

**IN-HOME SUPPORTIVE SERVICES (IHSS)
PROGRAM PROVIDER ENROLLMENT AGREEMENT**

PROVIDER NUMBER

PROVIDER NAME (FIRST, MIDDLE, LAST)

1. I attended the required provider enrollment orientation for IHSS providers and I understand and agree to the following:
 - I was given information about being a provider in the IHSS program.
 - I was informed of my responsibilities as an IHSS provider.
 - I was informed of the consequences of committing fraud in the IHSS program.
 - I was given the Medi-Cal toll-free telephone fraud hotline number, 1-800-822-6222 and web site, <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx> for reporting suspected fraud or abuse in the IHSS program.

2. I understand the following requirements for timesheets:
 - The IHSS program can only pay me for the hours I worked providing authorized services for the recipient that I report on my timesheet.
 - By signing my timesheet I am saying that the information I reported on it is true and correct.
 - Whenever I submit a timesheet, whether on paper or electronically, it must be completed and submitted within two weeks after the end of each pay period. If the timesheet is properly completed and submitted on time, I will get paid within 10 days of the day it is received by the timesheet processing facility. If the timesheet is not submitted within two weeks after the end of the pay period, my pay will be delayed.
 - I cannot sign my timesheet for the recipient or approve my timesheet electronically (even if the recipient shares his/her Electronic Services Portal (ESP) username and password or Telephone Timesheet System (TTS) passcode with me) unless I am the recipient's legal representative (court-appointed guardian or conservator or parent of a minor recipient) and a completed IHSS Designation of Authorized Representative form (SOC 839), Part C has been submitted to the county.
 - I cannot sign another provider's timesheet for the recipient or approve another provider's timesheet electronically (even if the recipient shares his/her ESP username and password or TTS passcode with me) unless I am the recipient's legal representative (court-appointed guardian or conservator or parent of

PROVIDER NUMBER

a minor recipient) OR I have been designated as the recipient's timesheet signatory through the submission of a completed SOC 839, Part C to the county.

- Approving a timesheet, either on paper or electronically, on behalf of the recipient when I am not authorized to do so as specified above may be considered fraud, which can result in criminal charges being brought against me. It is my personal responsibility to confirm that the SOC 839, Part C has been properly completed and submitted to the county prior to me signing or approving any timesheet on the recipient's behalf.
 - Providing false information on my timesheet is a crime and may result in a criminal prosecution.
 - If I am convicted of fraudulently reporting information on my timesheet, in addition to any program or criminal penalties, I may be required to pay back any overpayment I received and to pay civil penalties of at least \$500, and not more than \$1,000, for each act of fraud.
3. I understand that I am required to complete the Employment and Eligibility Verification form (Form I-9), which is kept on file by the recipient. That form states that I have the legal right to work in the United States.
4. I understand that I have the option to submit an Employee's Withholding Allowance Certification (Form W-4) to request federal income tax withholding and/or California Employee's Withholding Allowance Certification (Form DE 4) to request state income tax withholding from my wages. I understand that if I do not submit Form W-4 and/or DE 4, federal and state income taxes will not be withheld from my wages.
5. I understand that I will receive the IHSS Program Notification Of Recipient Authorized Hours and Services and Maximum Weekly Hours (SOC 2271), that names my recipient(s) and the services I am authorized to perform for each recipient to whom I provide services.
6. I received information regarding the maximum weekly hour and travel time requirements and understand the following:
- I will get paid overtime if I work more than 40 hours in a workweek. The workweek begins at 12:00 am (midnight) on Sunday and ends at 11:59 pm on the following Saturday.

PROVIDER NUMBER

- If I work for only one recipient, I can only work up to my recipient's maximum weekly hours each workweek unless we adjust my hours to balance out any extra hours I worked during the workweek by working fewer hours in another week of the month to avoid exceeding my recipient's monthly authorized hours. If these additional hours would cause me to work more than 40 hours in the workweek or to receive more overtime hours in the month than I would in a normal month, the recipient must obtain approval from the county before I can work the additional hours.
- If I submit a timesheet which goes over the maximum weekly hours and causes me to claim more overtime than I normally would claim during a workweek without authorization from the county, I will get a violation.
- If I work for more than one recipient, the maximum number of hours I can work in a workweek for all of my recipients combined is 66 hours. If one of my recipients asks me to work additional hours that would cause me to work over my 66 maximum weekly hours, I must either decline or reduce the hours I work for another recipient so I don't work more than 66 hours in the workweek.
- If I work for more than one recipient on the same day, I can be paid for travel time for the time spent traveling directly from one location where I provide authorized services to a recipient to another location where I provide authorized services for a different recipient. This travel time will not be counted as part of my maximum weekly hours.
- The maximum amount of time I can claim for travel during a workweek is seven hours.
- If I submit a timesheet in which I claim more than seven hours travel time in a workweek, I will get a violation.
- If I claim more travel time hours on my timesheet than I stated on the IHSS Program Provider Workweek & Travel Time Agreement (SOC 2255), I may be asked by the county to provide documentation of this additional travel. If I cannot, the extra travel time claimed may be considered an overpayment and/or result in a fraud referral.
- For each violation I receive, there will be a consequence:

PROVIDER NUMBER

<p>First Violation</p>	<ul style="list-style-type: none"> • I will receive a written warning notification from the county with information on how to request a county review.
<p>Second Violation</p>	<ul style="list-style-type: none"> • I will get a notice of the second violation with information on how to request a county review. With the second violation notice, I will have the choice to review instructional materials about the workweek and travel time limits and sign and submit a certification notice to the county IHSS office. If I choose to complete this review and submit the notice, I will avoid getting a second violation. However, if I choose not to complete the review and submit the notice within 14 calendar days of the date of my notice, I <u>will</u> get a notice confirming my second violation.
<p>Third Violation</p>	<ul style="list-style-type: none"> • I will get a notice of the third violation with information on how to request a county review. • If my county review request is denied, I will get information on how to request a state administrative review of the violation. • I will be <u>suspended</u> as a provider with the IHSS program for <u>90 days</u>.
<p>Fourth Violation</p>	<ul style="list-style-type: none"> • I will get a notice of the fourth violation with information on how to request a county review. • If my county review request is denied, I will get information on how to request a state administrative review of the violation. • I will be determined <u>ineligible</u> as a provider with the IHSS program for <u>one year</u>.

- If I am determined ineligible to work as an IHSS provider because I get a fourth violation, I can reapply to be an IHSS provider when the one year ineligibility ends. I will have to complete all of the provider enrollment requirements again, including the criminal background check, the provider orientation, and completing all required forms before I can be reinstated.

PROVIDER NUMBER

7. I understand that I will be eligible to earn and use paid sick leave once I have completed the eligibility requirements. My paid sick leave can be used for time off when I am sick or have a medical appointment or when a family member is sick or has a medical appointment.
8. I understand that, if my recipient has a Medi-Cal Share of Cost, he/she will be responsible for paying this amount to me directly as a part of my wages and it will not be included in my paycheck.
9. I understand that I am a “mandated reporter.” This means I am required by law to report any abuse or neglect that I observe while working. The abuse may be of:
 - an elder or dependent adult which must be reported to the County Adult Protective Services immediately or as soon as feasibly possible, as required under Welfare and Institutions Code 15630(b)(1), or
 - a child which must be reported to the County Child Protective Services within 36 hours of receiving the information, as required under Penal Code 11166(a).The abuse might be of the recipient I serve, someone else in the recipient’s home, or anyone else.
10. I understand that Government Code section 6253.2 requires that my name, address, home and cell telephone numbers, and personal email address be given to the local labor organization so they may contact me to invite me to join the union.
11. I understand that I will not be paid to perform authorized IHSS services when my recipient is away from his/her home (at an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or board and care facility). If I provide any assistance to my recipient at any of these facilities, it is outside of my work as an IHSS provider. If I claim IHSS hours on a timesheet for that time, it will be considered fraudulent.
12. I will cooperate with state or county staff to provide requested information related to the evaluation of a recipient’s IHSS case.

PROVIDER NUMBER

I UNDERSTAND THE IHSS PROGRAM RULES EXPLAINED AT THE PROVIDER ORIENTATION (WHICH INCLUDES THE INFORMATION PROVIDED IN THIS FORM) AND INFORMATION GIVEN TO ME BY THE COUNTY IHSS OFFICE. I ACCEPT THE RESPONSIBILITY TO FOLLOW THE INFORMATION PROVIDED BY THE COUNTY. I UNDERSTAND THAT MY FAILURE TO FOLLOW THE REQUIREMENTS PROVIDED TO ME MAY RESULT IN MY TERMINATION AS AN IHSS PROVIDER.

IHSS PROVIDER'S SIGNATURE

DATE

PROVIDER NAME (FIRST, MIDDLE, LAST)