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

<table>
<tr><td colspan="2">Name of Applicant:</td><td colspan="2">Social Security Number:</td></tr>
<tr><td colspan="2">Street Address:</td><td colspan="2">City:</td></tr>
<tr><td>State:</td><td>Zip Code:</td><td colspan="2">Telephone:</td></tr>
<tr><td colspan="2"></td><td colspan="2">Email:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">Sex: ☐ Male ☐ Female</td></tr>
</table>

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.

FOR AGENCY USE ONLY

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.