IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
RECIPIENT DESIGNATION OF PROVIDER

INSTRUCTIONS:

- Use black or blue ink. Print information clearly.
- You (or your authorized representative) must complete PART A of this form to let the county know who you have chosen to provide your authorized services.
- If you have multiple providers, you must fill out a separate form for each person who will be providing authorized services for you.
- You must sign the acknowledgement in PART C of this form.
- Please return this completed and signed form to the county. The county will keep the original form and give you a copy.

PART A. RECIPIENT DESIGNATION OF PROVIDER		
1.	Recipient's Name:	➡ PERSON YOU ARE CARING FOR
2.	County IHSS Case #:	➡ RECIPIENT'S IHSS CASE #
3.	Provider's Name:	➡ YOUR NAME
4.	Provider's Address:	➡ YOUR ADDRESS
	City, State, ZIP Code:	➡ YOUR CITY, STATE, ZIP CODE
5.	Provider's Telephone Number:	➡ YOUR TELEPHONE #
6.	Provider's Date of Birth	➡ YOUR DATE OF BIRTH
7.	Provider's Social Security #*:	➡ YOUR SOCIAL SECURITY #
8.	Provider's Gender (check box):	☐ Male ☐ Female ➡ YOUR GENDER
9.	Provider's Relationship to Recipient (if any):	☐ Parent ☐ Child ☐ Spouse/Domestic Partner ☐ Conservator ☐ Guardian ☐ Other _____
10.	Provider's Start Date:	➡ DATE YOU STARTED WORKING

*NOTE: The collection of the Social Security Number is required by the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a), for the purposes of verifying the individual's identity and authorization to work in the United States.

➡ YOUR RELATIONSHIP TO RECIPIENT

I choose the person listed above to be my IHSS provider. This person will provide some or all of the services authorized by the county.

PART B. RECIPIENT AGREEMENT

I UNDERSTAND AND AGREE THAT:

- The person I have chosen to be my provider cannot be paid federal and/or state money for providing services to me until he/she completes all of the provider enrollment requirements. These requirements include completing, signing, and returning (in person) the Provider Enrollment Form (SOC 426), submitting fingerprints and being cleared of disqualifying crimes through a criminal background check, completing a provider orientation, and returning a signed Provider Enrollment Agreement (SOC 846).
- The county will send me a notice telling me if the person I have chosen as my provider does not complete the provider enrollment requirements or if he/she is not eligible to be an IHSS provider.
- If I choose to have this person provide services for me before he/she is enrolled as an IHSS provider, and the county sends me a notice telling me that he/she is not eligible to be an IHSS provider, I will have to pay him/her with my own money for the services that he/she provided before he/she was determined ineligible to be a provider and for any services he/she provides after the county notifies me that he/she is ineligible.
- Neither the county nor the State will be held responsible for any claims and/or losses caused by the above-named person I choose to hire as my IHSS provider. I agree to hold harmless the State and county, their officers, agents, and employees, and to take responsibility for any and all claims and/or losses to any person caused by the named person I choose to hire as my IHSS provider.
- The county can provide information about my authorized services and service hours to the person I have chosen as my provider. The county will send my provider the IHSS Provider Notice of Recipient Authorized Hours and Services (SOC 2271).
- My total monthly authorized hours will be divided by 4 to determine my <u>maximum weekly hours</u>. The maximum weekly hours is a guideline telling me the highest number of hours my provider(s) will be able to work for me during a workweek. However, since most months are slightly longer than 4 weeks, I will work with my provider(s) to spread his/her hours throughout the month in order to make sure I have all the service hours I need for the month.
- Sometimes I may need my provider to work more than my maximum weekly hours. I must ask for county approval to adjust my maximum weekly hours only if the change requires my provider to work:

  1. More overtime hours in the month than he/she would normally work.

2. More than 40 hours for me in a workweek if my maximum weekly hours are 40 hours or less in a workweek.

- If I do not get an approved exception, my provider will get a violation for working more than my maximum weekly hours.
- I can **never** authorize my provider to work more than my total authorized monthly service hours. Therefore, when I authorize my provider to work extra hours in one week, I must have the provider work fewer hours in the other week(s) of the month.
- If my provider works for another recipient, the maximum number of hours that he/she may claim in a workweek for all of the time he/she works for his/her recipients combined is 66 hours. I **must make a work schedule for my provider to determine how many hours he/she will be working for me each week to make sure he/she does not work more than 66 hours per workweek.** I will get a Recipient Notification of Maximum Weekly Hours (SOC 2271A) which will include information on my maximum weekly hours so I can use it to make the work schedule for my provider(s). In order to make the schedule, my provider must tell me how many hours he/she is available to work for me each workweek. If my provider cannot work all of my authorized hours, I will need to hire additional provider(s). **If I need help finding and hiring another provider(s), I can call my county IHSS Public Authority to obtain a provider from the registry or my county IHSS office.**
- The county will send me a notice each time my provider gets a violation. If my provider gets three violations, he/she will be suspended from providing IHSS for three months. If he/she gets another violation after being reinstated from the three-month suspension, he/she will be terminated as a provider for one year.

PART C. RECIPIENT ACKNOWLEDGMENT

I understand and agree to follow all of the requirements listed in this form.

RECIPIENT'S SIGNATURE:	DATE:
➡ RECIPIENT'S SIGNATURE	➡ DATE
PRINTED NAME:	
➡ RECIPIENT'S PRINTED NAME	
AUTHORIZED REPRESENTATIVE'S SIGNATURE:	DATE:
➡ IF RECIPIENT IS UNABLE TO SIGN	➡ DATE
PRINTED NAME:	
➡ IF YOU ARE THE AUTHORIZED REPRESENTATIVE AND ALSO THE PROVIDER, YOU CANNOT SIGN	
WORKER NAME:	DATE: