

(A)

Robert's Rules of Order  
IHSS Advisory committee

"Whether these forms be in all cases the most rational or not is really not of so great importance. It is much more material that there should be a rule to go by than what that rule is; that there may be a uniformity of proceeding in business, not subject to the caprice of the chairman or captiousness of the members. It is very material that order, decency, and regularity be preserved in a dignified public body."

H.M.R.

*February, 1915.*

## **Plan of Work**

- ✘ Manual – there should be a manual of rules that is kept and held by the Committee.

## **What does Robert's Rules cover?**

The object of Rules of Order is to assist an assembly to accomplish in the best possible manner the work for which it was designed. To do this it is necessary to restrain the individual somewhat, as the right of an individual, in any community, to do what he pleases, is incompatible with the interests of the whole. Where there is no law, but every man does what is right in his own eyes, there is the least of real liberty. Experience has shown the importance of definiteness in the law; and in this country, where customs are so slightly established and the published manuals of parliamentary practice so conflicting, no society should attempt to conduct business without having adopted some work upon the subject as the authority in all cases not covered by its own special rules.

In other words it is important to have rules. These rules must work for the Committee that is using them. Using Robert's Rules as a baseline, every Committee should create a set of rules that works for their own group, agree upon them and put them in writing.

## Parliamentary Law

× **Parliamentary Law** refers originally to the customs and rules for conducting business in the English Parliament. Eventually this led to rules for governmental and other meetings in general. In England these usages of Parliament form a part of the unwritten law of the land, and in our own legislative bodies they are of authority in all cases where they do not conflict with existing rules or precedents.



What that means is that we follow Robert's Rules of Order unless our Bylaws or precedents (those rules that are not written down, but that we always follow anyway). Robert's rules also states that members should not be made uncomfortable by rules.

## Meeting Organization

- ✘ Agenda
- ✘ The chair follows the agenda and announces each item (business) on the agenda.
- ✘ If there is no response the chair will announce that there are no reports for this item and move on through the agenda. When the end of the agenda has been reached, the chair will call for an adjournment motion.



## **Introduction of Business**

### **× By Motion** (not common)

If there is disagreement among the committee about whether or not information (business) should be presented to the Committee then there must be a motion to determine if it should.

**× By presentation** (common) Anyone making a presentation to the Committee may bring information and hand it out to the Committee during the presentation.

**× By communication** (common) Any member, presenter or interested party may bring information in any form of communication (talking, pictures, hand outs etc.) to the committee.

Information can be brought by motion, but usually isn't. This committee has never had information brought to them by a motion, but if a member disagreed with information scheduled to be brought before the Committee, he/she could voice disagreement and then there must be a motion and the information would be voted on. For instance, the coordinator regularly brings the newsletter to the committee for review or for information. If a member thought the committee should not deal with the newsletter he or she could disagree. At that time someone would introduce a motion to review the newsletter. (Or not and that would decide the issue as well) then it would be voted on

## **Obtaining the floor**

- ✘ Before a member can call for or make a motion, speak or rebut, he or she must "Obtain the Floor."

This means that in some way or another, the person who wishes to speak must get the "official" attention of the Committee. Without restrictions like this discussions could go on for hours, or people could speak over one another and the business of the meeting might not get done.



## **✘ Robert's Rules**

According to Robert's Rules a member must stand after the floor has been yielded. This means that the person talking has sat down. Once the member stands he must address the chairman or moderator if one is used. The Chairman recognizes the member and then the member can speak. "Robert's Rules" state that one cannot stand (or in our case raise their hand) until the person is finished speaking. The reason the open discussion is a part of the agenda is so that members can speak freely on many issues.

## **✘ Our Rules**

Our rules (which is our precedent, so that is more important than Robert's Rules.) in the past have been to raise our hand and wait for the Chair to say our name.

## **Motions and Resolutions**

### **What is a Motion?**

- ✘ A motion is a proposal that the committee takes a specific action about or expresses a specific view about.

A motion is a proposal that the assembly take certain action, or that it express itself as holding certain views. It is made by a member's obtaining the floor as already described and saying, "I move that" or (which is equivalent to saying, "I propose that"), and then stating the action he proposes to have taken. A member "moves" (proposes) that a resolution be adopted, or amended, or referred to a committee, or that a vote of thanks be extended, etc. As a general rule no member can make two motions at a time except by general consent.

### **What is a Resolution?**

- ✘ When a motion is of great importance or of great length, then there is need to put the motion in writing. Thus the motion becomes a resolution.

