

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM

HEALTH CARE CERTIFICATION FORM

SW# X8A1

A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name: KALEB XIONG		Date of Birth: 03/13/2020
Address: 9582 Village Tree Dr, Elk Grove, CA 95758-1198		
County of Residence: Sacramento	IHSS Case #: 1951916	
IHSS Worker Name: GLENDA BLAND ihss email: dcfas-sas-ihss-elig@saccounty.gov		
IHSS Worker Phone #: 916-874-9471	IHSS Worker Fax #: 916-854-8828	

B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (To be completed by the applicant/recipient)

I, KALEB XIONG _____, authorize the release of health care information
(PRINT NAME)
related to my physical and/or mental condition to the In-Home Supportive Services program as it
pertains to my need for domestic/related and personal care services.

Signature:  _____ Date: 08 / 08 / 2023
(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

Witness (if the individual signs with an "X"): _____ Date: ____ / ____ / ____

TO: LICENSED HEALTH CARE PROFESSIONAL* –

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This health care certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual's present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

**Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.*

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM HEALTH CARE CERTIFICATION FORM

Applicant/Recipient Name: KALEB XIONG
 IHSS Case #: 1951916

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.

1. Is this individual <u>unable</u> to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<p><i>If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below, and complete the rest of the form including the certification in PART D at the bottom of the form.</i></p> <p><i>If you answered "YES" to both Question #1 AND #2, respond to Questions #3 and #4 below, and complete the certification in PART D at the bottom of the form.</i></p>	
3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program: Patient is legally blind. Needs assistance with eating, bathing, dressing, and other instrumental activities (play time, learning) for age.	
4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months OR expected to result in death within 12 months?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.): MEDICAL TREATMENT

6. How long have you provided service(s) to this individual? since 2/10/2021

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.): every 6 to 12 months

8. Indicate the date you last provided services to this individual: 1 / 2023

NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and all information provided above is correct.

Name: IRMA MUMINOVIC, MD Title: MD

Address: 1600 FORREKA ROAD, BUILDING C, MOB 2

Phone #: (916) 784-4185 Fax #: (916) 474-2714

Signature: [Signature], MD Date: 8/15/2023

Professional License Number: 24 A 158 138600 Licensing Authority: THE MEDICAL BOARD OF CALIFORNIA

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.