Health and Human Services Department

Sherri Z. Heller, Ed. D.
Director

Divisions
Behavioral Health Services
Child Protective Services
Department Administration
Primary Health Services
Public Health
Senior and Adult Services

County of Sacramento

IHSS Recipient Designation of Provider

INSTRUCTIONS:

- Use black or blue ink. Print information clearly.
- You (or your legally authorized representative) must fill out both sides of this form to let the county know who you have chosen to provide your services.
- You (or your legally authorized representative) must sign the declaration at the bottom to show that you understand and agree to all of the terms and conditions listed.
- If you have multiple providers, you must fill out a separate form for each person who will be providing services.
- Please return this form to the county. The county will keep the original form and give you a copy.
- You must let the county know if you change your provider(s). You must tell the county within 10 calendar days of the change.

Recipient Name:	
County IHSS Case Number (#):	
Provider's Name:	
Provider's Social Security Number	
Provider's Gender (check box)	☐ Male ☐ Female
Providers Date of Birth	
Provider's Address:	
Provider's City, State, Zip Code:	
Provider's Telephone Number:	
Provider's Relationship to Recipient (if any)	☐ Parent ☐ Child ☐ Spouse/Domestic Partner ☐ Conservator ☐ Guardian ☐ Other ________________
Provider's Start Date:	

Sacramento County IHSS
9750 Business Park Drive
Sacramento, CA 95827
(916) 874 9471 Fax: (916) 876-8706

RECIPIENT DECLARATION

• I DECLARE that the person named above is my choice to provide IHSS for me as authorized by the county.

• I UNDERSTAND that the above-named person cannot be paid federal and/or state IHSS funds for any services provided to me until he/she has completed the entire provider enrollment process, which includes completing, signing and returning (in person) the Provider Enrollment Form (SOC 426), submitting fingerprints and being cleared of disqualifying crimes through a criminal background check, completing a provider orientation, and signing and returning the Provider Enrollment Agreement (SOC 846).

• I UNDERSTAND that I will be informed by the county if the person I have chosen to be my provider does not complete the provider enrollment process or if he/she is determined ineligible to be a provider.

• I UNDERSTAND that if the above-named person has been convicted of a felony which requires me to submit a provider waiver for that individual to work for me as an IHSS provider, that individual cannot sign the waiver document as my authorized representative.

• **I UNDERSTAND that if I choose to receive services from this person before he/she is enrolled as a provider, and he/she is ultimately found ineligible, or after I have been informed that he/she is ineligible, I will be responsible for paying him/her with my own money.**

• I UNDERSTAND AND AGREE that neither the County nor the State is liable for any claims and/or losses to any person caused by the above named person I choose to hire as my IHSS provider. I agree to hold harmless the State and County, their officers, agents, and employees, and take responsibility for any and all claims and/or losses to any person caused by the named person I choose to hire as my IHSS provider.

• I UNDERSTAND AND AGREE that the county can provide information about my authorized services and service hours to the provider named above.

RECIPIENT'S OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE:	DATE:
PRINTED NAME:	

If Applicable:

REQUEST TO DELETE A SERVICE PROVIDER:

Name of Provider to be deleted:	
Last 6 digits of Provider's Social Security #	
Last day Provider worked for you (month/day/year):	

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