Alameda County
Social Services
Agency

IN-HOME SUPPORTIVE SERVICES PROVIDER AGREEMENT

As the In-Home Supportive Services (IHSS) Provider, I acknowledge, understand, and agree to the following:
[Please initial <u>each</u> statement after reading it]

_____ I will inform the IHSS Payroll department **within 10 days** of any changes regarding my home address, telephone number, or name.

_____ I will notify the IHSS Payroll department **within 10 days** when my job as an IHSS provider ends.

_____ I understand that IHSS hours **<u>cannot be paid</u>** when the IHSS recipient is **out of his/her home**. Examples of this include when the recipient **is staying in a hospital, skilled nursing facility, or board and care home; is in jail/prison; or travels out of the state** (unless the travel is approved by the recipient's Social Worker).

_____ I understand that my IHSS provider employment ends **immediately** if the recipient dies.

- Claiming hours on the provider timesheet during the time the recipient is out of the home or deceased is considered **fraudulent** reporting. Instances of suspected fraud will be reported immediately to the District Attorney's Office for criminal investigation and potential prosecution.

_____ I will verify with the recipient the dates and number of hours worked before completing and signing the timesheet. I understand that only the **actual hours worked** can be claimed on a timesheet, and that claiming more hours than are actually worked is **fraudulent**, and upon discovery, will be reported to the District Attorney.

- The IHSS recipient is the employer, and therefore he/she must sign the timesheet **after** it is filled out and the services have been performed. Having someone other than the recipient sign the timesheet is considered **fraudulent**. If circumstances (e.g., death or incapacitation) make it impossible for the recipient to sign the timesheet, the provider should contact the IHSS Payroll department. Also, it is **fraudulent** conduct for a provider to claim hours that occurred **past** his/her termination date.

_____ I understand that hours are assigned to the recipient on a **monthly** basis, and that unused hours **<u>do not</u>** carry over ("roll over") into the next month.

- If the provider is not employed for a full month (from the first day of the month through the last day of the month), his/her authorized hours may be **adjusted (pro-rated)** for that month. Hours are adjusted by IHSS Payroll.

_____ I understand that I **<u>should not</u>** work beyond the recipient's **monthly authorized hours**, and if additional hours are worked, IHSS will not pay for those additional hours.

_____ I understand that if the recipient has a Share of Cost (SOC), he/she may be responsible for paying me some of my wages. If the recipient does not pay me what he/she owes me, he/she may be terminated from IHSS services.

- It is **<u>not</u>** the County's responsibility to ensure that recipients pay providers their portion of the SOC.

Under penalty of perjury, I verify that I understand and agree to the terms listed above. I understand that I may be terminated as an IHSS provider and/or referred to the District Attorney's Office for criminal investigation and prosecution if I violate one or more terms of this agreement.

IHSS Provider Signature: _____ Date: _____

IHSS Provider Name (*Print*): _____ Recipient Name: _____