IHSS Child Ranking Evaluation

Patient's Name _____ SSN _____ DOB _____

Date Patient last seen:____

Duration of the needs indicated below ☐ 3-month ☐ 6 months ☐ 1 year ☐ Indefinite

Please check the level of assistance needed	None	Able to perform the function, but needs verbal assistance, such a reminding, guidance.	Can perform the function with some human assis-tance including physical help for a provider.	Can perform the function but only with substantial human assistance.	Cannot perform the function with or without human assistance.	Other children of the same age do not routinely need this service.
1. Bathing, Oral Hygiene	☐	☐	☐	☐	☐	☐
2. Feeding	☐	☐	☐	☐	☐	☐
3. Bed Baths	☐	☐	☐	☐	☐	☐
4. Bowel & Bladder Care	☐	☐	☐	☐	☐	☐
5. Dressing	☐	☐	☐	☐	☐	☐
6. Reposition	☐	☐	☐	☐	☐	☐
7 Skin Care	☐	☐	☐	☐	☐	☐
8. Ambulation	☐	☐	☐	☐	✔	✔
9. Transferring from Bed	☐	☐	☐	☐	✔	✔

CERTIFICATION – I certify that I am licensed to practice in the State of California and that all information above is true and correct.

_____ _____ _____

Physician Signature MD Provide # Date

CCWRO 2018-11-IHSS