**City and County of San Francisco** **Department of Aging and Adult Services**

**In-Home Supportive Services Independent Provider Assistance Center (IPAC)**
77 Otis Street San Francisco, CA 94103 Office: 415-557-6200 l Fax: 415-557-5813 www.sfhsa.org

# Employment/Income Verification Release Form

**Please read the instructions on the back of this form before completing this form.**
**To request verification of employment or income, please complete this form. If this form is completed by an individual other than the IHSS provider, a signed authorized release of information is required for the release of employment/income verification.**

| **Section I. IHSS Provider Information** | |
|---|---|
| Last, First Name | |
| Social Security Number | Phone Number |

| **Section II. Requester Information** | |
|---|---|
| Name of Individual, Agency, or Business requesting verification. | |
| Address | Verification Period (MM/YY):<br>From To |
| Fax Number (if applicable) | Fax to the Attention of : |

| **Section III. Delivery Method.** | |
|---|---|
| Please check one of the following options: | |
| ☐ PICK-UP VERIFICATION (Provider only). Photo ID is required. | ☐ FAX VERIFICATION to phone number listed in Section II. |
| MAIL VERIFICATION TO: ☐ Myself (Provider) ☐ Business or Agency listed in Section II. | |

| **Section IV. Release of Information.** | |
|---|---|
| *I hereby authorize the IHSS IPAC to release the information indicated above to the individual, agency or business.* | |
| **Provider Signature** | **Date** |

Fax completed form to 415-557-5813

# Instructions for Completing the Employment/Income Verification Release Form, Form IPAC 01-17

To request verification of In-Home Supportive Services (IHSS) employment or income, please complete the **Employment/Income Verification Release Form, Form IPAC 01-17**. Please allow up to **ten calendar days** from the receipt date for processing.

## Section I. IHSS Provider Information

In this section, enter the IHSS provider's last and first name, social security number, and phone number.

## Section II. Requester Information

In this section, enter the individual, agency, or business requesting the information, including the address and fax number. If the requester is the IHSS provider, enter their name and address.

If the requester is an individual other than the IHSS provider, **Section IV must be signed by the provider.**

## Section III. Delivery Method

In this section, select one of the following delivery methods:

- Request pick-up in the office. Only the IHSS provider may pick up his/her verification. **Photo identification is required.**
- Fax the verification. Verification will be faxed to the fax number in Section II.
- Mail the verification. If the provider is requesting verification be sent to him/her-self, employment/income verifications will be mailed to the address that is currently in the Payroll System. If there is a change of address or telephone number, the change of address form, **IHSS Program Provider or Recipient Change of Address/Telephone Number, SOC 840 must be completed and returned to the IHSS payroll unit.**

The IHSS Independent Provider Assistance Center (IPAC) shall process the request within **ten calendar days** from the receipt date. The requester shall receive a completed **Employment/Income Verification** that may include all or some of the following:

- IHSS Provider's name, current address, and job title
- Date of Hire/Date of Termination
- Service period, warrant issue date, warrant status, warrant number (when applicable)
- Gross income per pay period, net income per pay period, and number of hours worked
- Gross year to date income
- Other additional permissible information requested by requesting agency