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.