IN-HOME SUPPORTIVE SERVICES PROGRAM RECIPIENT AND PROVIDER WORKWEEK AGREEMENT

IHSS RECIPIENT CASE NUMBER

RECIPIENT NAME (FIRST, MIDDLE, LAST)

My total authorized hours are _____.

My total monthly authorized hours will now be divided by 4 to determine my maximum weekly hours. My maximum weekly hours are _____. Under certain circumstances, I may be able to adjust my weekly authorized hours which will allow me to give more hours in one week than I normally give to use, as long as I use less hours in another week.

I understand that this form is a tool to help me schedule hours for my provider(s). This schedule helps me to ensure that my provider(s) stay(s) within my monthly authorized hours.

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 provider number of each of your providers. (The number is located on the timesheet.)
3. In Column C below, enter the total maximum hours assigned per week to each of your providers.
4. The TOTAL maximum weekly hours for all of your providers (Column C) must add up to your total weekly maximum service hours.

A	B	C
PROVIDER NAME (FIRST, MIDDLE, LAST)	PROVIDER NUMBER	HOURS ASSIGNED PER WEEK
1.		
2.		
3.		
4.		
5.		
RECIPIENT'S TOTAL MAXIMUM WEEKLY 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 scheduling authorized hours to the named provider(s).

- I understand that it is my responsibility to make a schedule for each provider so that the total hours worked by all of my providers do not exceed my maximum weekly hours or monthly authorized hours.

- I understand that in certain circumstances I can adjust my authorized weekly hours but that my monthly authorized hours do not change unless I receive a new Notice of Action with a new authorization by the county.

- I understand that my providers will not be paid by the IHSS program for any excess hours if the number of hours they provide services for me exceeds my monthly authorized hours. If my providers work more than my monthly authorized hours or provide services not authorized by the IHSS program, it is my responsibility to pay for those additional hours or services.

- 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

RECIPIENT NAME (FIRST, MIDDLE, LAST)

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 the work schedule and work no more for the recipient than the hours assigned to me, unless he/she adjusts the schedule of hours.

- I understand that if more than the recipient's authorized monthly hours are worked, those services are not considered IHSS and it will not be paid by the IHSS program. It is the responsibility of my recipient to provide payment for those additional hours. The IHSS program only pays for IHSS program authorized hours and services.

- 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 AND PROVIDER NUMBER	TELEPHONE NUMBER
2. PROVIDER SIGNATURE	DATE
PROVIDER #2 PRINTED NAME AND PROVIDER NUMBER	TELEPHONE NUMBER
3. PROVIDER SIGNATURE	DATE
PROVIDER #3 PRINTED NAME AND PROVIDER NUMBER	TELEPHONE NUMBER
4. PROVIDER SIGNATURE	DATE
PROVIDER #4 PRINTED NAME AND PROVIDER NUMBER	TELEPHONE NUMBER
5. PROVIDER SIGNATURE	DATE
PROVIDER #5 PRINTED NAME AND PROVIDER NUMBER	TELEPHONE NUMBER

FOR COUNTY USE ONLY

WORKER NAME (FIRST MIDDLE LAST):	WORKER PHONE: