

Attachment A:

Provider Enrollment Packet



# SAN BENITO COUNTY

Health & Human Services Agency

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DIRECTOR

Public Authority for In-Home Supportive Services  
1111 SAN FELIPE ROAD, SUITE 108 • HOLLISTER, CA 95023  
(831) 634-0784 • FAX (831) 634-0796

## IHSS Referral to Public Authority

Provider: After you complete this application, please call Public Authority at 831-634-0784 to schedule an appointment from Monday through Friday from 9am to 4pm. Thank you.

### PROVIDER MUST BRING ORIGINAL PHOTO IDENTIFICATION & SOCIAL SECURITY CARD

During your appointment you will receive the necessary requirements to complete the Provider Enrollment Process. Also, you will need to bring proper form of identification such as CA Identification, CA Driver License, US Passport and Social Security Card. (no copies)

From IHSS Social Worker:    I. P.                    L. M.                    M. G.                    Z. L.

Date: \_\_\_\_\_

Recipient/Employer Name: \_\_\_\_\_ Case #: \_\_\_\_\_

Authorized Monthly Hours: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider Enrollment #: \_\_\_\_\_

### Do not write below this line for Public Authority staff ONLY

Inter-County Transfer (ICT): \_\_\_ No \_\_\_ Yes    Date: \_\_\_\_\_

Completed Orientation: \_\_\_ No \_\_\_ Yes    Date: \_\_\_\_\_

SOC 846 Signed: \_\_\_ No \_\_\_ Yes    Date: \_\_\_\_\_

Live Scan Form Issued    Date: \_\_\_\_\_

DOJ Background Check: \_\_\_ Pass \_\_\_ Failed \_\_\_ Delayed

Reviewed by \_\_\_\_\_ Date: \_\_\_\_\_

SOC 426A completed: \_\_\_ No \_\_\_ Yes    SOC 426: \_\_\_ No \_\_\_ Yes

IDs Checked: \_\_\_ No \_\_\_ Yes

Submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

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

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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 within 90 days from the date you began the process before you can be enrolled as a provider and receive payment from the IHSS Program for providing services. These steps do not need to be done in any particular order. If you believe you have a criminal arrest and/or conviction within the previous ten years, no matter how minor, you should begin the process with Step 2 because you only have 90 days to complete all of the steps and it may take longer for the California Department of Justice (DOJ) to review your criminal history and provide the county with your Criminal Offender Record Information.

### **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 valid photo ID issued by a U.S. federal or state government agency or by a federally-recognized Native American or Alaskan Native tribal organization **AND** an original Social Security card or replacement card issued by the Social Security Administration.
- The information you provide on the SOC 426 will be verified by a criminal background check by the DOJ.

### **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. *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 been convicted** of any Tier 1 or Tier 2 crimes, please read the sections below and on the next page.

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

If your recipient signs an individual waiver form which allows you to work only for him/her and either he/she moves to another county or you decide to work for another recipient that lives in another county, you will have to do another criminal background check in the new county and the recipient you work for will need to complete and submit another request for an individual waiver in the new county.

### **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 you believe 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: Attend 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 you must 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 have received from the county for your records.

Once you have successfully completed these four (4) steps and 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 do not complete these four (4) steps within 90 days after you began the provider enrollment process, you will be found ineligible to work and be paid as an IHSS provider and will need to begin the process over again in order to be enrolled as an IHSS provider.**

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

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

### INSTRUCTIONS:

- Use black or blue ink. Print information clearly.
- You (or your authorized representative) must complete PART A of this form to let the county know who you have chosen to provide your authorized services.
- If you have multiple providers, you must fill out a separate form for each person who will be providing authorized services for you.
- You must sign the acknowledgement in PART C of this form.
- Please return this completed and signed form to the county. The county will keep the original form and give you a copy.

### PART A. RECIPIENT DESIGNATION OF PROVIDER

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 Social Security #*:	
8. Provider's Gender (check box):	<input type="checkbox"/> Male <input type="checkbox"/> Female
9. 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 _____
10. Provider's Start Date:	

\*NOTE: The collection of the Social Security Number is required by 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.

I choose the person listed above to be my IHSS provider. This person will provide some or all of the services authorized by the county.

