



CDSS

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STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

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EDMUND G. BROWN JR.
GOVERNOR

April 11, 2012

ALL COUNTY LETTER (ACL) NO: 12-19

REASON FOR THIS TRANSMITTAL

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

TO: ALL COUNTY WELFARE DIRECTORS
IHSS PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDERS
SIGNING INDIVIDUAL WAIVER REQUESTS AS AUTHORIZED
REPRESENTATIVES FOR RECIPIENTS

REFERENCE: ACL NO. 11-12, DATED JANUARY 26, 2011
ACL NO. 12-04, DATED JANUARY 26, 2012

This letter provides information and instructions for implementing Assembly Bill (AB) 876 (Chapter 73, Statutes of 2011), which prohibits an In-Home Supportive Services (IHSS) program provider applicant from signing his/her own individual waiver request as a recipient's authorized representative, with certain exceptions.

BACKGROUND

Senate Bill (SB) 1104 (Chapter 229, of Statutes 2004) established three crimes for which a conviction, or incarceration following a conviction, within the last ten years, excludes an individual from being an IHSS provider. These crimes, which are specified in Welfare & Institutions Code (WIC) section 12305.81, are referred to as Tier 1 crimes:

- Specified abuse of a child (Penal Code (PC) section 273a(a));
- Abuse of an elder or dependent adult (PC section 368); and
- Fraud against a government health care or supportive services program.

AB 1612 (Chapter 725, Statutes of 2010) added WIC section 12305.87, expanding the exclusionary crimes to include the following, which are referred to as Tier 2 crimes:

- A violent or serious felony, as specified in PC section 667.5(c), and PC section 1192.7(c);
- A felony offense for which a person is required to register as a sex offender, pursuant to PC section 290(c); and
- A felony offense for fraud against a public social services program, as defined in WIC section 10980(c)(2) and (g)(2).

In addition, AB 1612 added WIC section 12305.87(d)(1) to establish a provision which allows an IHSS recipient to request an individual waiver in order to hire an individual convicted of a Tier 2 crime(s) as his/her provider in spite of the conviction(s), thereby permitting the convicted individual to be enrolled as a provider for that particular recipient. Unfortunately, AB 1612 failed to address the potential consequences of allowing an applicant provider who is also the IHSS recipient's authorized representative to sign the waiver on the recipient's behalf.

NEW STATUTE

The previous enacted legislation did not prohibit a provider applicant, who also serves as the recipient's authorized representative, from signing the individual waiver form to request approval as the recipient's provider. This allowed an individual to waive his or her own exclusion as an IHSS program provider without consulting the recipient. AB 876 was enacted to prevent this action from occurring except under certain circumstances. The bill amended WIC section 12305.87(d)(4) to specify that, "Except for a parent, guardian, or person having legal custody of a minor recipient, a conservator of an adult recipient, or spouse or registered domestic partner of a recipient, a provider applicant shall not sign his or her own individual waiver form as the recipient's authorized representative."

Effective January 1, 2012, the county/Public Authority (PA)/Non-Profit Consortium (NPC) may not accept an IHSS Recipient Request for Provider Waiver (SOC 862) which has been signed by a provider applicant who is also the recipient's authorized representative unless it is documented that the provider applicant is the parent, guardian or person having legal custody of a minor recipient or the conservator, spouse or registered domestic partner of an adult recipient. Documentation of the relationship between the recipient and the provider applicant can be established by referring to the information entered in the Provider's Relationship to Recipient field (Item #8) on the IHSS Program Recipient Designation of Provider form (SOC 426A).

Should the county/PA/NPC receive an SOC 862 which has been signed by a provider applicant who is also the recipient's authorized representative and that individual is not one of the exempted individuals, the county/PA/NPC must notify the recipient that the SOC 862 is invalid. The attached Acknowledgment of Receipt of Invalid Request for Provider Waiver (SOC 857A) has been created for this purpose. The SOC 857A provides the IHSS recipient with the following options:

- Recipient may sign the SOC 862 himself/herself, if he/she is able;
- Recipient may request that a non-provider authorized representative sign form SOC 862, if the recipient has more than one authorized representative; or
- Recipient may choose another provider.

