In-Home Supportive Services Application Referral Form

I. CONTACT INFORMATION	REFERRAL DATE:
1. Who is making the referral? ☐Self ☐Parent ☐ Adult son ☐ Adult Daughter ☐ Friend ☐ Hospital Discharge Planner ☐ Other, please explain: Your name: Telephone Number:	
2. Applicant Name:	**3.** Gender: ☐Male ☐ Female
4. Social Security Number:	**5.** Birthdate:
6. Language/Ethnicity:	**7.** Marital Status:
8. Address: City State Zip	
9. Email Address:	**10.** Telephone Number:
11. Are you related to a Napa County Employee? ☐ Yes ☐ No If yes, who?	
12. Whom should we contact for additional information? ☐ Applicant ☐ Other, please provide name & telephone number:	
II. HOUSEHOLD COMPOSITION	
13. Does the applicant live alone? ☐ Yes ☐ No (List household members below)	
Name of Spouse:	
Birthdate:	Social Security Number:
Name of:☐Parent☐Child☐Other Relative☐Non-Relative	
Birthdate:	Social Security Number:
Name of:☐Parent☐Child☐Other Relative☐Non-Relative	
Birthdate:	Social Security Number:
Name of:☐Parent☐Child☐Other Relative☐Non-Relative	
Birthdate:	Social Security Number:
Name of:☐Parent☐Child☐Other Relative☐Non-Relative	
Birthdate:	Social Security Number:
Name of:☐Parent☐Child☐Other Relative☐Non-Relative	
Birthdate:	Social Security Number:
III. DIAGNOSIS/HEALTH PROBLEMS	
14. What is your disabling condition(s) (including mental illness)?	
15. Is the applicant on hospice or end of life care? ☐Yes ☐No **16.** Is the applicant currently in a care facility? ☐Yes ☐No If yes, discharge date:	
17. Do you expect your disability to last 12 months or more? ☐ Yes ☐ No	
NOTE: State law requires that each person applying for IHSS provide a health care certification from a licensed health care professional. Here is the link to the required Health Care Certification Form (SOC 873): https://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC873.pdf	
IV. CARE PROVIDER NEEDS	
18. Is there someone currently helping you? ☐ Yes ☐ No If yes, who?	
19. Additional Information:	
V. ELIGIBILITY/ACCOMMODATIONS	
20. Do you have Medi-Cal? ☐ Yes ☐ No – If no, you will need to apply.	
21. Are you blind or visually impaired? ☐ Blind ☐ Visually Impaired ☐ N/A	
22. If you are blind or visually impaired, would you like an accommodation? ☐ No ☐ N/A ☐ 18 point font documents ☐ Audio CD ☐ Data CD ☐ County Support	

FOR COUNTY USE ONLY		
Referral Complete: ☐ Yes ☐ No	Recommend Expedite Application: ☐ Yes ☐ No	
Follow-Up Required: ☐ Yes ☐ No	Follow-Up Completed On:	
Previously Received IHSS: ☐ Yes ☐ No	Social Worker Name:	
Confirmation/Case #:		
Assign To:	SW Phone #:	Date Assigned:
QA Medi-Cal Aid Code:	QX Living Arrangement:	SOC:

APPLICATION FOR IN-HOME SUPPORTIVE SERVICES

To the Applicant: All sections of this form must be completed. Information provided is subject to verification.

NOTE: Retain your copy of your completed application. Regarding your Social Security Number, it is mandatory that you provide your Social Security Number(s) as required in 42 USC 405, or that you apply for a Social Security Number(s) with the Social Security Administration. This information will be used in eligibility determination and coordinating information with other public agencies.

Date of Application:	**Case Number (if known):**

Section 1 – Personal Information

<table>
<tr><td colspan="2">Name of Applicant:</td><td colspan="2">Social Security Number:</td></tr>
<tr><td colspan="2">Street Address:</td><td colspan="2">City:</td></tr>
<tr><td>State:</td><td>Zip Code:</td><td colspan="2">Telephone:</td></tr>
<tr><td colspan="2" rowspan="2"></td><td colspan="2">Email:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">Sex: ☐ Male ☐ Female</td></tr>
</table>

Section 2 – Sexual Orientation and Gender Identity (Optional)

Providing responses in the sections below is optional and confidential. Any information you provide in this section will not be used in your eligibility determination.