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**PART B. RECIPIENT AGREEMENT**

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**I UNDERSTAND AND AGREE THAT:**

- The person I have chosen to be my provider cannot be paid federal and/or state money for providing services to me until he/she completes all of the provider enrollment requirements. These requirements include 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 returning a signed Provider Enrollment Agreement (SOC 846).
- The county will send me a notice telling me if the person I have chosen as my provider does not complete the provider enrollment requirements or if he/she is not eligible to be an IHSS provider.
- If I choose to have this person provide services for me before he/she is enrolled as an IHSS provider, and the county sends me a notice telling me that he/she is not eligible to be an IHSS provider, I will have to pay him/her with my own money for the services that he/she provided before he/she was determined ineligible to be a provider and for any services he/she provides after the county notifies me that he/she is ineligible.
- Neither the county nor the State will be held responsible for any claims and/or losses 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 to 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.
- The county can provide information about my authorized services and service hours to the person I have chosen as my provider. The county will send my provider the IHSS Provider Notice of Recipient Authorized Hours and Services (SOC 2271).
- My total monthly authorized hours will be divided by 4 to determine my maximum weekly hours. The maximum weekly hours is a guideline telling me the highest number of hours my provider(s) will be able to work for me during a workweek. However, since most months are slightly longer than 4 weeks, I will work with my provider(s) to spread his/her hours throughout the month in order to make sure I have all the service hours I need for the month.
- Sometimes I may need my provider to work more than my maximum weekly hours. I must ask for county approval to adjust my maximum weekly hours only if the change requires my provider to work:
  1. More overtime hours in the month than he/she would normally work.



2. More than 40 hours for me in a workweek if my maximum weekly hours are 40 hours or less in a workweek.
- If I do not get an approved exception, my provider will get a violation for working more than my maximum weekly hours.
  - I can **never** authorize my provider to work more than my total authorized monthly service hours. Therefore, when I authorize my provider to work extra hours in one week, I must have the provider work fewer hours in the other week(s) of the month.
  - **If my provider works for another recipient**, the maximum number of hours that he/she may claim in a workweek for all of the time he/she works for his/her recipients combined is **66** hours. **I must make a work schedule for my provider to determine how many hours he/she will be working for me each week to make sure he/she does not work more than 66 hours per workweek.** I will get a Recipient Notification of Maximum Weekly Hours (SOC 2271A) which will include information on my maximum weekly hours so I can use it to make the work schedule for my provider(s). In order to make the schedule, my provider must tell me how many hours he/she is available to work for me each workweek. If my provider cannot work all of my authorized hours, I will need to hire additional provider(s). **If I need help finding and hiring another provider(s), I can call my county IHSS Public Authority to obtain a provider from the registry or my county IHSS office.**
  - The county will send me a notice each time my provider gets a violation. If my provider gets three violations, he/she will be suspended from providing IHSS for three months. If he/she gets another violation after being reinstated from the three-month suspension, he/she will be terminated as a provider for one year.

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### PART C. RECIPIENT ACKNOWLEDGMENT

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**I understand and agree to follow all of the requirements listed in this form.**

RECIPIENT'S SIGNATURE:

DATE:

PRINTED NAME:

AUTHORIZED REPRESENTATIVE'S SIGNATURE:

DATE:

PRINTED NAME:

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### FOR COUNTY USE ONLY

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WORKER NAME:

DATE:

## STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

*NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE*

NAME

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POSITION

FACILITY

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California law **REQUIRES** certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

### PERSONS WHO ARE REQUIRED TO REPORT ABUSE

**Mandated reporters** include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility (Welfare and Institutions Code (WIC) Section 15630(a)). **Care custodian** means an administrator or an employee of most public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff (WIC Section 15610.17).

### PERSONS WHO ARE THE SUBJECT OF THE REPORT

**Elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age and those admitted as inpatients in 24-hour health facilities (WIC Section 15610.23).

### REPORTING RESPONSIBILITIES AND TIME FRAMES

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect occurred, shall complete form SOC 341, "Report of Suspected Dependent Adult/Elder Abuse" for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury (as defined in WIC Section 15610.67), report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, and was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
  - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
  - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.
- For all other abuse, mandated reporters shall report by telephone or through a confidential internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

#### PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both (WIC Section 15630(h)). The reporting duties are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report (WIC Section 15630(f)).

#### CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order. Any violation of confidentiality is a misdemeanor punishable by jail time, fine, or both (WIC Section 15633(a)).

