County of Inyo

HEALTH & HUMAN SERVICES DEPARTMENT

Adult Social Services- Aging, APS & IHSS, Suite 203-B
1360 N. Main Street, Bishop CA 93514
TEL: (760) 872-1727 FAX: (760)872-1749

Marilyn Mann, Director
mmann@inyocounty.us

Dear Recipient:

To be eligible for the IHSS program you must meet all of the following requirements:

1. You must be disabled, or age 65 or older, or blind.
2. Unable to live safely in your home without help.
3. You are Medi-Cal eligible and financially unable to pay for your services to keep you in your home safely.

This service is offered to the aged, blind or disabled persons who are limited in their ability to care for themselves and cannot live safely at home without help.

Enclosed are the forms you will need to complete to apply for In-Home Supportive Services. Once we receive your completed forms we have thirty (30) days by law to schedule an appointment for an assessment. **Services are not available until the assessment has been completed.**

The social worker will determine what your needs are based on your medical condition, your living arrangements, and what assistance you may be getting from your family, friends or available community services. You must sign a release of information and your Doctor may be consulted to verify your medical condition. With the above information, the social worker will determine which services are needed, how often they are to be provided to keep you in your home safely and if you did not have this service are you at risk for being placed in a facility.

As the recipient, it is your responsibility to find and hire a provider to work for you, as well as terminate any provider if they are un-satisfactory. There is a registry that can give you a list of providers and we can give you their phone numbers. The state sets the rate of pay in the amount of **$16.25 per hour** (subject to change).

The local registry is responsible for hiring and providing a list of Providers, they are: ***Community Service Solutions*** which is located at 407 West Line Street, #3., Bishop, CA 93514. Their telephone number is (760) 872-2121.

Please feel free to call us if you need assistance with the application or if you have any questions.

Respectfully,
In-Home Supportive Services Staff
1360 N. Main Street, Ste. 203-B
Bishop, CA 93514 (760) 873-6364

APPLICATION FOR IN-HOME SUPPORTIVE SERVICES

To the Applicant: All sections of this form must be completed. Information provided is subject to verification.

NOTE: Retain your copy of your completed application. Regarding your Social Security Number, it is mandatory that you provide your Social Security Number(s) as required in 42 USC 405, or that you apply for a Social Security Number(s) with the Social Security Administration. This information will be used in eligibility determination and coordinating information with other public agencies.

Date of Application:	**Case Number (if known):**

Section 1 – Personal Information

Name of Applicant:		**Social Security Number:**
Street Address:		**City:**
State:	**Zip Code:**	**Telephone:**
		Email:
Date of Birth:		**Sex:** ☐ **Male** ☐ **Female**

Section 2 – Sexual Orientation and Gender Identity (Optional)

Providing responses in the sections below is optional and confidential. Any information you provide in this section will not be used in your eligibility determination.

What is your gender identity?
(check the box that best describes your current gender identity)

☐ Female
☐ Male
☐ Transgender: male to female
☐ Transgender: female to male
☐ Non-Binary (neither male nor female)
☐ Another gender identity
☐ Decline to state

What sex was listed on your original birth certificate? ☐ Female ☐ Male
How do you describe your sexual orientation? Select one answer. ☐ Straight/heterosexual ☐ Another sexual orientation ☐ Gay or lesbian ☐ Unknown ☐ Bisexual ☐ Decline to state ☐ Queer

Section 3 – Veteran Information

Are you a Veteran? ☐ Yes ☐ No	**Are you a Spouse/Child of a Veteran?** ☐ Yes ☐ No
If YES, give Veteran name and Claim Number:	

Section 4 – SSI/SSP Information

Do you receive SSI/SSP benefits? ☐ Yes ☐ No
If yes, check your type of living arrangement: ☐ Independent Living ☐ Board and Care ☐ Home of Another
Services being requested:

Section 5 – Past IHSS Information

Have you received In-Home Supportive Services (IHSS) in the past? ☐ Yes ☐ No	
If Yes, complete the following. **Date and county where service was last received:**	
Total Monthly Hours:	**Name Used (if different from above):**

Section 6 – Household Information

List Household Members:

Name of Spouse:	
Birthdate:	**Social Security Number:**
Name of: ☐ **Parent** ☐ **Child** ☐ **Other Relative** ☐ **Non-Relative**	
Birthdate:	**Social Security Number:**
Name of: ☐ **Parent** ☐ **Child** ☐ **Other Relative** ☐ **Non-Relative**	
Birthdate:	**Social Security Number:**
Name of: ☐ **Parent** ☐ **Child** ☐ **Other Relative** ☐ **Non-Relative**	
Birthdate:	**Social Security Number:**
Name of: ☐ **Parent** ☐ **Child** ☐ **Other Relative** ☐ **Non-Relative**	
Birthdate:	**Social Security Number:**
Name of: ☐ **Parent** ☐ **Child** ☐ **Other Relative** ☐ **Non-Relative**	
Birthdate:	**Social Security Number:**

Section 7 – Ethnic and Language Information

The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.

A. My Ethnic Origin is: Please choose one (See Page 8 for a list of Ethnicities and Codes)	**B1. What language do you prefer to read?** Please choose one **B2. What language do you prefer to speak?** Please choose one (Please choose one from the list of Languages and Codes on Page 8)

Section 8 – Communication Accommodations

To accommodate blind or visually-impaired applicants, IHSS information is available in the following alternative formats. Please indicate which format you would prefer, if applicable. Providing information in this section will not affect your eligibility for services.

I am Blind: ☐ Yes ☐ No

If yes, please choose one of the following for each of the three types of Department of Social Services (DSS) documents listed.

For Notices of Action: ☐ No accommodation is needed ☐ Braille Documents
☐ Audio CD ☐ Data CD ☐ County Support

(If County Support, describe requested support)

For IHSS Required forms: ☐ No accommodation is needed ☐ Braille Documents
☐ Audio CD ☐ Data CD ☐ County Support

(If County Support, describe requested support)

For Timesheets: ☐ No accommodation is needed
☐ Telephonic System (4 Digit RAN:) ☐ County Support
☐ Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)

(If County Support, describe requested support)

I am Visually Impaired: ☐ Yes ☐ No

If yes, please choose one of the following for each of the three types of Department of Social Services (DSS) documents listed.

For Notices of Action: ☐ No accommodation is needed ☐ 18 point font documents ☐ Audio CD ☐ Data CD ☐ County Support
(If County Support, describe requested support)
For IHSS Required forms: ☐ No accommodation is needed ☐ 18 point font documents ☐ Audio CD ☐ Data CD ☐ County Support
(If County Support, describe requested support)
For Timesheets: ☐ No accommodation is needed ☐ Telephonic System (4 Digit RAN:) ☐ 18 point font documents ☐ County Support ☐ Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)
(If County Support, describe requested support, including blind-only services)

Section 9 – Affirmation

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1. Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2. Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3. Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4. Notifying the County IHSS office within 10 days when I hire or fire a provider.

In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1. In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2. If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3. The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4. I will be responsible for paying for any services I receive that are not included in my IHSS authorization.
5. I will be responsible for paying my Share-of-Cost (SOC) and informing my individual provider(s) of that SOC.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity and quality assurance, I may be subject to (un)announced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

Section 10 – Signature(s)

Signature of Applicant:	**Date:**
Signature of Applicant's Representative (only if applicable):	**Date:**
Representative's Relationship to Applicant (only if applicable):	**Representative's Telephone Number (only if applicable):**
Representative's Address (only if applicable):	

To report suspected fraud or abuse in the provision or receipt of IHSS services, please call the fraud hotline at 1-800-822-6222, email at stopmedicalfraud@dhcs.ca.gov, or go to http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

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Income Eligible: ☐ Yes ☐ No	**Status Eligible:** ☐ Yes ☐ No	**Medi-Cal Aid Code:**
MAGI Eligible Recipient: ☐ Disabled 12 months or longer ☐ At risk without IHSS	**Verification:**	
Notes:		
Signature of Social Worker or Agency Representative:		**Telephone Number:**

Ethnic Codes:

A. White.
B. Hispanic.
C. Black.
D. Other Asian or Pacific Islander.
E. American Indian or Alaskan Native.
F. Filipino.
G. Chinese.
H. Cambodian.
I. Japanese.
J. Korean.
K. Samoan.
L. Asian Indian.
M. Hawaiian.
N. Guamanian.
O. Laotian.
P. Vietnamese.
Q. Other.
R. Mixed Ethnicity.

Language Codes:

1. American Sign Language (AMISLAN or ASL).
2. Spanish - NOA will be issued in Spanish.
3. Cantonese.
4. Japanese.
5. Korean.
6. Tagalog.
7. Other non-English.
8. English.
9. Spanish - NOA will be issued in English.
10. Other Sign Language.
11. Mandarin.
12. Other Chinese Languages.
13. Cambodian.
14. Armenian.
15. Ilacano.
16. Mien.
17. Hmong.
18. Lao.
19. Turkish.
20. Hebrew.
21. French.
22. Polish.
23. Russian.
24. Portuguese.
25. Italian.
26. Arabic.
27. Samoan.
28. Thai.
29. Farsi.
30. Vietnamese.

STATEMENT OF FACTS FOR IN-HOME SUPPORTIVE SERVICES

Note: *Your eligibility for In-Home Supportive Services (IHSS), under Welfare and Institutions Code Section 12300, will be determined by the information you provide on this form.*

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1. APPLICANT INFORMATION

NAME (FIRST, MIDDLE, LAST) | BIRTHDATE

HOME ADDRESS | CITY | ZIP CODE

MAILING ADDRESS (IF DIFFERENT) | HOME PHONE ( ) | MESSAGE PHONE ( )

PLACE OF BIRTH | SOCIAL SECURITY NUMBER | MEDI-CAL CARD NUMBER

ARE YOU:

☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

MARITAL STATUS:

☐ MARRIED (Date / /) ☐ SEPARATED (Date / /) ☐ WIDOWED (Date / /) ☐ DIVORCED (Date / /)

☐ SINGLE

COMPLETE THE FOLLOWING:

NAME OF SPOUSE OR PARENT(S) *(IF YOU ARE UNDER 18 YEARS OF AGE)*

IS SPOUSE/PARENT(S):

☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

SPOUSE/PARENT(S) SOC. SEC. NO. | SPOUSE/PARENT(S) ADDRESS *(IF DIFFERENT THAN APPLICANT'S)*

2. DO YOU RESIDE IN CALIFORNIA WITH THE INTENTION TO CONTINUE RESIDING HERE? ☐ YES ☐ NO

3. ARE YOU A CITIZEN OF THE UNITED STATES? *(IF "YES", GO TO "ITEM 4")* ☐ YES ☐ NO

(A.) IF YOU ARE NOT A UNITED STATES CITIZEN, ARE YOU LAWFULLY ADMITTED TO PERMANENT RESIDENCE OR LEGALLY PERMITTED TO REMAIN IN THE U S.? ☐ YES ☐ NO

(B.) WHAT IS YOUR ALIEN REGISTRATION NUMBER?

(C.) WHAT IS NAME OF SPONSOR?

(D.) WHAT IS SPONSOR'S ADDRESS?

