

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.***

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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.

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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: If you are under 18 years of age, you must submit a valid Work Permit with this form. | 3. Gender: <input type="checkbox"/> M <input type="checkbox"/> F |
| 4. Home Address (Must be physical address, not 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.

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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.

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
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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: _____ |
|------------------------------------------------------------|--------------------|