STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
**DEPARTMENT OF SOCIAL SERVICES**
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October 1, 2009

ALL-COUNTY LETTER NO. 09-52

Reason For This Transmittal

[X] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by one or More Counties
[ ] Initiated by CDSS

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: NEW IN-HOME SUPPORTIVE SERVICES PROVIDER ENROLLMENT REQUIREMENTS AND REVISED PROVIDER ENROLLMENT FORM

This All-County Letter (ACL) provides information regarding new In-Home Supportive Services (IHSS) Program provider enrollment requirements mandated by statutory changes resulting from the passage of recent legislation. It also transmits the revised Provider Enrollment Form (SOC 426) and the new Recipient Designation of Provider Form (SOC 426A), for use in the IHSS programs (including the Personal Care Services Program, the IHSS Plus Waiver and/or 1915J Option Program under the Medicaid State Plan, and the IHSS-Residual Program).

## NEW PROVIDER ENROLLMENT REQUIREMENTS

Assembly Bill, Fourth Extraordinary Legislative Session (ABX4) 19 (Chapter 17, Statutes of 2009), added various sections to Welfare and Institutions Code (W&IC) to establish additional enrollment requirements for all IHSS providers. Under these new provisions, in addition to completing the revised SOC 426, all current and prospective providers must:

1) Submit fingerprints and undergo a criminal background check by the California Department of Justice (DOJ);
2) Attend a provider orientation providing information about the rules, regulations and requirements for being an IHSS provider - (Other options for current providers to receive orientation information will also be available.); and
3) Sign a provider agreement stating that they understand and agree to the rules of the program and responsibilities of being a provider.

The attached flow chart (Attachment A) provides a simplified outline of the new provider enrollment process requirements and specifies the responsibilities of county staff, current and prospective providers, and recipients.

As outlined in All-County Information Notice I-69-09, existing providers (and recipients) will receive a mailing explaining the new provider enrollment requirements. An informational document which summarizes the provider enrollment requirements for prospective providers (SOC 847) has been developed and is also attached (Attachment B). Separate ACLs detailing implementation instructions for each of the new requirements are being developed and will be released shortly.

This ACL provides notices that counties shall use to inform recipients and providers when a provider has been determined eligible or, for various reasons, ineligible to be enrolled as an IHSS provider (Attachments C–K).

Eligibility for Retroactive Services Payment for Current Providers Prior to Completion of Enrollment Requirements

Prospective providers are not eligible to receive retroactive payment for services provided to an IHSS recipient before the provider has completed all of the enrollment requirements. However, consistent with Medi-Cal regulations, current providers may be eligible for retroactive payment for services they provide before they have completed the enrollment requirements back to the date of the recipient's eligibility determination.

**REVISED SOC 426**

The SOC 426 has been revised to comply with:

- ✓ Senate Bill (SB) 1104 (Chapter 229, Statutes of 2004), which added W&IC Section 12305.81;
- ✓ ABX4 4 (Chapter 4, Statutes of 2009), which amended W&IC Section 12305.81;
- ✓ ABX4 19, which added W&IC Section 12305.85; and
- ✓ Existing federal and state statutes and regulations governing the federal Medicaid program and state Medi-Cal program under which the majority of IHSS recipients' services are funded.

W&IC Section 12305.81 requires the California Department of Social Services (CDSS), in consultation with the California Department of Health Care Services (CDHCS), to develop a form to advise IHSS providers of provisions prohibiting anyone who has been convicted of or incarcerated for certain serious crimes from being enrolled as an IHSS provider and from receiving payment from the IHSS program for providing supportive services. All current and prospective IHSS providers must sign the form, under penalty of perjury, declaring that, within the last 10 years, they have not been convicted of or incarcerated for:

- ✓ A crime involving fraud against a government health care or supportive services program; or

- ✓ A crime of abuse of a child, elder or dependent adult, either in California or another state.

W&IC Section 12305.85 requires that current and prospective providers supply their current physical address, rather than a post office box address, when completing the provider enrollment form.

Additionally, existing federal Medicaid and state Medi-Cal statutes and regulations provide that any person who has ever been convicted of a felony crime or certain serious misdemeanor crimes is ineligible to be a provider of Medicaid/Medi-Cal-funded services. These rules also prohibit an individual from becoming a provider who, within the past 10 years, has either been found liable in a civil proceeding or entered into a legal settlement in place of a conviction, for fraud or abuse involving a government program. Under certain circumstances, Medicaid/Medi-Cal rules prohibit an individual from being a provider if he/she has:

1) Ever been a health care provider (licensed or non-licensed) who was suspended from the Medicare or Medicaid/Medi-Cal programs;
2) Ever lost or surrendered his/her professional license or certificate to provide health care; or
3) Ever had his/her professional license or certificate disciplined by any licensing authority.

A subsequent ACL will provide more specific information about the misdemeanor crimes and licensure conditions that would make an individual ineligible to be an IHSS provider.

