**IN-HOME SUPPORTIVE SERVICES (IHSS)**

**EMPLOYMENT VERIFICATION (EV)**

**PROCESSING INFORMATION**

Employment Verification (EV) requests are processed within **four to six business days** from the **date the request is received by the Public Authority (PA)**. Allow four to six business days to pass prior to calling the PA to check the status of your EV request. If you have not received your EV response by the 6th business day, contact the PA at 1-866-985-6322 and select option 2.

The IHSS Electronic Supportive Services Portal (ESP) provides access to view up to six months of prior paycheck information. To register to use the ESP website, go to [www.etimesheets.ihss.ca.gov](https://www.etimesheets.ihss.ca.gov/login) to set up an account.

**Note:** On-the-spot and same-day EV requests cannot be processed. The PA does not provide verbal EV information to outside agencies unless an EV form has been previously completed.

**Instructions to Staff**: Give this page to the provider and retain the second page.

**SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS)**

**VERIFICACIÓN DE EMPLEO (EV)**

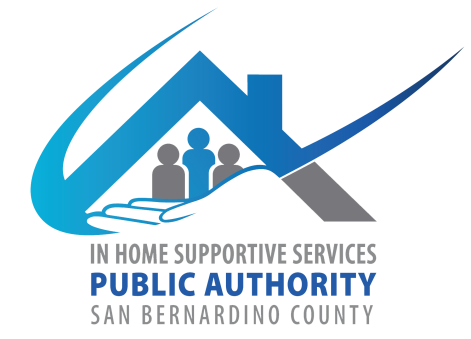
**INFORMACIÓN DE PROCESAMIENTO**

Las solicitudes de Verificación de Empleo (EV) se procesan en un plazo de **cuatro a seis días laborales** a partir **de la fecha en que la solicitud fue recibida por la Autoridad Pública (PA)**. Permita de cuatro a seis días laborables antes de llamar al PA para comprobar el estado de su solicitud de EV. Si no ha recibido su respuesta EV antes del sexto día laboral, póngase en contacto con la PA al 1-866-985-6322 y seleccione la opción 2.

El Portal Electrónico de Servicios de Apoyo (ESP) de IHSS proporciona acceso para ver hasta seis meses de la información del sueldo previa. Para registrarse para usar el sitio de web de ESP, vaya a [www.etimesheets.ihss.ca.gov](https://www.etimesheets.ihss.ca.gov/login) para crear una cuenta

**Nota:** Solicitudes inmediatas y del mismo-día de EV no se pueden procesar. El PA no proporciona información verbal sobre EV a agencias externas a menos que se haya completado previamente un formulario EV.

**Instrucciones para el personal**: Entregue esta página al proveedor y retenga la segunda página.



784 E. Hospitality Lane

San Bernardino, CA 92415-0034

Business: (909) 386-5014 • TTY: (909)891-9135

Toll Free: (866) 985-6322 • Fax: (909)891-9130

Email: [IHSSProviderEV@hss.sbcounty.gov](mailto:IHSSProviderEV@hss.sbcounty.gov)

