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

IHSS RECIPIENT CASE NUMBER

RECIPIENT NAME (FIRST	MIDDLE	LAST)

PROVIDER NAME (FIRST MIDDLE LAST)	PROVIDER IDENTIFICATION NUMBER	HOURS ASSIGNED PER MONTH

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

COUNTY USE ONLY

COMMENTS

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