Every resolution should be in writing, and the presiding officer has a right to require any main motion, amendment, or instructions to a committee to be in writing. When a main motion is of such importance or length as to be in writing it is usually written in the form of a *resolution*, that is, beginning with the words, "*Resolved, That,*" So when a member wishes a resolution adopted (like the resolution that went with the Bylaws) after having obtained the floor, he or she would say, "I move the adoption of the following resolution."

## Seconding a Motion

- ✗ A motion is seconded by a member's saying "I second the motion," or "I second it," which he does without obtaining the floor

As a general rule, every motion should be seconded. This is to prevent time being consumed in considering a question that only one person favors, and consequently little attention is paid to it in routine motions. When the chair is certain the motion meets with general agreement, and yet members are slow about seconding it, he or she may ask, "Is the motion seconded?"

The person who is announcing his or her second does not need to repeat the motion.

The chair may, at his or her discretion, choose to repeat the motion.

If no second is made after what the chair believes to be a reasonable time, he or she should point out that no second has been made and if no second is made at this point the motion is ruled "out of order" and not voted upon.



## Stating the Question

- ✗ When a motion has been made and seconded, it is the duty of the chair, unless he or she rules it out of order, to immediately "*state the question.*"

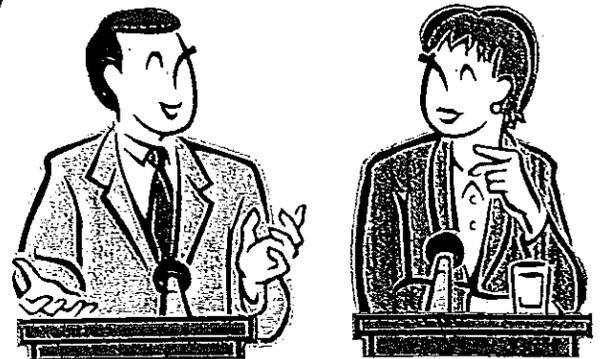
The chair simply repeats the exact question that is before the assembly for its consideration and action. This he may do in various ways, depending somewhat on the nature of the question. For example he or she may say, "It is moved and seconded to amend the resolution by striking out the word 'very' before the word 'good';" or "It is moved and seconded that we adjourn." If the question is debatable or amendable, the chair should immediately ask, "Are you ready for the question?" (Chair generally asks if Committee is ready to vote.) If no one then raises his or her hand the chair should state the question.

## Debating the Question

- ✗ After a question has been stated by the chair, it is before the assembly for consideration and action.

When the chair asks if the Committee is "ready for the questions" or "ready for the vote," any member wishing to address, debate or in any way speak about the motion, would raise his or her hand and be recognized by the chair.

- ✗ All motions except the Undebatable Motions may be debated before final action is taken on them.



An undebateable motion could be a move to adjourn or to "lay a motion on the table."

In the debate each member has the right to speak twice on the same question on the same day (except on an appeal), but cannot make a second speech on the same question as long as any member who has not spoken on that question desires the floor. No one can speak longer than ten minutes at a time without permission of the assembly.

Debate must be limited to the *immediately pending question* -- that is, the last question stated by the chair that is still pending. Speakers must address their remarks to the chair, be courteous in their language and deportment, and avoid all personalities, never alluding to the officers or other members by name, where possible to avoid it, nor to the motives of members.

## Putting the Question to a Vote

- ✘ When the debate appears to have closed, the chair asks again, "Are you ready for the question?" If no one rises he or she proceeds to *put the question* -- that is, to take the vote on the question.

The chair calls for the affirmative and then for the negative votes. The question (motion) should be read again unless it was just read very recently. "The question is on the adoption of the resolution [which the chair reads]; those in favor of the resolution say aye; those opposed say no.

If the vote is by "show of hands," the question is put and the vote announced in a form similar to this; "It has been moved and seconded to lay the resolution on the table. Those in favor of the motion will raise the right hand; those opposed will make their vote it in the same way.

Once the vote is taken, the chair announces the result, "The ayes have it, and the resolution is adopted."







