

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

### INSTRUCTIONS:

- Use black or blue ink. Print information clearly.
- You (or your legally authorized representative) must fill out this form to let the county know who you have chosen to provide your services.
- You (or your legally authorized representative) must sign the declaration at the bottom to show that you understand and agree to all of the terms and conditions listed.
- If you have multiple providers, you must fill out a separate form for each person who will be providing services.
- Please return this form to the county. The county will keep the original form and give you a copy.
- You must let the county know if you change your provider(s). You must tell the county within 10 calendar days of the change.

1. Recipient's Name:	
2. County IHSS Case #:	
3. Provider's Name:	
4. Provider's Address:	
City, State, ZIP Code:	
5. Provider's Telephone Number:	
6. Provider's Date of Birth:	
7. Provider's Gender (check box):	<input type="checkbox"/> Male <input type="checkbox"/> Female
8. Provider's Relationship to Recipient (if any):	<input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____
9. Provider's Start Date:	

### RECIPIENT DECLARATION

- I DECLARE that the person named above is my choice to provide IHSS for me as authorized by the county.
- I UNDERSTAND that the above-named provider cannot be paid federal and/or state IHSS funds for any services provided to me until he/she has completed the entire provider enrollment process, which includes 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 signing and returning the Provider Enrollment Agreement (SOC 846).
- I UNDERSTAND that I will be informed by the county if the person I have chosen to be my provider does not complete the provider enrollment process, or if he/she is determined ineligible to be a provider.
- **I UNDERSTAND that if I choose to receive services from this person before he/she is enrolled as a provider, and he/she is ultimately found ineligible, or after I have been informed that he/she is ineligible, I will be responsible for paying him/her with my own money.**
- I UNDERSTAND AND AGREE that the county can provide information about my authorized services and service hours to the provider named above.

RECIPIENT'S OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE:

DATE:

PRINTED NAME: