ATTN: IHSS Screener

Letter of Request for IHSS Services Authorization to A.R. FORM

Name_____

Address _____

DOB _____ SSN _____ _____ _____ Contact Number

Sex : Male ☐ Female ☐ **Language:** ☐ Armenian ☐ Russian ☐ Spanish ☐ other

The applicant is receiving SSI/CAPI benefits at this time? Yes☐ No☐ Has Medi-Cal

Living Arrangements : ☐ Self ☐ Relative ☐ Spouse ☐ Family

How many people at this address? _____

Reason for Seeking IHSS Assistance

Various medical problems. The applicant will provide medical verification of this need.

Please provide the applicant with the form needed so the applicant can have the doctor complete the form and the applicant will provide the county with the medical verifica-

Types of Assistance Needed

- ☐ Domestic Services
- ☐ Shopping for Food
- ☐ Doctor Visits
- ☐ Preparation of Meals
- ☐ Meal Cleanup
- ☐ Pers. Hygiene
- ☐ Dressing
- ☐ Feeding
- ☐ Ambulation
- ☐ Moving in and out of bed
- ☐ Respiration
- ☐ Bowel and Bladder
- ☐ Other Shopping & Errants
- ☐ Forgetful
- ☐ Disoriented
- ☐ Loses things
- ☐ Confusion
- ☐ Protective Services

Regarding Waiver of Confidentiality. PLEASE TAKE NOTICE that I hereby REFUSE to waive my rights to confidentiality. I also refuse to sign the HIPPA release of information form, also known as the Form 2099 series. Any signing of such forms will be obtained through coercion by DHS and they are invalid, void and immoral.

I, _____, hereby authorize _____, at _____ or any other person/attorney designated him or _____, to be my authorized representative in this matter or any other matter relative to my public assistance case, including the right to make statements on my behalf, or the filing for any fair hearing and the initiation of litigation.

This authorization shall also be construed as an authorization to release any and all information to _____ or any person designated by them, including an attorney.

I further authorize _____ or any other persons designated by them to apply for and represent me during all aspects of the application process or any other matter relative to the process of eligibility determination for any and all benefits that I and/or my family may be eligible for.

Dated: _____ **Signature of applicant** _____