IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM ACCOMPANIMENT TO MEDICAL APPOINTMENT

Date:

Recipient Name:
Case Number:

Dear Licensed Health Care Professional:

This patient/IHSS recipient has stated that he/she needs assistance to attend medical appointments. You are asked to indicate on this form the frequency that this patient is seen in a year (weekly, monthly, bi-annually, etc.) and the typical duration of those appointments (15, 20, 30, 60 minutes).

Assistance by the IHSS provider is available for transportation when the recipient's presence is required at the destination and such assistance is necessary to accomplish the travel to and from appointments with physicians, dentists and other health practitioners. Medical Accompaniment **is <u>not</u> intended** for the purpose of transportation to a medical facility, rather it shall only be authorized when the recipient needs assistance to accomplish the travel.

In order to assist the social worker in assessing this service, please complete the following information and return it to the county office.

PRIMARY CARE PHYSICIAN-NAME AND TITLE:	TELEPHONE NUMBER:	SIGNATURE/DATE:
TYPE OF PRACTICE:	FREQUENCY OF APPOINTMENTS PER YEAR:	DURATION/LENGTH OF TIME OF THE APPOINTMENT:

OTHER MEDICAL PROVIDER:	TELEPHONE NUMBER:	SIGNATURE/DATE:
TYPE OF PRACTICE:	FREQUENCY OF APPOINTMENTS PER YEAR:	DURATION/LENGTH OF TIME OF THE APPOINTMENT:

OTHER MEDICAL PROVIDER:	TELEPHONE NUMBER:	SIGNATURE/DATE:
TYPE OF PRACTICE:	FREQUENCY OF APPOINTMENTS PER YEAR:	DURATION/LENGTH OF TIME OF THE APPOINTMENT:

RETURN TO: (COUNTY WELFARE DEPARTMENT)
(Add county address here)

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