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October 31, 2009

ALL-COUNTY LETTER NO. 09-69

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: IHSS PROVIDER ENROLLMENT AGREEMENT, (FORM SOC 846),
AND REVISED IHSS RECIPIENT/EMPLOYER CHECKLIST, (FORM
SOC 332)

REFERENCE: ASSEMBLY BILL, FOURTH EXTRAORDINARY LEGISLATIVE
SESSION (ABX4) 19 (Chapter 17, Statutes of 2009) AND
ALL-COUNTY LETTER NO. 09-52

<u>REASON FOR THIS TRANSMITTAL</u>	
<input type="checkbox"/>	State Law Change
<input type="checkbox"/>	Federal Law or Regulation Change
<input type="checkbox"/>	Court Order
<input type="checkbox"/>	Clarification Requested by One or More Counties
<input checked="" type="checkbox"/>	Initiated by CDSS

The purpose of this All-County Letter (ACL) is to provide the counties a new form, the In-Home Supportive Services (IHSS) Provider Agreement (SOC 846), mandated by statutory changes resulting from the passage of recent legislation. Additionally, this ACL transmits the IHSS Recipient/Employer Checklist (SOC 332) which has been revised to provide information specific to the recipient's responsibilities.

BACKGROUND

Development of the new form SOC 846, Provider Enrollment Agreement, is necessary to implement provisions of AB X4 19, which requires all prospective providers and current providers to either attend a provider orientation or receive information regarding the new IHSS provider requirements, to be eligible to be enrolled or to receive payment for providing supportive services in the IHSS program. Upon the conclusion of the provider orientation or completion of the review of the IHSS provider requirements, the current/prospective providers must submit the signed agreement, specifying that they agree to the IHSS program provider requirements. This new requirement becomes effective November 1, 2009 for prospective providers. Current providers must submit the signed form by July 1, 2010.

USE OF FORM SOC 846

Form SOC 846 will be distributed to current/prospective providers by the counties and maintained by the counties. As required by AB X4 19, the form requires current and prospective providers to acknowledge receipt of the IHSS program requirements to be an eligible provider.

It also addresses timesheet issues such as recording time performing only authorized services for the recipient, the importance of the provider's signature to attest that the information reported is true and correct, and civil penalties that may apply if the provider is convicted of fraudulently reporting timesheet information. Additional anti-fraud measures presented on the form include the future requirement of the provider's fingerprint placed on each timesheet submitted and information on the Medi-Cal toll-free fraud hotline number and Internet Website for reporting suspected fraud or abuse in the IHSS program. (ACL 09-54, which details the content of the IHSS provider orientation, was released October 28, 2009.)

The California Department of Social Services (CDSS) has identified the SOC 846 as a "required" form. Forms in this category may not be modified, reconstructed, or substituted. Regulations regarding this new requirement, as well as the other provider enrollment responsibilities, will follow. These regulations shall address the required completion of form SOC 846 as part of the IHSS provider eligibility process.

County Responsibilities

To meet the requirements of the statute, counties must retain the SOC 846 for an indefinite period. It is advised that the county furnish a copy of the signed agreement form to the current/prospective provider.

In addition, form SOC 846 references completion of form I-9 by the provider, which documents the provider as authorized to work in the United States. The counties or Public Authorities that currently retain copies of the I-9, on behalf of the recipient, may continue to do so. A copy of this form may be maintained in the provider file. If a provider file has not yet been established, it may be maintained in the recipient's case file.

Forms W-4 and DE 4 are completed by providers if they wish to have federal and/or state income tax withheld from their wages. The counties may continue their practice of supplying these forms to the applicant providers at the time of enrollment. For your convenience, the forms are available at the links below.

IRS Publication - Form W-4 (2009)
<http://www.irs.gov/pub/irs-pdf/fw4.pdf?portlet=3>

EDD State of California - DE 4 Rev. 36 (4-09): http://www.edd.ca.gov/pdf_pub_ctr/de4.pdf

REVISION AND USE OF FORM SOC 332

The IHSS Recipient/Employer Checklist (SOC 332) addresses the recipient's responsibilities as the employer. Because this form previously included the provider's acknowledgement of information given to the provider by the recipient, its revision was necessary to avoid duplication of entries on the new SOC 846.

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As counties are aware, 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. Form SOC 332 notifies IHSS recipients of their responsibilities toward the social worker and the provider. This form is also a required form.

CAMERA-READY COPIES AND TRANSLATIONS OF FORMS

Counties may access camera-ready versions of English forms referenced in this ACL on CDSS' Forms/Brochures web page at <http://www.dss.cahwnet.gov/cdssweb/PG183.htm>.

Questions about accessing the forms may be directed to Forms Management Unit at FMUdss@dss.ca.gov.

We are in the process of translating the IHSS Provider Enrollment Agreement form and the Recipient/Employer Responsibilities Checklist. Language Translation Services (LTS) will make available on the web site camera-ready copies of Spanish, Armenian, and Chinese translated forms as soon as they have been completed which should be prior to 11/10/09 and you may access these translated forms at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

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).

For questions regarding the use of these forms, please contact Carey Yamanaka, Analyst in the APB Policy, Legislation, and Litigation Unit at (916) 229-4000.

Sincerely,

Original Document Signed By:

EVA L. LOPEZ
Deputy Director
Adult Programs Division

Attachments

c: CWDA

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, whichever 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 \$_____, 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 timesheet 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's 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.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER ENROLLMENT AGREEMENT

I, _____, UNDERSTAND I AM REQUIRED TO ATTEND THE IHSS PROVIDER

(PRINT NAME)

ORIENTATION TO BE ELIGIBLE TO PROVIDE IHSS. HOWEVER, IF I HAVE BEEN A PROVIDER (ON OR BEFORE OCTOBER 31, 2009), I HAVE THE OPTION TO ATTEND AN IHSS ORIENTATION OR I MAY RECEIVE THE PROVIDER ORIENTATION INFORMATION DIRECTLY FROM THE COUNTY IHSS OFFICE.

1. During the required orientation for IHSS providers:
 - I was given the requirements to be an eligible IHSS provider and a description of 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 Internet Web site, <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx> for reporting suspected fraud or abuse in the IHSS program.
2. I received a demonstration of, and understand, how to complete my timesheet. If I have been a provider (on or before October 31, 2009), I received information on the new timesheet and understand how to complete it.
 - I understand the timesheet should indicate only the authorized services I performed for the recipient and the time needed to perform those authorized services. I understand that my signature on my timesheet verifies that the information I reported on it is true and correct.
 - I understand that, if I am convicted of fraudulently reporting information on my timesheet, in addition to any criminal penalties, I may be required to pay civil penalties of at least \$500, and not more than \$1,000, for each violation of fraud.
 - I understand that when required, it will be necessary for me to place my fingerprint on my timesheet in order to be paid.
3. I understand that I am required to complete Form I-9, a form kept on file by the recipient, which states that I have the legal right to work in the United States.
4. I understand I have the option to submit Form W-4 to request federal income tax withholding and/or 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, no withholding will be taken out of my wages.
5. I understand services cannot be performed when the recipient is away from his/her home (for example, when the recipient is in the hospital or away on vacation). I will contact the recipient's social worker for approval of any services that may be performed when the recipient is away from the home.
 - I understand that, in the future, I will receive an information sheet that names the recipient and the services I am authorized to perform for that recipient.
6. I will cooperate with state or county staff to provide requested information related to the evaluation of a recipient's IHSS case.

I UNDERSTAND THE IHSS PROGRAM RULES EXPLAINED AT THE PROVIDER ORIENTATION OR BY THE PROVIDER ORIENTATION INFORMATION GIVEN TO ME BY THE COUNTY IHSS OFFICE. I ACCEPT THE RESPONSIBILITY TO FOLLOW ANY INFORMATION PROVIDED BY THE COUNTY. I UNDERSTAND THAT FAILURE TO FOLLOW THE REQUIREMENTS PROVIDED TO ME MAY RESULT IN BEING TERMINATED AS AN IHSS PROVIDER.

Provider's Signature

Date