



INFORMATION/ INDIVIDUAL PROVIDER (IP) CHECKLIST

IP NAME: _____ DATE: _____

General Information

1. The Home Care Referral Registry does not guarantee employment. If you are hired as an Individual Provider (IP), you are considered an independent contractor and not an employee of the state. Your **client is your employer.**
2. All IP's who have been hired by a DSHS client may contribute union dues to Service Employees International Union 775NW. You may contact them at 866-371-3200 for more information.
3. Providers are to satisfactorily perform duties and services as specified in the client's **Assessment Details and Service Summary**, sometimes referred to as a **Care Plan**. These documents serve as your job description and failure to comply may result in termination of your contract and/or your employment.
4. Unless otherwise specified in the clients Assessment Details and Service Summary, **work is to take place in the client's home.** Exceptions include transportation, shopping or accompanying your client to medical appointments.
5. **You must call the Case Manager or Social Worker** if your client's condition changes, they are hospitalized or are out of the home for any other reasons, have an address or phone number change, or if you are unable to work, wish to stop working for your client or intend to take a vacation.
6. Most long-term care workers hired after January 7, 2012 are required to submit a DSHS **fingerprint-based background check**. Your HCRR Coordinator will assist you through this process and will provide you with an OCA number; this number must be written on your Home Care Aide Certification application.

DSHS Training and Certification

7. In order to provide care to a client you must complete required training. This includes five (5) hours of **Safety and Orientation** which must be completed before you begin working. The **Home Care Aide (HCA)** Basic Training consists of 70 hours for standard IP's and 30 hours for parent/child providers and Limited Service Providers. Once you begin working you must schedule your training by calling the **Training Partnership** at **866-371-3200**. You are responsible for scheduling, completing, and keeping records of your training.
8. Most long-term care workers must complete 75 hours of training within **120 days** of hire and become certified home care aides within **200 days** or within 260 days for IP's with limited English proficiency. In order to become certified, you must complete the required training, submit an application to the Department of Health (DOH), and pass the Home Care Aide Certification exam. The exam is available in multiple languages. DSHS pays for the classes.
9. Unless you are a parent provider, you must complete 12 hours of **Continuing Education (CE)** by your birth date of each calendar year after the year you completed your Basic Training.



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Eligibility and Authorization to Start Working

10. Your new prospective employer will have a Case Manager or Social Worker, who is stationed at an Area Agency on Aging, Home and Community Services or Division of Developmental Administration office. **You cannot be paid for any work done until you:** satisfactorily complete a state background check, sign an IP contract, and are authorized to start working by your client's AAA Case Manager/Social Worker. **Failure to receive authorization may result in unpaid work.**
11. You will need to **notify the Home Care Referral Registry** office with your start date and client's name prior to working with all new Clients. Local office numbers are available at: www.hcrr.wa.gov or dial 800-970-5456 to contact your local HCRR Coordinator and advise of your employment activity.

Timesheets and Payment Processing

12. **Beginning March 1, 2016** you will use Individual **ProviderOne**, also known as **IPOne**, to submit your timesheets and receive payment. IPOne also provides real-time access to important information in a secure environment, 24 hours a day, 7 days a week.
13. When you are initially authorized to provide services, you will **receive a welcome packet** with instructions on how to register and use IPOne to submit timesheets.
14. If you have questions about using the portal to submit your timesheet, contact the **IP One Call Center** at **844-240-1526** (call center information: www.ipone.org/call.htm).
15. If you want to have **Federal Income Taxes** taken from your paycheck, change your status, change allowances or indicate additional amounts to be withdrawn from your paycheck, you need to complete and submit an Internal Revenue Service (IRS) Form W-4. You can get an IRS Form W-4 by:
 - Downloading it at <http://www.irs.gov/pub/irs-pdf/fw4.pdf>, or
 - Calling the IRS office at 1-800-829-3676 and asking them to send you a form.Mail form to: Public Partnerships, LLC-WA IPOne, 7776 S Pointe Pkwy W, Suite 150, Phoenix AZ 85044, or FAX to: 1-855-901-6904.
16. In most situations, **Social Security and Medicare taxes** will be deducted from your pay check. Keep all documentation that arrives with your check or payment. This paperwork contains important information regarding your deductions.
17. Keep your **address, telephone and contact information** up to date.
18. **Time Sheet** - With the IPOne system, you have the option to submit your timesheets electronically (e-timesheets) by using a computer, laptop, smart phone, or tablet or the IP One mobile app.
 - The fastest way to submit your timesheet is electronically using a computer, tablet, or smart phone.
 - If you use a paper timesheet you can send it by fax. If you choose to send your timesheet in the mail you may not get your timesheet in on time and payment will be delayed. Mailing Address: Public Partnerships LLC, Individual ProviderOne, PO Box 98698, Seattle WA 98198
19. If your client pays **participation** (indicated by DSHS) for personal care services, **they are responsible for paying this amount directly to you**. The amount of their payment responsibility is subtracted from your payment.



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I have read and accept the aforementioned requirements and provisions.

IP Signature: _____

Date: _____

PRINT Name: _____

HCRR Representative Signature: _____

Date: _____

PRINT Name: _____