IHSS 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.	
1. Preparation of meals	☐	☐	☐	☐	☐	
2. Meal Clean-up	☐	☐	☐	☐	☐	
3. Feeding	☐	☐	☐	☐	☐	
4. Bed Baths	☐	☐	☐	☐	☐	
5. Bathing, Oral Hygiene	☐	☐	☐	☐	☐	
6. Dressing	☐	☐	☐	☐	☐	
7, Bowell & Bladder Care	☐	☐	☐	☐	☐	
8. Reposition	☐	☐	☐	☐	☐	
9. Skin Care	☐	☐	☐	☐	☐	
10. Transferring from Bed	☐	☐	☐	☐	☐	
11. Ambulation	☐	☐	☐	☐	☐	

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