The county/PA/NPC shall provide a copy to the recipient of the signed SOC 862 along with the SOC 857A and a new unsigned SOC 862 to be properly signed by the recipient or another authorized representative. A copy of the SOC 857A should be retained in the recipient's case file along with the invalid SOC 862.

California Department of Social Services (CDSS) has revised the attached SOC 862 and three additional forms (IHSS Provider Enrollment Form [SOC 426], IHSS Recipient Designation of Provider [SOC 426A], and Important Information for Prospective Providers About the IHSS Program Provider Enrollment Process [SOC 847]) to include a statement indicating that the SOC 862 may not be signed by a provider applicant who is also the recipient's authorized representative. As previously stated, exceptions include when the individual is the parent, guardian or person having legal custody of a minor recipient or the individual is the conservator, spouse or registered domestic partner of an adult recipient.

As noted in ACL No. 12-04, dated January 26, 2012, the SOC 426 has also been revised to reflect the provisions of SB 930 (Chapter 649, Statutes of 2011), which repealed previously enacted legislation related to providers' use of Post Office (P.O.) Boxes. The notation in Part A stating that, "A paycheck for a provider cannot be mailed to a P.O. Box unless the county has approved a request from the provider," has been removed.

AVAILABILITY OF FORMS AND NOTICES

Counties/PAs/NPCs are advised that the forms and notices referenced in this ACL are designated as "Required – No Substitutes Permitted." Forms in this category shall be used, and they may not be modified or reconstructed.

Camera-ready copies of the English versions of the forms and notices are available on the CDSS Forms/Brochures web page at:

<http://www.dss.cahwnet.gov/cdssweb/PG183.htm>.

Spanish, Armenian, and Chinese translations of the forms and notices are being developed. Upon completion of the translation, camera-ready copies will be posted on the CDSS Translated Forms and Publications web page at:

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

The designated Forms Coordinator for your county shall 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/or by state regulation (California Department of Social Services Manual of Policies and Procedures Division 21, Civil Rights Nondiscrimination, section 115).

Questions about accessing the forms may be directed to the Forms Management Unit at fmudss@dss.ca.gov. Questions about translations may be directed to the Language Services Unit at LTS@dss.ca.gov.

Should you have questions regarding the policies contained in this ACL, please contact the Adult Programs Policy & Operations Bureau at (916) 651-5350.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Attachments

c: CWDA

**IN-HOME SUPPORTIVE SERVICES (IHSS)
RECIPIENT REQUEST FOR PROVIDER WAIVER**

County of: _____
Notice Date: _____
Applicant Provider Name: _____
Recipient Name: _____
Recipient Case Number: _____
IHSS Office Address: _____

IHSS Office Phone Number: _____

I, _____, am submitting this waiver request to _____ in
(Name of County/Public Authority/Non-Profit Consortium)

order to hire the person named below to be my In-Home Supportive Services (IHSS) provider. I understand he/she has been denied eligibility to be paid from the IHSS program, due to a felony criminal conviction(s). Despite this information, I accept the responsibility for my decision, and the possible risks involved, in allowing this person to work in my home as my IHSS provider.

I have chosen to hire _____ to be my IHSS provider and acknowledge
(Applicant Provider)
that he/she has been convicted of the following crime(s):

<u>Date of Conviction</u>	<u>Penal Code Section</u>	<u>Felony Conviction Description</u>
1. _____	_____	_____ _____ _____
2. _____	_____	_____ _____ _____
3. _____	_____	_____ _____ _____
4. _____	_____	_____ _____ _____
5. _____	_____	_____ _____ _____

**IN-HOME SUPPORTIVE SERVICES (IHSS)
RECIPIENT REQUEST FOR PROVIDER WAIVER**

**AS THE IHSS RECIPIENT WHO WILL HIRE THIS PERSON TO PROVIDE IN-HOME
SUPPORTIVE SERVICES, I UNDERSTAND AND AGREE TO THE FOLLOWING
STATEMENTS AND ACTIVITIES LISTED BELOW**

- I am hiring a person who has been convicted of the felony crime(s) listed on this form.
- I am required to keep this person's criminal information confidential and I am prohibited, by law, from sharing any part of it with any other individual or entity.
- I am completing this waiver request form, which applies only to the crime(s) listed on this form.
- If the county notifies me that this person is convicted of an additional disqualifying felony crime(s) in the future, I will be required to complete and submit another waiver if I wish to continue receiving services from this person.
- A notice will be sent to me when the county has accepted this waiver.
- The county will send a timesheet to the provider I have chosen to hire only after this waiver has been accepted.

By signing this form, I accept the responsibility for hiring the person named on this form to work in my home. I understand the County and the State of California are immune from any liability, due to the risk of any actions that may occur, because of my decision to hire him/her as my IHSS provider.

This document may only be signed by the recipient or by an authorized representative who is not the provider named on this form.

Signature of Recipient or Recipient's Authorized Representative

Print Name

Date

Without an approved waiver to hire the person named on this form, you will be responsible for paying him/her with your own money for any services provided.

Submit this form within ten (10) calendar days from the "Notice Date" listed on the upper right corner of Page 1. You may submit this form by mail or in person to your IHSS county, Public Authority, or Non-Profit Consortium office at the following address:

By mail: _____

In person: _____

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM RECIPIENT DESIGNATION OF PROVIDER

INSTRUCTIONS:

- Use black or blue ink. Print information clearly.
- You (or your legally authorized representative) must fill out both sides of this form to let the county know who you have chosen to provide your services.
- You (or your legally authorized representative) must sign the declaration at the bottom to show that you understand and agree to all of the terms and conditions listed.
- If you have multiple providers, you must fill out a separate form for each person who will be providing services.
- Please return this form to the county. The county will keep the original form and give you a copy.
- You must let the county know if you change your provider(s). You must tell the county within 10 calendar days of the change.

1. Recipient's Name:	
2. County IHSS Case #:	
3. Provider's Name:	
4. Provider's Address:	
City, State, ZIP Code:	
5. Provider's Telephone Number:	
6. Provider's Date of Birth:	
7. Provider's Gender (check box):	<input type="checkbox"/> Male <input type="checkbox"/> Female
8. Provider's Relationship to Recipient (if any):	<input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Conservator <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____
9. Provider's Start Date:	

RECIPIENT DECLARATION

- I DECLARE that the person named above is my choice to provide IHSS for me as authorized by the county.
- I UNDERSTAND that the above-named person cannot be paid federal and/or state IHSS funds for any services provided to me until he/she has completed the entire provider enrollment process, which includes completing, signing and returning (in person) the Provider Enrollment Form (SOC 426), submitting fingerprints and being cleared of disqualifying crimes through a criminal background check, completing a provider orientation, and signing and returning the Provider Enrollment Agreement (SOC 846).
- I UNDERSTAND that I will be informed by the county if the person I have chosen to be my provider does not complete the provider enrollment process or if he/she is determined ineligible to be a provider.
- I UNDERSTAND that if the above-named person has been convicted of a felony which requires me to submit a provider waiver for that individual to work for me as an IHSS provider, that individual cannot sign the waiver document as my authorized representative.
- **I UNDERSTAND that if I choose to receive services from this person before he/she is enrolled as a provider, and he/she is ultimately found ineligible, or after I have been informed that he/she is ineligible, I will be responsible for paying him/her with my own money.**
- I UNDERSTAND AND AGREE that neither the County nor the State is liable for any claims and/or losses to any person caused by the above named person I choose to hire as my IHSS provider. I agree to hold harmless the State and County, their officers, agents, and employees, and take responsibility for any and all claims and/or losses to any person caused by the named person I choose to hire as my IHSS provider.
- I UNDERSTAND AND AGREE that the county can provide information about my authorized services and service hours to the provider named above.

RECIPIENT'S OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE:

DATE:

PRINTED NAME:

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY
ACKNOWLEDGEMENT OF RECEIPT OF INVALID
REQUEST FOR PROVIDER WAIVER**

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

On _____, you were notified that, based on state law*, _____,

(DATE)

(PROVIDER APPLICANT NAME)

the person you chose to be your IHSS provider, was ineligible because he/she had been convicted of a disqualifying crime in the last 10 years. The notice explained that if you wanted him/her to be your provider, even though he/she had been convicted of a disqualifying crime, you could submit a signed request for a provider waiver to the county/Public Authority (PA)/Non-Profit Consortium (NPC) IHSS office.

On _____, the county/PA/NPC IHSS program office received an invalid request

(DATE)

for a provider waiver. The waiver request is invalid because it was signed by _____

(PROVIDER APPLICANT NAME)

as your authorized representative. State law* does not allow your authorized representative to sign the waiver request to be your provider unless he/she is:

- Your parent, guardian or person having legal custody (if you are a minor), or
- Your conservator, spouse or registered domestic partner (if you are an adult).

County/PA/NPC records show that _____ is NOT your parent, guardian

(PROVIDER APPLICANT NAME)

or a person having legal custody (if you are a minor), or your conservator, spouse or registered domestic partner (if you are an adult). If he/she IS your parent, guardian or a person having legal custody (if you are a minor), or if he/she is your conservator, spouse or registered domestic partner (if you are an adult), call your IHSS worker at the number shown at the top of this notice.

If you still want _____ to be your provider, you can either:
(PROVIDER APPLICANT NAME)

- Sign the attached waiver request yourself if you are able, or
- Name another person to be your authorized representative, who will not be your provider, and ask him/her to sign the Recipient Request for Provider Waiver (form SOC 862).

Once the waiver request has been signed, you must return it to the county/PA/NPC IHSS program office, either in person or by mail.

If this person provides services for you without a valid waiver request, you will be responsible for paying him/her with your own money for any services he/she provides.

As an alternative, you may choose someone else to be your provider. If you need help finding a provider, call _____.

If you have any questions about this notice, call your IHSS worker at the number listed at the top of the first page of this notice.

*Welfare and Institutions Code Section 12305.87

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

READ THE INFORMATION BELOW CAREFULLY BEFORE YOU BEGIN TO COMPLETE THIS FORM

Under state law, if you have been convicted of, or incarcerated following a conviction, for certain exclusionary crimes within the past 10 years, you are not eligible to be enrolled as a provider or to receive payment from the IHSS program for providing supportive services except as specified below. There are two categories of exclusionary crimes.

- **Tier 1 crimes, as set forth in Welfare and Institutions Code (W&IC) section 12305.81, are:**
 1. Specified abuse of a child (Penal Code [PC] section 273a[a]*),
 2. Abuse of an elder or dependent adult (PC section 368*), and
 3. Fraud against a government health care or supportive services program.

- **Tier 2 crimes, as set forth in W&IC section 12305.87, are:**
 1. A violent or serious felony, as specified in PC section 667.5(c)*, and PC section 1192.7(c)*,
 2. A felony offense for which a person is required to register as a sex offender pursuant to PC section 290(c)*, and
 3. A felony offense for fraud against a public social services program, as defined in W&IC sections 10980(c)(2)* and (g)(2)*.

A complete listing of Tier 2 crimes is available upon request from the County IHSS Office or IHSS Public Authority.

*See attached form SOC 426C for the text of these PC and W&IC sections.

- As part of the IHSS provider enrollment process, you must submit fingerprints and undergo a criminal background check conducted by the California Department of Justice.
- If your responses on this form or the results of the criminal background check show that you have been convicted of, or incarcerated following a conviction for, either a Tier 1 or Tier 2 crime within the last 10 years, you will not be eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing supportive services.
- For Tier 2 crimes, if you have obtained a certificate of rehabilitation or an expungement (dismissal pursuant to PC section 1203.4), the conviction will not disqualify you from working as an IHSS provider.
- If your conviction is for a Tier 2 crime, you may qualify for an individual waiver or a general exception under certain circumstances which are described below.
- ***There are no waivers or exceptions allowed for Tier 1 crimes.***

GO ON TO THE NEXT PAGE 

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

**CONTINUE READING THE INFORMATION BELOW CAREFULLY BEFORE
YOU BEGIN TO COMPLETE THIS FORM**

Individual Waiver of an Exclusion for Conviction for a Tier 2 Crime

If you are found ineligible based on a conviction for a Tier 2 exclusionary crime but an IHSS recipient (or his/her authorized representative) wishes to hire you as his/her provider in spite of your criminal background, you may obtain a waiver as follows.

- The IHSS recipient who wishes to hire you (or his/her authorized representative) will be informed of your conviction and will be directed to keep the information confidential.
- The recipient who wishes to hire you as his/her provider (or his/her authorized representative) must submit an IHSS Recipient Request for Provider Waiver (SOC 862) to the County IHSS Office or IHSS Public Authority.
- The waiver will allow you to be enrolled to provide services only for the recipient who requested the waiver.
- If you, as the provider, are also the recipients' authorized representative, you are NOT allowed to sign the waiver on behalf of the recipient to waive crimes for which you have been convicted. In this case, the waiver must either be signed directly by the recipient or, if that is not possible, another individual must be declared an authorized representative for purposes of signing this waiver.
- For more information about requesting a waiver, the IHSS recipient who wishes to hire you as his/her provider should contact the County IHSS Office or IHSS Public Authority.

General Exception of an Exclusion for Conviction for a Tier 2 Crime

If you are found ineligible based on a conviction for a Tier 2 exclusionary crime and you want to be listed on a provider registry or want to provide services for a recipient who has not requested an individual waiver –

- You may apply for a general exception of the exclusion by completing the IHSS Applicant Provider Request for General Exception (SOC 863).
- You will be required to provide backup documentation, (e.g., employment history, personal references, etc.), to support your request for a general exception.
- For more information about requesting a general exception, contact the County IHSS Office or IHSS Public Authority.

-
- Completion of this form satisfies ONE of the IHSS provider enrollment requirements.
 - You must complete ALL of the provider enrollment requirements BEFORE you can be enrolled as an IHSS provider or get paid from the IHSS program for providing authorized services for an eligible IHSS recipient.

GO ON TO THE NEXT PAGE 

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

INSTRUCTIONS:

- Use black or blue ink to fill out. Print information clearly.
- Fill out, sign and return this form in person to the office or location designated by the county. Bring original federal or state government-issued identification and your original Social Security card when returning this form.
- Complete all items in PART A, answer the questions in PART B, and read and sign the declaration in PART C.
- The county will: 1) Review the form to make sure it is complete; 2) Make photocopies of your identification and Social Security card; and 3) Provide you with a copy of the completed form for your records.
- You must let the county know if anything you report on this form changes within ten (10) calendar days of the change.

PART A: PROVIDER INFORMATION

1. Full Name (First Name, Middle Initial, Last Name):	2. Date of Birth: <small>If you are under 18 years of age, you must submit a valid Work Permit with this form.</small>	3. Gender: <input type="checkbox"/> M <input type="checkbox"/> F
4. Home Address (Must be physical address, <u>not</u> a Post Office box):	City:	State: ZIP:
5. Mailing Address (if different from home address):	City:	State: ZIP:
6. Telephone Number (with Area Code):	7. Social Security Number*:	
8. a. Driver's License # or Government Issued ID #:	b. Expiration Date:	
	c. Issuing State:	
9. a. Primary Spoken Language:	b. Primary Written Language:	

NOTES:

* The collection of the Social Security Number is required pursuant to W&IC 12305.81(a), and the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a), for the purposes of verifying the individual's identity and authorization to work in the United States.

PART B: PROVIDER DISCLOSURE

ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX:

- 1. WITHIN THE PAST 10 YEARS, HAVE YOU BEEN –**
 - a. Convicted of or incarcerated following a conviction for a Tier 1* crime? YES NO
 - b. Convicted of or incarcerated following a conviction for a Tier 2* crime? YES NO

**See Page 1 of this form for a definition of Tier 1 and Tier 2 crimes.*
- 2. IF YOU ANSWERED "YES" TO QUESTION 1.b. ABOVE,** have you obtained a certificate of rehabilitation or expungement (dismissal pursuant to PC section 1203.4) of the Tier 2 crime? YES NO
If YES, you must provide the county with a copy of the certificate of rehabilitation or documentation of the expungement along with this completed form.

