



County of San Diego IHSS Public Authority

Dear Registry Applicant,

All Registry Applicants are required, by local ordinance, to pass a Department of Justice (DOJ) criminal background check in order to become active on the County of San Diego's IHSS Provider Registry. The Public Authority is required to exclude and/or remove from the Registry, anyone who has been convicted of a felony or a qualifying misdemeanor. If you are excluded or removed from the Registry, keep in mind that you may continue to work for an IHSS Consumer if you are already employed as a Provider or if you find work on your own with an IHSS Consumer.

In order to be added to the Provider Registry you **MUST** obtain your DOJ clearance by the date listed below. Your background will be checked, at **NO COST** to you, via fingerprint scanning by the County of San Diego. It is **your** responsibility to make all necessary arrangements to have your fingerprints scanned there (see the enclosed contact information). To obtain your fingerprint scan call the County of San Diego at 619-338-2846 to schedule your appointment. **Please note that prior background checks or fingerprint clearances will not be accepted.**

You have until: _____, to have your fingerprints scanned for purposes of the background check.

If you do not complete your fingerprint scan by the date indicated above, you will not be allowed to join the Provider Registry and will need to re-apply (1) year from the date of this letter. If you decide to re-apply, you will be required to undergo a criminal background check at that time.

If you fail the background check and wish to obtain information about your specific background, please contact Record Review at the Department of Justice at (916) 227-3832. **Please note, you will not have the right to appeal your removal from the Provider Registry based on your failure to pass the background check.**

If at any time an IHSS Consumer on the Registry asks whether or not you have successfully completed the DOJ requirement, the Registry staff will not provide

780 Bay Boulevard, Suite 200, Chula Vista, CA 91910
Phone: 866.351.7722
Website: www.sdihsspa.com

any information to the Consumer regarding your specific background as reported to us by DOJ due to confidentiality. If at any time you have been removed from the Registry for failing or for not complying with the DOJ requirement, we will let the Consumer know that you have been removed from the Registry, but will not inform them of the reason why. If you have passed the DOJ background check, the Registry will indicate that you have successfully met the requirement in order to join and/or remain on the Registry.

Please follow the four steps below to comply with the DOJ requirement:

1. Complete the enclosed form, BCII-8016, "Request for Live Scan Service." Complete only those areas that are highlighted; if you make an error and need a new form; please call the Registry staff at the number below.
2. Call the County of San Diego at 619-338-2846 to schedule your fingerprint appointment. This appointment may require up to one hour of your time.
3. Take form BCII-8016 and two forms of ID (including at least one valid, government-issued photo ID such as your drivers' license) with you to the fingerprint scanning appointment.
4. Please wait (up to four weeks) to receive the "Acknowledgement Letter" from the Provider Registry staff. If you pass the clearance, we will send you a letter stating that you have passed the DOJ background check. We will continue to process your application and contact you when you are ready to move to next step. If you do not pass the DOJ background check, we will send you a "Denial Letter" notifying you that you are not eligible to join the Registry.

Please note that you will not receive any stipend or payment for your time spent while obtaining the fingerprint scan. You cannot claim hours for this time on the IHSS timesheet. While you remain an active IP on the Registry, if you are arrested for criminal activity, DOJ will notify the Registry of the arrest, at that point in time your status on the Registry will be reviewed. If the arrest leads to a disqualifying felony or qualifying misdemeanor, you will be removed from the Registry.

We appreciate your commitment to providing quality care to persons who are elderly and/or disabled, and we thank you for your time. Please feel free to contact us at 1-866-351-7722 if you have any further questions.

Sincerely,

Public Authority Registry Staff
Enclosures

780 Bay Boulevard, Suite 200, Chula Vista, CA 91910
Phone: 866.351.7722
Website: www.sdihsspa.com



**COUNTY OF SAN DIEGO
IN-HOME SUPPORTIVE SERVICES
Client/Employer and Provider Responsibilities**

CASE NAME: _____ **CASE NUMBER:** _____ **PHONE:** _____

As a recipient of In-Home Supportive Services (IHSS), I understand I have the following responsibilities:

- ◆ To provide the documentation required to determine if I am eligible to, and have a need for, services.
- ◆ To cooperate with Quality Control regulations and reviews.
- ◆ To inform my Social Worker within ten calendar days of any changes including:
 - Change in income of any household member (including myself) or if someone is paying my expenses;
 - Change in my address, phone number, marital status, or if household members move in or out;
 - Being out of my home for more than a day (Examples: hospital stay, vacation);
 - Acquiring or giving away any property including a house, land, cars, cash, etc.;
 - Moving out of San Diego County, so that my case can be transferred to another county;
 - Any change in my need for IHSS services.

I understand that there is a property limit of \$2,000.00 for one person and \$3,000.00 for two persons. People with income over the SSI level of \$_____for one person or \$_____for two persons may have to pay a portion, or share, of the cost for their services. This Share-of-Cost must be paid each month.

I understand that failure to provide necessary information, giving false information or not reporting changes timely can result in the denial or discontinuance of my IHSS benefits and an investigation of my case for fraud. I will be responsible to pay the County back if I receive services for which I am not eligible.

I understand that I am the employer of any Individual Provider (IP) whom I hire to provide IHSS services. My responsibilities include:

- ◆ Finding, hiring, training, supervising and firing any Individual Provider I employ, and reporting these changes to my Social Worker, including the start and end dates of my individual provider’s employment.
- ◆ Obtaining a work permit if I hire anyone under the age of 18.
- ◆ Verifying that my Individual Provider is a legal resident and keeping an I-9 form for each Provider for 3 years.
- ◆ Informing my Individual Provider about their pay, work schedule, working conditions, services authorized and the time given to perform those services, and any changes in my authorized hours.
- ◆ Informing my Individual Provider that the County will send them a packet that includes information about Workers Compensation, State Disability Insurance (SDI), and Unemployment Insurance Benefits (UIB).
- ◆ Providing the completed and signed copy of form 12-58A (IHSS Provider Responsibilities) to my Social Worker. I understand that my provider will not receive timesheets until my Social Worker receives a completed form. When I change providers, a new form must be completed and returned to my Social Worker.
- ◆ Informing my Individual Provider of Social Security and State Disabilities tax deductions and the need to complete form W-4 so that form W-2 will be sent to him/her every January.
- ◆ Verifying and signing provider timesheets only if accurately completed.

I affirm under penalty of perjury that I understand my responsibilities and that I have received a copy of the Civil Rights information.

Recipient/Authorized Representative Signature: _____ **Date:** _____

Social Worker Signature: _____ **Date:** _____



CONDADO DE SAN DIEGO
SERVICIOS DE AYUDA EN EL HOGAR
(In-Home Supportive Services-IHSS)
Responsabilidades del Cliente/Patrón y del Proveedor

NOMBRE DEL CASO: _____ **NÚMERO DEL CASO:** _____ **TEL:** _____

Como beneficiario de los servicios de IHSS, comprendo que mis responsabilidades son las siguientes:

- ◆ Proveer todos los documentos requeridos para determinar mi elegibilidad y necesidad de los servicios.
- ◆ Cooperar con las regulaciones y revisiones de Control de Calidad.
- ◆ Informar a mi Trabajador(a) Social dentro de diez (10) días de cualquier cambio, incluyendo:
 - Cambio de ingreso por parte de cualquier persona en mi hogar (incluyéndome a mí) o si alguien esta cubriendo mis gastos;
 - Cambio de mi domicilio, número de teléfono, estado civil o si personas se han mudado a/de mi hogar;
 - Vivir fuera de mi hogar por más de un día (Ejemplos: estancia en un hospital o vacaciones);
 - Adquirir o donar cualquier propiedad, incluyendo una casa, terreno, automóviles, dinero en efectivo, etc.;
 - Mudarme fuera del condado de San Diego, para que mi caso se transfiera a otro condado;
 - Cualquier cambio de servicios que requiero por parte de IHSS.

Entiendo que hay un límite de bienes/propiedades por parte del programa IHSS que es de \$2,000 para una persona y \$3,000 para dos personas. Personas que rebasen el límite de ingresos SSI de \$_____ para una persona o \$_____ para dos personas, se les podría requerir pagar parte del costo de los servicios. Este “Share of Cost” o Costo Compartido tiene que pagarse cada mes.

Comprendo que puedo perder total o temporalmente los beneficios de IHSS por no proporcionar la información necesaria, dar información falsa o no reportar cambios a tiempo. Además, se iniciaría una investigación de mi caso por fraude. Si recibo servicios por los cuales no califico, seré responsable de devolverle el dinero al condado.