What is your gender identity?
(check the box that best describes your current gender identity)

- ☐ Female
- ☐ Male
- ☐ Transgender: male to female
- ☐ Transgender: female to male
- ☐ Non-Binary (neither male nor female)
- ☐ Another gender identity
- ☐ Decline to state

What sex was listed on your original birth certificate? ☐ Female ☐ Male
How do you describe your sexual orientation? Select one answer. ☐ Straight/heterosexual ☐ Another sexual orientation ☐ Gay or lesbian ☐ Unknown ☐ Bisexual ☐ Decline to state ☐ Queer

Section 3 – Veteran Information

Are you a Veteran? ☐ Yes ☐ No	**Are you a Spouse/Child of a Veteran?** ☐ Yes ☐ No
If YES, give Veteran name and Claim Number:	

Section 4 – SSI/SSP Information

Do you receive SSI/SSP benefits? ☐ Yes ☐ No
If yes, check your type of living arrangement: ☐ Independent Living ☐ Board and Care ☐ Home of Another
Services being requested:

Section 5 – Past IHSS Information

Have you received In-Home Supportive Services (IHSS) in the past? ☐ Yes ☐ No	
If Yes, complete the following. **Date and county where service was last received:**	
Total Monthly Hours:	**Name Used (if different from above):**

Section 6 – Household Information

List Household Members:

Name of Spouse:	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**
Name of: ☐ Parent ☐ Child ☐ Other Relative ☐ Non-Relative	
Birthdate:	**Social Security Number:**

Section 7 – Ethnic and Language Information

The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.

A. My Ethnic Origin is: **Please choose one** (See Page 8 for a list of Ethnicities and Codes)	**B1. What language do you prefer to read?** **Please choose one** **B2. What language do you prefer to speak?** **Please choose one** (Please choose one from the list of Languages and Codes on Page 8)

Section 8 – Communication Accommodations

To accommodate blind or visually-impaired applicants, IHSS information is available in the following alternative formats. Please indicate which format you would prefer, if applicable. Providing information in this section will not affect your eligibility for services.

I am Blind: ☐ Yes ☐ No

If yes, please choose one of the following for each of the three types of Department of Social Services (DSS) documents listed.

For Notices of Action: ☐ No accommodation is needed ☐ Braille Documents
☐ Audio CD ☐ Data CD ☐ County Support

(If County Support, describe requested support)

For IHSS Required forms: ☐ No accommodation is needed ☐ Braille Documents
☐ Audio CD ☐ Data CD ☐ County Support

(If County Support, describe requested support)

For Timesheets: ☐ No accommodation is needed
☐ Telephonic System (4 Digit RAN:) ☐ County Support
☐ Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)

(If County Support, describe requested support)

I am Visually Impaired: ☐ Yes ☐ No

If yes, please choose one of the following for each of the three types of Department of Social Services (DSS) documents listed.

For Notices of Action: ☐ No accommodation is needed ☐ 18 point font documents ☐ Audio CD ☐ Data CD ☐ County Support
(If County Support, describe requested support)
For IHSS Required forms: ☐ No accommodation is needed ☐ 18 point font documents ☐ Audio CD ☐ Data CD ☐ County Support
(If County Support, describe requested support)
For Timesheets: ☐ No accommodation is needed ☐ Telephonic System (4 Digit RAN:) ☐ 18 point font documents ☐ County Support ☐ Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)
(If County Support, describe requested support, including blind-only services)

Section 9 – Affirmation

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1. Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2. Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3. Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4. Notifying the County IHSS office within 10 days when I hire or fire a provider.

In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1. In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2. If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3. The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4. I will be responsible for paying for any services I receive that are not included in my IHSS authorization.
5. I will be responsible for paying my Share-of-Cost (SOC) and informing my individual provider(s) of that SOC.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity and quality assurance, I may be subject to (un)announced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

Section 10 – Signature(s)

Signature of Applicant:	**Date:**
Signature of Applicant's Representative (only if applicable):	**Date:**
Representative's Relationship to Applicant (only if applicable):	**Representative's Telephone Number (only if applicable):**
Representative's Address (only if applicable):	

To report suspected fraud or abuse in the provision or receipt of IHSS services, please call the fraud hotline at 1-800-822-6222, email at stopmedicalfraud@dhcs.ca.gov, or go to http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

FOR AGENCY USE ONLY

Income Eligible: ☐ Yes ☐ No	**Status Eligible:** ☐ Yes ☐ No	**Medi-Cal Aid Code:**
MAGI Eligible Recipient: ☐ Disabled 12 months or longer ☐ At risk without IHSS	**Verification:**	
Notes:		
Signature of Social Worker or Agency Representative:	**Telephone Number:**	

Ethnic Codes:

A. White.
B. Hispanic.
C. Black.
D. Other Asian or Pacific Islander.
E. American Indian or Alaskan Native.
F. Filipino.
G. Chinese.
H. Cambodian.
I. Japanese.
J. Korean.
K. Samoan.
L. Asian Indian.
M. Hawaiian.
N. Guamanian.
O. Laotian.
P. Vietnamese.
Q. Other.
R. Mixed Ethnicity.

Language Codes:

1. American Sign Language (AMISLAN or ASL).
2. Spanish - NOA will be issued in Spanish.
3. Cantonese.
4. Japanese.
5. Korean.
6. Tagalog.
7. Other non-English.
8. English.
9. Spanish - NOA will be issued in English.
10. Other Sign Language.
11. Mandarin.
12. Other Chinese Languages.
13. Cambodian.
14. Armenian.
15. Ilacano.
16. Mien.
17. Hmong.
18. Lao.
19. Turkish.
20. Hebrew.
21. French.
22. Polish.
23. Russian.
24. Portuguese.
25. Italian.
26. Arabic.
27. Samoan.
28. Thai.
29. Farsi.
30. Vietnamese.

IN-HOME SUPPORTIVE SERVICES
Recipient/Employer Responsibility Checklist

I, _____ , HAVE BEEN INFORMED BY MY SOCIAL WORKER THAT AS A RECIPIENT/EMPLOYER, I AM RESPONSIBLE FOR THE ACTIVITIES LISTED BELOW.

1) Provide required documentation to my Social Worker to determine continued eligibility and need for services. Information to report includes, but is not limited to, changes to my income, household composition, marital status, property ownership, phone number, and time I am away from my home.

2) Find, hire, train, supervise, and fire the provider I employ.

3) Comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

NOTE: Refer to Industrial Welfare Commission (IWC) Order Number 15 regarding wages/hours/working conditions obtainable from the State Department of Industrial Relations, Division of Labor Standards and Enforcement listed in the telephone book. Additional information regarding the hiring of minors may be obtained by contacting your local school district.

4) Verify that my provider legally resides in the United States. My provider and I will complete Form I-9. I will retain the I-9 for at least three (3) years or one (1) year after employment ends, which ever is longer. I will protect the provider's confidential information, such as his/her social security number, address, and phone number.

5) Ensure standards of compensation, work scheduling and working conditions for my provider.

6) Inform my Social Worker of any future change in my provider(s), including:

- ___ Name
- ___ Address
- ___ Telephone Number
- ___ Relationship to me, if any
- ___ Hours to be worked and services to be performed by each provider

7) Inform my provider that the gross hourly rate of pay is $ 13.00 , and that Social Security and State Disability Insurance taxes are deducted from the provider's wages.

8) Inform my provider that he/she may request that Federal and/or State income taxes be deducted from his/her wages. Instruct the provider to submit Form W-4 (for federal income tax withholding) and/or Form DE 4 (for state income tax withholding).

9) Inform my provider that he/she is covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.

10) Inform my provider that he/she will receive an information sheet that will state my authorized services and the authorized time given to perform those services. Inform the provider that he/she is not paid to perform work when I am away from my home (for example, when in a hospital or away on vacation).

11) Pay my share of cost, if any.

12) Verify and sign my provider's timesheet for each pay period, showing the correct day(s) and the total number of hours worked. I understand I can be prosecuted under Federal and State laws for reporting false information or concealing information. I understand that when required, it will be necessary for me to place my fingerprint on my provider's timehsheet to verify the correct day(s) and hours worked. This will be necessary, so my provider can be paid.

13) Ensure my provider signed his/her timesheet.

14) Advise my provider to mail his/her signed timesheet to the appropriate address at the end of each pay period.

_____ _____
Recipient' Signature Date

_____
Printed Name

INSTRUCTIONS FOR USE OF THE RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST

1. This form is used for review with recipients receiving service from Individual Providers **only**.
2. Counties shall use this form to assure that recipients have been advised of and understand their basic responsibilities as employers of IHSS providers.
3. Review each item with the recipient and explain how the recipient can comply with each requirement.
4. Leave a copy of the form with the recipient.

A Tradition of Stewardship
A Commitment to Service

Social Worker: _____

Phone Number: _____

In-Home Supportive Services Guidelines

1. You have the right & responsibility to self-direct. This includes: deciding where you want to live, having choice and control over your daily schedule, having the choice to participate in community activities and having the choice to seek employment if you so desired

2. If you are determined eligible for In-Home Supportive Services (IHSS), you will receive a Notice of Action (NOA) that describes what services you are authorized to receive and the total number of IHSS hours that have been authorized per month. You will also receive notification of your weekly authorized hours (SOC2271A). Some months have more days than others; however, your IHSS hours will remain the same. **You are responsible for payment of any hours your provider works that exceed your monthly authorization.**

3. Your NOA identifies those services you are eligible to receive. **Do not** ask your provider to do things that are not included on your NOA.

