

IN-HOME SUPPORTIVE SERVICES (IHSS) RECIPIENT REQUEST FOR ASSIGNMENT OF AUTHORIZED HOURS TO PROVIDERS

IHSS RECIPIENT CASE NUMBER

RECIPIENT NAME	(FIRST	MIDDLE	LAST)
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PROVIDER NAME	(FIRST	MIDDLE	LAST)	PROVIDER IDENTIFICATION NUMBER	HOURS ASSIGNED PER MONTH
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I understand that by completing and submitting this form to the county In-Home Supportive Services (IHSS) program, I am requesting the IHSS program to assign the indicated number of my authorized hours to the named provider. I further understand that by making this request, my provider's timesheets will NOT be processed for more than the hours I have requested be assigned to him/her on this form. This request will remain in effect until I submit a new request form to the county IHSS program.

RECIPIENT SIGNATURE	DATE
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AUTHORIZED REPRESENTATIVE (IF RECIPIENT CANNOT SIGN ON THEIR OWN BEHALF)	RELATIONSHIP TO RECIPIENT	TELEPHONE NUMBER
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SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE
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PROVIDER SIGNATURE	DATE
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COUNTY USE ONLY

COMMENTS

SOCIAL WORKER NAME	(FIRST	MIDDLE	LAST)	SOCIAL WORKER IDENTIFICATION NUMBER
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