



County of Riverside Department of Public Social Services  
 In-Home Supportive Services (IHSS) Public Authority  
 12125 Day St., Suite S-101, Moreno Valley, CA 92557  
 Phone: (888) 470-4477 or (951) 321-6160  
 Fax: (951) 686-1419 or 951-779-3053

Tape government issued ID here & make copy for IP to complete.

## Home Care Provider Verification of Employment (VOE) Request Form

This form is to be used when an In-Home Supportive Services (IHSS) home care provider is requesting to obtain verification of employment to the IHSS program.

### Requestor/IHSS Provider Information (please complete entire form)

PROVIDER FULL NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 STREET CITY ZIP  
 TELEPHONE NUMBER: \_\_\_\_\_ ALT. TELEPHONE NUMBER: \_\_\_\_\_

**PLEASE NOTE: A new signed form must be completed for every verification of employment request.**

### Information Being Requested:

For assistance regarding verbal verification of employment and/or paystub images (up to 4 images in total) please contact the IHSS HOME Call Center at 1-888-960-4477 or Public Authority Call Center at 1-888-470-4477. Paystub images will be sent by mail.

#### Salary/Income Report

Please specify below the time frame needed

From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_  
 Month Year Month Year

#### Response Method:

\_\_\_ FAX to: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Attention: \_\_\_\_\_  
 Name of Company: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_ MAIL to the Address Listed Above

### Reason for Request (Check the box applicable):

- Self (Personal Record)
- Housing Authority
- Social Security Administration (SSA)
- Dept. of Public Social Services (DPSS) (i.e. Medical, Food Stamps, Cal-Works)
- Other (specify): \_\_\_\_\_
- Apartment
- Lender
- Employment Development Dept. (EDD)

### AUTHORIZATION:

A signed and dated *Request for IHSS Provider Record* must be received by the Public Authority before any request is processed. This form may be faxed to (951) 686-1419.

*I authorize the County of Riverside IHSS Public Authority to release my IHSS employment information.*

PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_