The revised SOC 426 (Attachment L) is the product of a comprehensive review and development process initiated in 2005 following the passage of SB 1104. CDSS' Adult Programs Branch (APB), in consultation with the SB 1104 Stakeholder Forms Workgroup, and the CDHCS' Provider Enrollment Division, revised the SOC 426 to meet the above-referenced statutory mandates. Throughout the lengthy revision process, the APB solicited input on various draft versions of the SOC 426 from counties, Public Authorities, labor union representatives, and other stakeholders.

<u>Composition of the Form</u>

The revised SOC 426 is composed of three parts:

- ✓ Part A, Provider Information, in which the current or prospective provider reports general information about himself/herself;

- ✓ Part B, Provider Disclosure Statement, which is required to be completed only by individuals who are or who previously have been: 1) an IHSS provider, 2) a provider in the Medi-Cal program, or another state's Medicaid program, or 3) a licensed or certified health care provider. In this part, the current or prospective providers responds to questions about his/her history as a service provider and, in certain circumstances, attaches documentation regarding disciplinary actions against him/her; and

- ✓ Part C, Provider Declaration, in which the current or prospective provider declares, under penalty of perjury, that he/she: 1) has not been convicted of any of the disqualifying crimes; 2) understands and agrees to program rules; and 3) attests to the truth of the information he/she has provided.

An informational document has been developed to answer current and prospective providers' Frequently Asked Questions about the SOC 426 (Attachment M). The document, which has been assigned the form number SOC 426B, shall be provided to each person completing the SOC 426.

Time Line for Implementation

Counties are instructed to begin using the revised SOC 426 for all prospective providers effective November 2, 2009. As of that date, the latest version of the SOC 426 must be completed by each prospective provider before he/she can begin the process of enrollment as a provider and receive payment for providing services. All current providers must complete the revised version of the SOC 426 by July 1, 2010, the same date by which current providers must complete the other new provider enrollment process requirements outlined above. Current providers who have not completed all of the requirements by July 1, 2010, will no longer be eligible to continue providing services or receiving payment for services provided. Counties will have the flexibility to develop implementation schedules and processes which meet their individual needs, provided that the requirements are met for all providers by July 1, 2010.

County Responsibilities

For each existing current or prospective provider, county staff will be responsible for obtaining a signed SOC 426. At the time that the SOC 426 is accepted, county staff will be required to:

1) Perform an initial review of the form to ensure no items have been left blank;
2) View and photocopy the current or prospective provider's ID and Social Security Card (See below for information on acceptable documents.);
3) Keep original signed SOC 426 and other accompanying documents for further review (More detailed review procedures will be provided in follow-up ACL.);

4) Give the current or prospective provider a photocopy of the completed SOC 426 for his/her records;
5) After the review has been completed, enter provider information into the Case Management, Information and Payrolling System (CMIPS); and
6) File the original signed SOC 426, along with photocopies of ID and any other documents in either a provider file (if a county maintains separate provider files) or the recipient's case file.

Additionally, counties which contract with an agency to provide services to recipients must ensure that the contracted agencies utilize the SOC 426 and that they obtain a completed form from all employees providing services.

CMIPS Modifications

When it is implemented, CMIPS II will have the capacity to fully support the new provider enrollment requirements. In the interim, legacy CMIPS is being modified so that counties can track providers' completion of the new enrollment requirements. Modifications include the creation of a provider eligibility information screen which will display a grid showing all of the enrollment process requirements (SOC 426 submitted, SSN verified, criminal background check information reviewed, etc.) with data entry fields that county staff will update to show completion dates, status changes, etc. Additional technical information about the system changes will be provided via an Electronic Bulletin Board (EBB) message.

Acceptable ID

The two primary ID documents which can be accepted along with a current or prospective provider's SOC 426 are an original, unexpired California Driver License or ID card (issued by the California Department of Motor Vehicles [DMV]). Also acceptable would be an original, unexpired ID document issued by a state or federal government agency, preferably one including a photograph (or physical description) and/or signature. Examples of these documents include the following: Driver License or ID card issued by another state's DMV, United States (U.S.) Military ID card, Permanent Resident Card (Green Card), or U.S. passport.

If the current or prospective provider is unable to provide an original Social Security Card, county staff may accept original official correspondence from the Social Security Administration verifying the person's Social Security Number (SSN).

If the current or prospective provider fails to provide acceptable ID or documentation of his/her SSN, county staff should inform that current or prospective provider that the form cannot be accepted without county staff first viewing these original documents.

Validity Period

The current or prospective provider is required to inform the county of any change in the information reported on the SOC 426 within 10 calendar days of the change. This time period is consistent with IHSS program rules. For changes in address or telephone number only, the provider may use a change of address form developed and utilized by the county. For more substantive changes, the provider will be required to submit a new SOC 426, and the county will need to review the new information to determine whether it affects the individual's eligibility to continue providing services.

Provided there are no changes in the information that was reported, once an individual has submitted a SOC 426 and has been enrolled as a provider, it remains valid for a period of one year beyond the time that the individual stops providing services. If an enrolled provider stops providing services for a period longer than one year, the person will be required to complete a new SOC 426 (which must go through the standard county review process) before he/she can be begin providing services again.