#### DEFINITIONS OF ABUSE

**Physical abuse** means any of the following: (a) Assault, as defined in Section 240 of the Penal Code; (b) Battery, as defined in Section 242 of the Penal Code; (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code; (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water; (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code; (2) Rape, as defined in Section 261 of the Penal Code; (3) Rape in concert, as described in Section 264.1 of the Penal Code; (4) Spousal rape, as defined in Section 262 of the Penal Code; (5) Incest, as defined in Section 285 of the Penal Code; (6) Sodomy, as defined in Section 286 of the Penal Code; (7) Oral copulation, as defined in Section 288a of the Penal Code; (8) Sexual penetration, as defined in Section 289 of the Penal Code; or (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code; or (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment; (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or (3) For any purpose not authorized by the physician and surgeon (WIC Section 15610.63).

**Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

**Neglect** (a) means either of the following: (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or (2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise. (b) Neglect includes, but is not limited to, all of the following: (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment; (3) Failure to protect from health and safety hazards; (4) Failure to prevent malnutrition or dehydration; or (5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health (WIC Section 15610.57).

**Financial abuse** of an elder or dependent adult occurs when a person or entity does any of the following: (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or (3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 15610.70 (WIC Section 15610.30(a)).

**Abandonment** means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody (WIC Section 15610.05).

**Isolation** means any of the following: (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons; (3) False imprisonment, as defined in Section 236 of the Penal Code; or (4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors (WIC Section 15610.43).

**Abduction** means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court (WIC Section 15610.06).

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY. IF YOU ARE A LONG-TERM CARE OMBUDSMAN, YOU MUST COMPLY WITH FEDERAL AND STATE LAWS, WHICH PROHIBIT YOU FROM DISCLOSING THE IDENTITIES OF LONG-TERM RESIDENTS AND COMPLAINANTS TO ANYONE UNLESS CONSENT TO DISCLOSE IS PROVIDED BY THE RESIDENT OR COMPLAINANT OR DISCLOSURE IS REQUIRED BY COURT ORDER (Title 42 United States Code Section 3058g(d)(2); WIC Section 9725).

I, \_\_\_\_\_, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE	DATE
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# Form W-4 (2018)

**Future developments.** For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no tax liability, and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no tax liability.**

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

## General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

**Filers with multiple jobs or working spouses.** If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to find out if you should adjust your withholding on Form W-4 or W-4P.

**Nonresident alien.** If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

## Specific Instructions

### Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

#### Line C. Head of household please note:

Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

**Line E. Child tax credit.** When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

#### Line F. Credit for other dependents.

When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <span style="font-size: 2em; font-weight: bold;">2018</span>	
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."			
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>			
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . . . .				5	
6 Additional amount, if any, you want withheld from each paycheck . . . . .				6 \$	
7 I claim exemption from withholding for 2018, and I certify that I meet <b>both</b> of the following conditions for exemption.					
<ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no tax liability, and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no tax liability.</b></li> </ul> If you meet both conditions, write "Exempt" here . . . . .				7	
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶				Date ▶	
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)		9 First date of employment		10 Employer identification number (EIN)	

your wages and other income, including income earned by a spouse, during the year.

**Line G. Other credits.** You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

### Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App). If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

### Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more

than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make your withholding more accurate.

**Tip:** If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

### Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

**New hire reporting.** Employers are

required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to [www.acf.hhs.gov/programs/css/employers](http://www.acf.hhs.gov/programs/css/employers).

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

**Box 8.** Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

**Box 9.** If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

**Box 10.** Enter the employer's employer identification number (EIN).

**Personal Allowances Worksheet (Keep for your records.)**

- A Enter "1" for yourself . . . . . A \_\_\_\_\_
- B Enter "1" if you will file as married filing jointly . . . . . B \_\_\_\_\_
- C Enter "1" if you will file as head of household . . . . . C \_\_\_\_\_
- D Enter "1" if:
  - You're single, or married filing separately, and have only one job; or
  - You're married filing jointly, have only one job, and your spouse doesn't work; or
  - Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.
 . . . . . D \_\_\_\_\_
- E **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.
  - If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "4" for each eligible child.
  - If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "2" for each eligible child.
  - If your total income will be from \$175,551 to \$200,000 (\$339,001 to \$400,000 if married filing jointly), enter "1" for each eligible child.
  - If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" . . . . . E \_\_\_\_\_
- F **Credit for other dependents.**
  - If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "1" for each eligible dependent.
  - If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
  - If your total income will be higher than \$175,550 (\$339,000 if married filing jointly), enter "-0-" . . . . . F \_\_\_\_\_
- G **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here . . . . . G \_\_\_\_\_
- H Add lines A through G and enter the total here . . . . . ► H \_\_\_\_\_

