

**INFORMATION about the
“IHSS PROVIDER WORKWEEK & TRAVEL TIME AGREEMENT” (SOC 2255) FORM**

Providers who work for multiple recipients on the same day and travel between locations to provide IHSS services to those recipients can be paid for that travel time as long as the SOC 2255 Form is completed. **If the SOC 2255 Form is not completed and submitted to the county IHSS office for processing, you will not be paid for any travel time you may be compensated for until after the form is submitted.** Payment for travel time is separate from your regular payment.

- As a provider working for more than one IHSS recipient, it is important to know that your **total combined workweek hours cannot exceed the maximum 66 hours per workweek limit.** Additionally, the **total travel time cannot exceed the maximum 7 hours per workweek limit.** Please thoroughly read the SOC 2255 Form.
- If you sign/previously signed the Pre-Authorization Release Form, we can assist you with making any necessary corrections over the phone and send you an updated copy of the SOC 2255 Form.
- If you are hired by additional recipients in the future, you will be sent another SOC 2255 Form to complete and submit.

Please see **EXAMPLE** below of a completed SOC 2255 Form **with travel time** requested.

A	B	C	D			E							F
Recipient's Name	Recipient Case #	Start Date	Recipient's Address			Total Number of Hours I Work or Plan							Total Hours
			Street Address	City	Zip Code	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	
RECIPIENT A	1234567	8/1/2020	LOCATION ST	CITY	00000	5	5	5	5	5	5	6	36
RECIPIENT B	0000000	9/1/2020	ADDRESS ST	CITY	00000	5	4	4	4	4	4	5	30
TOTAL HOURS I WORK OR PLAN TO WORK PROVIDING AUTHORIZED SERVICES FOR ALL RECIPIENTS:												66	

DO NOT EXCEED THE RECIPIENT'S MAXIMUM WORKWEEK HOURS AND YOUR TOTAL COMBINED WORKWEEK HOURS CANNOT EXCEED **66** HOURS.

Do you plan to travel from a location where you provide authorized services to another location where you provide authorized services to another recipient directly on the same day?

YES NO

If you answer NO, you do not need to complete PART B, go directly to PART C.

A	B	C	D	E	F	G
Names of the Recipients You Will Be Traveling Between		Start Date	Distance Between Recipients' Locations (in miles)	Estimated Travel Time Between Recipients' Locations (in minutes)	Number of Days You Will Travel Between Recipients' Locations Each Workweek	Total Estimated Travel Time Between Recipients' Locations Each Workweek (Col. E x Col.F)
From	To					
RECIPIENT A	RECIPIENT B	9/1/2020				
TOTAL ESTIMATED TRAVEL TIME EACH WORKWEEK:						

LEAVE COLUMNS D-G BLANK. PA STAFF WILL CALCULATE THIS INFORMATION BY USING BING MAPS.

How will you travel between recipients' locations?
 CAR* PUBLIC TRANSIT OTHER Specify: _____

PART C. PROVIDER AGREEMENT

I declare that I have read and understood the requirements as stated in this document and I agree to comply with these requirements. I further declare that all of the information I have provided on this form is true and correct to the best of my knowledge. I agree to notify the county within 10 calendar days if any of the information I have provided in this Provider Workweek and Travel time Agreement changes, and depending on what information has changed, I may be required to complete a new SOC 2255.

PROVIDER SIGNATURE:

firstlast

DATE:

10/1/2020

PROVIDER'S PRINTED NAME:

FIRST LAST

PRINT YOUR NAME, SIGN, AND DATE THE FORM.