**NEW SOC 426A**

The previous SOC 426 included a section which the IHSS recipient was required to complete to designate his/her provider. This section has been removed from the revised SOC 426 and a separate form, the SOC 426A (Attachment N), has been developed for this purpose. Each recipient must complete a separate SOC 426A for each person he/she has chosen to provide his/her services. The SOC 426A is a single page form that collects general information about the provider. The recipient must sign the certification at the bottom of the page to acknowledge that he/she understands and agrees that:

- ✓ The person chosen to provide services for the recipient cannot be paid federal and/or state IHSS funds for any services provided until that person has completed the entire provider enrollment process, which includes completing and signing the Provider Enrollment Form (SOC 426), submitting fingerprints and undergoing a criminal background check, attending a provider orientation, and signing the Provider Enrollment Agreement (SOC 846);

- ✓ The county will notify the recipient if the person he/she has chosen to be his/her provider does not complete the provider enrollment process, or if that person is determined ineligible to be a provider;

- ✓ If the recipient chooses to receive services from someone before that person is enrolled as a provider, or after the recipient has been informed that the person is ineligible to be a provider, the recipient will be responsible for paying the provider with his/her own money; and

- ✓ The county can provide information about the recipient's authorized services and service hours to his/her provider(s).

County staff are responsible for providing each IHSS recipient a blank copy(ies) of the SOC 426A and obtaining a completed one for each individual who will be providing services to the recipient. They are required to review the form to ensure no information has been omitted and provide the recipient with a copy of the form(s) for his/her records. County staff are required to update CMIPS to reflect the recipient's provider information, and to file the original signed form(s) in the recipient's case file.

## MEDI-CAL SUSPENDED AND INELIGIBLE (S&I) PROVIDER LIST

A forthcoming ACL will provide information about how the provider enrollment process outlined in this ACL relates to the Medi-Cal S&I Provider List. In the interim, counties should follow existing procedures for checking the S&I Provider List to determine whether a current or prospective provider is ineligible to be enrolled, and for requesting that individuals whom the county has determined to be ineligible but whose names do not already appear on the S&I Provider List, are added to it.

## APPEALS PROCESS

ABX4 19 added a new requirement for CDSS to develop a written appeal process for the current and prospective providers who are determined ineligible to receive payment for the provision of services in the IHSS program.

The process allows a provider applicant who disagrees with the county's decision to deny the enrollment of a provider for failure to meet the mandated requirements, to file an appeal in writing. The Appeal Request will appear on the back side of all ineligibility notices sent to applicants. The applicant may complete the form to request an appeal of the county's decision. This form must be sent to CDSS, IHSS Provider Enrollment Appeals Unit (PEAU), of the Litigation and Appeals Bureau. Consistent with W&IC Section 14043.65, the applicant will have 60 days from the date of the county's notification of denial to request the appeal, and the PEAU will have 90 days to provide a decision to the applicant.

The applicant as well as the county will be notified via letter of the receipt of the appeal request. Upon receipt of the letter, the county is required to provide within 30 days the following information by secure mail service to the PEAU:

- ✓ The provider's completed SOC 426;
- ✓ Criminal Record Offender Information received from the California;
- ✓ Any documentation supporting the county's decision to deny the provider's application, including licensure documents; and
- ✓ County's written summary of the decision to deny the applicant.

The PEAU may also request additional information from the applicant or other governmental agencies during the review process. All information forwarded to CDSS by the county must be sent by secure mail service to ensure confidentiality.

The PEAU will review all documentation and make a decision. Once a decision has been made by the PEAU, a copy of this decision will be forwarded to the applicant and the county. If the PEAU determines the applicant is eligible to provide IHSS, the county will be notified to take the appropriate steps to ensure the appellant's eligibility to be enrolled as an IHSS provider is granted or restored.

Additional information regarding the appeals process, including the letters to be sent by CDSS to the applicant will be provided in a subsequent ACL.

## FILE MAINTENANCE

The APB recognizes that file systems vary from county to county. Some counties maintain separate provider and recipient files while other counties only keep recipient files. As noted above, when CMIPS II is implemented, it will have the capacity to fully support the provider enrollment process and will allow for correlation between providers and recipients. In the interim, counties may continue to maintain file systems which best meet their needs; however, they must ensure that the system utilized has the capacity to show the linkage between providers and all recipients.

## CAMERA-READY COPIES AND TRANSLATIONS OF FORMS

Counties may access camera-ready versions of English forms referenced in this ACL on CDSS' Forms/Brochures web page at:

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

Questions about accessing the forms may be directed to Forms Management Unit at FMUdss@dss.ca.gov, or via telephone, (916) 657-1907.

We are in the process of translating the provider enrollment forms. Language Translation Services (LTS) will make available camera-ready copies of Spanish, Armenian, and Chinese translated forms and letters as soon as they have been completed. You may access these translated forms and letters at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm. For any questions regarding translated materials, please contact the Language Services Unit at (916) 651-8876 or at LTS@dss.ca.gov.

Your County Forms Coordinator should distribute translated forms to each program and location. Each county shall provide bilingual/interpretive services and written

translations to non-English or limited English proficient populations as required by the Dymally Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and by State regulation (MPP Division 21, Civil Rights Nondiscrimination, section 115).

Should you have questions regarding information in this ACL, please contact Brad Elftmann, Analyst in the APB Policy, Legislation and Litigation Unit at brad.elftmann@dss.ca.gov.

Sincerely,

***Original Document Signed By:***

EVA L. LOPEZ
Deputy Director
Adult Programs Division

Attachments

**ATTACHMENT A**

# IHSS PROGRAM PROVIDER ENROLLMENT PROCESS

## PROVIDER ENROLLMENT FORM (SOC 426)

**COUNTY/PUBLIC AUTHORITY STAFF:**

- Provides current or prospective provider with:
  - ✓ Blank Provider Enrollment Form (SOC 426), and
  - ✓ FAQs (SOC 426B).

**CURRENT OR PROSPECTIVE PROVIDER (APPLICANT):**

- Completes and signs SOC 426; and
- Returns completed SOC 426 in person at county IHSS Office/Public Authority along with original ID.

**COUNTY/PUBLIC AUTHORITY STAFF:**

- Reviews SOC 426 for completeness;
- Views and photocopies current or prospective provider's ID;
- Files original SOC 426 with photocopy of ID; and
- Updates CMIPS Provider Eligibility Information screen.

## PROVIDER ORIENTATION & PROVIDER ENROLLMENT AGREEMENT (SOC 846)

**COUNTY/PUBLIC AUTHORITY STAFF:**

- Informs current/prospective providers of dates, times, locations of Provider Orientation sessions;
- Conducts orientation sessions; and
- Provides blank copy of Provider Enrollment Agreement (SOC 846) to attendees.

**CURRENT OR PROSPECTIVE PROVIDER (APPLICANT):**

- Attends Provider Orientation session; and
- Signs SOC 846.

**COUNTY/PUBLIC AUTHORITY STAFF:**

- Collects signed SOC 846 forms from attendees;
- Files original SOC 846; and
- Updates CMIPS Provider Eligibility Information screen.

## CRIMINAL BACKGROUND CHECK

**COUNTY/PUBLIC AUTHORITY STAFF:**

- Provides current or prospective provider with Request for Live Scan Service (BCII 8016) with county information completed; and
- List of nearby Public Live Scan locations.

**CURRENT OR PROSPECTIVE PROVIDER (APPLICANT):**

- Completes Applicant Information section of BCII 8016;
- Presents BCII 8016 at chosen Live Scan location;
- Pays fees for fingerprinting and background check; and
- Provides fingerprints.

**COUNTY/PUBLIC AUTHORITY STAFF:**

- Receives results of background check from Dept. of Justice;
- Reviews information to determine if individual is ineligible; and
- Updates CMIPS Provider Eligibility Information screen.

## RECIPIENT DESIGNATION OF PROVIDER (SOC 426A)

**COUNTY/PUBLIC AUTHORITY STAFF:**

- Provides current or prospective provider with blank SOC 426A for each provider.

**RECIPIENT (OR AUTHORIZED REPRESENTATIVE):**

- Completes a SOC 426A for each provider; and
- Returns SOC 426A forms to county.

**COUNTY/PUBLIC AUTHORITY STAFF:**

- Reviews SOC 426A form(s) for completeness;
- Photocopies form and provides copy to recipient;
- Files original form(s) in recipient case file; and
- Updates CMIPS to show recipient/provider relationship(s).

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

An IHSS provider is someone who provides services to a person who receives 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.

- You can get a blank copy of the SOC 426 from the county IHSS Office or Public Authority. The county IHSS Office or Public Authority will also give you an information sheet that gives answers to Frequently Asked Questions (FAQs) about the SOC 426. You should read the FAQs carefully before you complete the SOC 426.
- You must report on the SOC 426 whether you have been convicted of certain crimes that would make you ineligible to receive payment from the IHSS Program for providing services.
- It is important that you read the SOC 426 carefully and that all of your responses are complete and truthful because the information you provide will be verified by a criminal background check that you must also go through as part of the provider enrollment process (See Step 2.).

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

- 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 businesses that offer 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 from your own money. Fees vary depending where you choose to get fingerprinted; however, the cost is about $70.
- The background check will verify that you have not been convicted of any crimes that make you ineligible to receive payment from the IHSS Program for providing services.

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 present important information about the IHSS Program and the rules and requirements for being a provider.

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

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.

Once you have completed these 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 new requirements, contact your county IHSS Office or IHSS Public Authority.

**ATTACHMENT C**

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

# IN-HOME SUPPORTIVE SERVICES PROGRAM
# NOTICE OF PROVIDER ELIGIBILITY

COUNTY OF

**(ADDRESSEE)**

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider Applicant

As of the date of this notice, you have been officially enrolled as an IHSS provider. You can now begin providing services for an IHSS recipient(s) and receiving payment from the IHSS program for providing services.

If you have any questions, call your local IHSS Office or IHSS Public Authority.

**ATTACHMENT D**

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES PROGRAM

COUNTY OF

NOTICE OF PROVIDER INELIGIBILITY

**(ADDRESSEE)**

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider Applicant

The county has found that you are not eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing services. Here's why:

As part of the provider enrollment process, you submitted fingerprints and went through a criminal background check by the California Department of Justice and the Federal Bureau of Investigation. The background check showed that you had been convicted of a crime(s) that makes you ineligible to be an IHSS provider and to receive payment from the IHSS Program for providing services. The crime(s) which disqualified you is/are shown below:

If you disagree with this decision, the back of this page explains how you can request an appeal. You must submit your appeal request within 60 calendar days from the date of this letter.

If you have any questions about this letter, you may call your local IHSS Office or IHSS Public Authority.

**ATTACHMENT E**

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES PROGRAM

COUNTY OF

NOTICE OF PROVIDER INELIGIBILITY

**(ADDRESSEE)**

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider Applicant

The county has found that you are not eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing services. You are not eligible because you did not complete one or more of the required steps of the IHSS provider enrollment process. You did not complete the step(s) marked below:

- ☐ You did not complete, sign or return the IHSS Provider Enrollment Form (SOC 426).
- ☐ You did not attend an IHSS Provider Orientation session.
- ☐ You did not sign the IHSS Provider Enrollment Agreement (SOC 846).
- ☐ You did not submit fingerprints and go through a criminal background check.

If you disagree with this decision, the back of this page explains how you can request an appeal. You must submit your appeal request within 60 calendar days from the date of this letter.

If you have any questions about this letter, call your local IHSS Office or IHSS Public Authority.

**ATTACHMENT F**

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES PROGRAM

COUNTY OF

NOTICE OF PROVIDER INELIGIBILITY

**(ADDRESSEE)**

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider Applicant

As of the date of this notice, you are no longer eligible to be an IHSS provider or to receive payment from the IHSS Program for providing services. Here's why:

- ☐ On _____, we sent you a notice telling you that the Provider Enrollment Form (SOC 426) you submitted to the county was incomplete. We asked you to provide the missing information within 15 business days. You did not submit the requested information by the date we requested it.

- ☐ On _____, we provided you with a blank Provider Enrollment Form (SOC 426) and asked you complete it and return it to the county by _____. We told you that if you did not submit the completed form within 30 days, you would not be able to continue to get paid for providing IHSS. You did not submit the completed SOC 426 by the date we requested it.

If you disagree with this decision, the back of this page explains how you can request an appeal. You must submit your appeal request within 60 calendar days from the date of this letter.

If you have any questions about this letter, call your local IHSS Office or IHSS Public Authority.

**ATTACHMENT G**

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

# IN-HOME SUPPORTIVE SERVICES PROGRAM
# NOTICE TO RECIPIENT OF PROVIDER ELIGIBILITY

COUNTY OF

**(ADDRESSEE)**

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider Applicant

Based on the information you provided on the Provider Enrollment Form (SOC 426), you are not eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing services. Here's why:

- ☐ Within the past 10 years, you were found liable for fraud or abuse involving a government program in a civil proceeding. State law prohibits anyone who has been found liable for fraud or abuse involving a government program in a civil proceeding from being enrolled as a provider or receiving payment for providing supportive services.

- ☐ Within the past 10 years, you entered into a legal settlement in place of conviction for fraud or abuse involving a government program. State law prohibits anyone who has entered into a legal settlement in place of conviction for fraud or abuse involving a government program from being enrolled as a provider or receiving payment for providing supportive services.

- ☐ You were suspended as a provider from the Medicare, Medicaid or Medi-Cal programs, and you were not reinstated. Any provider who has been suspended from the Medicare, Medicaid or Medi-Cal program and who has not been reinstated is ineligible to be enrolled as a provider or to receive payment for providing supportive services.

- ☐ A licensing authority took disciplinary action against your professional license, certificate or other authorization to provide health care. We reviewed the terms and conditions of the licensing authority's decision(s) and found that the terms and conditions prohibit you from providing supportive services.

Because you are not eligible to be an IHSS provider, we will forward this information to the California Department of Health Care Services (CDHCS) and ask that your name be placed on the Medi-Cal Suspended and Ineligible Providers list. You will get a letter from CDHCS when your name is added to the list.

If you disagree with this decision, the back of this page explains how you can request an appeal. You must submit your appeal request within 60 calendar days from the date of this letter.

If you have any questions about this letter, call your local IHSS Office or IHSS Public Authority.

IN-HOME SUPPORTIVE SERVICES PROGRAM COUNTY OF
NOTICE OF INCOMPLETE PROVIDER ENROLLMENT FORM

**(ADDRESSEE)**

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider Applicant

The County reviewed the Provider Enrollment Form (SOC 426) you submitted and has found that the information you provided is incomplete. We are not able to determine if you are eligible to be enrolled as an IHSS provider because you did not provide all of the necessary information. You must submit all of the information indicated below within 15 business days of the date of this letter.

- ☐ Response to Item Number(s) _____ on the SOC 426
- ☐ Copy of notice of reinstatement as a provider in Medicare, Medicaid and/or Medi-Cal programs
- ☐ Copy of written confirmation from licensing authority that your professional privileges have been restored
- ☐ Copy of licensing authority's decision(s), including terms and conditions, regarding disciplinary action(s)
- ☐ Other: _____

If you do not provide all of the requested information within 15 business days, you will not be eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing services.

If you have any questions about this letter, call your local IHSS Office or IHSS Public Authority.