4. WHAT IS YOUR LIVING ARRANGEMENT?

MY HOME IS A: ☐ HOUSE ☐ APARTMENT ☐ ROOM ☐ ROOM & BOARD ☐ TRAILER/ MOTOR HOME ☐ OTHER

IN WHICH I: ☐ OWN/ AM BUYING ☐ RENT ☐ LIVE COST FREE ☐ RECEIVE BOARD AND CARE

LANDLORD'S NAME | AMOUNT OF RENT, BOARD AND/OR MORTGAGE PAID $_____/MONTH

ADDRESS | CITY | ZIP CODE

5. ARE THERE OTHERS LIVING IN THE HOUSEHOLD? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

NAME	RELATIONSHIP	AGE

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6. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN REAL PROPERTY OTHER THAN YOUR HOME? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW: OR ON PAGE 4 PARAGRAPH 21.)

ADDRESS	CITY	COUNTY

STATE	ZIP CODE	PARCEL NUMBER

ASSESSED VALUE	TOTAL AMOUNT OWED ON MORTGAGE(S)	MONTHLY PAYMENT
$	$	$

ANNUAL TAXES	ANNUAL INSURANCE	ANNUAL ASSESSMENTS
$	$	$

HOW IS PROPERTY UTILIZED?	IF USED AS RENTAL, INDICATE AMOUNT OF RENT.	ARE TAXES INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO

OTHER PROPERTY EXPENSES	IS INSURANCE INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO

7. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN MOTOR VEHICLES (CARS, TRUCKS, MOTORCYCLES, BOATS, MOTORHOMES)? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

MAKE AND MODEL	YEAR	ESTIMATED VALUE	CHECK IF USED FOR WORK	CHECK IF USED FOR MEDICAL TRANS.	MODIFIED FOR DISABLED PERSON?

8. WHAT IS THE VALUE OF YOUR LIQUID RESOURCES?
(IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE RESOURCES OF PARENT(S) RESPONSIBLE FOR CHILD, INDICATE IF ANY RESOURCE IS EXCLUSIVELY FOR BURIAL EXPENSES FOR YOU OR YOUR IMMEDIATE FAMILY.)

LIQUID RESOURCES	(✓) IF NONE	ENTER VALUE UNDER OWNER: SELF	SPOUSE/PARENTS	JOINTLY	(✓) FOR BURIAL
CASH ON HAND AND/OR MONEY KEPT IN THE HOME		$	$	$	
CHECKING ACCOUNT		$	$	$	
SAVINGS ACCOUNT, CREDIT UNION TRUST FUNDS		$	$	$	
CHECKS OR CASH IN SAFETY DEPOSIT BOX		$	$	$	
STOCKS, BONDS, OR MUTUAL FUNDS NOTES, MORTGAGES, DEEDS		$	$	$	
IRA, CERTIFICATES OF DEPOSIT, MONEY MARKET		$	$	$	
OTHER *(SPECIFY)*:		$	$	$	

9. DO YOU, YOUR SPOUSE OR PARENT(S) (IF APPLICANT IS UNDER 18) HAVE ANY PERSONAL GOODS OR HOUSEHOLD EFFECTS WITH A COMBINED EQUITY VALUE OF MORE THAN $2,000? (E. G., HOUSEHOLD FURNISHINGS, CLOTHING, AND JEWELRY.) *(IF ADDITIONAL SPACE IS NEEDED, SPECIFY IN ITEM 21.)* ☐ YES ☐ NO
(IF "YES", GIVE INFORMATION BELOW:) *(EXCLUDE REHABILITATION DEVICES AND EQUIPMENT.)*

DESCRIPTION	CURRENT MARKET VALUE	AMOUNT OWED
A.	$	$
B.	$	$
C.	$	$

10. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY LIFE INSURANCE? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

NAME OF OWNER	NAME OF INSURED	NAME AND ADDRESS OF INSURANCE COMPANY

POLICY NUMBER	TOTAL FACE VALUE OF POLICY	CASH SURRENDER VALUE	WHEN WAS THE POLICY PURCHASED	IF THERE IS A LOAN AGAINST THE POLICY WHAT IS THE AMOUNT

