

**COYOTE VALLEY TRIBAL HEALTH AND HUMAN SERVICES DEPARTMENT
 IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
 ELDER CARE ASSISTANCE QUALIFICATION FORM**

A. APPLICANT INFORMATION (TO BE COMPLETED BY THE TRIBE)	
Applicant/Recipient Name:	Date of Birth:
Address:	
County of Residence:	
IHSS Worker Name:	
IHSS Worker Phone #:	IHSS Worker Fax #:
B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (TO BE COMPLETED BY THE APPLICANT/RECIPIENT)	

I, _____, authorize the release of health
 (PRINT NAME)
 care information related to my physical and/or mental condition to the In-Home Supportive Program as it
 pertains to my need for domestic/related and personal care services.

Signature: _____
 (APPLICANT OR LEGAL GUADIAN/CONSERVATOR)

Date: ____/____/____

Witness (if the individual signs with an "X"): _____

Date: ____/____/____

TO: LICENSED HEALTH CARE PROFESSIONAL*

The above-named individual has applied for the In-Home Supportive Services (IHSS) Program. Tribal Policy requires that in order for IHSS Services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual may be at risk of placement in out-of-home care. This health care certification from 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, adult tribal members 65 years of age or older and disabled 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.

**Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license of certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.*

Applicant Name:

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

1. 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.)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In your opinion, is one or more IHSS services recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. 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:	
4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months?	
5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):	
6. How long have you provided service(s) to this individual?	
7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):	
8. Indicate the date you last provided services to this individual: ____/____/____	

NOTE: THE IHSS 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/or certified as a Medi-Cal provider, 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 IHSS WORKER LISTED ON PAGE 1