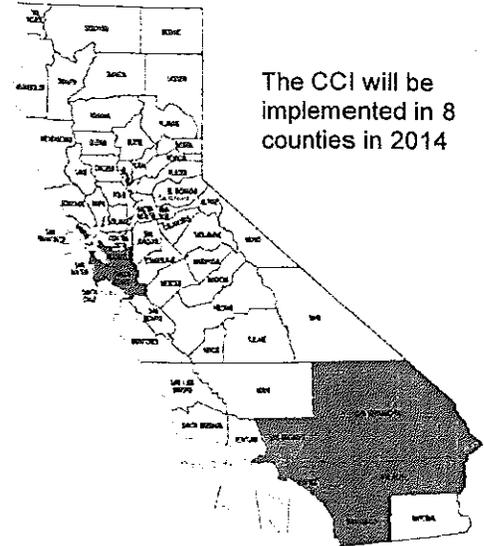
B

## Coordinated Care Initiative Executive Summary

FACT SHEET | Updated August 2013

Passage of the Coordinated Care Initiative (CCI) in 2012 marked an important step toward transforming California's Medi-Cal (Medicaid) care delivery system to better serve the state's low-income seniors and persons with disabilities. Building upon many years of stakeholder discussions, the CCI begins the process of integrating delivery of medical, behavioral, and long-term care services and also provides a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" beneficiaries.

Created through a public process involving stakeholders and health care consumers, the CCI was enacted through SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).



The CCI will be implemented in 8 counties in 2014

### Two Parts of the Coordinated Care Initiative

- 1 *Cal MediConnect*: A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a single health plan. The CCI provides state authority for Cal MediConnect. The MOU executed in March 2013 with the federal Centers for Medicare & Medicaid Services (CMS) provides federal approval.
- 2 *Managed Medi-Cal Long-Term Supports and Services (LTSS)*: Nearly all Medi-Cal beneficiaries age 21 and older,<sup>1</sup> including dual eligible beneficiaries, will be required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

### Better Care Improves Health and Drives Lower Costs

The CCI is expected to produce greater value for the Medicare and Medi-Cal programs by improving health outcomes and containing costs; primarily through shifting service delivery into the home and community and away from expensive institutional settings. Better prevention will keep people healthy. Better care coordination will reduce unnecessary tests and medications. Better chronic disease management will help people avoid unnecessary hospital care.

<sup>1</sup> Populations excluded from passive enrollment into Cal MediConnect and mandatory enrollment in Medi-Cal managed care can be found on a populations summary fact sheet: [www.calduals.org/wp-content/uploads/2013/03/CCIPopulationSummary.pdf](http://www.calduals.org/wp-content/uploads/2013/03/CCIPopulationSummary.pdf)

Under the CCI, the participating managed care health plans will receive a monthly payment to provide beneficiaries access to all covered, medically necessary services through a process called “capitation.” These capitated payments create strong financial incentives for health plans to ensure beneficiaries receive preventive care and home- and community-based options to avoid unnecessary admissions to the hospital or nursing home.

Significant stakeholder feedback informed the beneficiary protections needed to drive success and quality in the CCI’s design and implementation. The CCI includes comprehensive protections to ensure beneficiary health, safety, and high quality care delivery, including medical care, LTSS, and behavioral health.

**Coordinated Care Initiative Goals**

By consolidating the responsibility for all of these covered services into a single health plan, the CCI expects to achieve the following goals:

- 1 Improve the quality of care for beneficiaries.
- 2 Maximize the ability of beneficiaries to remain safely in their homes and communities, with appropriate services and supports, in lieu of institutional care.
- 3 Coordinate Medi-Cal and Medicare benefits across health care settings and improve continuity of care across acute care, long-term care, behavioral health, and home- and community-based services settings using a person-centered approach.
- 4 Promote a system that is both sustainable, person- and family-centered, and enables beneficiaries to attain or maintain personal health goals by providing timely access to appropriate, coordinated health care services and community resources, including home- and community-based services and mental health and substance use disorder services.

**Location and Timing**

The CCI will be implemented in eight counties no sooner than April 2014. The eight counties are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The participating health plans are part of the state’s existing network of Medi-Cal health plans and have experience providing Medicare managed care. Each underwent a rigorous selection process.

**Implementation Status**

With the signing of the MOU in March 2013, the state and federal governments will now conduct a comprehensive readiness review to evaluate each health plan’s major systems

<b>Counties and Primary Health Plans Implementing the CCI</b>	
<b>County</b>	<b>Health Plans</b>
<b><u>Alameda</u></b>	Alameda Alliance for Health
	Anthem Blue Cross
<b><u>Los Angeles</u></b>	L.A. Care
	Health Net
<b><u>Orange</u></b>	CalOptima
<b><u>San Diego</u></b>	Care 1st
	Community Health Group
	Health Net
	Molina Health
<b><u>San Mateo</u></b>	Health Plan of San Mateo
<b><u>Riverside</u></b>	Inland Empire Health Plan
	Molina Health Care
<b><u>San Bernardino</u></b>	Inland Empire Health Plan
	Molina Health Care
<b><u>Santa Clara</u></b>	Anthem Blue Cross
	Santa Clara Family Health Plan

and ensure they are prepared to provide the required continuity of care, seamless access to medically necessary services, and coordinate care across LTSS, behavioral health and medical care. Health plans must pass this review before three-way contracts between the health plans, CMS, and DHCS are signed and before any beneficiary is enrolled.

### ***Enrollment Process***

Enrollment will begin no sooner than April 2014. Notification of these changes will be mailed to eligible participants starting in January 2014.

Enrollment will be phased in over 12 months in all counties, except Los Angeles and San Mateo. The Los Angeles enrollment strategy is currently in development and in San Mateo enrollment will occur the first month of the program.

### ***Understanding Enrollment for Different Populations***

- **For people with both Medicare and Medi-Cal eligible for Cal MediConnect:** The state will use a passive enrollment process. This means that the state will enroll eligible individuals into a health plan that combines their Medicare and Medi-Cal benefits unless the individual actively chooses not to join and notifies the state of this choice. The state will send eligible individuals multiple notices describing their choices, including the option to “opt out” of joining a Cal MediConnect health plan.

**“Opting out”:** This is when an eligible beneficiary chooses not to join a demonstration health plan and keep his or her Medicare benefits separate and out of the demonstration health plan. Beneficiaries who enroll in a Cal MediConnect health plan may opt out or change health plans at any time.

**Note:** Opting out applies only to Medicare benefits. Beneficiaries must still get their Medi-Cal benefits through a health plan, as described below. This

- **For nearly all people with Medi-Cal:** The state will require mandatory enrollment into a Medi-Cal health plan. This means that nearly all people with Medi-Cal in the eight CCI counties **MUST** get all their Medi-Cal benefits, including long-term services and supports, through a Medi-Cal health plan. Most people with only Medi-Cal already are enrolled in a Medi-Cal health plan; now they will also get their long-term supports and services through their health plan.
- **For people with both Medicare and Medi-Cal who do not enroll in a Cal MediConnect Health Plan:** The state will require enrollment in a Medi-Cal plan for all Medi-Cal long-term services and supports and any Medicare deductibles or costs. For dual eligible beneficiaries, enrolling in a Medi-Cal health plan does not change their Medicare benefits. They can still go to their Medicare doctors, hospitals, and providers.

### **Participating Populations**

An estimated 456,000 dual eligible beneficiaries will be eligible for passive enrollment into the Cal MediConnect program in the eight counties, with a maximum of 200,000 in Los Angeles County. An estimated one-third of those beneficiaries already are enrolled in managed care for Medi-Cal, Medicare, or both. Certain people with Medicare and Medi-Cal will not be eligible to enroll in a Cal MediConnect health plan. (A full list of the populations included and excluded is listed in another fact sheet.)

While nearly all people with Medi-Cal in the eight CCI counties will be required to enroll in a Medi-Cal health plan, there are some exceptions. (All exceptions are listed in a separate fact sheet.)

Dual eligible beneficiaries and Medi-Cal seniors and persons with disabilities are among California's highest-need residents. They tend to have many chronic health conditions and need a complex range of medical and social services from many providers. This fragmentation leads to beneficiary confusion, poor care coordination, inappropriate utilization, and unnecessary costs.

Under the CCI, enrolled beneficiaries will have one point of contact for all their covered benefits. They will have one health plan membership card and access to a nurse or social worker whose job is to act as a care coordinator or navigator and help beneficiaries receive the services needed to achieve their personal health goals and continue living in the setting of their choice. The state is developing care coordination standards that will guide how services are linked.

### **Managed Long-Term Supports and Services**

The following Medi-Cal long-term services and supports will only be available through a health plan in the eight CCI counties. The health plan may be a Cal MediConnect health plan or a Medi-Cal only plan, depending on a beneficiary's coverage and choices.

- **In-Home Supportive Services (IHSS)** is personal care for people who need help to live safely at home. In a health plan, people will keep their IHSS providers and can still hire, fire, and manage them. The county IHSS social worker will still assess consumers' needs and approve IHSS hours. The rights to appeal will stay the same.
- **Community Based Adult Services (CBAS)** is adult day health care provided at special centers. This service is available through the health plans.
- **Multipurpose Senior Services Program (MSSP)** provides social and health care coordination services for people 65 and older. Health plans will work with MSSP providers to provide this service.
- **Nursing home care** is long-term care provided in a facility. Health plans will work with enrollees, their doctors and the nursing homes to coordinate care.

### **Behavioral Health Coordination**

Cal MediConnect health plans are responsible for ensuring enrollees have seamless access to all necessary behavioral health services. They will be financially responsible for all Medicare behavioral health services. However, Medi-Cal specialty mental health and Drug Medi-Cal services are carved out of Cal MediConnect benefit packages because they are financed and administered by counties. Cal MediConnect health plans will be expected to coordinate services with county behavioral health agencies.

# Shasta County

# In-Home Supportive Services

## Summer 2013



## Message from the Chair



Sometimes in our lives we take things for granted. IHSS, for example, has now been available in California for 40 years. This incredibly empowering and sustaining program has been a part of our lives for so long that we seldom wonder about its rich history. Of course, with the California budget crisis wreaking havoc on IHSS for practically a decade, we've been in "survival mode," working endlessly to save the program from the scrap heap of budget cuts. We've been mostly successful in our efforts, despite the current cuts to the program that are covered elsewhere in this edition.

So, on the occasion of the 40<sup>th</sup> anniversary of IHSS in 2013, I encourage you to take a little time to explore the historic efforts made by pioneering disability rights advocates that resulted in the establishment of the IHSS program in California. We should always remember and be appreciative of the fact that IHSS wasn't simply granted to the disability community; rather, it was earned through years of tireless struggle by truly heroic advocates.

If you have internet access, or next time you're visiting your local public library, go online and visit [www.capaihss.org](http://www.capaihss.org) and search "history of IHSS." There you'll find an amazing history of the monumental effort it took to establish IHSS and, therefore, free hundreds of thousands of Californians with disabilities from lives in institutions where they don't belong. This history not only provides us with a sense of appreciation for the work that came before us, but also it inspires us for the work that lies before us in preserving IHSS – our lifeline to independence and dignity.

I'm honored to continue as the Chair of the Shasta County IHSS Advisory Committee. I look forward to working with you, my fellow board members and the dedicated IHSS county staff to keep the Shasta County IHSS program as strong as possible.



## IHSS Advisory Committee

Shasta County's IHSS Advisory Committee (IHSSAC) is a group of volunteers who advise on the administration and delivery of the In-Home Supportive Services (IHSS) Program. Members are often people who have either used or provided IHSS services or who have an interest in supporting the program.

The IHSSAC can make recommendations to the Board of Supervisors and any County administrative body that is involved in administering IHSS. Shasta County's IHSSAC distributes an annual newsletter to recipients providing important information about changes in IHSS program and gathers feedback from providers and recipients to find out what types of training and education is needed most. This information is used by IHSS and the Public Authority to provide clarification and education for recipients as they work with new providers.

The IHSSAC meets at least twice a year with additional smaller workgroups meeting in-between. Bi-annual meetings are open to the public. The next IHSSAC meeting is scheduled for Friday, September 20, at the Redding Library, 1100 Parkview Ave., at 1:30 p.m. Visit the [IHSSAC webpage](#) for more information.

# 2013-14 Budget Impacts IHSS Program

## Court Settlement Prevents Major Cuts to IHSS

Beginning July 1, 2013, IHSS recipients will face an 8% across-the board cut in hours. These cuts are a result of a settlement agreement that repeals previously enacted permanent cuts to the IHSS program, including a 20% reduction in hours, cuts in the State's contribution toward IHSS worker wages and major cuts to IHSS recipients based on their functional index scores and rankings.

The 8% reduction in services hours replaces the 3.6% reduction that ended on June 30, 2013. The 8% cut in IHSS hours beginning July 1, 2013 through June 30, 2014, falls to 7% on July 1, 2014 and ends on June 30, 2015.

Some portion of the 7% cut could remain indefinitely if the Governor's Department of Finance, under the settlement agreement, determines that the State will not receive sufficient federal funding for the IHSS program. The reduction of service hours is expected to result in an estimated \$160 million savings in State general funds in 2013-14, and \$159 million savings in 2014-15.

IHSS recipients who have "documented unmet need" hours that exceed the maximum 283 hours, can have the 8% reduction and the later 7% reduction taken first from those hours. If an IHSS recipient requests a reassessment based only on the 8% or 7% reductions, the request can be administratively denied. However, an IHSS recipient has the right to request a reassessment when there are changes in circumstances.



## IHSS Caseload

The number of IHSS recipients in Shasta County and the State has continued to steadily rise. In addition, the average number of service hours associated with each case has also increased. These factors, coupled with the fact that more recipients secured required health care certification than was expected, has caused an estimated increase in IHSS costs to the State General Fund of \$80.3 million in 2012-13, and \$120 million in 2013-14.

## Partnership HealthPlan of California to Manage Medi-Cal

Hundreds of Medi-Cal beneficiaries will soon be receiving notifications from the Department of Health Care Services informing them about big changes to their health plan.

Beginning in September, individuals enrolled in Medi-Cal and those previously enrolled in Healthy Families will transition into a managed health care program called Partnership HealthPlan of California (PHC).

Members can expect better care coordination, access to an Advice Nurse 24 hours a day, seven days a week, and additional program benefits like pulmonary rehabilitation, podiatry for diabetics, weight management and over-the-counter drugs.

With the exception of a few special categories, all Medi-Cal beneficiaries will automatically be transitioned to PHC and will have the opportunity to choose a Primary Care Provider (PCP) to ensure continuous access to quality health care. A list of PCPs will be included with New Member Packets.

It will be *critically important* that Medi-Cal enrollees select a PCP by September 25<sup>th</sup> by calling PHC's Member Services Department at 800-863-4155 or filling out paperwork provided at their doctor's office.

# Communication is Key to Working Well



Communicating successfully with your provider is essential for a happy, productive working relationship. Knowing the best way to

communicate with employees, friends and family starts with good observation and asking questions.

Keep the following techniques in mind to establish good communication:

- **Set a comfortable pace for communication:** Speak in at a slow, conversational pace to allow the person you are speaking with to process what you are saying. Watch facial expressions to see if they fully understand what you are saying. If you are not sure, be sure to ask follow-up questions and clarify.
- **Practice active listening:** Make eye contact when listening. Clarify what you've heard... "What I heard you say is..." Listening in this way communicates interest and respect. Be aware of your own body language. Body language that conveys frustration, impatience or anger sends a stronger message than your words.
- **Make "I" statements:** Take responsibility for your own feelings and respect the other person's feelings. Remember people's feelings are their own and no one can tell them they *do not* or *should not* feel a particular way. The pattern for an "I" statement is "I see/hear/feel (state the issue at hand). It makes me feel (state your feelings). I need (state a possible solution)". Try to avoid "you" statements.

- **Accept a person's individuality:** Recognize that people are different and be open to how they may change over time. Respect their right to be an individual. Sometimes cultural differences lead to misunderstandings. It is helpful to identify when cultural preferences or customs are behind a disagreement. Using "I" statements, learn how your traditions may be different than the person you are working or communicating with.



## CMIPS II Update

On May 1, 2013, the new IHSS payroll system, CMIPS II went live in Shasta County. Since then all timesheets have been processed at the processing center in Chico.

**Thank you for your patience during this transition.**

Please keep in mind the following for timely processing of timecards:

- Please allow 10 business days from the time the processing center in Chico receives your timesheet until you receive payment.
- If errors occur, your paycheck will be delayed - remember that both the provider and recipient must sign the back of the timesheet before submitting.
- To speed up payment time, you may sign up for direct deposit if you have been a provider for at least 90 days. Pick up a direct deposit form at the IHSS office or have one mailed by calling 225-5507.
- If you are unsure how to complete your timecard, an instructional video is available at [www.cdss.ca.gov/agedblinddisabled](http://www.cdss.ca.gov/agedblinddisabled) or at Public Authority, 2640 Breslauer Way, Redding.

Shasta County Public Authority/ IHSSAC  
2634 Breslauer Way  
Redding, CA 96001

PRSR STD  
US POSTAGE  
PAID  
REDDING CA  
PERMIT NO. 7

## Important Phone Numbers

Adult Protective Services (APS) .....	225-5798
California United Homecare Workers Union .....	1-855-834-4034
Golden Umbrella .....	223-6034
IHSS general information .....	225-5507
Independent Living Services .....	242-8550
Public Authority .....	229-8330
Public Guardian .....	225-5103



### Looking for help?

- Talk to a person 24 hours a day, 7 days a week
- Get help with food, health care, utility assistance, and much more
- Referrals to services and programs in *your area*
- By telephone or online



Get updates and IHSSAC news at  
[www.shastahhsa.net](http://www.shastahhsa.net)  
Look for us under About Us, Advisory Boards.

**Dial 2-1-1 or  
visit [211shasta.org](http://211shasta.org)**