**ATTACHMENT I**

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES PROGRAM COUNTY OF
NOTICE TO RECIPIENT OF PROVIDER ELIGIBILITY

**(ADDRESSEE)**

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

As of the date of this notice, _____, the person you have chosen to provide services for you has been officially enrolled as a provider. He/she can now begin providing services for you.

If you have any questions, call your social worker or your county IHSS Office or IHSS Public Authority.

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

IN-HOME SUPPORTIVE SERVICES PROGRAM COUNTY OF
NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY

**(ADDRESSEE)**

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

The person you have chosen to provide services for you, _____, is not eligible to receive payment from the IHSS program for providing services to you or to any other person. Here's why:

He/she did not complete one or more of the required steps of the provider enrollment process shown below.

- He/she did not complete, sign and return the IHSS Provider Enrollment Form (SOC 426) to the county; and/or
- He/she did not attend an IHSS Provider Orientation; and/or
- He/she did not sign an IHSS Provider Enrollment Agreement (SOC 846); and/or
- Either he/she did not go through a criminal background check, or he/she did go through a criminal background check but he/she was found ineligible based on a conviction for a crime.

You must choose a different person to provide services. If you choose to continue receiving services from this provider, you will be responsible for paying him/her with your own money for any services provided.

If you need help finding a different provider, call your social worker or your county IHSS Office or IHSS Public Authority.

**ATTACHMENT K**

TO ASK FOR AN APPEAL:

- You must ask for an appeal within 60 days of the day the county tells you that you are not eligible to be an IHSS provider.
- Fill out and sign this page.
- Make a copy of the front and back of this page for your records.
- For questions about the request to appeal: (916) 556-1156
- Send this page to:

California Department of Social Services
Adult Programs Branch
IHSS Provider Enrollment Appeals Unit, MS 19-04
PO Box 944243
Sacramento, CA 94244-2430

## APPEAL REQUEST

I want to appeal the decision of _____ County about my ineligibility to be a provider of In-Home Supportive Services. I believe that the County's decision is not correct. Here's why:

☐ If you need more space, check the box at left and attach a page.

| | | |
|---|---|---|
| NAME: | | |
| STREET ADDRESS: | | |
| CITY: | STATE: | ZIP CODE: |
| TELEPHONE NUMBER: | DATE OF BIRTH: | |
| SIGNATURE: | DATE: | |

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

**INSTRUCTIONS:**

- Use pen to fill out. Print information clearly.
- You must fill out, sign and return this form to the county IN PERSON as part of the provider enrollment process before you can be enrolled as an IHSS provider or get paid from the IHSS program for providing services for an IHSS recipient.
- You must complete all items in PART A and you must answer Question #9 in PART B on Page 2. If you answer "YES" to any part of Question #9 (either a., b., or c.), you must also answer the other questions in PART B. You must sign the declaration in PART C on Page 3.
- The county will review the form to make sure it is complete and will need to see and make photocopies of your original identification. The county will provide you a copy of the completed form for your records.
- You MUST let the county know if anything you report on this form changes in the future. You must tell the county what has changed WITHIN 10 CALENDAR DAYS of the change.

## ****IMPORTANT INFORMATION – PLEASE READ CAREFULLY****

It is important that all of your responses on this form be complete and truthful. The information you provide will be verified through a criminal background check that you must go through as part of the provider enrollment process. You have to pay for the costs of fingerprinting and the criminal background check with your own money. If the criminal background check shows any disqualifying convictions, you will NOT be eligible to be enrolled as a provider or to receive payment from the IHSS program for providing supportive services.

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If you have been convicted of OR in prison for one of the following 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:

- ✓ Fraud against a government health care or supportive services program; or
- ✓ Abuse of a child, elder or dependent adult, either in California or another state.

If you have EVER been convicted of a felony crime OR certain serious misdemeanor crimes, you are NOT eligible to be enrolled as a provider or to receive payment from the IHSS program for providing supportive services.

## PART A: PROVIDER INFORMATION

| | | | |
|---|---|---|---|
| **1.** Full Name (First Name, Middle Initial, Last Name): | **2.** Date of Birth:<br>If you are under 18 years of age, you must submit a valid Work Permit with this form. | | **3.** Gender:<br>☐ M ☐ F |
| **4.** Home Address (May **not** be a Post Office box): | City: | State: | ZIP: |
| **5.** Telephone Number (with Area Code): | **6.** Social Security Number: | | |
| **7. a.** Driver's License # or Government Issued ID #: | **b.** Expiration Date:<br>**c.** Issuing State: | | |
| **8.** Primary Language -<br>**a.** Spoken: | **b.** Written: | | |

**GO ON TO THE NEXT PAGE ➔**

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

**NAME:**

## PART B: PROVIDER DISCLOSURE STATEMENT

**9.** Are you currently **OR** have you **EVER** been a -

**a.** Provider of In-Home Supportive Services (IHSS)? ☐ YES ☐ NO

**b.** Provider in the Medi-Cal program or in another state's Medicaid program? ☐ YES ☐ NO

**c.** Licensed or certified health care provider? ☐ YES ☐ NO

**Note: You are NOT required to have a professional health care license or certificate to be an IHSS provider.**

**STOP – PLEASE READ THE FOLLOWING:**

**YOU ARE REQUIRED TO ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU ANSWERED "YES" TO ANY PART (a., b., OR c.) OF QUESTION #9 ABOVE.**

