IN-HOME SUPPORTIVE SERVICES PROGRAM RECIPIENT AND PROVIDER WORKWEEK AGREEMENT

IHSS RECIPIENT CASE NUMBER

RECIPIENT NAME (FIRST, MIDDLE, LAST)

My total authorized hours are _____ per week and _____ per month.

I understand that I have to assign hours to my provider(s) which is why I must complete this form. This schedule helps to ensure that my provider(s) stay(s) within my monthly authorized hours. Under certain circumstances I may be able to adjust the hours I have assigned.

INSTRUCTIONS:

1. In Column A below, enter the **names** of all the providers you wish to receive services from.
2. In Column B below, enter the **identification number** of each of your providers.
3. In Column C below, enter the total hours assigned **per week** to each of your providers.
4. The TOTAL authorized hours per week for all of your providers (Column C) must add up to your total weekly authorized service hours.

A	B	C
PROVIDER NAME (FIRST, MIDDLE, LAST)	PROVIDER IDENTIFICATION NUMBER	HOURS ASSIGNED PER WEEK
1.		
2.		
3.		
4.		
5.		
RECIPIENT'S TOTAL AUTHORIZED HOURS		PER WEEK:

RECIPIENT ACKNOWLEDGMENT:

- I understand that by completing and submitting this form to the county In-Home Supportive Services (IHSS) program, I am requesting the IHSS program to assign the indicated number of my authorized hours to the named provider(s).

- I understand that I have received information on the workweek requirements and overtime limitations which I must follow.

- I understand that if I want the weekly assigned hours of my provider(s) to stay the same and the timesheets of my provider(s) to always be processed for the hours I have assigned to him/her, I will request and complete a Recipient Assignment of Authorized Hours to Providers (SOC 838) form and submit it to the county.

RECIPIENT SIGNATURE		DATE
AUTHORIZED REPRESENTATIVE (IF RECIPIENT CANNOT SIGN ON THEIR OWN BEHALF)	RELATIONSHIP TO RECIPIENT	TELEPHONE NUMBER
SIGNATURE OF AUTHORIZED REPRESENTATIVE		DATE

PROVIDER ACKNOWLEDGMENT:

- I understand that by signing this form I agree to work the number of authorized hours assigned to me on this form.
- I understand that I must follow the program requirements that are stated on the Provider Enrollment Agreement (SOC 846).

1. PROVIDER SIGNATURE	DATE
PROVIDER #1 PRINTED NAME	TELEPHONE NUMBER

2. PROVIDER SIGNATURE	DATE
PROVIDER #2 PRINTED NAME	TELEPHONE NUMBER

3. PROVIDER SIGNATURE	DATE
PROVIDER #3 PRINTED NAME	TELEPHONE NUMBER

4. PROVIDER SIGNATURE	DATE
PROVIDER #4 PRINTED NAME	TELEPHONE NUMBER

5. PROVIDER SIGNATURE	DATE
PROVIDER #5 PRINTED NAME	TELEPHONE NUMBER

FOR COUNTY USE ONLY

WORKER NAME (FIRST MIDDLE LAST):	WORKER PHONE: