

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814

**REASON FOR THIS TRANSMITTAL**

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

September 20, 2006

ALL-COUNTY INFORMATION NOTICE NO. I-71-06

TO: ALL-COUNTY WELFARE DIRECTORS
ALL-COUNTY ADULT PROTECTIVE SERVICES PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES RECIPIENT/EMPLOYER
CHECKLIST, FORM SOC 332

REFERENCE: MANUAL OF POLICIES AND PROCEDURES SECTION
30-764.31

The purpose of this All County Information Notice is to inform counties that the In-Home Supportive Services (IHSS) Recipient/Employer Checklist (SOC 332) form has been revised. This notice directs counties on the use of the form. State regulation [Manual of Policies and Procedures (MPP) section 30-764.31] requires counties to ensure that all IHSS recipients understand their basic responsibilities as employers. The SOC 332 form notifies IHSS recipients of their responsibilities toward the social worker and provider. The revised SOC 332 integrates changes recommended by an IHSS and Case Management, Information, and Payrolling Systems forms workgroup and provides clarification of previously included responsibilities.

The California Department of Social Services (CDSS) has identified the SOC 332 as a "required" form since August 2003. Forms in this category may not be modified, reconstructed, or substituted. In compliance with MPP 30-764.31, the form shall be completed each time the recipient hires a new provider. The social worker will retain the original; the recipient and provider will receive copies. The SOC 332 will only be available on-line.

For camera-ready versions of English and Spanish forms, please contact the Forms Management Unit at (916) 657-1907. If your office has internet access, you may obtain these forms from the CDSS webpage at:

http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

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As soon as translations are completed, they will be posted at the Language Services website. Copies of the translated forms and publications can be obtained from the CDSS webpage at:

http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

For any questions on translated materials or to request a copy of a translated form or message, please contact Language Services at (916) 651-8876.

Your County Forms Coordinator should distribute translated forms to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English or limited English proficient populations as required by the Dymally Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and by State regulation (MPP Division 21, Civil Rights Nondiscrimination, section 115).

Sincerely,

Original Document Signed By:

EVA L. LOPEZ
Deputy Director
Adult Programs Division

Attachments

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.
- 5) Ensure standards of compensation, work scheduling and working conditions for my provider.
- 6) Provide my Social Worker with the following information regarding my provider, and any future change in my provider.

- | | |
|----------------------------|--|
| ___ Name | ___ Primary Language* |
| ___ Address | ___ Telephone Number |
| ___ Social Security Number | ___ Relationship to me, if any |
| ___ Date of Birth* | ___ Hours to be worked and services to be performed by each provider |
| ___ Ethnicity* | |

*Please provide this information if it is available to you.

- 7) Inform my provider that the gross hourly rate of pay is \$_____, 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 or State Income Taxes be deducted from his/her wages. Instruct the provider to complete Form W-4 so Form W-2 (Wage and Tax Statement) will be sent at the end of January for income tax filing.
- 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 of the services authorized and the 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, directly to my provider or directly to the county social services department.
- 12) Verify and sign my provider's timesheet for each pay period, showing the correct day and the correct total number of hours worked. I understand that any falsification or concealment of information may be prosecuted under Federal and State laws.
- 13) Ensure my provider signed his/her timesheet.
- 14) Advise my provider to mail his/her signed timesheet to the appropriate county social services department at the end of each pay period.

I HAVE EXPLAINED THE RESPONSIBILITIES LISTED ON THIS FORM TO THE IHSS RECIPIENT.

Social Worker	Telephone	Date
Recipient		Date
Provider		Date

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. Sign and date the form.
5. Leave a copy of the form with the recipient and provider.