***PROVIDER EMPLOYMENT VERIFICATION REQUEST***

***AND AUTHORIZATION TO RELEASE INFORMATION***

*PROCESSING TIME WILL BE 4 TO 6 BUSINESS DAYS*

***Client names are not provided in employment verification due to confidentiality.***

**Please provide a copy of your valid government issued identification when submitting this form.**

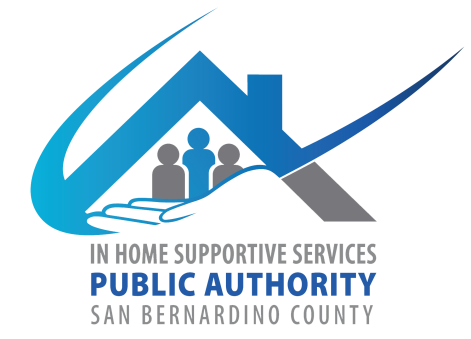
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Is this Employment Verification Request for the Transitional Assistance Department? Yes**  **No** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***1. Please provide the following information about yourself.*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | |  | | | | | | |  | | | | | | | | |
|  | | First Name | | | | | | | | |  | | | | | | | Last Name | | | | | | | | |
| Provider Social Security Number: | | | | | | | | –     – | | | | | **(Required)** | | | | | | | | | | | | | | | |
| Phone Number: | | | | | | (     )      – | | | **(Required)** | | | | | | | | | | | | | | | | | | | |
| ***2. Please provide the information you want included on your employment verification.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Income printout (No more than 3 years) | | | | | | | | | |  | | | | | | | | | | thru | | | | |  | | | |
|  |  | | | | | | | | | Month/Year | | | | | | | | | |  | | | | | Month/Year | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Letter indicating start date(s)/end date(s) | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Other (please specify): | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| ***3.Return my completed request via (select one of the following):*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email: | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | |
| Email Address | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | |
| Mail | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Attention: | | | | |  | | | | | | | | | |  | | | |  | | | | | | | | | |
|  | | | | | First Name | | | | | | |  | | | | Last Name | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| City: | | |  | | | | | | | | | | | State: | | |  | | | | | Zip: | |  | | | |

|  |
| --- |
| **I,** **hereby authorize San Bernardino County, Public Authority,**  **In-Home Supportive Services (IHSS) to release my employment history**. |

|  |  |  |  |
| --- | --- | --- | --- |
| **X** |  |  |  |
|  | **Signature** |  | **Date** |

**ID checked and accepted by DAAS/PA staff:**

*Printed staff name*



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***SOLICITUD DE VERIFICACIÓN DE EMPLEO DEL PROVEEDOR DE IHSS Y***

***AUTORIZACION PARA DIVULGAR INFORMACION DE EMPLEO***

*El TIEMPO DE PROCESAMIENTO SERA DE 4 A 6 DIAS LABORALES*

***Debido a la confidencialidad, los nombres de los clientes no serán proporcionados.***

**Por favor proporcione una copia de su identificación válida emitida por el gobierno al enviar este formulario.**

|  |  |  |  |
| --- | --- | --- | --- |
| **¿Es esta Solicitud de Verificación de Empleo para el Departamento de Asistencia Transitoria? Sí**  **No** | | | |
| 1. ***Por favor proporcione la siguiente información sobre usted mismo.*** | | | |
| Nombre: |  |  |  |
| Nombre |  | Apellido |

|  |  |  |
| --- | --- | --- |
| Proveedor Número de Seguro Social: | –     – | **(Requerido)** |

|  |  |  |
| --- | --- | --- |
| Número de Teléfono | (     )      – | **(Requerido)** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. ***Por favor proporcione la información que desea incluir en su verificación de empleo.*** | | | | | |
| Ingreso por el periodo de (Máximo 3 años) | | |  | hasta |  |
|  |  | | Mes(es)/Año(s) |  | Mes(es)/Año(s) |
| Carta indicando la(s) fecha(s) de inicio/fecha(s)de finalización | | | |  | |
|  | | | |  | |
| Otra (por favor especifique): | |  | | | |

|  |
| --- |
| 1. ***Devolver mi solicitud completa a través de (Seleccione una de las siguientes opciones):*** |

|  |  |  |  |
| --- | --- | --- | --- |
| Correo Electrónico: |  |  | |
| Correo Electrónico | |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Correo | |  | | | | | | |
| A la atención de: | |  |  | |  | | | |
| Dirección: | | Nombre |  | | Apellido | | | |
|  | | | | | | |
| Ciudad: |  | | |  | |  |  |  |
|  | | | Estado: | |  | Código Postal: |  |

|  |
| --- |
| **Yo,       por lo presente autorizo a la Autoridad P**ú**blica de IHSS del Condado de San Bernardino divulgar mi historial de empleo**. |

|  |  |  |  |
| --- | --- | --- | --- |
| **X** |  |  |  |
|  | **Firma** |  | **Fecha** |

**ID checked and accepted by DAAS/PA staff:**

*Printed staff name*