IHSS Provider Change Request Form

CURRENT PROVIDER		
Recipient		
Provider		
NEW PROVIDER		
Recipient		
New Provider		
New Provider DOB		
New Provider SSN		
New Provider Address		
New Provider Phone		
New Provider Email		

Date: _____ Signatute_____

Authorization Form

I, _____, hereby authorize CCWRO & Kevin Aslanian, **1111 Howe Ave., Sacramento, Suite 635, CA 95825 • Tel. - 916-736-0616 •FAX - 916-736-2645** or any other person/attorney designated by him, to be my authorized representative, and to represent me, relative to my public social services matter, **or any other matter,** including the right to make statements on my behalf, or the filing for any fair hearing and the initiation of any litigation.

This authorization shall also be construed as an authorization to release any and all information to CCWRO or any person designated by them, including an attorney, to review my case file, including my IHSS case records.

I further authorize CCWRO 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_____