



IHSS Provider Employment Verification Request Form

County of Santa Barbara and Department of Social Services In-Home Supportive Services (IHSS) or IHSS Public Authority are not the employer for IHSS providers. However, verification that the care provider has been employed by one or more IHSS recipients can be provided.

****Please allow up to 7 business days to process your request.****

This form must be completed (Sections I-V) and signed by the IHSS provider for all employment verifications. A third party (i.e. Lenders, Housing Authority) may use their own form but must be accompanied with a signed authorization from IHSS provider with full SSN listed. Verifications can only be faxed or mailed. There is no "pick-up" option available.

The **only** employment information that we can verify for IHSS providers is:

- Start Date
- Job Title
- Hourly Wage
- Total gross year-to-date income for current year only
- Last pay-period date, and if terminated

Information that **will not** be provided:

- Letters of termination or reasons
- Verbal verifications
- Number of hours worked, assigned, or overtime hours
- Employment verification for another County
- Additional dates or additional historical information
- Verification of wages or employment status pertaining to a specific IHSS recipient (all wages will be combined)
- Pay Stubs
- Additional dates, re-verification, or any other information
- IHSS Recipient names or case numbers
- Projected amounts

Please note:

1. All requests should be submitted via US mail or fax only. No drop-off.
2. If seeking year-to-date information on prior years, the IHSS Provider must request a W-2 from the Internal Revenue Service (IRS).
3. Electronic & Digital signatures are not accepted.
4. If the form is incomplete, completed incorrectly or illegible, there could be a delay or we may not be able to process your request.
5. If the requested verification will be returned to the care provider, the address above must match the current address on file. To change your address and/or phone number on file, you must also submit the Address/Phone Number Change (SOC 840) form.



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Please read the information and instructions on first page of this form before completing.

****Allow up to 7 business days for processing****

Section I. IHSS Provider Information

Full Name

Social Security Number

Phone

Section II. IHSS Provider Release of Information

I have read and understand the instructions for completion of this form. I hereby authorize County of Santa Barbara Department of Social Services – IHSS Public Authority to release verify my IHSS employment and/or wage information to the individual, agency, or business indicated below. This authorization will expire after (1) calendar year.

IHSS Provider Signature

Date

Section III. Requestor Information

Check this box if you are the IHSS provider

Name of Agency or Business
requesting verification

Address

Phone

Email address

Fax

Section IV. Wage Verification/Payment History Request

(check box for requested information)

Start Date:

Job Title:

Payment Summary

from: (date)

to: (date)

Year-to-Date
Total Gross:

Hourly Wage:

Last Pay Period:

Terminated? Yes / No

Office Use Only

Completed by (name):

Title:

Phone number (direct line):

Date:

Fax requests to IHSS Public Authority (805) 346-7601

OR mail completed form to IHSS Public Authority at

304 Carmen Ln, Santa Maria CA, 93458