

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MEDICAL 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 MEDICAL INFORMATION (To be completed by the applicant/recipient)

I, \_\_\_\_\_, authorize the release of medical information  
(PRINT NAME)  
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: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

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 medical 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 medical 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.

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Applicant/Recipient Name:

IHSS Case #:

**\*\*ONLY A LICENSED HEALTH CARE PROFESSIONAL SHOULD COMPLETE THE REMAINDER OF THIS FORM.\*\***

## C. MEDICAL INFORMATION (To be completed by a Licensed Health Care Professional)

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

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

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

4. Indicate the date you last provided services to this individual: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

5. 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

6. 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 #5 OR #6, skip Questions #7 and #8 below, and complete the certification in PART D at the bottom of the form.*

*If you answered "YES" to both Question #5 AND #6, respond to Questions #7 and #8 below, and complete the certification in PART D at the bottom of the form.*

7. 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:

8. Is the condition(s) or functional limitation(s) expected to last more than 12 consecutive months?  YES  NO

**NOTE: THE SOCIAL 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 SOCIAL WORKER LISTED ON PAGE 1.