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IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

PROVIDER'S NAME: _____

PART C: PROVIDER DECLARATION

I UNDERSTAND AND AGREE THAT –

- I cannot receive IHSS program funds as payment for authorized services I provide to any eligible recipient of IHSS until I have completed the entire provider enrollment process and I have been officially enrolled as a provider by the county.
- As a part of the provider enrollment process, I must provide fingerprints and undergo a criminal background check. I am responsible for paying the costs of fingerprinting and the background check.
- If it is found, either through my responses on this form, the results of the criminal background check, or some other means, that within the past 10 years, I have been convicted of or incarcerated following a conviction for a Tier 1 exclusionary crime, I will not be eligible to be an IHSS provider, and the recipient who wished to hire me will be informed that I am ineligible to be a provider because of a disqualifying criminal conviction which will not be specified.
- If it is found, either through my responses on this form, the results of the criminal background check, or some other means, that within the past 10 years, I have been convicted of or incarcerated following a conviction for a Tier 2 exclusionary crime, and I have not received a certificate of rehabilitation or had the conviction expunged –
 - I will not be eligible to be an IHSS provider, unless an IHSS recipient who wishes to hire me to provide his/her services, requests an individual waiver, or I apply for and I am granted a general exception; and
 - The IHSS recipient who wishes to hire me as his/her provider will be informed of my conviction and the types of crimes for which I was convicted, and he/she will be directed to keep the information confidential.

IF I AM ENROLLED BY THE COUNTY AS AN IHSS PROVIDER, I UNDERSTAND AND AGREE THAT –

- If the person I provide services for receives IHSS through the Medi-Cal program, I will be considered to be a Medi-Cal provider of personal care services. Therefore, I will be required to comply with all Medi-Cal program rules relating to the provision of services.
- Payment for the authorized services I provide to an IHSS recipient will be from federal, state and/or county IHSS funds. Any false statement I provide, including false entries on the timesheet or withholding of information, may be prosecuted under federal and/or state laws.
- I will reimburse the IHSS program for any overpayments paid to me and any overpayment, individually or collectively, may be deducted from a future paycheck for services I provide to any recipient of IHSS.
- I will provide all services without discrimination based on race, religion, color, national or ethnic origin, gender, age, sexual orientation, or physical or mental disability.

I declare, UNDER PENALTY OF PERJURY, that all of the information I have provided on this form is true and correct to the best of my knowledge, and that I agree to all of the statements listed above.

Signature: _____ Date: _____

Printed Name: _____

FOR COUNTY USE ONLY

County Representative's Signature (Optional): _____ DATE: _____

IMPORTANT INFORMATION FOR PROSPECTIVE PROVIDERS ABOUT THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT PROCESS

An IHSS provider is someone who gets paid to provide services to a person who receives in-home supportive services under the IHSS Program. If you want to become an IHSS provider, you must complete all of the steps outlined below before you can be enrolled as a provider and receive payment from the IHSS Program for providing services.

STEP 1. Complete and sign the IHSS Program Provider Enrollment Form (SOC 426), and return it in person to the County IHSS Office or IHSS Public Authority.

- Get a blank copy of the SOC 426 from the County IHSS Office or Public Authority. *Read the information carefully before you complete the form.*
- Complete the SOC 426 form and answer all questions completely and truthfully. You **must report** if you have been convicted of any crimes that would not allow you to provide services.
- Bring a U.S. government issued picture ID **AND** an original Social Security card. If you do not have a Social Security card, you may show the original official letter from the Social Security Administration (SSA) showing your Social Security number (SSN).
- The information you provide on the Provider Enrollment Form (SOC 426) will be verified by a criminal background check by the California Department of Justice (DOJ). The criminal background check is required to be a provider (See Step 2).

STEP 2. Be fingerprinted and go through a criminal background check by the California Department of Justice.

- The County IHSS Office or Public Authority will give you instructions on how to get fingerprinted when you turn in the completed and signed SOC 426. *Do not try to be fingerprinted until you have received instructions from the county.*
- You can get fingerprinted at some local law enforcement agencies (Police or Sheriff Department) or at a business that offers digitally scanned fingerprinting (Live Scan) services. The County IHSS Office or Public Authority can give you a list of nearby locations.
- State law requires that you pay the costs for fingerprinting and the criminal background check. Fees vary depending where you choose to get fingerprinted; the costs range from \$40 to \$90.
- If the background check verifies that you have **not** been convicted of any Tier 1 or Tier 2 crimes, **proceed to Step 3.**
- If the background check verifies that you **have been convicted** of any Tier 1 or Tier 2 crimes, please read the sections on the next pages.

If you **have been** convicted of, OR incarcerated following a conviction for, either a **Tier 1 or Tier 2** crime WITHIN THE PAST 10 YEARS, you are **NOT** eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing supportive services.

<p>Tier 1 crimes include:</p> <ul style="list-style-type: none"> Specified abuse of a child (Penal Code (PC) section 273a(a); Abuse of an elder or dependent adult (PC section 368); or Fraud against a government health care or supportive services program. 	<p>If you have a conviction for any of the Tier 1 crimes in the past 10 years, you are NOT eligible to be a provider.</p> <ul style="list-style-type: none"> You are NOT eligible even if you had a Tier 1 crime that was expunged from your record.
<p>Tier 2 crimes include:</p> <ul style="list-style-type: none"> A violent or serious felony, as specified in PC section 667.5(c), and PC section 1192.7(c), A felony offense for which a person is required to register as a sex offender pursuant to PC section 290(c), and A felony offense for fraud against a public social services program, as defined in W&IC section 10980(c) (2) and (g) (2). <p><i>You can ask the County IHSS Office or IHSS Public Authority for a list of the Tier 2 crimes.</i></p>	<p>If you have a conviction for any of the Tier 2 crimes in the past 10 years you may be eligible—</p> <ul style="list-style-type: none"> If your Tier 2 crime has been or can be expunged from your record. If a recipient requests an individual waiver to hire you. If you are approved for a general exception. <p><i>Read sections below for more information.</i></p>

Expungement for Tier 2 crime:

- If you have a certificate of rehabilitation or an expungement for a Tier 2 crime, you may be eligible to be an IHSS provider. Provide copies of your certification of rehabilitation or documentation regarding the expungement with your completed SOC 426.
- If you are in the process of having a crime expunged, you should complete the expungement process before continuing the criminal background check.

Individual Waiver of Exclusion for a Tier 2 crime:

An individual waiver allows you to provide services ONLY to a specific recipient who chooses to hire you in spite of your criminal conviction (s).

- A recipient must request and submit the Recipient Request for Provider Waiver (SOC 862) to the County IHSS Office to allow you to provide services.
- The IHSS recipient who wants to hire you must be told of your conviction; however, he/she will be directed to keep the conviction information confidential.
- If you, as the provider, are also the recipient's authorized representative, you are not allowed to sign the waiver on behalf of the recipient to waive crimes for which you have been convicted. In this case, the waiver must either be signed directly by the recipient or, if that is not possible, another individual must be declared an authorized representative for purposes of signing this waiver.

General Exception for a Tier 2 crime:

An individual who has been found ineligible to be enrolled as a provider based on a conviction for a Tier 2 crime, but who wishes to be listed on a provider registry, may apply for a general exception of the exclusion.

- Apply for a General Exception by completing the IHSS Applicant Provider Request for General Exception (SOC 863) form.
- You will be required to provide backup documentation (e.g., employment history, personal references, etc.), to support your request for a general exception.

If you have been disqualified based on a Tier 1 or Tier 2 conviction, you may request a copy of your criminal offender record information (CORI) from the county. Please be advised that the CORI can ONLY be used for this enrollment process.

If the information on your criminal background is incorrect, you can dispute the information through the DOJ record review process.

The DOJ record review process includes submitting fingerprints, paying a processing fee and following the instructions found on the DOJ website at <http://ag.ca.gov/fingerprints/security.php>. If there is criminal information on your record, a Claim of Alleged Inaccuracy or Incompleteness (FORM BCII 8706) will be included along with the response.

STEP 3. Go to an IHSS Program Provider Orientation given by the county.

- The County IHSS Office or Public Authority will tell you when and where you can attend an orientation session.
- The orientation will give you important information about the IHSS Program and the rules and requirements for you to follow as a provider.

STEP 4. At the end of the Provider Orientation session, sign an IHSS Program Provider Enrollment Agreement (SOC 846).

- By signing the SOC 846, you are saying that you understand and agree to the rules and requirements for being a provider in the IHSS Program.

You should maintain copies of all documents you submitted and any that you received from the county for your records.

Once you have successfully completed these four (4) steps and you have been approved by the county or Public Authority to be an IHSS provider, as long as you are an active provider and your criminal background check remains clear, you will continue to be eligible to provide services for any IHSS recipient.

If you have any questions about these provider enrollment requirements, contact your County IHSS Office or IHSS Public Authority.