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you have **more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed \$52,000 (\$24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

**Deductions, Adjustments, and Additional Income Worksheet**

**Note:** Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

- 1 Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details . . . . . 1 \$ \_\_\_\_\_
- 2 Enter:
  - \$24,000 if you're married filing jointly or qualifying widow(er)
  - \$18,000 if you're head of household
  - \$12,000 if you're single or married filing separately
 . . . . . 2 \$ \_\_\_\_\_
- 3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 \$ \_\_\_\_\_
- 4 Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) . . . . . 4 \$ \_\_\_\_\_
- 5 **Add** lines 3 and 4 and enter the total . . . . . 5 \$ \_\_\_\_\_
- 6 Enter an estimate of your 2018 nonwage income (such as dividends or interest) . . . . . 6 \$ \_\_\_\_\_
- 7 **Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . . . 7 \$ \_\_\_\_\_
- 8 **Divide** the amount on line 7 by \$4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction . . . . . 8 \_\_\_\_\_
- 9 Enter the number from the **Personal Allowances Worksheet**, line H above . . . . . 9 \_\_\_\_\_
- 10 **Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . . . . . 10 \_\_\_\_\_

**Two-Earners/Multiple Jobs Worksheet**

**Note:** Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1 Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) 1 \_\_\_\_\_
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" 2 \_\_\_\_\_
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet. 3 \_\_\_\_\_

**Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 \_\_\_\_\_
- 5 Enter the number from line 1 of this worksheet 5 \_\_\_\_\_
- 6 **Subtract** line 5 from line 4 6 \_\_\_\_\_
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ \_\_\_\_\_
- 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ \_\_\_\_\_
- 9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ \_\_\_\_\_

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$7,000	0	\$0 - \$24,375	\$420	\$0 - \$7,000	\$420
5,001 - 9,500	1	7,001 - 12,500	1	24,376 - 82,725	500	7,001 - 36,175	500
9,501 - 19,000	2	12,501 - 24,500	2	82,726 - 170,325	910	36,176 - 79,975	910
19,001 - 26,500	3	24,501 - 31,500	3	170,326 - 320,325	1,000	79,976 - 154,975	1,000
26,501 - 37,000	4	31,501 - 39,000	4	320,326 - 405,325	1,330	154,976 - 197,475	1,330
37,001 - 43,500	5	39,001 - 55,000	5	405,326 - 605,325	1,450	197,476 - 497,475	1,450
43,501 - 55,000	6	55,001 - 70,000	6	605,326 and over	1,540	497,476 and over	1,540
55,001 - 60,000	7	70,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 90,000	8				
70,001 - 75,000	9	90,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 105,000	10				
85,001 - 95,000	11	105,001 - 115,000	11				
95,001 - 130,000	12	115,001 - 120,000	12				
130,001 - 150,000	13	120,001 - 130,000	13				
150,001 - 160,000	14	130,001 - 145,000	14				
160,001 - 170,000	15	145,001 - 155,000	15				
170,001 - 180,000	16	155,001 - 185,000	16				
180,001 - 190,000	17	185,001 and over	17				
190,001 - 200,000	18						
200,001 and over	19						

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and

U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be

retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



**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, include the following:**
  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, include the following:**
  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 and only in the county in which the waiver was filed.
- 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 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.

**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 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. E-Mail Address (if any):		
9. a. Driver's License # or Government Issued ID #:	b. Expiration Date:	
	c. Issuing State:	
10. a. Primary Spoken Language:	b. Primary Written Language:	

#### NOTES:

- \* A paycheck for a provider cannot be mailed to a P.O. Box unless the county has approved a request from the provider.
- \*\* 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.

**GO ON TO THE NEXT PAGE**

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

PROVIDER'S NAME: \_\_\_\_\_

**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.*

**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.
- I have 90 calendar days from the date I first began the provider enrollment process to complete all of the enrollment requirements. If I do not complete all of the enrollment requirements within 90 calendar days, I shall be deemed ineligible to serve as a provider in the IHSS program and cannot be paid by the IHSS program for providing authorized services to an IHSS recipient.
- 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.

**GO ON TO THE NEXT PAGE →**

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

PROVIDER'S NAME: \_\_\_\_\_

**PART C: PROVIDER DECLARATION (Continued)**

**I UNDERSTAND AND AGREE THAT –**

- 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 and 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 the declaration and agreements listed above.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

County Representative's Signature (Optional): \_\_\_\_\_

DATE: \_\_\_\_\_