

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):
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Section 1 – Personal Information

Name of Applicant:		Social Security Number:
Street Address:		City:
State:	Zip Code:	Telephone:
		Email:
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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)	
<input type="checkbox"/> Female	<input type="checkbox"/> Non-Binary (neither male nor female)
<input type="checkbox"/> Male	<input type="checkbox"/> Another gender identity
<input type="checkbox"/> Transgender: male to female	<input type="checkbox"/> Decline to state
<input type="checkbox"/> Transgender: female to male	

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

Section 3 – Veteran Information

Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a Spouse/Child of a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, give Veteran name and Claim Number:	

Section 4 – SSI/SSP Information

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

Section 5 – Past IHSS Information

Have you received In-Home Supportive Services (IHSS) in the past? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	
Birthdate:	Social Security Number:
Name of: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	
Birthdate:	Social Security Number:
Name of: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	
Birthdate:	Social Security Number:
Name of: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	
Birthdate:	Social Security Number:
Name of: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	
Birthdate:	Social Security Number:
Name of: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	
Birthdate:	Social Security Number:
Name of: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	
Birthdate:	Social Security Number:
Name of: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	

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: (See Page 8 for a list of Ethnicities and Codes)	B1. What language do you prefer to read?
	B2. What language do you prefer to speak? (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.

<p>For Notices of Action: <input type="checkbox"/> No accommodation is needed <input type="checkbox"/> Braille Documents <input type="checkbox"/> Audio CD <input type="checkbox"/> Data CD <input type="checkbox"/> County Support</p>
<p>(If County Support, describe requested support)</p>
<p>For IHSS Required forms: <input type="checkbox"/> No accommodation is needed <input type="checkbox"/> Braille Documents <input type="checkbox"/> Audio CD <input type="checkbox"/> Data CD <input type="checkbox"/> County Support</p>
<p>(If County Support, describe requested support)</p>
<p>For Timesheets: <input type="checkbox"/> No accommodation is needed <input type="checkbox"/> Telephonic System (4 Digit RAN:) <input type="checkbox"/> County Support <input type="checkbox"/> Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)</p>
<p>(If County Support, describe requested support)</p>

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.

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

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Status Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Aid Code:
MAGI Eligible Recipient: <input type="checkbox"/> Disabled 12 months or longer <input type="checkbox"/> 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.**