

IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER AGREEMENT

Failure to return this form to the Public Authority will cause a delay in your enrollment as a provider.

I acknowledge, understand, and/or agree with the following (please read and initial EACH statement):

____ I will inform the Public Authority **within 5 days** of any changes to my home address, mailing address, telephone number, or name.

____ I will notify the Public Authority **within 5 days** when my job as an IHSS Provider ends.

____ I understand that authorized hours are assigned to the IHSS recipient **monthly**, and that unused hours in a month **do not** carry over to the next month.

____ I understand that it is **my** responsibility to **verify** with the IHSS recipient the dates and number of hours I worked before completing and signing my timesheets. Only **actual hours worked** can be claimed on a timesheet. Claiming more hours than those worked is **fraudulent** and upon discovery, it will be reported to the District Attorney's Office. It is also **fraudulent** for a provider to claim hours for dates beyond their termination date and for dates after the recipients dies.

____ I understand that the IHSS recipient is the employer and as such they must sign the completed timesheet **after** services have been performed. Having someone other than the recipient sign the timesheet is **fraudulent**.

____ I understand that if the IHSS recipient is incapacitated or passes away, thereby making it impossible for them to sign the timesheet, I need to contact the Social Worker.

____ I understand that I **should not** work extra hours in any month for an IHSS recipient unless the recipient has already received an increase in hours, and that I should **always check with the recipient** about **any changes** in their authorized hours. A provider **will not** be paid for working additional hours until the Social Worker authorizes an *increase* in a recipient's monthly hours. The recipient will receive a **Notice of Action** informing them of their authorized hours. **Whether the recipient's hours are increased or decreased the provider will need to adjust their hours accordingly.**

____ I understand that if the IHSS recipient has a Share of Cost (SOC), they are responsible for paying me part of my wages. It is **not** the responsibility of the Public Authority or the County to ensure recipients pay providers their SOC. **Before** beginning work for a recipient, **always** ask if they have a SOC and if they can pay it. Before a check is issued with a SOC deduction, the State will notify the recipient and the provider of the exact amount of the SOC for the pay period.

____ I understand that IHSS hours **cannot be paid** when the IHSS recipient is **out of their home** for reasons that include, *but not limited to*, **staying in a hospital, skilled nursing facility, rehabilitation center, or board and care home; being in jail/prison.**

____ I understand that my employment as an IHSS provider **ends immediately** if the IHSS recipient dies.

Under penalty of perjury, I affirm by my signature that I have read, understand, and agree to the statements above. I also understand that instances of suspected fraud will be reported to the District Attorney's Office for investigation and potential prosecution.

Provider Signature: _____ Date: _____

Provider Name (*Print*): _____ Social Security #: _____