San Bernardino County
DEPARTMENT OF AGING & ADULT SERVICES
EMPLOYMENT VERIFICATION REQUEST FORM

THIS IS THE ONLY FORM THAT IS AUTHORIZED FOR USE BY CARE PROVIDERS FOR REQUESTING EMPLOYMENT VERIFICATION.

All employment verification requests must be accompanied by this, or another, signed authorization. Verifications will only be mailed or faxed to the identified party; there is NO "PICK UP" option available.

*****All requests are completed within 5 business days of receipt.*****

The **ONLY** employment information that will be verified is the Provider:

- Start Date
- Job Title
- Hourly Wage
- Total Gross Year to Date Income for Current and Previous Year, and
- Last Pay Period Date, if Terminated.

Information that WILL NOT be provided includes the following:

- **Letters of termination**
- **Number of hours worked or assigned**
- **Employment verification for another County, and**
- **Additional dates or other information.**

For information regarding paychecks, please contact IHSS Provider Paycheck Customer Service at 1-800-722-4595 or ihsspaycheck@hss.sbcounty.gov. If any additional information is needed, please contact the appropriate Unit Office Assistant or Social Worker assigned to the client for which care was provided.

The County of San Bernardino Department of Aging & Adult Services is not the Provider's employer. However, we are able to provide verification that the Care Provider is and/or has been employed by one or more clients of the program. The name of the client(s) is confidential and cannot be released by this agency.

Provider payments are issued by the State Controller's office, based on the number of service hours worked. The information being provided is based on available data. Care Providers do not receive sick leave, holiday pay, overtime or bonuses. The rate of pay is set by the State Legislature each July.

Please complete Employment Verification Request Form on back of this page.

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Date: _____

I _____ hereby authorize County of San Bernardino,
Print First and Last Name
Department of Aging & Adult Services to release my employment history. If the requested verification will be sent to the Care Provider completing this form, the address provided below must match the current address on file.
The following information is required to process your request.

Name of Individual or Business: _____

Street Address: _____

City, State, Zip Code: _____

Business Phone Number: _____-_____-_____

Fax Number: _____-_____-_____

Provider Social Security Number: _____-_____-_____

PROVIDER SIGNATURE_____

MAIL TO: Employment Verification
Department of Aging and Adult Services
686 East Mill Street
San Bernardino, CA 92415-0640

FAX TO: (909) 891-9077

EMPLOYMENT VERIFICATION

Start Date: _____

Job Title: Home Care Provider **Hourly Wage:** $9.25

Total Gross Year to Date for Current Year: _____ Through _____

Total Gross for Previous Year: _____

Last Pay Period Date if Terminated: _____

Processed By:_____ **Date:** _____