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(11.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BURIAL FUNDS, INSURANCE, TRUSTS, SPACES OR CONTRACTS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

OWNER OF EACH ITEM	NAME OF EACH ITEM	TOTAL PURCHASE VALUE OF EACH ITEM	HOW MUCH IS OWED ON EACH ITEM	NAME AND ADDRESS OF COMPANY/SOURCE
			$	
			$	

(12.) HAVE YOU, YOUR SPOUSE OR PARENT(S) (IF A MINOR IS APPLYING) SOLD, TRANSFERRED OR GIVEN AWAY ANY PROPERTY, INCLUDING MONEY, IN THE LAST 36 MONTHS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	DATE OF TRANSFER	ESTIMATED VALUE	AMOUNT RECEIVED
		$	$
		$	$

(13.) ARE YOU OR YOUR SPOUSE EMPLOYED OR SELF—EMPLOYED? *(IF "YES", GIVE THE INFORMATION BELOW.) (IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER 18 INCLUDE EMPLOYMENT OF PARENT(S).)* ☐ YES ☐ NO

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	
OCCUPATION	GROSS SALARY PER PAY PERIOD $	HOW OFTEN PAID?

IF SELF-EMPLOYED, ATTACH VERIFICATION OF ALL ORDINARY AND NECESSARY BUSINESS EXPENSES, PRINCIPAL PAYMENTS OR ENCUMBRANCES AND PERSONAL INCOME TAX.

(14.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BUSINESS EQUIPMENT INVENTORY, OR MATERIAL? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	PURPOSE	ESTIMATED VALUE	AMOUNT OWED
		$	$
		$	$

(15.) IF YOU ARE BLIND OR DISABLED AND WORKING, DO YOU HAVE ANY WORK—RELATED EXPENSES DUE TO BLINDNESS OR DISABILITY? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

COST OF TRANSPORTATION TO AND FROM WORK	COST OF ITEMS OR SERVICES TO PREPARE FOR WORK	COST OF ITEMS OR SERVICES NEEDED FOR JOB PERFORMANCE
$	$	$

(16.) LIST INCOME RECEIVED EACH MONTH FROM SOURCES OTHER THAN EMPLOYMENT. IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE INCOME OF PARENT(S) RESPONSIBLE FOR CHILD.

TYPE OF INCOME	(✓) NONE	ENTER MONTHLY AMOUNT RECEIVED BY: SELF	ENTER MONTHLY AMOUNT RECEIVED BY: SPOUSE/PARENT(S)	CLAIM NUMBER
A. SOCIAL SECURITY *(RETIREMENT, SURVIVOR, DISABILITY INSURANCE)*		$	$	
B. CASH CONTRIBUTIONS		$	$	
C. STATE DISABILITY/ UNEMPLOYMENT INSURANCE		$	$	
D. VETERAN'S PENSION/COMPENSATION		$	$	
E. V.A. AID AND ATTENDANCE CARE/ HOUSEBOUND ALLOWANCE		$	$	
F. GOVERNMENT PENSION		$	$	
G. PRIVATE AND/OR MILITARY RETIREMENT PENSION		$	$	
H. ALIMONY, CHILD SUPPORT		$	$	
I. RENTAL INCOME		$	$	
J. INTEREST, DIVIDENDS, ROYALTIES		$	$	
K. RAILROAD RETIREMENT PENSION		$	$	
L. WORKER'S COMPENSATION		$	$	
M. AFDC PAYMENTS		$	$	
N. OTHER: *(SPECIFY)*		$	$	

(17.) HAVE YOU, YOUR SPOUSE OR YOUR PARENT(S) APPLIED FOR OR DO YOU EXPECT TO START RECEIVING INCOME FROM ANY OF THE SOURCES LISTED IN "ITEM 16"? ☐ YES ☐ NO

(IF "YES", GIVE THE INFORMATION BELOW.)

TYPE OF INCOME	PLACE APPLIED	DATE APPLIED	DATE EXPECTED

(18.) HAVE YOU, YOUR SPOUSE OR YOUR PARENTS HAD MEDICAL EXPENSES WITHIN THE LAST 3 MONTHS AND WANT MEDI-CAL FOR THOSE EXPENSES? ☐ YES ☐ NO

(19.) (A.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE ANY NON-CASH GIFTS OR CONTRIBUTIONS OF RENT, FOOD, CLOTHING OR OTHER ITEMS OF NEED? ☐ YES ☐ NO

(B.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE NON-CASH COMPENSATION IN RETURN FOR WORK? ☐ YES ☐ NO

(IF "YES" TO "(A)" OR "(B)", GIVE THE INFORMATION BELOW:)

ITEM CONTRIBUTED	FREQUENCY OF RECEIPT	CASH EQUIVALENT
		$
		$

(20.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE HEALTH OR HOSPITALIZATION INSURANCE (INCLUDING PAID BY AN EMPLOYER)? ☐ YES ☐ NO

(IF "YES", GIVE THE INFORMATION BELOW:)

INSURANCE CARRIER (CHECK APPLICABLE(S))	PERSON(S) INSURED
☐ MEDICARE *(CLAIM NO)*	
☐ CHAMPUS	
☐ VETERAN'S ADMINISTRATION COVERAGE	
☐ KAISER	
☐ ROSS–LOOS	
☐ BLUE SHIELD	
☐ BLUE CROSS	
☐ PREPAID HEALTH PLAN	
☐ HEALTH MAINTENANCE ORGANIZATION *(SPECIFY:)*	
☐ OTHER CARRIER *(SPECIFY:)*	

(21.)

ITEM NUMBER	ADDITIONAL INFORMATION (ATTACH ADDITIONAL SHEETS IF NECESSARY)

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EXPECTED INCOME

How Verified:

a. _____

b. _____

c. _____

IN-KIND INCOME
30-775.11

How Verified: _____

_____

_____

_____

_____

PREMIUM PAYMENTS

Amount Paid: $ _____

How often: _____

How Verified: _____

_____

_____

_____

_____

SOC 310 VERIFICATION

☐ ELIGIBLE ☐ INELIGIBLE

REASON (IF INELIGIBLE):

SOCIAL SERVICE WORKER:

DATE:

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I HEREBY STATE BY MY SIGNATURE THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

I AGREE TO TELL THE COUNTY DEPARTMENT OF SOCIAL SERVICES WITHIN 10 DAYS IF THERE ARE ANY CHANGES IN MY INCOME, POSSESSIONS, OR EXPENSES, OR IN THE NUMBER OF PERSONS IN MY HOUSEHOLD, OR IF ANY CHANGE OF ADDRESS, AND I AGREE TO MEET ALL OTHER RESPONSIBILITIES EXPLAINED IN THE "MEDI-CAL RESPONSIBILITIES CHECKLIST" I HAVE RECEIVED.

I UNDERSTAND THAT I MAY BE ASKED TO PROVE MY STATEMENTS, BUT THAT THE COUNTY IS REQUIRED BY LAW TO KEEP THEM CONFIDENTIAL.

I UNDERSTAND THAT IF I AM DISSATISFIED WITH ANY ACTIONS TAKEN BY THE COUNTY DEPARTMENT OF SOCIAL SERVICES, I HAVE THE RIGHT TO A STATE HEARING.

I UNDERSTAND THAT I MUST DISPOSE OF ANY EXCESS RESOURCES WITHIN A SIX-MONTH PERIOD IN THE CASE OF REAL PROPERTY AND WITHIN THREE MONTHS IN THE CASE OF PERSONAL PROPERTY AND REPAY ANY OVERPAYMENTS WITH THE PROCEEDS OF THE DISPOSED PROPERTY.

