IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM AND WAIVER PERSONAL CARE SERVICES (WPCS) PROGRAM LIVE-IN SELF-CERTIFICATION FORM FOR FEDERAL AND STATE TAX WAGE EXCLUSION

Provider Name	Recipient Name
Provider Number	Recipient Case Number
County Of Residence	

ALL INFORMATION MUST BE COMPLETED IN ENGLISH.
SEE PAGE 2 FOR INSTRUCTIONS.

Provider Self-Certification

By completing this form, you are certifying that the wages you receive for providing IHSS and/or WPCS services to the recipient named above will be excluded from your federal and state personal income taxes.

Under penalties of perjury, I declare that I am a provider receiving payments under the IHSS and/or WPCS programs for care I provide to _____, who lives with me in the same home.

Provider Signature:	Date of Signature:

RETURN COMPLETED FORM TO:

IHSS – IRS Live-In Self-Certification
P.O. Box 1677
West Sacramento, CA 95691-6677

Instructions for filling out the Live-In Self-Certification Form

1. All requested information must be entered in English on the form in the designated area.

2. You must sign the form on the designated line.

3. You must provide the date the form was signed on the designed line.

4. Only use black ink and please print clearly.

5. Do not wrinkle or staple the form.

6. Provider Name: Enter your name as it appears on your IHSS paperwork.

7. Provider Number: May be found on your IHSS paperwork – (Provider Notification of Recipient Authorized Hours and Services and Maximum Weekly Hours, Provider Timesheet, etc.).

8. Recipient Case Number: May be found on your IHSS paperwork – Provider Notification of Recipient Authorized Hours and Services and Maximum Weekly Hours, Provider Timesheet, etc.

9. Recipient County of Residence: Please enter the county where you and your Recipient reside.