**IF YOU ANSWERED "NO" TO ALL PARTS OF QUESTION #9, GO ON TO PART C.**

**10. a.** State(s) in which You Worked as a Provider:

**b.** Name(s) (both Legal and Doing Business As):

**c.** National Provider Identifier and/or Provider Number(s):

**Answering "YES" to any of the following questions may affect your eligibility to be an IHSS provider.**

**11.** Either as a licensed health care provider **OR** as a provider of IHSS, have you **EVER** been suspended from the Medicare, Medicaid or Medi-Cal programs? ☐ YES* ☐ NO

***IF YES**, have you been reinstated? ☐ YES* ☐ NO

***IF YES**, attach verification of reinstatement.

**12.** Have you **EVER** lost or surrendered your professional license (to provide health care), certificate (to provide health care), or other authorization to provide health care while a disciplinary hearing was pending? ☐ YES* ☐ NO

***IF YES**, has your license/certificate been restored? ☐ YES* ☐ NO

***IF YES**, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored.

**13.** Has your professional license (to provide health care), certificate (to provide health care), or other authorization to provide health care EVER been disciplined by any licensing authority? ☐ YES* ☐ NO

***IF YES**, attach a copy of the licensing authority's decision(s), including any terms and conditions for each decision.



**GO ON TO THE NEXT PAGE ➔**

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

## PART C: PROVIDER DECLARATION

**READ CAREFULLY: YOU ARE MAKING THE FOLLOWING DECLARATIONS UNDER PENALTY OF PERJURY.**

**I DECLARE, UNDER PENALTY OF PERJURY, THAT –**

- WITHIN THE PAST 10 YEARS, I HAVE NOT been convicted of OR in prison for a crime involving fraud against a government health care or supportive services program.
- WITHIN THE PAST 10 YEARS, I HAVE NOT been found liable for fraud or abuse involving a government program in any civil proceeding.
- WITHIN THE PAST 10 YEARS, I HAVE NOT entered into a legal settlement in place of a conviction for fraud or abuse involving a government program.
- WITHIN THE PAST 10 YEARS, I HAVE NOT been convicted of OR in prison for a crime involving abuse of a child, elder, or dependent adult, either in California or another state.
- I HAVE NEVER been convicted of any felony crime.
- I HAVE NEVER been convicted of a serious misdemeanor crime.

**I UNDERSTAND AND AGREE THAT –**

- I CANNOT RECEIVE federal and/or state IHSS funds as payment for services I provide to any recipient of IHSS until I have completed the entire provider enrollment process and 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 will have to pay for the costs of fingerprinting and the background check from my own money. If it is found that I have been convicted of certain serious crimes, I will be ineligible to be an IHSS provider.

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

- I WILL BE considered to be a Medi-Cal provider of personal care services.
- Payment for the authorized services I provide to an IHSS recipient will be from federal and/or state IHSS funds and that 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 state for any overpayments paid to me and I understand that any overpayment, individually or collectively, may be deducted from a future warrant for services I provide to any recipient of IHSS.
- I WILL PROVIDE all services without discrimination based on race, religion, color, national or ethic origin, sex, 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 complete to the best of my knowledge.**

Signature: _____ Date: _____

Printed Name: _____

# FREQUENTLY ASKED QUESTIONS (FAQ'S) ABOUT THE IHSS PROGRAM PROVIDER ENROLLMENT FORM (SOC 426)

## ****PLEASE READ THIS INFORMATION CAREFULLY BEFORE YOU BEGIN TO COMPLETE THE SOC 426****

1. WHO MUST COMPLETE THE PROVIDER ENROLLMENT FORM (SOC 426)?

   An IHSS provider is someone who gets paid from the IHSS program for providing supportive services for an IHSS recipient (someone who gets services through the IHSS program).

   Any person who is already an IHSS provider OR who wants to become an IHSS provider has to complete and sign the SOC 426.

2. WHEN DO I HAVE TO COMPLETE THE SOC 426?

   *If you are already an IHSS provider*, you have to complete, sign and return the SOC 426 BY JULY 1, 2010. If you do not submit the SOC 426 BY JULY 1, 2010, you will no longer be eligible to be an IHSS provider.

   *If you want to become an IHSS provider*, you have to complete, sign and return the SOC 426 BEFORE you can be enrolled as an IHSS provider and get paid for providing services.

3. WHERE DO I RETURN THE SOC 426?

   After you have completed and signed the SOC 426, you must return it IN PERSON TO THE COUNTY IHSS OFFICE OR COUNTY PUBLIC AUTHORITY.

   You will have to show identification (ID) when you return the SOC 426. See Question #7 on this page for information about what kind of ID is required.

4. WHAT ITEMS ON THE SOC 426 DO I HAVE TO COMPLETE?

   You have to complete all of the items in PART A and you must also answer all part of #9 (a., b. and c.) in PART B. If you answer "YES" to any part of item #9 (a., b., or c.) in PART B., you must also answer all the remaining questions in PART B (#'s 10, 11, 12 and 13). You have to read and sign the declaration in PART C. If you do not answer all of the required questions and sign the SOC 426, you will not be eligible to be enrolled as an IHSS provider.

5. WHY DO I HAVE TO SIGN THE SOC 426?

   You have to sign the SOC 426 to show that you fully understand and agree to all of the statements listed in the declaration in PART C. You are signing the SOC 426 under penalty of perjury.

6. WHAT DOES "UNDER PENALTY OF PERJURY" MEAN?

   The words, "under penalty of perjury," mean that you swear that all of the information you are giving is true and correct. If you intentionally give false information or hold back information so you can get a benefit or payment that you are not entitled to, you can be prosecuted for fraud under federal and state law. If you are convicted of fraud, you can be fined, jailed and/or disqualified from becoming an IHSS provider.

   As part of the provider enrollment process, you will also have to be fingerprinted and go through a criminal background check. The criminal background check will show whether you have provided any false information on the SOC 426.

7. WHAT KIND OF ID DO I HAVE TO PROVIDE?

   You must provide two original pieces of ID. Photocopies of ID are not acceptable. You must provide:

   - An unexpired Driver's License or ID card issued by the California (or another state's) Department of Motor Vehicles, OR
   - Some other unexpired ID issued by a government agency (e.g., military ID, passport, permanent resident card, etc.); AND
   - A Social Security Card; OR
   - Other official correspondence from the Social Security Administration verifying your Social Security Number.

   If you are under the age of 18, you also have to provide a valid Work Permit.

8. WHY DO I HAVE TO COMPLETE THE SOC 426?

You have to complete the SOC 426 to let the county know if you have been convicted of OR in prison for a crime that would disqualify you from being an IHSS provider.

9. WHAT CRIMES WOULD MAKE ME INELIGIBLE TO BE AN IHSS PROVIDER?

Under state law, any person WHO WITHIN THE LAST 10 YEARS has been convicted of OR in prison for one of the following crimes is not eligible to be an IHSS provider or to received payment from the IHSS program for providing supportive services:

- A crime involving fraud against a government health care of supportive services program; or
- Abuse of a child, elder or dependent adult.

Also, any person who has EVER been convicted of or in prison for a felony crime OR certain serious misdemeanor crimes is not eligible to be an IHSS provider or to receive payment from the IHSS program for providing supportive services.

Generally, misdemeanor crimes involving violence or threats of violence would disqualify a person from being an IHSS provider.

Minor infractions, such as traffic violations, would not disqualify a person from being an IHSS provider.

10. WHAT HAPPENS IF I'M CONVICTED OF A CRIME AFTER I'M ENROLLED AS AN IHSS PROVIDER?

You must let the county know of any changes to the information you reported on the SOC 426 within 10 calendar days of the change. If you get convicted of one of the disqualifying crimes, you will no longer be eligible to be an IHSS provider. The county will receive information about any criminal convictions through the criminal background check process that you must also go through to be enrolled as a provider.

11. WHAT HAPPENS TO THE INFORMATION I PROVIDE?

The county will review the information you provide on the form to make sure it is complete, and will determine whether you are eligible to be an IHSS provider. They will also check to see if your name appears on the Medi-Cal Suspended and Ineligible (S&I) Providers list, which includes the names of persons who have been:

1) Convicted of a crime involving fraud or abuse of the Medi-Cal Program, or
2) Suspended from the federal Medicare program for any reason.

If your name is on the S&I Providers list, you will not be able to be an IHSS provider. The county will send you a letter informing you that you are ineligible to be an IHSS provider.

If you are determined to be ineligible to be an IHSS provider, and your name is not already on the S&I Providers list, the county will ask to have your name added to the list.

12. CAN I APPEAL IF I'M FOUND INELIGIBLE TO BE AN IHSS PROVIDER?

Yes. The letter the county sends you if you are found ineligible to be an IHSS provider will tell you how to request an appeal. You will need to ask for an appeal IN WRITING WITHIN 60 DAYS OF THE DECISION. You must send your request for appeal to the following address:

California Department of Social Services
Adult Programs Branch
IHSS Provider Enrollment Appeals, MS 19-04
PO Box 944243
Sacramento, CA 94244-2430

For further questions about your request for appeal, you may contact the IHSS Provider Enrollment Appeals Unit at 916/556-1156.

If you have any other questions about the SOC 426, ask your county IHSS Office or IHSS Public Authority.

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

INSTRUCTIONS:

- Use pen to fill out. Print information clearly.
- You (or your legally authorized representative) must fill out 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.
- 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): | ☐ Male ☐ Female |
| 8. Provider's Relationship to Recipient (if any): | |

## 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 provider 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 and signing the Provider Enrollment Form (SOC 426), submitting fingerprints and undergoing a criminal background check, attending a provider orientation, and signing 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 I choose to receive services from this person before he/she is enrolled as a provider, 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 the county can provide information about my authorized services and service hours to my provider(s).

Recipient's or Legally Authorized Representative's Signature: _____ Date: _____

Printed Name: _____