE REVIEW SUMMARY		
Case Sample (Month/Year): Click or tap here to enter text.		
Case Name: Click or tap here to enter text.	Case Number: Click or tap here to enter text.	Case Worker: Click or tap here to enter text.
Reviewed by: Click or tap here to enter text.	Reviewed Date: Click or tap here to enter text.	Response Due Date:
TYPE OF FINDING		
☐ No Finding	☐ Procedural	
☐ Action Item	☐ Informational Item	

During the Desk Review, QA found the following Action/Informational items:

Action Items:

Informational Items:

RESPONSE REQUIRED	
☐ YES	☐ NO
TO BE COMPLETED BY IHSS STAFF	
☐ I agree with findings and corrective action has been taken	☐ I disagree with findings.

*Explanation must state the specific corrective action(s) taken or reason for disagreement; please include applicable regulation(s) (ACL, ACIN, MPP, WIC).

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*Disagreement response must be submitted within 10 calendar days of Review Date.

Response to Action Item:

Disagreement:

FOR IHSS USE AND PURPOSE ONLY:					
Received by IHSS PM on:		Assigned to:		Date Assigned:	
Completed by:		Completion Date:		Verification Date:	

Attachment E

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IMMEDIATE ACTION NOTICE		
Sample Month/Year:	Review Date Completed:	Response Due Date:
Case Name:	Case Number:	Case Worker:
Reviewed By:		

IMMEDIATE ACTION ITEMS: The above case was reviewed by QA and found items that need immediate action.

☐ **Critical Incident:** the health and safety of the recipient is at risk due to inadequate service delivery or inaccuracy of current assessment.

☐ **IHSS Services Ineligible:** recipient has been found to be ineligible for a specific IHSS service; for instance, any case without a Request for Order and Consent – Paramedical Services Form (SOC 321).

For the options stated below, the IHSS caseworker is required to immediately close the case, subject to the 10-day NOA.

☐ **1. Recipient moved out of State/County:** recipient is no longer an Imperial County resident.

☐ **2. Recipient is unwilling to give information/complete a home visit:** in case a recipient agrees to cooperate with QA, caseworker must contact QA. Case cannot be reopened unless recipient has cooperated with QA first.

☐ **3. Recipient is ineligible for IHSS:** recipient has been found to be ineligible for IHSS services; for instance, any case without a Health Care Certification Form (SOC 873) or alternative documentation.

ESSENTIAL FACTS:

RECOMMENDATION:

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APPLICABLE REGULATION(S):

TO BE COMPLETED BY IHSS STAFF	
☐ I agree with findings and corrective action has been taken	☐ I disagree with findings.

*Explanation must state the specific corrective action(s) taken or reason for disagreement; please include applicable regulation(s) (ACL, ACIN, MPP, WIC).

*Disagreement response must be submitted within 3 calendar days of Review Date.

RESPONSE TO IMMEDIATE ACTION:

DISAGREEMENT:

FOR IHSS USE AND PURPOSE ONLY:					
Received by IHSS PM on:		Date of action:		Effective Date:	
Completed by:		Completion Date:		Approval Date:	

Attachment F

Imperial County Dept. of Social Services-IHSS-Quality Assurance | Attachment I

CASE REVIEW FINDINGS DECISION		
Review Month/Year:	Date Review Completed:	Date Received: Click or tap here to enter text.
Case Name: Click or tap here to enter text.	Case Number: Click or tap here to enter text.	Case Worker: Click or tap here to enter text.

Thank you for your response to the case review findings. Disposition to your challenge/corrective action is indicated below:

CORRECTIVE ACTIONS:

☐ The documents you provided as verification of your corrective action(s) are not sufficient.

DISAGREEMENT WITH FINDINGS:

☐ Your challenge to the findings is accepted; the finding will be removed.

☐ Your challenge to the findings is not accepted; the finding stands and corrective action(s) is required.

☐ As a result of the corrective action taken, a new finding was identified requiring corrective action(s).

EXPLANATION OF DECISION:

QA Reviewer:	Date:Click or tap here to enter text.
QA Supervisor: Click or tap here to enter text.	Date:

IHSS RESPONSE:

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FOR IHSS USE AND PURPOSE ONLY:							
Received by IHSS PM on:		Assigned to:		Date Assigned:			
Completed by:		Completion Date:		Verified by:		Verification Date:	