In-Home Supportive Services Program
Medical Certification Form

A. Applicant/Recipient Information (to be completed by the county)	
Applicant/Recipient Name:	Date of Birth:
Address:	
County of Residence:	Case #:
Social Worker Phone #:	Social Worker Fax #:
Social Worker Name:	

B. Authorization to Release Medical Information (to be completed by the applicant/recipient)

I _____ authorize the release of my medical information 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

This release of information expires 12 months from the date above.

The above individual has requested assistance from the In-Home Supportive Services program (IHSS). IHSS is a Medi-Cal 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 and personal care services such as: housekeeping, preparing meals, meal clean up, routine laundry, shopping for food, errands, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, ambulation, transfers, assistance with bathing and grooming, rubbing skin and repositioning, care and assistance with prosthesis, accompaniment to medical appointments and alternative resources, yard hazard abatement, protective supervision, and paramedical services. The IHSS program provides hands on and/or verbal assistance (reminding or prompting) for the services described above.

<u>This form must be completed before IHSS services can be authorized.</u> The social worker has the responsibility to authorize service hours. However, this medical certification is used to help the social worker evaluate the individual's present condition and their need for out-of-home care if IHSS services were not provided. This form will be considered as one indicator of need for services, but the social worker will consider all relevant documentation in making the IHSS determination.

Only the Licensed Health Care Professional should complete the remainder of this form.

C. Medical Information (to be completed by the licensed health care professional)

1) Nature of services you provide to this individual? _____
(Examples: Medical treatment, Nursing Care, Discharge planning)

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

3) Frequency of contact with this individual and date last seen? _____ _____
(Monthly, Yearly, etc.) (Date Last Seen)

4) Is this individual unable to independently perform one or more activities of daily living? Yes [ ] No [ ]

5) In your opinion, is one or more IHSS services recommended in order to prevent the need for out-of-home care? Yes [ ] No [ ]

If you answered **no** to both question # 4 or # 5, skip the remainder of the form and complete the signature box at the bottom of the form.

If you answered **yes** to either questions # 4 and #5, please respond to questions 6 and 7, and complete the signature box at the bottom of the form.

6) Please provide a description of any condition or functional limitation that has resulted in or contributed to the need for assistance from the IHSS program (see description of services on page 1):

_____
_____
_____
_____
_____
_____

7) Is the functional impairment(s) expected to last more than 12 consecutive months? Yes [ ] No [ ]

Please be advised: the social worker may contact you to clarify the responses you provided above.

D. Licensed Health Care Professional's Certification

By signing this form I certify I am licensed in the State of California and all information provided above is correct.

Name:	Title:
Address:	
Phone # :	Fax # :
Signature:	**Date:**
License Number:	