COYOTE VALLEY TRIBAL HEALTH AND HUMAN SERVICES DEPARTMENT
IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
ELDER CARE ASSISTANCE
RECIPIENT DESIGNATION OF PROVIDER

INSTRUCTIONS:

- You must fill out both sides of this form to let the Coyote Valley Tribal Health and Human Services Department know who you have chosen to provide your services.
- You must sign the declaration at the bottom to show that you understand and agree to all of the terms and conditions listed.
- Please return this form to the Coyote Valley Health and Human Services Department
- You must notify the Coyote Valley Tribal Health and Human Services Department prior to changing providers.

1. Recipient's Name:	
2. Provider's Name	
3. Provider's Address: City, State, ZIP Code:	
4. Provider's Telephone Number:	
5. Provider's Date of Birth:	
6. Provider's Gender (check box):	□ Male □ Female
7. Provider's Relationship to Recipient (if any):	□ Parent □ Child □ Spouse/Domestic Partner □ Conservator □ Guardian □ Other:_____

RECIPIENT DECLARATION

- I declare that the person named above is my choice to provide IHSS for me as authorized by the Coyote Valley Health and Human Services Department

  I understand that the above-named person cannot be paid for any services provided to me until he/she has completed the entire provider enrollment process, which includes completing, signing and returning the contractor agreement, request for taxpayer identification number and certification (w-9) and submitting proof of identification and social security card.

- I understand that I will be informed by the department if the person, I have chosen to be my provider does not complete the provider enrollment process or if he/she determined ineligible to be a provider.

- I understand that if I choose to receive services from this person before he/she is enrolled as a provider, or after I have been informed that he/she is ineligible, I will be responsible for paying him/her with my own money.

- I understand and agree that the county can provide information about my authorized services and service hours to the provider named above.

RECIPIENT'S SIGNATURE	DATE:
PRINTED NAME	