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). Additionally you are asked to indicate what type of assistance is needed to support the patient at the appointment and whether your medical staff **is or is not** able to perform this assistance. Examples of this would be assisting the patient in getting to the exam room, undressing and dressing and help with getting onto or providing support to the patient on the exam table.

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 not intended** for the purpose of transportation to a medical facility, rather it shall only be authorized when the recipient needs assistance with specific IHSS tasks during the appointment.

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

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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:
TYPE OF ASSISTANCE NEEDED:		

SPECIALIST NAME AND TITLE:	TELEPHONE NUMBER:	SIGNATURE/DATE:
TYPE OF PRACTICE:	FREQUENCY OF APPOINTMENTS PER YEAR:	DURATION/LENGTH OF TIME OF THE APPOINTMENT:
TYPE OF ASSISTANCE NEEDED:		

LAB NAME:	TELEPHONE NUMBER:	SIGNATURE/DATE:
PURPOSE OF VISIT:	FREQUENCY OF APPOINTMENTS PER YEAR:	DURATION LENGTH OF TIME OF THE APPOINTMENT:
TYPE OF ASSISTANCE NEEDED:		

DENTIST NAME:	TELEPHONE NUMBER:	SIGNATURE/DATE:
PURPOSE OF VISIT:	FREQUENCY OF APPOINTMENTS PER YEAR:	DURATION/LENGTH OF TIME OF THE APPOINTMENT:
TYPE OF ASSISTANCE NEEDED:		

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

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

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