



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
 E-mail: IHSSPACOR@rivco.org
 FAX: (951) 686-1419

FOR COUNTY USE ONLY
 Attach image of government-issued ID here

Home Care Provider Verification of Employment (VOE) Request Form

This form must be completed for In-Home Supportive Services (IHSS) home care provider requesting verification of employment from the IHSS program. Please allow **7 business days** for processing. Multiple inquiries will delay processing. County of Riverside VOE responses are effective for 90 days. Due to processing volume, we do not reissue results or re-verifications within that 90-day period.

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

FULL SOCIAL SECURITY NUMBER: _____

PROVIDER FULL NAME: _____

ADDRESS:

STREET _____

CITY _____

STATE _____

ZIP _____

TELEPHONE NUMBER: _____

ALT TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

Requested Information

NOTE: A new signed form must be completed for each verification of employment request.

For questions regarding verification of employment, contact the IHSS HOME Call Center at 1-888-960-4477

Salary/Income Report

Specify the time frame needed:

From: _____ / _____ To: _____ / _____

Without Salary/Income Report

REQUESTED RESPONSE METHOD

Same as Requestor/IHSS Provider Information

FAX: (_____) _____ - _____

Attention: _____

Company Name: _____

E-mail: _____

VOE will be emailed using a secured site

Reason for Request (Check applicable box):

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

AUTHORIZATION

A signed and dated Request for IHSS Provider Record must be received by the Public Authority before any request is processed. A copy of provider's government issued ID is required with this form. This form can be emailed to IHSSPACOR@rivco.org

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

PROVIDER SIGNATURE: _____

DATE: _____