NOTICE OF FORM CHANGE NO. 03-077

DATE: 7/7/03

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ District Attorney
☐ Private and Public Adoption Agencies
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE

SOC 431 (5/03) Personal Care Services Program Contract Agency Enrollment

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: 5/03	REPLACES: 2/93	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted

REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval

☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:

Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ OTHER:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☐ Use until exhausted
☒ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☒ Use new form effective immediately

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached are a Reproducible Copies

Check on the Internet to see if forms are available at www.dss.cahwnet.gov.

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

PERSONAL CARE SERVICES PROGRAM
CONTRACT AGENCY ENROLLMENT

Instructions:

- *This form is to be completed in duplicate.*
- *This form must be completed for each contract and prior to enrollment by each public or private agency contracted to provide services under the Personal Care Services Program.*
- *Part I is to be completed by the authorized representative of the contract agency.*
- *Part II is to be completed by the County.*
- *The original form is to be maintained by the County and a copy given to the contract agency.*

PART I - CONTRACT AGENCY

CONTRACT AGENCY NAME	STATE CONTRACT NUMBER
ADDRESS (Street, City, Zip)	PHONE ( )

CERTIFICATION STATEMENT

- I certify that all employees of this agency are qualified to provide the care authorized.
- I certify that all claims submitted to the County for services to recipients of the Personal Care Services Program and provided by this agency will be provided as authorized for the recipient.
- I understand that payment of these claims will be from federal and/or state funds and that any false statement, claim, or concealment of information may be prosecuted under federal and/or state laws.
- I agree that services will be offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE	DATE

PART II - RECORD RETENTION

The County shall ensure that the contract agency shall keep all records which are necessary to fully disclose the extent of services to the client for a minimum of three years from the date of service during the effective dates of this contract. At the expiration of this contract the County shall keep said records for a minimum of three years from the date of service. On request, the County shall furnish records for audit to the State of California or the U.S. Department of Health and Human Services or their duly appointed representatives.

SIGNATURE AND TITLE OF AUTHORIZED COUNTY REPRESENTATIVE	COUNTY	DATE

PART III - HEALTH SERVICES APPROVAL

The Department certifies that the agency named above will be an enrolled Medi-Cal provider of personal care services.

California Department of Health Services