4. IHSS providers are eligible to receive overtime pay for IHSS work over 40 hours per workweek. It is important you create a schedule with your provider to assure they do not work more overtime than is authorized for your situation.

5. Your signature verifies the accuracy and truthfulness of the timesheet. Keep track of the days and hours your care provider works. Write on your calendar the time your care provider starts work and the time they finish.

6. You must report, **within 10 days**, any hospitalizations, changes in income (including SSI), the number of persons in your household, changes in your address or telephone number, trips out of the area and provider changes.

7. You must report, as soon as possible, any immediate threats to your health and safety, such as: serious injury, abuse or neglect.

8. When transportation is authorized it is specific to accompaniment to medical appointments &/or alternative resources.

9. If medical accompaniment is authorized, **do not** expect your provider to transport you in their car free of charge. Agree on an amount to be paid per mile or per trip before work begins. If your provider is unable to provide medical accompaniment, contact your IHSS social worker to discuss alternatives.

10. Federal and State laws require the recovery of all Medi-Cal benefits received after age 55 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children or permanently and totally disabled children. If you would like more information on the Medi-Cal Estate Recovery Program, please contact your Medi-Cal eligibility worker.

11. Publication 13 – Your Rights under California Welfare Programs.

12. Napa County resource guide.

My IHSS social worker has reviewed the above information with me.

_____ _____

Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

This box to be completed by SP/DDSD (Internal use only)

Whose records are to be disclosed:

Name—First	Middle	Last	Social security number	Date of birth (mm/dd/yyyy)

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING.

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT: All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
   - Psychological, psychiatric, or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome [AIDS] or tests for HIV) or sexually transmitted diseases
   - Genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living or affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological or speech evaluations, and any other records that can help evaluate function; also teacher's observations and evaluations.
4. Not only past information, but also information created within 12 months after the date this authorization is signed.

FROM WHOM:
- All medical sources (hospitals, clinics, physicians, psychologists, labs, etc.) including mental health facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by State Programs–Disability Determination Service Division (SP–DDSD)
- Employers
- Others who may know about my condition (family, neighbors, friends)

TO WHOM: The California Department of Social Services (CDSS) or the Department of Health Care Services (DHCS) for the purpose of determining whether I qualify for disability benefits, including contract copy services used to duplicate the records and doctors or other professionals consulted during the process of making the determination.

PURPOSE: Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet the Social Security Administration's definition of disability.

EXPIRES WHEN: This authorization is good for 12 months from the date signed.
- I authorize the use of a copy (including electronic copy or fax) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- Except for actions already taken, I may write to the Disability Determination Service Division and my sources to revoke this authorization at any time (see page 2 for details).
- I am entitled to a copy of this form, if I ask; I also have a right to ask the source to let me inspect or get a copy of the material to be disclosed.
- **I have read both pages of this form and agree to the disclosure above from the types of sources listed.**

INDIVIDUAL authorizing disclosure

Signature	Date	MINOR CONSENT SERVICES ONLY
		☐ Yes ☐ No

If not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain relationship to subject and why the subject is unable to sign.)

NOTE: MINORS AGE 12 AND OLDER WHO COULD CONSENT TO SERVICES UNDER THE FAMILY CODE, MUST SIGN A RELEASE. ADDITIONALLY, THE PARENT OR GUARDIAN OF EVERY MINOR MUST SIGN A SEPARATE RELEASE EXCEPT IN THOSE CASES INVOLVING MINOR CONSENT ONLY. (See explanation on the reverse.)

WITNESS: I know the person signing this form or am satisfied of this person's identity: (Required for "X," illegible, or foreign character signatures)

Signature		Date	
Street address (number, street)	City	State	ZIP code

This general and special authorization to disclose information has been developed to comply with the provisions regarding disclosure of medical and other information under: The Health Insurance Portability and Accountability Act, Section 262 (a), 42 U.S. Code, Section1320d–1320d-8 (45 CFR Part 164); 42 U.S. Code, Section 290dd-2 (42 CFR part 2); 38 U.S. Code, Section 7332; 20 U.S. Code, Section 1232g (34 CFR Parts 99 and 300); and state law, including Civil Code, Section 56.10(b), Welfare and Institutions Code, Sections 10850 and 14100.2 and Civil Code, Sections 1798–1798.78.

DO NOT ALTER THIS FORM

Explanation of MC 220
AUTHORIZATION FOR RELEASE OF INFORMATION

We need your written authorization to help you get the information required to process your application for disability. Laws and regulations require that sources have an authorization before releasing information to us. Also, laws require authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form MC 220. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. If you sign such a single authorization, we will make copies of it for each source we contact to get your information. If for any reason we need additional authorizations, we will contact you.

The reason we need minors age 12 and older to sign an authorization, in addition to the authorization signed by the parent/ guardian, is that a confidential physician-patient relationship can exist between a child and his/her doctor based on Family Code, Sections 6920–6929 under certain circumstances once the child turns 12 years of age. HIPAA authorizes disclosure in reliance on the authorization of an unemancipated minor when other provision of law allows the minor to authorize the treatment or care described in the documents to be disclosed. [45 CFR § 164.502(g)(3).] Consequently, it may be necessary to secure the child's consent in lieu of or in addition to consent by a parent in order to secure access to the needed information.

You have the right to revoke and/or modify this authorization at any time, except to the extent an action has already occurred. To do so, send a written statement to State Programs - Disability Determination Service Division (DDSD), Attn: Professional Relations Specialist. If you do, also send a copy directly to any of your sources of information that you no longer wish to disclose information about you. The California Department of Social Services can tell you if we identified any sources you did not originally tell us about. As described below, revocation or modification could result in loss of benefits.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE INFORMATION PRACTICES ACT

All personal information collected by CDSS is protected by the Information Practices Act of 1977. In addition, information made or kept by CDSS or the DHCS in connection with the Medi-Cal program is protected by California Welfare & Institutions Code, Section 14100.2; and Title 42, United States Code (USC), Section 1396a(a)(7). Information is retained by CDSS in adherence to retention schedules prescribed by the department.

CDSS is authorized to collect the information, acting under an agreement with the DHCS, on this form under Section 14011 of the California Welfare and Institutions Code and regulations in Title 22, California Code of Regulations (CCR). The information on this form is needed to make a decision on the named applicant or beneficiary's application for, or continued eligibility for, Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application or on the continuation of benefits. Although the information obtained with this form is not typically used for any purpose other than making a determination of the applicant's disability status, such information may be disclosed by CDSS or DHCS for reasons related to the administration of the Medi-Cal Program, such as, but not necessarily limited to: (1) to enable a third party or agency to assist CDSS or DHCS in establishing rights to Medi-Cal benefits, (2) to facilitate statistical research, audit activities and fraud and abuse investigations/programs necessary to assure the integrity and improvement of the Medi-Cal Program, and (3) in administrative and related legal proceedings involving your appeal of a decision of the Medi-Cal Program. An individual has a right to access records containing his/her personal information that are maintained by CDSS. The official responsible for maintaining the information is the Deputy Director of the Disability Determination Service Division, 744 P Street, Sacramento, CA, 95814, (916) 657-2265.

ATTENTION APPLICANTS/RECIPIENTS FOR CASH ASSISTANCE PROGRAM FOR AGED, BLIND OR DISABLED IMMIGRANTS (CAPI)

In CAPI cases, in addition to the protection afforded to personal records by the Information Practices Act, as discussed above, the documents and information collected based on this authorization are subject to the protection accorded by Welfare and Institutions Code, Section 10850, et. seq., but not that provided by Welfare and Institutions Code, Section 14100.2 or other provisions applicable to the Medi-Cal Program. In general, Section 10850 forbids disclosure of lists of recipients on nonmedical public social services such as CAPI, or other identifying information or personal information for any purpose not connected with the administration of CAPI. The law authorizes the use of the records in connection with investigation, auditing, and in administrative, civil and criminal proceedings connected with CAPI program administration. The law also authorizes the sharing of such information with other public agencies for the purposes of determining eligibility for and other purposes connected with the administration of public social services, and with school officials for the purposes of administering federally assisted programs providing cash assistance or in-kind services directly to individuals based on need. Also, the law authorizes disclosure of information for research purposes, provided that information identifying the person who the records are about, is removed from the records. There is also the possibility of disclosure pursuant to an order of a court of competent jurisdiction. In reality, however, the kinds of records actually collected for the CAPI program based on this authorization are likely to be used exclusively for determining disability, except where a court orders disclosure for other purposes.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Check One)

☐ Already registered. I am registered to vote at my current residence address.

☐ Yes. I would like to register to vote. (Please fill out the attached voter registration form.)

☐ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

_____

Applicant Name Date

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.

2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.