Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SERVICES ADMINISTRATION (ALTSA)
DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA0)

Individual Provider (IP) Planned Action Notice Training / Certification

DATE OF NOTICE

PROVIDER NAME AND ADDRESS

Planned Action

Washington Administrative Code (WAC) Chapter 388-71 contains training and/or certification requirements necessary to be eligible to work and be paid by ALTSA or DDA as an Individual Provider (IP) / Long Term Care Worker.

This is to notify you that effective , the Department of Social and Health Services (DSHS) or the Area Agency on Aging (AAA) is:

- ☐ Denying / terminating payment to you as an IP;
- ☐ Taking steps to terminate your IP Client Service Contract.

_____

You are not permitted to work as an IP and DSHS will not pay you for any hours worked on or after the effective date above if you :

- ☐ Have not completed **training** within the required timeframe based on information from the Training Partnership.

  The required training due is:
  - ☐ **Basic Training** WAC 388-71-0870 through WAC 388-71-0932;
  - ☐ **Continuing Education** WAC 388-71-0985 through WAC 388-71-1006.

- ☐ Have not been **certified by the Department of Health (DOH)** as a home care aide within the required timeframe. WAC 388-71-0975, Chapter 246-980 WAC, and RCW 18.88B.021(1)-(2)

- ☐ No longer have a Home Care Aide or other DOH-issued qualifying **credential that is both active and in good standing**. WAC 388-71-0975, Chapter 246-980 WAC, and RCW 18.88B.021(1)-(2)

You may not work for DSHS payment again until you have completed the requirements and are authorized to do so by DSHS or the Area Agency on Aging (AAA).

This action is being taken per the WAC authorities listed above or under the following rules:

WAC 388-71-0520; WAC 388-71-0523; WAC 388-71-0540; WAC 388-71-0551; WAC 388-71-0836; WAC 388-71-0975

The DSHS client(s) you work for will be notified that if you do not complete the required training/certification by the deadline, DSHS will not pay for your services on or after the effective date listed above and that he/she will need to find another provider.

Your Appeal Rights

You have a right to an administrative hearing pursuant to WAC 388-71-0561. You may not challenge an action by DOH that affects your certification. Actions by DOH must be challenged through an appeal to DOH.

You have the following rights:

- To receive copies of all information used by ALTSA or DDA in making its decision;
- To submit documents into evidence;
- To testify at the hearing and to present witnesses to testify on your behalf; and
- To cross examine witnesses testifying for the department.

You have 30 calendar days from the effective date on this notice for the Office of Administrative Hearings (OAH) to receive your request for appeal. To request an administrative hearing, you must send, deliver, or fax a written request to the OAH. A form for requesting an administrative hearing is included.

Who you may contact for information

NAME	TELEPHONE NUMBER
OFFICE	AGENCY ☐ AAA ☐ DDA ☐ HCS

Copy in Provider File.

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AGING AND LONG-TERM SERVICES ADMINISTRATION (ALTSA)

Request for Hearing

Per Chapter 388-526 for DSHS hearing rules

Mail your request to this address:
OFFICE OF ADMINISTRATIVE HEARINGS (OAH)
PO BOX 42489
OLYMPIA WA 98504-2489

OR

Fax to this number:
(360) 586-6563

I am requesting a hearing because I want to challenge the following decision made by Aging and Long Care Support Administration (ALTSA) or Developmental Disabilities Administration (DDA).

Select one of the following:

ALTSA or DDA is:

- ☐ Denying / terminating payment to me as an Individual Provider;
- ☐ Taking steps to terminate my Individual Provider Client Service Contract.

DSHS determined I:

- ☐ Have not been certified by DOH as a home care aide within the required timeframe;
- ☐ No longer have a Home Care Aide or other qualifying credential by DOH that is both active and in good standing;
- ☐ Have not completed required training within the required timeframe based on information from the Training Partnership.

PRINT YOUR NAME HERE

YOUR TELEPHONE NUMBER	YOUR PROVIDER NUMBER	THE OFFICE YOU RECEIVED THIS NOTICE FROM: ☐ AAA ☐ DDA ☐ HCS

PRINT YOUR ADDRESS | CITY | STATE | ZIP CODE

If you have a representative

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

PRINT YOUR REPRESENTATIVE'S NAME HERE	PRINT YOUR REPRESENTATIVE'S TELEPHONE NUMBER HERE

ADDRESS | CITY | STATE | ZIP CODE

If you have accommodation needs

Do you need an interpreter or other assistance for the hearing? ☐ Yes ☐ No

If yes, what language or assistance do you need?