**In-Home Support Services (IHSS)**

**Client and Provider Agency Responsibilities**

**Section I: Client Information**

Client Full Name: Medicaid ID:

IHSS Provider Agency:

**Section II: Responsibilities**

The client’s physician has indicated the client is able to participate in IHSS with the requirement of having either:

1. An Authorized Representative designated by the client to direct and manage IHSS services.

**OR**

1. An agreement to receive additional support from an IHSS provider agency in directing and managing IHSS. The client must receive one or more of the additional supports listed below.

**The client has elected to receive additional support from an IHSS provider agency. The client and IHSS provider agency have agreed for the agency to provide the following supports for the client:**

|  |  |
| --- | --- |
| Introduce potential attendant(s) to the client. | Train attendant(s) to meet the client’s needs. |
| Dismiss attendant(s) who are not meeting the client’s needs. | Manage and supervise attendant(s). |
| Directly schedule attendant(s) and document any permanent and significant changes in scheduling. | Work with the client to determine the level of oversight needed by a licensed health care professional. |

Client Signature Date

Provider Agency Representative Signature Date

The provider agency must work with the client to update this form when there is a change to the elected supports. A copy must be sent to the case manager within 5 days of the change in elected supports.