Acknowledgement of My Responsibilities As The Employer of My Individual Providers

I, the employer of my individual providers, hereby accept the responsibilities as outlined by the Washington State Department of Social & Health Services (DSHS) and the Aging and Long-Term Support Administration (ALTSA) for the provision of long-term support services to the disabled adults in my care. I understand that these responsibilities include:

- Ensuring that all providers are trained and licensed as required by state law.
- Paying all providers promptly and accurately.
- Complying with all state and federal regulations governing long-term support services.
- Reporting any concerns or complaints to DSHS.
- Providing a safe and healthy environment for the individuals in my care.
- Ensuring that all services are provided in accordance with the individual provider's care plan.

I also understand that failing to fulfill these responsibilities may result in disciplinary action by DSHS.

IP Name:


dhhs.wa.gov
હું મારા IPના કામગીરી કૌંઠો હું મારા IP ના કામગીરી કૌંઠો હું મારા IP ના કામગીરી કૌંઠો.