I UNDERSTAND THAT IF I AM ELIGIBLE FOR IHSS SERVICES, I WILL BE PROVIDED A MEDI-CAL CARD AT NO SHARE-OF-COST TO ME IF I PAY THE IHSS SHARE OF COST I AM OBLIGATED TO PAY.

I UNDERSTAND THAT FEDERAL AND STATE LAW REQUIRE THE RECOVERY OF ALL MEDI-CAL BENEFITS RECEIVED AFTER AGE 55 FROM THE ESTATE OF A MEDI-CAL BENEFICIARY IF THERE IS NO SURVIVING SPOUSE, MINOR CHILDREN, OR PERMANENTLY AND TOTALLY DISABLED CHILDREN.

I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF WITNESS *(REQUIRED IF APPLICANT SIGNED BY MARK)*	DATE
SIGNATURE OF PERSON ACTING FOR APPLICANT (RELATIONSHIP: PARENT, GUARDIAN, CONSERVATOR)	DATE	SIGNATURE OF PERSON HELPING APPLICANT COMPLETE FORM	DATE

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
NOTICE TO APPLICANT OF HEALTH CARE CERTIFICATION REQUIREMENT

State Law (Welfare and Institutions Code section 12309.1) requires that each person applying for IHSS provide a health care certification from a licensed health care professional (LHCP) before they can get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Health Care Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

The county may accept alternative documentation in place of the SOC 873 as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own and without services you are at risk of placement in out-of-home care,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP within the last 60 days.

Whether you give the SOC 873 to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within **45 days** from the date the county worker requested it.

If you do not provide the SOC 873 or alternative documentation to the county within 45 days, your application for IHSS will be denied. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

Under certain limited circumstances, such as when services are requested because you are being discharged from a hospital or nursing facility and you need services to return safely to your home, or the county determines that you are at risk of placement in out-of-home care, the county may grant an exception that would allow you to get IHSS on a temporary basis before the county receives the completed SOC 873 or alternative documentation. However, even if an exception is granted, you will still be required to provide one of these documents for the county within the 45-day timeframe to determine if you can continue getting IHSS. If you have been granted an exception but you are not able to get the SOC 873 from your LHCP within 45 days, call your social worker **before the due date** to tell him/her why you are not able to meet the due date and ask if the county can grant you more time.

If you have questions about the health care certification requirement, ask the social worker who has been assigned to your case.

DUE BY: ____/____/____

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
HEALTH CARE CERTIFICATION FORM

A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name:	Date of Birth:
Address:	
County of Residence:	IHSS Case #:
IHSS Worker Name:	
IHSS Worker Phone #:	IHSS Worker Fax #:

B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (To be completed by the applicant/recipient)

I, _____ (PRINT NAME), authorize the release of health care information related to my physical and/or mental condition to the In-Home Supportive Services program as it pertains to my need for domestic/related and personal care services.

Signature: _____ (APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR) Date: ____/____/____

Witness (if the individual signs with an "X"): _____ Date: ____/____/____

TO: LICENSED HEALTH CARE PROFESSIONAL* –

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This health care certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual's present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

**Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.*

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM HEALTH CARE CERTIFICATION FORM

Applicant/Recipient Name:	IHSS Case #:

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.

1. Is this individual unable to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)?	☐ YES ☐ NO
2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?	☐ YES ☐ NO
***If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below**, and complete the rest of the form including the certification in PART D at the bottom of the form.* ***If you answered "YES" to both Question #1 AND #2, respond to Questions #3 and #4 below,** and complete the certification in PART D at the bottom of the form.*	
3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program:	
4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months OR expected to result in death within 12 months?	☐ YES ☐ NO

Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

6. How long have you provided service(s) to this individual?

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

8. Indicate the date you last provided services to this individual: ____ / ____

NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and all information provided above is correct.

Name:	Title:
Address:	
Phone #:	Fax #:
Signature:	Date:
Professional License Number:	Licensing Authority:

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.