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.

REQUEST FOR IHSS PROVIDER RECORD

This form is to be used when a home care provider is requesting to obtain copies of his or her own records pertaining to In-Home Supportive Services enrollment or payment.

Requestor/IHSS Provider Information (please complete entire form)

PROVIDER FIRST NAME: _____ PROVIDER LAST NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

STREET CITY ZIP

TELEPHONE NUMBER: _____ ALT. TELEPHONE NUMBER: _____

RECORD REQUEST: ***A new signed form must be completed for every record request.***

Information Being Requested:

(Same day processing time) *Not a Verification of Employment*

___ Dates/Period of Employment **(No salary or authorized hours information)**

___ Paycheck Stub images (**up to 6 images**)
Pay Period From: _____ To:_____

___ Timesheet images (**up to 6 images**)
Pay Period From: _____ To: _____

Response Method:

___ PICK UP at IHSS District Office:_____

___ PICK UP at Public Authority Office

___ Mail to the Address Listed Above

(10 business day processing time) *Verification of Employment*

____ Salary/Income Report

Please specify the period being requested:
From: _____/_____ To: _____/_____
Month Year Month Year

Format the report based on Annual: ___ Pay Period:___ Monthly:___

Response Method:

___ PICK UP at IHSS Public Authority Office

___ FAX to: ( ) _____ - _____
Attention: _____
Name of Company:_____

___ MAIL to the Address Listed Above

(15 business day processing time)

____ IHSS Enrollment Forms

Response Method:

PICK UP at IHSS Public Authority Office only

Reason for Request (Check the box applicable):

□ Department of Public Social Services (DPSS) □ Housing Authority □ Lender
□ Social Security Administration (SSA) □ Employment Development Dept. (EDD) □ Apartment
□ Other (specify): _____

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 Public Authority to produce the records as specified above.

PROVIDER SIGNATURE: _____ DATE: _____