Entiendo que yo contrato al y soy el patrón del proveedor de cuidado (IP por sus siglas en inglés) que me proporcione los servicios de IHSS. Mis responsabilidades al respecto incluyen:

- ◆ Encontrar, contratar, entrenar, supervisar y despedir al proveedor de cuidado que emplee, y reportar estos cambios a mi Trabajador(a) Social, incluyendo las fechas de inicio y terminación de mi proveedor de cuidado.
- ◆ Obtener un permiso de trabajo si empleo a una persona menor de diez y ocho (18) años de edad.
- ◆ Verificar que mi proveedor de cuidado es un residente legal de Estados Unidos y retener formularios I-9 para cada proveedor, por tres (3) años.
- ◆ Informar a mi proveedor de cuidado de los términos de pago, horarios, condiciones laborales, servicios autorizados, tiempo autorizado para desempeñar los servicios, y cambios en horas autorizadas de servicio.
- ◆ Informar a mi proveedor de cuidado que el Condado le enviará un paquete con información referente a Compensación al Empleado (“Workers Compensation”), Seguro del Estado en Caso de Incapacidad (“State Disability Insurance” o SDI) y Seguro de Beneficios en Caso de Desempleo (“Unemployment Insurance Benefits” o UBI).
- ◆ Proporcionar una copia del formulario 12-58A (Responsabilidades del Proveedor de IHSS) completo a mi Trabajador(a) Social, junto con fechas de inicio y terminación. Entiendo que mi proveedor de cuidado no recibirá hojas de tiempo hasta que mi Trabajador(a) Social reciba el formulario completo. Si cambio de proveedor debo completar un nuevo formulario y regresarlo a mi Trabajador(a) Social.
- ◆ Informar a mi proveedor de cuidado de las deducciones de impuestos estatales de Incapacidad y del Seguro Social, que se harán de su sueldo. También informarle que debe llenar un formulario W-4 para que se le envíe un formulario W-2 cada enero.
- ◆ Verificar y firmar las hojas de tiempo del proveedor sólo si la información esta correcta y completa.

Declaro bajo pena de perjurio que comprendo mis responsabilidades y he recibido copia de mis Derechos Civiles.

Firma del Beneficiario: _____ **Fecha:** _____

Firma de Trabajador(a) Social: _____ **Fecha:** _____



**COUNTY OF SAN DIEGO
IN-HOME SUPPORTIVE SERVICES
Client/Employer and Provider Responsibilities**

CASE NAME: _____ **CASE NUMBER:** _____ **PHONE:** _____

As an IHSS Individual Provider I am responsible for:

- ◆ Providing all services for which I was hired and accurately reporting hours worked on my timesheets. I am aware that I am not paid to perform work when the IHSS recipient I work for is away from his/her home (Examples: hospital stay, vacation).
- ◆ Complying with Quality Control regulations and reviews.
- ◆ **Providing this form and showing my Social Security card or providing a copy to an IHSS employee before timesheets will be issued to me.**
- ◆ Reporting any suspected elder or dependent adult abuse to Adult Protective Services at 1-800-510-2020. Persons who are paid or volunteer caregivers, including IHSS Individual Providers, are Mandated Reporters (W&I Code 15630(b) (1)).

I understand that giving false information or reporting hours I did not work on my timesheets can result in an investigation for fraud. I am responsible to pay back the County of San Diego for the overpayment.

Individual Provider Signature: _____ **Date:** _____

Relationship to IHSS Recipient: _____

Social Security Number: _____ Birth date: _____

Address: _____ Telephone: _____

City, Zip: _____ Start Date: _____

<p>COUNTY USE ONLY</p> <p>SUMMARY OF INFORMATION FROM EVIDENCE VIEWED</p> <p>(Complete the information only as appropriate)</p>	
Name on Social Security Card:	_____
Social Security Number:	_____
Resident Alien Number:	_____
Employment Authorization Expiration Date:	_____
Other Form of Identification:	_____
This is to certify that the above evidence was viewed on _____	
	<small>(date)</small>
by:	_____
	<small>Worker Name and Number</small>
Most recent 12-58 dated by client on: _____	



**COUNTY OF SAN DIEGO
IN-HOME SUPPORTIVE SERVICES
Client/Employer and Provider Responsibilities**

NOMBRE DEL CASO: _____ **NÚMERO DEL CASO:** _____ **TEL:** _____

Como proveedor de cuidado de IHSS, tengo las responsabilidades de:

- ◆ Proporcionar todos los servicios por los que se me contrató y correctamente reportar las horas que trabajé en las hojas de tiempo.
- ◆ Cooperar con las regulaciones y revisions de Control de Calidad.
- ◆ **Proporcionar este formulario y mostrar mi Tarjeta de Seguro Social o proporcionarle una copia de la misma a un empleado de IHSS, antes de que se me proporcionen hojas de tiempo.**
- ◆ Reportar toda sospecha de abuso de personas mayores o dependientes a la oficina de Servicios de Protección al Adulto (“Adult Protective Services” - APS) al 1-800-510-2020. Personas que cuidan de un anciano o persona dependiente, ya sea de manera voluntaria o por pago, incluyendo a los proveedores de cuidado de IHSS, son considerados informantes por ley (“Mandated Reporters”) (W &I Code 15630(b)(1)).

Entiendo que dar información falsa o reportar horas que no trabajé en mis hojas de tiempo puede resultar en una investigación por fraude. Seré responsable de pagarle el sobrepago al Condado de San Diego.

Firma del Proveedor de Cuidado: _____ **Fecha:** _____

Mi Relación al Beneficiario: _____

Número de Seguro Social: _____ Fecha de Nacimiento: _____

Domicilio: _____ Número de Teléfono: _____

Ciudad, Código Postal: _____ Fecha de Inicio: _____

<p>COUNTY USE ONLY</p> <p>SUMMARY OF INFORMATION FROM EVIDENCE VIEWED</p> <p>(Complete the information only as appropriate)</p> <p>Name on Social Security Card: _____</p> <p>Social Security Number: _____</p> <p>Resident Alien Number: _____</p> <p>Employment Authorization Expiration Date: _____</p> <p>Other Form of Identification: _____</p> <p>This is to certify that the above evidence was viewed on _____ (date)</p> <p>by: _____</p> <p align="center"><small>Worker Name and Number</small></p> <p>Most recent 12-58 dated by client on: _____</p>
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Distribution: White- Case File; Yellow- Provider

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1- Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record:** 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:

- examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C),
- record the document title, document number and expiration date (if any) in Block C, and
- complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

**EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS**

Form I-9 (Rev. 05/31/05)Y

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.		I attest, under penalty of perjury, that I am (check one of the following): <input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A Lawful Permanent Resident (Alien #) A _____ <input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____	
		Date (month/day/year)	
Employee's Signature			Date (month/day/year)

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name		Date (month/day/year)
Address (Street Name and Number, City, State, Zip Code)		

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____
I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.		
Signature of Employer or Authorized Representative		Date (month/day/year)

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility
<ol style="list-style-type: none"> 1. U.S. Passport (unexpired or expired) 2. Certificate of U.S. Citizenship (<i>Form N-560 or N-561</i>) 3. Certificate of Naturalization (<i>Form N-550 or N-570</i>) 4. Unexpired foreign passport, with <i>I-551</i> stamp or attached <i>Form I-94</i> indicating unexpired employment authorization 5. Permanent Resident Card or Alien Registration Receipt Card with photograph (<i>Form I-151 or I-551</i>) 6. Unexpired Temporary Resident Card (<i>Form I-688</i>) 7. Unexpired Employment Authorization Card (<i>Form I-688A</i>) 8. Unexpired Reentry Permit (<i>Form I-327</i>) 9. Unexpired Refugee Travel Document (<i>Form I-571</i>) 10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (<i>Form I-688B</i>) 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center; margin: 10px 0;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor or hospital record 12. Day-care or nursery school record
	AND	<ol style="list-style-type: none"> 1. U.S. social security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>) 2. Certification of Birth Abroad issued by the Department of State (<i>Form FS-545 or Form DS-1350</i>) 3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (<i>Form I-197</i>) 6. ID Card for use of Resident Citizen in the United States (<i>Form I-179</i>) 7. Unexpired employment authorization document issued by DHS (<i>other than those listed under List A</i>)

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

IHSS Provider Criminal Record Check Information Sheet

- You may request a criminal record check on your IHSS service provider.
- You must pay for the cost of this record check. The fingerprint scanning fee varies from \$20.00 to \$30.00 and the Department of Justice processing fee is \$32.00.
- The IHSS program WILL NOT PAY for this criminal record check. There is no government money to pay you back for a criminal record check on your IHSS service provider, even if your provider has a criminal record.
- If you are hiring a provider from the IHSS Public Authority Registry, you do not have to pay for a criminal background check. All Registry applicants are required to pass the Department of Justice (DOJ) criminal background check in order to become active on the County of San Diego’s IHSS Provider Registry.
- You will still decide if you will hire or fire your IHSS service provider. If a criminal record check indicates that a current or potential provider does have a criminal background, you will decide if you want to have the individual remain as your IHSS service provider.
- Fingerprint scanning is available at any Department of Justice authorized location including the San Diego Police Department. You may call before going to the fingerprinting site to check the required documentation, the cost and the method of payment (e.g. cash, check, money order, debit card, or credit card), the hours of operation, and the need for an appointment.
- The scanning location will provide the procedure for obtaining a status report on the criminal check record.
- Refer to the attached list of scanning locations. For an updated list of the “Live Scan” locations, go to: <http://ag.ca.gov/fingerprints>

FINGERPRINT SCANNING SITES POLICE DEPARTMENTS

Chula Vista Police 315 Fourth Street, Chula Vista 91910 619/691-5137	El Cajon Police 100 Fletcher Parkway, El Cajon 92020 619/579-3362
Escondido Police 700 West Grand Ave, Escondido 760/839-4431	UC San Diego Police 9500 Gilman Drive, La Jolla 92023 858/534-4361
La Mesa Police 6119 Lake Murray Blvd, La Mesa 91942 619/667-1342	La Mesa Police (Store Front) 6119 Lake Murray, La Mesa 91942 619/667-1447

OTHER SCANNING SITES

<p>Bonita Mail & Parcels Plus 4364 Bonita Rd., Bonita 91902 619/470-4008</p>	<p>Bonsall Bonsall Photo & Postal Center 5256 S, Mission Rd., Ste 703, Bonsall, 92003 760/941-9221</p>
<p>Carlsbad DBA-Coastal ID Services 1207 Carlsbad Vill Dr., Ste Y, Carlsbad 92008 866/592-5927; 760/434-5927</p>	<p>Carlsbad AAA Livescan on Grand 800 Grand Ave, Ste C-9, Carlsbad 92008 760/434-3533</p>
<p>Chula Vista Qwik Prints 629 3rd Ave, Ste K-1, Chula Vista 91910 619/691-5137</p>	<p>El Cajon AAA Livescan Fingerprinting 126 W. Bradley Ave 619/</p>
<p>El Cajon Excell Security, Inc. 700 N. Johnson Ave. Suite C, El Cajon 92020 619/ 275-5828</p>	<p>El Cajon Mail Plus Gifts & Shipping 1464 Graves Ave,Ste 107 El Cajon, 92021 619/447-7544</p>
<p>Encinitas Global Livescan at Postal Depot 119 N. El Camino Real, #E, Encinitas 92024 760/ 436-1250</p>	<p>Encinitas InternetBiz 2559 Manchester Ave.,Encinitas, 92007 760/809-1582</p>
<p>Escondido That Place That Ships 243 S. Escondido Blvd., Escondido 92025 760/741-7639</p>	<p>Escondido DBA Live Scan San Marcos 1310 E.Valley Parkway #B,Escondido,92027 760/752-1072</p>
<p>Escondido Escondido Live Scan 144 South Grape St, Escondido, CA 92025 760/546-5400</p> <p>Escondido AAA Live Scan of Escondido 431 W. Grand Ave., Ste.201 Escondido, 92025 760/480-6900</p>	<p>Escondido That Place That Ships 243 S. Escondido Blvd.,Escondido, CA 92025 760/741-7639</p> <p>Imperial Beach Identi-Port Inc. 662 10th Street, Imperial Beach 91932 619/934-3113</p>
<p>La Mesa Knott's Live Scan 5141 Guild StreetLa Mesa, CA 91942 619/466-3419</p>	<p>La Mesa La Mesa Mail Boxes 8130 La Mesa Blvd., La Mesa, CA 91941 619/460-7447</p>
<p>Mira Mesa Live Scan Mira Mesa 9164 Mira Mesa Blvd., Mira Mesa CA 92126 619/572-7783</p>	<p>National City Fingerprint Impressions 600 East 8th Street Ste 3, National City 91950 619/773-7200</p>
<p>National City International Services 1302 National City Blvd.Ste B, Nat City 91950 619/336-1177</p>	<p>National City Veriscan ID Services 1615 E. Plaza Blvd. #103, National City 91950 619/336-1924</p>

Oceanside C.I. Inc. 518 Oceanside Blvd. Ste 102,Oceanside 92054 760/752-1072	Oceanside Live Scan Fingerprinting 4140 Oceanside Blvd., #159, Oceanside 92056 760/583-5841;866/706-6465
San Diego AAA Live Scan of San Diego 2667 Camino Del Rio South, Ste #301-7 San Diego 92109 619/683-2660	San Diego Advance Live Scan 2859 El Cajon Blvd. Suite #2-A San Diego 92104 619/250-3282
San Diego American Background Services 1310 Rosecrans St, Ste A, San Diego 92106 619/523-9005	San Diego Del Mar Live Scan 3830 Valley Center Dr, Ste705 San Diego 92130 858/342-2389
San Diego EZ Livescan 3200 Adams Ave, Ste 209, San Diego 92116 619/283-7939	San Diego Heritage Security 1260 Morena Blvd. Ste. 200 San Diego 92110 619/275-7000
San Diego IBT an L-1 Identity Solutions Company 3333 Camino Del Rio South, Ste. 400 San Diego 92108 1-800-315-4507	San Diego IBT an L-1 Identity Solutions Company 7575 Metropolitan Dr., Suite 110 San Diego, CA 92108 1-800- 315-4507
San Diego Internetbiz 6440 Lusk Blvd. Suite D207, San Diego 92121 760/809-1582	San Diego Millenia Security Services 4797 Mercury St., Ste. A, San Diego 92111 858/576-1994
San Diego Rovers Live Scan 7850 Mission Center Ct, Ste 101B San Diego 92108 619/688-9833	San Diego San Diego Office of Education 6401 Linda Vista Rd, Room 104 San Diego 92111 619/569-5420
San Diego San Diego city Schools Police Services 4100 Normal St, San Diego 92103 619/725-7014	San Diego Scan Fingerprinting Service 7850 Mission Center Ct. Ste 101B San Diego 92108 1(866) 773-7783
San Diego San Diego State University 5500 Campanile Drive SSE-1410 San Diego, CA 92182-8210 619/594-3193	San Diego Theresa Insurance & Livescan Services 4425 47th Street, San Diego 92115 619/528-8055; 858/610-1399
San Marcos Live Scan San Marcos 500 W. San Marcos Blvd. #102 San Marcos 92069 760/752-1072	Santee Health Educational Consultants 9255-353 Magnolia Ave, Santee 92071 619/448-8448
Vista Global Livescan at Postal Annex 770 Sycamore Ave, Ste J, Vista 92081 760/598-0201	Vista All About Livescan Fingerprinting 1035 East Vista Way, Vista, CA 92084 Contact: (760) 630-7225

Página Informativa Sobre Chequeo de Antecedentes Criminales del Proveedor de Cuidado de IHSS

- Puede pedir un chequeo antecedentes criminales de su proveedor(a) de cuidado de IHSS.
- Debe de cubrir el costo por éste chequeo. El costo varía desde \$20 a \$30 y la cuota de procesamiento del Departamento de Justicia es de \$32.00.
- El Programa IHSS NO PAGARÁ por éste chequeo de antecedentes criminales. No existe dinero gubernamental para reembolsarle el costo de un chequeo de antecedentes criminales, aunque su proveedor(a) de cuidado de IHSS tenga antecedentes criminales.
- Si esta contratando a un(a) proveedor(a) del Registro del Departamento de Autoridad Pública de IHSS, no tiene que pagar por un chequeo de antecedentes criminales. Todos los solicitantes del Registro tienen el requisito de pasar un chequeo de antecedentes criminales del Departamento de Justicia, para estar activos en el Registro de Proveedores de IHSS del Condado de San Diego.
- Aún decidirá si gusta contratar o despedir a su proveedor(a) de cuidado de IHSS. Si un chequeo de antecedentes criminales indica que su actual o posible proveedor(a) tiene antecedentes criminales, usted decidirá si gusta que la persona permanezca como su proveedor(a) de cuidado de IHSS.
- La toma de huellas esta disponible en cualquier ubicación autorizada del Departamento de Justicia, incluyendo el Departamento de Policía de San Diego. Puede llamar antes de ir al sitio de toma de huellas para informarse de la documentación requerida, del costo, el método de pago (ej. dinero en efectivo, giro postal, tarjeta débito, tarjeta de crédito), las horas de negocio, y la necesidad de fijar cita.
- El sitio de la toma de huellas puede proveerle el procedimiento para obtener un reporte del estado del chequeo de antecedentes criminales.
- Para conseguir una lista actualizada de las ubicaciones de toma de huellas “Live Scan,” vaya a: <http://ag.ca.gov/fingerprints>

FINGERPRINT SCANNING SITES POLICE DEPARTMENTS

Chula Vista Police 315 Fourth Street, Chula Vista 91910 619/691-5137	El Cajon Police 100 Fletcher Parkway, El Cajon 92020 619/579-3362
Escondido Police 700 West Grand Ave, Escondido 760/839-4431	UC San Diego Police 9500 Gilman Drive, La Jolla 92023 858/534-4361
La Mesa Police 6119 Lake Murray Blvd, La Mesa 91942 619/667-1342	La Mesa Police (Store Front) 6119 Lake Murray, La Mesa 91942 619/667-1447

**IN HOME SUPPORTIVE SERVICES (IHSS)
INDIVIDUAL PROVIDER INITIAL/REPLACEMENT TIMESHEET**

Your IHSS Office

[]

[]

[]

[]

4. Your employer may have other providers working for him/her.
5. It is your employer's responsibility to tell you how many hours you may work during a pay period and what days you are to work.
6. If there is a share of cost liability or other liability shown on the attached timesheet, your employer is responsible for paying you that amount.
7. Be sure to enter the **hours you worked each day** and enter the **total hours** where indicated on the timesheet.
8. Be sure **both** you and your employer have **signed and dated** the timesheet.
9. **After you have worked** all of your hours for the pay period, **promptly return the attached timesheet** to the county address printed on the timesheet.
10. **Mail** the timesheet in the return envelope that was included with the timesheet.
11. Your next timesheet will be attached to the paycheck you receive in the mail.

Vea el reverso el cual contiene la traducción de instrucciones importantes.
Important Instructions

1. The person you work for is an IHSS **recipient** and shall be referred to as your **employer** in these instructions and on the timesheet.
2. You are referred to as a **provider** and are considered the **employee** of this recipient.
3. This timesheet is only for one pay period and includes those days you may have worked for an IHSS recipient.

DETACH ON DOTTED LINE (SAVE THE TOP PART FOR YOUR INFORMATION)

THE TIMESHEET MUST BE COMPLETED WITH THE HOURS YOU WORKED AND RETURNED TO THE COUNTY IHSS ADDRESS LISTED BELOW. LA HOJA DE HORAS TRABAJADAS TIENE QUE SER COMPLETADA CON LAS HORAS QUE USTED TRABAJÓ Y DEBE SER REGRESADA A LA DIRECCIÓN DEL CONDADO PARA IHSS.

IHSS Timesheet											
Recipient Number						Provider Number					
Address Change Yes <input type="checkbox"/> Write new address on reverse side						Address Change Yes <input type="checkbox"/> Write new address on reverse side					
Fill in hours for each day worked and place total here Llene las horas para cada día que trabajó y apunte el total aquí ▲											
Day of Month				Hours Worked							
Share of Cost Liability				Other Liability				Provider Overpayment			
"Do not sign unless you have read and understand instructions above." "No firme hasta que haya leído y entendido las instrucciones al dorso."											
						Recipient Signature			Date		
						X					
						Provider Signature			Date		
						X					
<p>← After work has been completed, sign, date and mail to this address: Una vez que se haya completado el trabajo, firmese y envíese a esta dirección:</p>											
<p>This is to certify that the information contained in this form is true, accurate and complete, and that the provider and recipient have read, understand and agree to be bound by and comply with the statements, affirmations and conditions contained on the back of this form. Por medio de la presente certifico que la información que contiene esta forma es verdadera, correcta y completa, y que el proveedor y la persona que recibe los beneficios han leído, entienden y están de acuerdo en someterse a, y cumplir con las declaraciones, afirmaciones y condiciones que contiene el dorso de esta forma.</p>											

SOC 361 IR (1/98)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY - DEPARTMENT OF SOCIAL SERVICES

Instrucciones Importantes

1. La persona para la cual usted trabaja recibe IHSS y en estas instrucciones así como en la hoja de horas trabajadas, nos referiremos a el/ella como su patrono.
2. Nos referiremos a usted como el proveedor y se le considerará el empleado de esta persona.
3. Esta hoja de horas trabajadas es para un periodo de pago solamente, e incluye los días que pudo haber trabajado para una persona que recibe IHSS.
4. Es posible que su patrono tenga otros proveedores trabajando para el/ella.
5. Su patrono tiene la responsabilidad de decirle cuantas horas puede trabajar usted en un periodo de pago, y los días que trabajará.
6. Si hay la obligación de pagar la parte del costo u otra obligación que se muestre en la hoja de horas trabajadas que se adjunta, su patrono tiene la responsabilidad de pagar esa cantidad.
7. Asegurese de anotar cada día, la horas que trabajó, y anote el total de horas trabajadas donde se le indica en la hoja.
8. Asegurese que tanto usted como su patrono firmen y le pongan la fecha a la hoja de horas trabajadas.
9. Después que haya trabajado todas sus horas correspondientes a ese periodo de pago, regrese de inmediato la hoja que se adjunta, a la dirección del condado que se encuentra impresa en la hoja de horas trabajadas.
10. Envíe la hoja de horas trabajadas en el sobre que se incluye con la misma.
11. Su hoja de horas trabajadas próxima, será incluida con el cheque que reciba en el correo.

SEPARE EN LA LINEA PUNTEADA (CONSERVE LA PARTE SUPERIOR PARA SU INFORMACIÓN)

<p>EXPLANATION: SHARE OF COST LIABILITY: The amount the recipient is to pay for his/her own care. OTHER LIABILITY: The amount to be collected by the provider from the recipient to pay for his/her own care. PROVIDER OVERPAYMENT: The amount of overpayment you owe which will be deducted from your check. EARNED INCOME CREDIT: The amount of the advance payment of your earned income credit.</p> <p>EXPLICACIÓN: RESPONSABILIDAD POR LA PARTE DEL COSTO: La cantidad que el recipiente debe pagar por su propio cuidado. OTRAS RESPONSABILIDADES: La cantidad que el proveedor debe cobrarle al recipiente para pagar por su propio cuidado. PAGO EXCESIVO DEL PROVEEDOR: La cantidad del pago excesivo que usted debe, que será reducida de su cheque. CRÉDITO POR INGRESOS GANADOS: La cantidad del pago por adelantado de su crédito por ingresos ganados.</p>	
<p>NOTE: The disclosure of information which identifies your employer as an IHSS recipient is prohibited by law. (Ref. Welfare and Institutions Code, Section 10850 and Department of Social Services Manual of Policies and Procedures, Division 19.)</p> <p>NOTA: La ley prohíbe la divulgación de información que identifique a su patrono como persona que recibe beneficios del IHSS. (Veá la Sección 10850 del Código de Bienestar e Instituciones y la División 19 del Manual de Prácticas y Procedimientos del Departamento de Servicios Sociales.)</p>	
<p>Please check the "Hours Worked" boxes and "Total Hours Worked" box to be sure they are mathematically accurate and that the hours you worked do not exceed the hours authorized.</p> <p>Por favor revise las casilla "Hours Worked" (Horas Trabajadas) y "Total Hours Worked" (Total De Horas Trabajadas) para asegurarse que las horas que usted trabajó no excedieron las horas autorizadas.</p>	
<p>AFFIRMATIONS - READ BEFORE SIGNING TIMESHEET</p>	
<p>We affirm that the share of cost and/or other liability amount shown on other side has been paid by the recipient for this period. We understand that payment of this claim will be from federal and state funds, and that any falsification, or concealment of a material fact, may be prosecuted under federal and state law.</p>	
<p>AFIRMACIONES - LÉALAS ANTES DE FIRMAR LA HOJA DE TIEMPO</p>	
<p>Afirmamos que la persona que recibe los beneficios, ha pagado la parte del costo y/u otras responsabilidades que se muestran al otro lado. Entendemos que los fondos para pagar este reclamo provienen de los gobiernos federal y estatal, y que cualquier falsificación u ocultamiento de la información pueden ocasionar enjuiciamiento en conformidad con las leyes federales y estatales.</p>	
<p>Write new address in this box: Escriba su nueva dirección en esta casilla:</p>	
<p>Write new telephone number in this box: Escriba su nuevo número de teléfono en esta casilla:</p>	
<p>For County Review Purposes Only</p>	
<p>Review Date and Initials</p>	<p>Comments</p>



County of San Diego

HEALTH AND HUMAN SERVICES AGENCY
1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417

AGING & INDEPENDENCE SERVICES
P O Box 23217, SAN DIEGO CA 92193-3217
(858) 495-5858 FAX (858) 495-5080

Recipient: _____
Social Worker: _____

Case Number: _____
Telephone No.: _____

TIMESHEET SIGNATURE AUTHORIZATION FORM

I _____, hereby authorize _____
Recipient's Name Authorized Individual

to sign my Individual Provider Timesheets to allow the County of San Diego, through the Case Management Information and Payrolling System (CMIPS), to issue payment for time worked and service provided.

I am unable to sign my timesheets because: _____

Authorized Signature: _____ Date _____

Relationship to Recipient: _____

TIMESHEET SIGNATURE VERIFICATION FORM

I _____, swear that the following mark is my true and legal signature.
Recipient's Name

Recipient's Mark

Subscribed and sworn to me this _____ day of _____ 20____.

By: _____
Social Worker Signature

Witness: _____ Date: _____

Witness: _____ Date: _____

Note: This form is required when the recipient cannot sign, or signs with a mark.

IHSS/CMIPS ELECTIVE STATE DISABILITY INSURANCE (SDI) FORM

This form is for elective State Disability Insurance Coverage (Unemployment Insurance Code Section 702.5) and is only for family member providers, who receive their paychecks from the State Controller's Office. **An eligible family member is the recipient's spouse, parent, or a child (includes adopted but not a stepchild or fosterchild) under the age of 18.** This Disability Insurance is not compulsory, and, by electing to be covered, the recipient and his/her family member provider agree to have State Disability Insurance premiums deducted from the family member provider's paychecks. Do not complete this form unless both the recipient/employer and the provider/employee wish to have the provider's services voluntarily covered for Disability Insurance under the provisions of Section 702.5 of the Code.

TO BE COMPLETED AND SIGNED BY THE RECIPIENT/EMPLOYER

RECIPIENT NAME		SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ()
STREET ADDRESS	CITY	STATE	ZIP CODE

I, the undersigned, certify that the statements made in this application are true and correct to my best knowledge and belief. I hereby elect and make application to have the exempt family services considered as employment subject to the Unemployment Insurance Code for disability insurance only. **THE ELECTIVE AGREEMENT IS TO BE IN EFFECT FOR AT LEAST TWO COMPLETE CALENDAR YEARS OR UNTIL TERMINATION OF THE PROVIDER SERVICES.** The elective agreement may be terminated by filing a request for termination by January 31 of any year following two complete years of elective coverage.

RECIPIENT/EMPLOYER SIGNATURE	DATE
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TO BE COMPLETED AND SIGNED BY THE PROVIDER/FAMILY MEMBER

TO BE COMPLETED AND SIGNED BY THE PROVIDER/FAMILY MEMBER				COUNTY USE ONLY	
PROVIDER NAME		SOCIAL SECURITY NUMBER		RECIPIENT CASE NUMBER	
STREET ADDRESS		CITY	STATE	ZIP CODE	COMMENTS
TELEPHONE NUMBER ()	RELATIONSHIP TO RECIPIENT (IF CHILD PLEASE CIRCLE) NATURAL ADOPTED (STEPCHILD OR FOSTERCHILD NOT ELIGIBLE)		DATE OF BIRTH		
1. Is the employment intended to be continuing and not intermittent or seasonal in nature?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
2. Are you able to perform normal and customary provider services with IHSS?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
Deductions for elective SDI will begin with your next warrant.					
I elect to be covered by State Disability Insurance and agree to have the contributions for this insurance deducted from my paychecks.					
SIGNATURE OF PROVIDER				DATE	

Note: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions of UI Code Sections 631, 702.5, 704 and 707.

ELIGIBILITY FOR DISABILITY INSURANCE BENEFITS UNDER THE CODE DOES NOT BEGIN WITH THE COMMENCEMENT DATE OF COVERAGE. GENERALLY, A MINIMUM OF 7 MONTHS MUST ELAPSE FROM THE COMMENCEMENT DATE OF COVERAGE BEFORE A VALID CLAIM MAY BE FILED BASED SOLELY ON WAGES REPORTABLE UNDER YOUR ELECTION.

Also note: Domestic services are not subject to Personal Income Tax Withholding, however, if a recipient and provider voluntarily agree, income tax can be withheld.

Wages and Contributions - Section 702.5: Contributions to be paid for 'Family Employment' elective coverage are to be based upon actual wages paid to covered family members for services performed up to a maximum wage limitation for the year for each family member. There is no provision in this section to permit the contributions to be based on other than actual wages paid. The amount of any disability benefits paid will also be determined on the basis of wages paid.

Social Security Number Disclosure: The disclosure of your Social Security Account Number is mandatory under the Federal Tax Reform Act of 1976. The number will be used for identification purposes and will be available only to authorized personnel within the Employment Development Department and other government agencies as permitted in Sections 322 and 1095 of the California Unemployment Insurance Code.

TERMINATION OF ELECTIVE SDI

Only the Recipient/Employer can apply to have elective SDI coverage stopped for his/her provider.

Elective SDI coverage can only be terminated during January after two complete years of elective coverage or upon terminating employment.

I request termination of elective SDI coverage for my provider.

SIGNATURE OF RECIPIENT	DATE
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Can I lose my job because of a workers' compensation injury?

The law prohibits your employer from discharging or discriminating against you because of your workers' compensation injury. If you believe you have been discriminated against because of your injury, you should discuss your rights with an Information and Assistance Officer at the Office of Benefit Assistance and Enforcement in the State Division of Workers' Compensation or with an attorney.

What if I have not received the benefits I think I am entitled to?

If you have not received the benefits you think you should have, ask for an explanation from your SCIF claims representative. Misunderstandings and errors sometimes do occur, but most can be cleared up by talking with your claims representative.

If you are not satisfied with your claims representative answers, you may call an Information and Assistance Officer at 1-800-736-7401 for additional information about your rights. You are also entitled to consult an attorney.

If I have questions, who should I ask for help?

If you have questions about your claim, seek help right away. You may call the SCIF at the number listed on this brochure for your County or an Information and Assistance Officer at 1-800-736-7401. You may also consult with an attorney.

Workers' compensation laws set some time limits for claiming compensation benefits. Generally, proceedings must begin within one year from the date of injury. It is very important that you act promptly so you do not risk losing your benefits because you waited too long.

FOR INFORMATION & ASSISTANCE ABOUT YOUR PENDING CLAIM.

If you are employed in the following counties:

Alameda	Madera	Santa Clara
Alpine	Marin	Santa Cruz
Amador	Mariposa	Shasta
Butte	Mendocino	Sierra
Calaveras	Merced	Siskiyou
Colusa	Modoc	Solano
Contra Costa	Mono	Sonoma
Del Norte	Monterey	Stanislaus
El Dorado	Napa	Sutter
Fresno	Nevada	Tehama
Glenn	Placer	Trinity
Humboldt	Plumas	Tulare
Inyo	Sacramento	Tuolumne
Kern	San Benito	Yolo
Kings	San Francisco	Yuba
Lake	San Joaquin	
Lassen	San Mateo	

Please Contact:

State Compensation Insurance Fund
P.O. Box 1609
Rohnert Park, CA 94927-1609
(707)586-5000 Fax: (707) 586-5199

If you are employed in the following counties:

Imperial	Riverside	San Luis Obispo
Los Angeles	San Bernardino	Santa Barbara
Orange	San Diego	Ventura

Please Contact:

State Compensation Insurance Fund
P.O. Box 59901
Riverside, CA 92517-1901
(909)697-7300 Fax: (909) 697-7301



PUB 203 (1/04)

STATE OF CALIFORNIA
Arnold Schwarzenegger, Governor
HEALTH AND HUMAN SERVICES AGENCY
S. Kimberly Belshé, Secretary
DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES

Guide
TO

Workers' Compensation Benefits for Individual Providers

What Is Workers' compensation:

It is insurance that your employer is required by law to carry to help you in case you are injured on the job or become ill due to your job.

What is a workers' compensation injury?

Any injury or illness that occurs due to employment is considered a workers' compensation injury. Under workers' compensation law, you will receive help if you are injured no matter who was at fault.

How much does it cost me?

There is no charge to you or to the recipient for whom you work. If you qualify for workers' compensation, all approved medical bills will be paid in addition to any temporary or permanent disability compensation you are entitled to.

What is State Compensation Insurance Fund (SCIF)?

SCIF is the insurance carrier that has been chosen to represent your recipient/employer to provide your workers' compensation coverage. They have over 75 years of experience providing workers' compensation throughout California.

Is workers' compensation the same as State Disability?

No. Workers' compensation is only for injuries or illnesses that occur due to employment. State disability is for injuries or illnesses that are not work related and is handled by the Employment Development Department.

How does this affect my own health insurance?

Workers' compensation is separate from personal health care insurance. Workers' compensation insurance covers work-related injuries and illnesses only. There is no deductible, all authorized medical bills will be paid. It is important to let the treating doctor know if your injury is work related.

If I'm injured do I have to file a claim form?

Yes. As soon as you can after your injury, tell your employer's social service worker that you have been hurt. The social service worker will give you a claim form on which you must describe your injury and how, when, and where it happened. Immediately return the completed form to the social service worker, who will send it to SCIF. The insurance company will then get in touch with you to explain any benefits you may be entitled to.

What are my benefits?

If your injury is determined to be work related, authorized medical and hospital bills will be paid. SCIF will also pay a portion of your lost wages if you cannot work due to the injury. This benefit is called temporary disability. If your injury results in permanent disability which decreases your ability to work, SCIF will also pay your permanent disability benefits.

In the event of a death caused by a workers' compensation injury, qualified surviving dependents will receive benefits. The maximum death benefit is \$150,000 and there is a separate allowance of up to \$5,000 for burial expenses.

What are temporary disability payments?

If you are unable to work for more than 3 calendar days, SCIF will pay you for a part of your lost wages. This 3-day "waiting period" will be paid, however, if you are unable to work for more than 14 calendar days or are hospitalized as an inpatient. The amount of temporary disability compensation is determined by law and is generally 2/3 of your wages with a maximum of \$406 per week. You will receive these temporary disability payments every two weeks during the time you qualify for this benefit. This compensation stops when the treating doctor releases you for work or says that your injury has reached a point of maximum improvement.

What are permanent disability payments?

Permanent disability is additional money that SCIF will pay to compensate you for any permanent disability you may suffer from an illness or injury due to your job. The amount you will receive depends on the extent of

your disability. Workers' compensation law provided guidelines to determine the amount of this injury or illness are also factors that are considered when calculating permanent disability. Permanent disability payments are paid at a rate of between \$70 and \$168 per-week. You will receive payments approximately every two weeks until the benefit is totally paid out.

Where do I go for treatment?

Upon reporting your injury to the social services worker, you may be referred to a doctor or medical facility. If not, call the SCIF office listed on this brochure for your county and a medical referral will be made.

What if I become dissatisfied with my treatment?

First, tell your State Fund claims representative why you are unhappy. He or she may want to talk with the doctor to try to solve the problem.

Second, after 30 days from the date your injury is reported to the social service worker, you may go to another medical doctor of your own choosing. SCIF will continue to pay the authorized medical bills and reasonable transportation costs, so be sure to tell your claims representative the name and address of your new doctor.

What if I have a recurrence and require further medical care?

If you need more medical care for your injury after your original treatment has ended, you have one full year after your last treatment or five years from the date of your injury to notify SCIF and have your case reopened.

What if I have to change my line of work because of a workers' compensation injury?

If you are unable to return to your job due to a workers' compensation injury, you may qualify for vocational rehabilitation benefits. Your rehabilitation plan may be as simple as modifying your current job to accommodate any limitations you have suffered or may involve training for a new job. SCIF's rehabilitation coordinators will help you obtain any needed services.



Distribution:

- White - State Compensation Insurance Fund
- Yellow - Employer's Copy
- Pink - Employee's Copy
- Goldenrod - Employee's Temporary Receipt

**IN-HOME SUPPORTIVE SERVICES (IHSS)
 EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS
 NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS**

If you are injured or become ill because of your job, you may be entitled to one or more of the following benefits provided for you as an Individual Provider of IHSS, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of the county's IHSS worker's knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

Failure to file this claim will make it impossible for you to receive any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury, you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1-800-736-7401. This service is provided to you at no cost. You also may consult an attorney.

ANY PERSON WHO MAKES, OR CAUSES TO BE MADE, ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

PART I - PROVIDER/EMPLOYEE: Complete the "Employee" section and give the form to the county IHSS worker. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from the county.

NAME OF EMPLOYEE	DATE OF INJURY OR ILLNESS / /	TIME OF DAY <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
HOME ADDRESS (NUMBER, STREET, CITY, ZIP CODE)		
WHERE DID ACCIDENT OR EXPOSURE OCCUR (NUMBER, STREET, CITY, ZIP CODE)		
DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED		
WHAT SPECIFIC PART OF YOUR BODY WAS INJURED?		
WHAT IS YOUR RELATIONSHIP TO THE IHSS RECIPIENT/EMPLOYER?		
SIGNATURE OF EMPLOYEE		SOCIAL SECURITY NO: - -

I gave this form to the county IHSS worker on (date) _____, 20__.

**PART 2 – COUNTY IHSS WORKER: COMPLETE THIS SECTION AND PROMPTLY GIVE THE EMPLOYEE A COPY AS A RECEIPT.
 SIGNING OF THIS FORM DOES NOT NECESSARILY CONSTITUTE ACCEPTANCE OF A CLAIM.**

NAME OF EMPLOYER	IHSS NO.	TELEPHONE
DATE OF KNOWLEDGE OF INJURY / /	DATE CLAIM FORM WAS PROVIDED TO EMPLOYEE / /	DATE CLAIM FORM WAS RECEIVED FROM EMPLOYEE / /
SIGNATURE OF IHSS WORKER	SSW NO.	

**STATE
 COMPENSATION
 INSURANCE
 FUND**



Distribution:
White - State Compensation Insurance Fund
Yellow - Employer's Copy
Pink - Employee's Copy
Goldenrod - Employee's Temporary Receipt

SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS) RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACION POR LESIONES DE TRABAJO NOTIFICACION DE POSIBLE ELEGIBILIDAD PARA BENEFICIOS

Si usted se lesiona o se enferma a causa de su trabajo, es posible que tenga derecho a uno o más de los beneficios siguientes, que se le ofrecen a usted en calidad de proveedor individual de IHSS, dependiendo de su situación en particular: tratamiento médico, compensación por tiempo perdido con respecto a esta lesión, compensación por un impedimento permanente, rehabilitación vocacional, y/o beneficios por muerte. La compensación se basa en un porcentaje de sus ingresos ganados. Si se le hospitaliza a usted o deja de trabajar más de tres días, como resultado de esta lesión, recibirá su primer pago de compensación o una notificación en un plazo de 14 días a partir de la fecha en que el trabajador(a) de IHSS del condado se dé cuenta de esta lesión. Junto con su primer pago, también recibirá un folleto que describe con más detalle los beneficios de compensación y los trámites.

El no presentar este reclamo le impedirá a usted recibir cualquier sanción por pago retrasado que pudiera deberse, y también le impedirá utilizar recursos legales en el futuro.

Si necesita ayuda para llenar esta forma, o tiene preguntas con respecto a su lesión en el trabajo, puede comunicarse con la Oficina de Asistencia en los Beneficios y Cumplimiento (Office of Benefit Assistance and Enforcement) del Estado de California, llamando al 1-800-736-7401. Se le proporciona este servicio sin costo alguno. También puede consultar a un abogado.

PARTE I - PROVEEDOR /EMPLEADO: Complete la sección del "empleado" y dé la forma al trabajador de IHSS del condado. Guarde la copia marcada "Recibo Temporal del Empleado" hasta que reciba del condado, la copia fechada.

NOMBRE DEL EMPLEADO	FECHA DE LA LESION O ENFERMEDAD / /	HORA DEL DIA <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
DIRECCION DEL HOGAR (NUMERO, CALLE, CIUDAD, ZONA POSTAL)		
¿DONDE OCURRIO EL ACCIDENTE O CONTACTO? (NUMERO, CALLE, CIUDAD, ZONA POSTAL)		
DESCRIBA LA LESION O ENFERMEDAD, Y LA MANERA EN QUE OCURRIO		
FIRMA DEL EMPLEADO		NO. DEL SEGURO SOCIAL - -

El (fecha) _____ de 19____, le di esta forma al trabajador de IHSS del condado.

PARTE 2 – TRABAJADOR DE IHSS DEL CONDADO: COMPLETE ESTA SECCION Y DE, DE INMEDIATO UNA COPIA AL EMPLEADO A MANERA DE RECIBO. EL FIRMAR ESTA FORMA NO CONSTITUYE NECESARIAMENTE ACEPTACION DEL RECLAMO.

NOMBRE DEL EMPLEADOR	NO. DE IHSS	TELEFONO
FECHA EN QUE SE DIO CUENTA DE LA LESION / /	FECHA EN QUE SE LE DIO AL EMPLEADO LA FORMA DE RECLAMO / /	FECHA EN QUE EL EMPLEADO RECIBIO LA FORMA / /
FIRMA DEL TRABAJADOR DE IHSS		NO. DEL TRABAJADOR DE SERVICIOS SOCIALES

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate (type, if possible). Mail original and one copy to: STATE COMPENSATION INSURANCE FUND ADJUSTING AGENCY P.O. Box 59901 Riverside, CA 92517-1901 BOTH SIDES OF THIS FORM MUST BE COMPLETED.	OSHA Case No. <input type="checkbox"/> Fatality
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Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

E M P L O Y E R	1. FIRM NAME		1a. CONTRACT NUMBER CONTØU		Please do not use this Column	
	2. MAILING ADDRESS (Number and Street, City, Zip)		2a. Phone Number			Case Number
	3. LOCATION, if different from Mailing Address (Number, Street, City and Zip)		3a. Location Code		Ownership	
	4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc. HOME CARE		5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.		Industry	
I N J U R Y O R I L L N E S S	6. TYPE OF EMPLOYER <input checked="" type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____		Occupation			
	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)	8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.	9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	Sex	
	11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	12. DATE LAST WORKED (mm/dd/yy)	13. DATE RETURNED TO WORK (mm/dd/yy)	14. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>	Age	
	15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO	16. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO	17. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy)	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)	Daily hours	
	19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning.			19a. BODY PART AFFECTED	Days per Week	
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)	20a. ZIP	20b. COUNTY	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	21a. WAS ANOTHER PERSON RESPONSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	Weekly Hours
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.		23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			Weekly Wage
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.					
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.					
	26. HOW INJURY/ILLNESS OCCURRED, DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.					
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)			27a. Phone Number		Part of body	
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)			28a. Phone Number			
			29. Employee treated in Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*						
E M P L O Y E E	30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER		32. DATE OF BIRTH (mm/dd/yy)	
	33. HOME ADDRESS (Number, Street, City, Zip)		33a. PHONE NUMBER			
	34. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		36. DATE OF HIRE (mm/dd/yy)		Secondary Source
	37. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours		37a. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> retired <input type="checkbox"/> on strike <input type="checkbox"/> temporary <input type="checkbox"/> seasonal <input type="checkbox"/> laid-off <input type="checkbox"/> other		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?	
38. GROSS WAGES/SALARY \$ _____ per _____		39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Completed By (type or print)		Signature & Title			Date (mm/dd/yy)	

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

SCIF 3167 (REV. 11-02) **FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.**

In Order to use your own doctor when you are injured at work, *prior to being injured*, you must complete and return this form to IHSS Public Authority 780 Bay Blvd. Chula Vista CA 91910

Employee's Predesignation of Personal Physician Form

- In order for an employee to predesignate a personal physician, the employer must offer group health insurance.
- The employee may use the predesignation of personal physician form to name a medical doctor or doctor of osteopathic medicine if all other requirements are met.
- The physician is not required to sign this form, but in lieu of a signature, other documentation of the physician's agreement is required.

For the employee:

If I am injured on the job, I wish to be treated by my **personal physician**, who meets all the following requirements: (1) is my regular physician; (2) is my primary care physician; (3) is licensed per Business & Professions Code; (4) has previously provided my treatment; (5) retains my records; (6) agrees to be my predesignated physician.

Or, I wish to be treated by my **personal chiropractor or acupuncturist**, who has treated me before and has my records. I understand my identification of a personal chiropractor or acupuncturist is allowed only if there is no medical provider network (MPN) applicable. If the MPN is not applicable, my **personal chiropractor or acupuncturist may treat my injury** during the first 30 days of the employer's medical control, but I must first be evaluated by my employer's physician before I may request a change to my personal chiropractor or acupuncturist.

EMPLOYEE'S INFORMATION:

NAME _____
ADDRESS _____
CITY STATE ZIP _____

YOUR DOCTOR'S INFORMATION:

DOCTOR _____
ADDRESS _____
CITY STATE ZIP _____
PHONE _____
DOCTOR'S SIGNATURE _____
EMPLOYEE'S SIGNATURE DATE _____

Formulario de Designación del Doctor Personal del Empleado

- Para que un empleado pueda designar su médico personal, el empleador debe ofrecer seguro médico de grupo.
- Si se han cumplido todos los otros requerimientos, el empleado puede utilizar el formulario de designación del médico personal para nombrar a un doctor médico o un doctor de medicina osteopática.
- No se requiere la firma del médico en este formulario, pero en lugar de una firma, otra documentación del acuerdo del médico es requerida.

Para el empleado:

Si me lesiono en el trabajo, deseo que me atienda mi **doctor personal**, quien llena todos los siguientes requisitos: 1) Es mi médico regular; 2) Es mi médico primario de cuidado; 3) Tiene una licencia de aprobación del Business & Professions Code; 4) Me ha proporcionado tratamiento médico anteriormente; 5) Tiene y mantiene mi historial médico; 6) Acepta ser mi médico designado.

Ó, deseo que me atienda mi **quiropático o acupunturista personal**, quien es el que me ha atendido anteriormente y tiene mi historial. Estoy por entendido que identificar a un quiropático o acupunturista solamente es permitido cuando la medical provider network (MPN) no es aplicable. Si la MPN no aplica, mi quiropático o acupunturista personal podrá ofrecerme tratamiento durante los primeros 30 días del control médico del empleador, pero un doctor asignado por mi empleador deberá **examinarme primero antes de solicitar que me cambien a mi quiropático o acupunturista personal**.

INFORMACIÓN DEL EMPLEADO:

NOMBRE _____
DIRECCIÓN _____
CIUDAD ESTADO CÓDIGO POSTAL _____

INFORMACIÓN DE SU DOCTOR:

DOCTOR _____
DIRECCIÓN _____
CIUDAD ESTADO CÓDIGO POSTAL _____
TELÉFONO _____
FIRMA DEL DOCTOR _____
FIRMA DEL EMPLEADO FECHA _____

Employer Name: _____
(Client you are working for.)

Case Number: _____

Social Worker _____

Retain in IHSS case folder with employment documentation

STATE
COMPENSATION
INSURANCE
FUND

To our policyholders:

California law requires employers to provide a form on which employees may indicate the name of their personal physician or personal chiropractor. The form must be provided to new hires either at the time the employee is hired or by the end of the first pay period.

This form is available from your State Fund representative at no cost to you. Keep a supply on hand. Document personnel records, indicating when this form was provided and when it was returned to you.

PLEASE SEE REVERSE SIDE

After completion by employee, keep original in the employee's personnel file, and provide a copy to your employee.

STATE
COMPENSATION
INSURANCE
FUND

A nuestros asegurados:

La legislación del Estado de California obliga a los empleadores a suministrar un formulario en el que los empleados pueden indicar el nombre de su médico personal o de su acupunturista o quiropráctico personal. El formulario debe entregarse al nuevo empleado en el momento de la contratación o al finalizar el primer período de pago.

Un representante del State Fund le entregará este formulario sin costo alguno. Siempre tenga formularios a la mano. Documente los registros personales, indicando cuándo se le entregó este formulario y cuándo se le ha devuelto.

LEA AL DORSO

Después de que el empleado haya completado el formulario, conserve el original en el archivo personal del empleado y entréquele una copia.



County of San Diego

DEPARTMENT OF SOCIAL SERVICES

1255 IMPERIAL AVENUE, SAN DIEGO, CALIFORNIA 92101-7439

DATE _____

NAME:
ADDRESS:

Case #:

Dear:

The State of California Department of Social Services provides In-Home Supportive Services regulations by which the County of San Diego administers the IHSS Program. The attached information is being provided to ensure your continued eligibility for advance pay under the program. It is your responsibility to adhere to the guidelines in a timely manner.

Please read the attached form to ensure your understanding of the advance pay requirements. Please sign and date the form and place the white page in the pre-addressed envelope and return it - **Retain the yellow copy for your records.**

IHSS Program Manager

Attachment

12-38A DSS (9/96)

(9/98)



County of San Diego

DEPARTMENT OF SOCIAL SERVICES

1255 IMPERIAL AVENUE, SAN DIEGO, CALIFORNIA 92101-7439

FECHA: _____

NOMBRE:
DIRECCION:

NUMERO DEL CASO:

Estimado(a) :

El Departamento de Servicios Sociales del Estado de California provee los reglamentos del Programa de Ayuda en Casa (IHSS). El Condado de San Diego administra el Programa IHSS. La informacion que le enviamos es para cerciorarnos que su elegibilidad para recibir el pago por adelantado sigue vigente.

Usted tiene la responsabilidad de cumplir puntualmente con los requisitos para recibir los pagos por adelantado. Esta forma los explica; leala cuidadosamente.

Favor de firmar y fechar la forma. Regresenos la copia blanca en el sobre incluido. Guarde la copia amarilla.

Gerente del Programa IHSS

CONDADO DE SAN DIEGO
DEPTO. DE SERVICIOS SOCIALES

12-38A (SP) DSS (2/97)

(2/99)

IN-HOME SUPPORTIVE SERVICES (IHSS) RESPONSIBILITIES OF ADVANCE PAY RECIPIENTS

In order for San Diego County In-Home Supportive Services to comply with the State of California, as well as Welfare and Institution Codes, in administering advance pay services, the following requirements must be complied with:

SPECIFIC REQUIREMENTS

1. Timesheets must be submitted within 90 days from the time the recipient receives his/her advance pay check.
2. Timesheets must be signed and dated by both the recipient (or the authorized signatory) and the provider.
3. Timesheets should not be submitted to payroll before the last day worked during the reporting month.
4. When a determination is made that there are unused hours during a month for which an advance payment has been made, the IHSS advance pay section will calculate the net dollar value of the unused hours. This information will be made available to the recipient so the recipient may prepare a check or money order payable to "Department of Social Services" and send the check to IHSS.
5. The timesheet(s) hours must equal the hours for which the recipient received advance payment. If hours submitted are less, an overpayment process may be initiated for the net dollar difference.
6. If a recipient moves from one county to another, the recipient is still responsible for ensuring that all timesheets are submitted to fully balance all advance payments. Monies for any unused hours must be refunded to the original county.
7. Advance Payees may request to have their checks directly deposited to the bank/financial institution after they have been on advance pay for one (1) year.

Failure to comply with the above requirements may result in the discontinuance of advance pay status.

GENERAL INFORMATION - ADVANCE PAY

1. The recipient is responsible for safeguarding and controlling his/her advance pay monies.
2. Withholding Federal and State Income Tax is not an option for providers servicing advance pay recipients. However, Social Security (FICA) and State Disability (SDI) will be withheld if appropriate.
3. The agency that the State of California DSS/IHSS has contracted with to manage the IHSS CMIPS Payroll Program issues W-2s to the appropriate taxpayers at the end of each taxable year.

I have read and understand the preceding information as it applies to my advance pay status. I will ensure that my provider(s) are made aware of this information.

Signed _____ Dated _____

**SERVICIOS de AYUDA EN CASA (IHSS)
RESPONSABILIDADES de CLIENTES QUE RECIBEN PAGO POR ADELANTADO**

Para que el condado de San Diego Servicios de Ayuda en Casa pueda debidamente cumplir con el Estado de California tocante la administración de pago por adelantado, se debe cumplir con los siguientes reglamentos:

REQUISITOS ESPECIFICOS

1. Hojas de tiempo deberán ser enviadas dentro de 90 días desde la fecha en que se recibe el pago por adelantado.
2. Hojas de tiempo deberán ser firmadas y con fecha por ambos: cliente (o persona autorizada a firmar) y proveedor(a).
3. Hojas de tiempo no deberán ser enviadas a la Sección de Pagos, antes del último día en que se trabajó durante el mes reportado.
4. Cuando se ha determinado que aún queda tiempo no usado durante un mes en donde se ha pagado por adelantado, la Sección de Pagos calculará el valor (ingreso neto) de las horas que aun no se usaron.
5. Las horas reportadas en las hojas de tiempo deben ser igual a las horas por las cuales el cliente recibió el pago por adelantado. Si las horas que se han reportado son menos, existe un pago de mas y se utilizará un proceso de colección para recuperar la diferencia de pago neto.
6. Si un cliente cambia residencia de un condado a otro el cliente tiene la responsabilidad de asegurar de que todas las hojas de tiempo sean enviadas para reconciliar completamente todos los pagos por adelantado. Dinero recibido por horas no trabajadas debe ser regresado al condado de origen.
7. La persona a quien se la paga por adelantado puede pedir que sus cheques sean depositados directamente al banco/institución financiera después de haber recibido el pago por adelantado durante el periodo de un (1) año.

Negarse a cumplir con los requisitos ya mencionados puede resultar en la discontinuación del pagos por adelantado.

INFORMACION GENERAL - PAGO POR ADELANTADO

1. El cliente tiene la responsabilidad de proteger y controlar su dinero pagado por adelantado.
2. Retener Impuestos Federales y Estatales no es una opción para proveedores sirviendo clientes recibiendo pago por adelantado. Sin embargo, Seguro Social (FICA) y Seguro Estatal de Incapacidad (SDI) será retenido en forma apropiada.
3. La agencia contratada por el Estado de California DSS/IHSS para administrar el Programa de Nómino de sueldo IHSS CMIPS entrega la forma W-2 a los contribuyentes de impuestos a fin de año.

He leído y entiendo la información ya mencionado en cuanto se aplica a mi pago por adelantado. Aseguraré que mis proveedores recibirán esta información.

Firma _____ Fecha _____

IHSS ADVANCE PAY TIME SHEET										County of: 37							
RECIPIENT NUMBER 37-										Office:							
Last Name First MI					Last Name First MI					PROVIDER NUMBER							
Address					Address												
City		City		ZIP	Addr. Change Yes <input type="checkbox"/> No <input type="checkbox"/>		City		State	ZIP	Addr. Change Yes <input type="checkbox"/> No <input type="checkbox"/>						
YOU ARE AUTHORIZED _____ HOURS FOR THE MONTH OF _____																	
Day of Month	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15		Total Hours
Hours Worked																	
Day of Month	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Hours
Hours Worked																	
FILL IN HOURS FOR EACH DAY WORKED AND PLACE TOTAL HOURS HERE (ILLENE LAS HORAS TRABAJADAS CADA DIA Y APUNTE EL TOTAL AQUÍ) †																	
WE AFFIRM THAT THIS TIME SHEET IS A TRUE AND CORRECT STATEMENT OF TIME WORKED UNDER THE IHSS PROGRAM AND THE SHARE OF COST LIABILITY _____ FOR THE PERIOD HAS BEEN MET (SIGN ONLY AFTER WORK HAS BEEN COMPLETED). AFIRMAMOS QUE ESTE HORARIO ES CUENTA CORRECTA DE HORAS TRABAJADAS BAJO EL PROGRAMA DE IHSS Y QUE LA PARTE DEL COSTO QUE PAGAMOS NOSOTROS POR ESTE PERIODO YA ESTA PAGADA (FIRME SOLAMENTE CUANDO EL TRABAJO ESTE COMPLETADO).																	
RECIPIENT SIGNATURE						DATE			PROVIDER SIGNATURE			DATE					
X									X								
<u>SIGN AND MAIL TIME SHEET TO THIS ADDRESS</u>									IHSS PAYROLL UNIT 1261 Third Avenue Chula Vista, CA 91911-3299								
Firme y desposite en el correo a esta direccion:																	

IHSS ADVANCE PAY TIME SHEET										County of: 37							
RECIPIENT NUMBER 37-										Office:							
Last Name First MI					Last Name First MI					PROVIDER NUMBER							
Address					Address												
City		City		ZIP	Addr. Change Yes <input type="checkbox"/> No <input type="checkbox"/>		City		State	ZIP	Addr. Change Yes <input type="checkbox"/> No <input type="checkbox"/>						
YOU ARE AUTHORIZED _____ HOURS FOR THE MONTH OF _____																	
Day of Month	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15		Total Hours
Hours Worked																	
Day of Month	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Hours
Hours Worked																	
FILL IN HOURS FOR EACH DAY WORKED AND PLACE TOTAL HOURS HERE (ILLENE LAS HORAS TRABAJADAS CADA DIA Y APUNTE EL TOTAL AQUÍ) †																	
WE AFFIRM THAT THIS TIME SHEET IS A TRUE AND CORRECT STATEMENT OF TIME WORKED UNDER THE IHSS PROGRAM AND THE SHARE OF COST LIABILITY _____ FOR THE PERIOD HAS BEEN MET (SIGN ONLY AFTER WORK HAS BEEN COMPLETED). AFIRMAMOS QUE ESTE HORARIO ES CUENTA CORRECTA DE HORAS TRABAJADAS BAJO EL PROGRAMA DE IHSS Y QUE LA PARTE DEL COSTO QUE PAGAMOS NOSOTROS POR ESTE PERIODO YA ESTA PAGADA (FIRME SOLAMENTE CUANDO EL TRABAJO ESTE COMPLETADO).																	
RECIPIENT SIGNATURE						DATE			PROVIDER SIGNATURE			DATE					
X									X								
<u>SIGN AND MAIL TIME SHEET TO THIS ADDRESS</u>									IHSS PAYROLL UNIT 1261 Third Avenue Chula Vista, CA 91911-3299								
Firme y desposite en el correo a esta direccion:																	