SAN LUIS OBISPO COUNTY DEPARTMENT OF SOCIAL SERVICES
IN-HOME SUPPORTIVE SERVICES
RECIPIENT-PROVIDER STATEMENT OF RESPONSIBILITIES

Service Worker Bill Richardson Telephone No. 549-4117

I. RECIPIENT DATA

Name Beal, Arthur Case No. 40-01606278
Address 881 Hillcrest Phone No.
City Cambria, CA Zip 93428

II. PROVIDER-EMPLOYEE DATA

Name Rosas, Maria Soc.Sec.No. 555-33-6943
Address P.O. Box 62 Phone No. 927-4308
City Cambria, CA Zip 93428 Birthdate 10/06/70 M F
Relationship to Recipient Independent Provider

III. CONDITIONS OF EMPLOYMENT

Starting Date 10/16/90 Rate of Pay $ 4.25 Per Hour
Share of Cost to be paid directly to the provider by the recipient is $ 0 Per Mo.

INCREASE OCTOBER TOTAL MONTHLY HOURS 88.0
NOVEMBER TOTAL MONTHLY HOURS 98.0

IV. SPECIFIC TASKS TO BE DONE BY THE PROVIDER

Domestic Services/Hours Per Month
6.00 Housekeeping

Related Services/Hours Per Week
7.00 Prepare Meals
2.00 Meal Clean-up, Menus
1.50 Routine Laundry, Mending
1.00 Shopping for Food
.50 Other Shopping Errands

Transportation Services/Hours Per Week
.50 Medical
Alternative Resources

Other Tasks/Hours Per Week
Specify

Personal Care Services/Hours Per Week
Respiration Assistance
2.50 Bowel, Bladder Care
Feeding
5.00 Routine Bed Baths
Dressing
Menstrual Care
1.25 Ambulation
Moving In/Out of Bed
Bathing, Oral Hygiene/Grooming
Skin Care, etc.
Care/Assistance with Prothesis

STATEMENT OF AGREEMENT

The Recipient agrees to hire the Provider-Employee to perform the services authorized in Section IV. above. The Recipient is responsible for paying the Provider the Share of Cost amount, if any, given in Section III.

The Provider-Employee agrees to perform the tasks specified in Section IV. The Provider understands that he/she is an employee of the Recipient and is NOT an employee of San Luis Obispo County nor the State of California. The Provider understands that the State of California issues the paycheck on behalf of the Recipient for services authorized and completed (not advance pay).

THE RECIPIENT AND PROVIDER UNDERSTAND THE STATE WILL NOT PAY FOR WORK DONE WHEN THE RECIPIENT IS IN A HOSPITAL, NURSING HOME OR OTHER MEDICAL FACILITY. ANY SUCH TIME PAID IS SUBJECT TO CIVIL COLLECTION PROCEDURES.

The Recipient and Provider agree to complete, sign and mail a time sheet for each pay period that is a true and correct statement of time worked under the IHSS Program to the San Luis Obispo County Department of Social Services, not to exceed the time in IV. above.

CONFIDENTIALITY: Anything transpiring within the client's household will be held as confidential and not discussed with anyone outside of the Social Services Agency.

All terms on the front and back of this page have been read, understood and agreed to by the undersigned.

Recipient/Authorized Representative Date

Maria G. Rosas 11/1/90
Provider/Employee Date

DSS 391 (NEW 6/87) [0575F]

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