APPLICATION FOR SOCIAL SERVICES

TO THE APPLICANT: *This form is subject to verification.*
NOTE: *Retain your copy of this application.*

*** SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

CASE NUMBER:	DATE OF APPLICATION:

1. NAME			*SOCIAL SECURITY NUMBER
ADDRESS			SEX ☐ Male ☐ Female
CITY	ZIP CODE	TELEPHONE ( )	BIRTHDATE

2. Are you a veteran? ☐ Yes ☐ No	ARE YOU A SPOUSE/CHILD OF A VETERAN? ☐ Yes ☐ No	IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER:

3. Do you receive SSI/SSP benefits? ☐ Yes ☐ No	IF "YES", CHECK YOUR TYPE OF LIVING ARRANGEMENT: ☐ Independent Living ☐ Board and Care ☐ Home of Another
SERVICES BEING REQUESTED:	

4. Have you received In-Home Supportive Services (IHSS) in the past? ☐ Yes ☐ No If "YES", complete the following:		
DATE AND COUNTY WHERE SERVICE WAS LAST RECEIVED	TOTAL MONTHLY HOURS	NAME USED (IF DIFFERENT FROM ABOVE)

5. **LIST FAMILY MEMBERS IN HOUSEHOLD**	**BIRTHDATE**	***SOCIAL SECURITY NUMBER**
NAME OF SPOUSE ☐ NAME OF PARENT ☐		
CHILD/OTHER RELATIVE		
CHILD/OTHER RELATIVE		

6. The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.	
A. My ethnic origin is (*see reverse side for correct code):* ☐	B. I speak and understand English: ☐ Yes ☐ No My primary language is *(see reverse side for correct code:)* ☐

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1) Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2) Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3) Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4) Notifying the County IHSS office when I hire or fire a provider.

In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1) In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2) If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3) The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4) I will be responsible for paying for any services I receive that are not included in my IHSS authorization.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity, I may be subject to unannounced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

SIGNATURE OF APPLICANT:	DATE:
SIGNATURE OF APPLICANT'S REPRESENTATIVE: *(ONLY IF APPLICABLE)*	DATE: *(ONLY IF APPLICABLE)*
REPRESENTATIVE'S RELATIONSHIP TO APPLICANT: *(ONLY IF APPLICABLE)*	REPRESENTATIVE'S TELEPHONE NUMBER: *(ONLY IF APPLICABLE)* ( )
REPRESENTATIVE'S ADDRESS: *(ONLY IF APPLICABLE)*	

To report suspected fraud or abuse in the provision or receipt of IHSS services please call the fraud hotline 800-822-6222 or go to www.stopmedicalfraud@dhcs.ca.gov.

FOR AGENCY USE ONLY

INCOME ELIGIBLE:	STATUS ELIGIBLE:	VERIFICATION:	SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTATIVE:	TELEPHONE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO			( )

RECIPIENT STATUS:	SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS (*EXPLAIN)*
☐ Refugee ☐ Cuban/Haitian Entrant	

A. Ethnic Codes:

1. White
2. Hispanic
3. Black
4. Other Asian or Pacific Islander
5. American Indian or Alaskan Native
7. Filipino
C. Chinese
H. Cambodian
J. Japanese
K. Korean
M. Samoan
N. Asian Indian
P. Hawaiian
R. Guamanian
T. Laotian
V. Vietnamese

B. Language Codes:

O. American Sign Language (AMISLAN or ASL)
1. Spanish - NOA will be issued in Spanish
2. Cantonese
3. Japanese
4. Korean
5. Tagalog
6. Other non-English
7. English
9. Spanish - NOA will be issued in English
A. Other Sign Language
B. Mandarin
C. Other Chinese Languages
D. Cambodian
E. Armenian
F. Ilacano
G. Mien
H. Hmong
I. Lao
J. Turkish
K. Hebrew
L. French
M. Polish
N. Russian
P. Portuguese
Q. Italian
R. Arabic
S. Samoan
T. Thai
U. Farsi
V. Vietnamese