COYOTE VALLEY TRIBAL HEALTH AND HUMAN SERVICES DEPARTMENT
IN HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
ELDER CARE ASSISTANCE
TO THE APPLICANT: *This form is subject to verification.*
NOTE: *Retain your copy of this application.*

	DATE OF APPLICATION
1. NAME	SOCIAL SECURITY NUMBER
ADDRESS	SEX □ MALE □ FEMALE
CITY STATE ZIP CODE TELEPHONE	BIRTHDATE

2. ARE YOU EMPLOYED □ YES □ NO	IF "YES" GIVE NAME, PHONE NUMBER AND ADDRESS OF EMPLOYER

3. ARE YOU A TRIBAL MEMBER □ YES □ NO

4. ARE YOU ELIGIBILE FOR MEDICARE □ YES □ NO If yes please attach Medicare eligibility determination.

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.
2) Ensuring the total hours reported by my provider does not exceed authorized hours.
3) Referring any individual I want to hire to the Coyote Valley Tribal Health and Human Services Department to complete the provider eligibility process.
4) Notifying the Coyote Valley Tribal Health and Human Services Department 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 may receive letters identifying program requirement concerns from the Coyote Valley Tribal Health and Human Services Department.

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

Signature of Applicant	Date