NOTICE OF FORM CHANGE NO. 03-056

DATE
5/28/03

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ District Attorney
☐ Private and Public Adoption Agencies
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE
SOC 412 (8/02) In-Home Supportive Services Employee's Claim For Worker's Compensation Benefits Notice Of Potential Eligibility For Benefits

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
SET	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM 8/02	REPLACES 9/94	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted

REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval

☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:

Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ OTHER:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☐ Use until exhausted
☒ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☒ Use new form effective immediately.

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached are a Reproducible Copies

The headers at the top of this form were updated to read "State of California - Health and Human Services Agency" and "California Department of Social Services". Also, the first two digits of the space for the year to be entered on the "I gave this form to the county IHSS worker on (date)" line were changed from "19" to "20". These were the only changes to this form from the 9/94 version.

Check on the Internet to see if forms are available at www.dss.cahwnet.gov.

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
IN-HOME SUPPORTIVE SERVICES PROGRAM

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

Distribution:

White	-	State Compensation Insurance Fund
Yellow	-	Employer's Copy
Pink	-	Employee's Copy
Goldenrod	-	Employee's Temporary Receipt

IN-HOME SUPPORTIVE SERVICES (IHSS)
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS
NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

If you are injured or become ill because of your job, you may be entitled to one or more of the following benefits provided for you as an Individual Provider of IHSS, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of the county's IHSS worker's knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

Failure to file this claim will make it impossible for you to receive any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury, you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1-800-736-7401. This service is provided to you at no cost. You also may consult an attorney.

ANY PERSON WHO MAKES, OR CAUSES TO BE MADE, ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

PART I - PROVIDER/EMPLOYEE: *Complete the "Employee" section and give the form to the county IHSS worker. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from the county.*

NAME OF EMPLOYEE	DATE OF INJURY OR ILLNESS	TIME OF DAY
	/ /	☐ A.M. ☐ P.M.
HOME ADDRESS (NUMBER, STREET, CITY, ZIP CODE)		
WHERE DID ACCIDENT OR EXPOSURE OCCUR (NUMBER, STREET, CITY, ZIP CODE)		
DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED		
WHAT SPECIFIC PART OF YOUR BODY WAS INJURED?		
WHAT IS YOUR RELATIONSHIP TO THE IHSS RECIPIENT/EMPLOYER?		
SIGNATURE OF EMPLOYEE	SOCIAL SECURITY NO: – –	

I gave this form to the county IHSS worker on (date) ____________________________________, 20____.

PART 2 – *COUNTY IHSS WORKER: COMPLETE THIS SECTION AND PROMPTLY GIVE THE EMPLOYEE A COPY AS A RECEIPT. SIGNING OF THIS FORM DOES NOT NECESSARILY CONSTITUTE ACCEPTANCE OF A CLAIM.*

NAME OF EMPLOYER	IHSS NO.	TELEPHONE
DATE OF KNOWLEDGE OF INJURY / /	DATE CLAIM FORM WAS PROVIDED TO EMPLOYEE / /	DATE CLAIM FORM WAS RECEIVED FROM EMPLOYEE / /
SIGNATURE OF IHSS WORKER		SSW NO.

STATE
COMPENSATION
INSURANCE
FUND