



TRINITY COUNTY HEALTH AND HUMAN SERVICES

Letty Garza, DIRECTOR
#51 INDUSTRIAL PARK WAY
P.O. BOX 1470, WEAVERVILLE, CALIFORNIA 96093
PHONE (530) 623-1265 (800) 851-5658 FAX (530) 623-1250

Dear Potential IHSS Provider,

Enclosed is the In Home Supportive Services (IHSS) Provider application packet you requested. You **must** bring the completed forms to the following address:

Trinity County Health and Human Services
In Home Supportive Services Program
51 Industrial Park Way
Weaverville, CA 96093

VERY IMPORTANT: *Please bring your original Social Security Card and picture ID when you return your forms.*

You may not want to start working for the recipient until you have passed the following procedures: fingerprinting, background/criminal check and orientation. If you do not pass the background check you will not be paid, this is a state requirement.

When you bring in your application, Social Security Card and picture ID to Trinity County Health & Human Services, you can ask for the "Live Scan" form. This form can be taken to the Trinity County Sheriff's Department, where you will pay \$47 for fingerprinting. When complete, bring back the form back to Trinity County Health and Human Services.

You will also be given a date and time for the next Provider Orientation.

We appreciate your interest in being an IHSS provider and look forward to working with you in the future.

Enclosures

Adult Services/IHSS
Public Guardian
PO Box 1470
Weaverville, CA96093
(530) 623-1265
Fax: (530) 623-6628

Child Protective Services
PO Box 1470
Weaverville, CA96093
(530) 623-1314
Fax: (530) 623-1488

CalWORKs
Eligibility/Employment
PO Box 1470
Weaverville, CA96093
(530) 623-1265
Fax: (530) 623-1250

Public Health
PO Box 1470
Weaverville, CA96093
(530) 623-8209 or
1-800-766-6147
Fax: (530) 623-1297

WIC
PO Box 1470
Weaverville, CA96093
(530) 623-3238
Fax: (530) 623-4072

IMPORTANT INFORMATION FOR PROSPECTIVE PROVIDERS ABOUT THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT PROCESS

An IHSS provider is someone who gets paid to provide services to a person who receives in-home supportive services under the IHSS program. If you want to become an IHSS provider, you must complete all of the steps outlined below within 90 days from the date you began the process before you can be enrolled as a provider and receive payment from the IHSS Program for providing services. These steps do not need to be done in any particular order. If you believe you have a criminal arrest and/or conviction within the previous ten years, no matter how minor, you should begin the process with Step 2 because you only have 90 days to complete all of the steps and it may take longer for the California Department of Justice (DOJ) to review your criminal history and provide the county with your Criminal Offender Record Information.

STEP 1. Complete and sign the IHSS Program Provider Enrollment Form (SOC 426) and return it in person to the County IHSS Office or IHSS Public Authority.

- Get a blank copy of the SOC 426 from the County IHSS Office or Public Authority. *Read the information carefully before you complete the form.*
- Complete the SOC 426 form and answer all questions completely and truthfully. You **must report** if you have been convicted of any crimes that would not allow you to provide services.
- Bring a valid photo ID issued by a U.S. federal or state government agency or by a federally-recognized Native American or Alaskan Native tribal organization **AND** an original Social Security card or replacement card issued by the Social Security Administration.
- The information you provide on the SOC 426 will be verified by a criminal background check by the DOJ.

STEP 2. Be fingerprinted and go through a criminal background check by the California Department of Justice.

- The County IHSS Office or Public Authority will give you instructions on how to get fingerprinted. *Do not try to be fingerprinted until you have received instructions from the county.*
- You can get fingerprinted at some local law enforcement agencies (Police or Sheriff Department) or at a business that offers digitally scanned fingerprinting (Live Scan) services. The County IHSS Office or Public Authority can give you a list of nearby locations.

- State law requires that you pay the costs for fingerprinting and the criminal background check. Fees vary depending where you choose to get fingerprinted; the costs range from \$40 to \$90.
- If the background check verifies that you **have been convicted** of any Tier 1 or Tier 2 crimes, please read the sections below and on the next page.

If you **have been** convicted of, **or** incarcerated following a conviction for, either a Tier 1 or Tier 2 crime **within the past 10 years**, you are **NOT** eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing supportive services.

| | |
|---|---|
| <p>Tier 1 crimes include:</p> <ul style="list-style-type: none"> • Specified abuse of a child (Penal Code (PC) section 273a(a); • Abuse of an elder or dependent adult (PC section 368); or • Fraud against a government health care or supportive services program. | <p>If you have a conviction for any of the Tier 1 crimes in the past 10 years, you are NOT eligible to be a provider.</p> <ul style="list-style-type: none"> • You are NOT eligible even if you had a Tier 1 crime that was expunged from your record. |
| <p>Tier 2 crimes include:</p> <ul style="list-style-type: none"> • A violent or serious felony, as specified in PC section 667.5(c), and PC section 1192.7(c), • A felony offense for which a person is required to register as a sex offender pursuant to PC section 290(c); and • A felony offense for fraud against a public social services program, as defined in Welfare & Institutions Code sections 10980(c)(2) and 10980(g)(2). <p><i>You can ask the County IHSS Office or IHSS Public Authority for a list of the Tier 2 crimes.</i></p> | <p>If you have a conviction for any of the Tier 2 crimes in the past 10 years, you may be eligible to be a provider:</p> <ul style="list-style-type: none"> • If your Tier 2 crime has been or can be expunged from your record. • If a recipient submits an individual waiver to hire you. • If you are approved for a general exception. <p><i>Read the sections below for more information.</i></p> |

Expungement for Tier 2 Crime:

- If you have a Certificate of Rehabilitation or an expungement for a Tier 2 crime, you may be eligible to be an IHSS provider. Provide copies of your Certificate of Rehabilitation or documentation regarding the expungement with your completed SOC 426.
- If you are in the process of having a crime expunged, you should complete the expungement process before continuing the criminal background check.

Individual Waiver of Exclusion for a Tier 2 Crime:

An individual waiver allows you to provide services **only** for a specific recipient who chooses to hire you in spite of your criminal conviction(s).

- A recipient must request and submit the Recipient Request for Provider Waiver (SOC 862) to the county IHSS Office or Public Authority to allow you to provide services.
- The IHSS recipient who wants to hire you must be told of your conviction; however, he/she will be directed to keep the conviction information confidential.
- If you, as the provider, are also the recipient's authorized representative, you are **not** allowed to sign the waiver on behalf of the recipient to waive crimes for which you have been convicted. In this case, the waiver must either be signed directly by the recipient or, if that is not possible, another individual must be declared an authorized representative for purposes of signing this waiver.

If your recipient signs an individual waiver form which allows you to work only for him/her and either he/she moves to another county or you decide to work for another recipient that lives in another county, you will have to do another criminal background check in the new county and the recipient you work for will need to complete and submit another request for an individual waiver in the new county.

General Exception for a Tier 2 Crime:

An individual who has been found ineligible to be enrolled as a provider based on a conviction for a Tier 2 crime, but who wishes to be listed on a provider registry, may apply for a general exception of the exclusion.

- Apply for a General Exception by completing the IHSS Applicant Provider Request for General Exception (SOC 863) form.
- You will be required to provide backup documentation (e.g., employment history, personal references, etc.) to support your request for a general exception.

If you have been disqualified based on a Tier 1 or Tier 2 conviction, you may request a copy of your Criminal Offender Record Information (CORI) from the county. Please be advised that the CORI can only be used for this enrollment process.

If you believe the information on your criminal background is incorrect, you can dispute the information through the DOJ record review process.

The DOJ record review process includes submitting fingerprints, paying a processing fee, and following the instructions found on the DOJ website at <http://ag.ca.gov/fingerprints/security.php>. If there is criminal information on your record, a Claim of Alleged Inaccuracy or Incompleteness (Form BCII 8706) will be included along with the response.

STEP 3: Attend an IHSS Program Provider Orientation given by the county.

- The County IHSS Office or Public Authority will tell you when and where you can attend an orientation session.
- The orientation will give you important information about the IHSS Program and the rules and requirements you must follow as a provider.

STEP 4: At the end of the Provider Orientation session, sign an IHSS Program Provider Enrollment Agreement (SOC 846).

- By signing the SOC 846, you are saying that you understand and agree to the rules and requirements for being a provider in the IHSS Program.

You should maintain copies of all documents you submitted and any that you have received from the county for your records.

Once you have successfully completed these four (4) steps and have been approved by the county or Public Authority to be an IHSS provider, as long as you are an active provider and your criminal background check remains clear, you will continue to be eligible to provide services for any IHSS recipient.

If you do not complete these four (4) steps within 90 days after you began the provider enrollment process, you will be found ineligible to work and be paid as an IHSS provider and will need to begin the process over again in order to be enrolled as an IHSS provider.

If you have any questions about these provider enrollment requirements, contact your County IHSS Office or IHSS Public Authority.

Keep this page for your records

IN-HOME SUPPORTIVE SERVICES (IHSS)

WHAT DOES IHSS DO?

In-Home Supportive Services (IHSS) is the largest publicly funded non-medical home care program to help the frail, elderly and other functionally impaired persons with limited financial resources to stay at home rather than be institutionalized.

IHSS pays workers (care providers) to perform tasks for disabled and elderly persons who could not remain safely in their homes without help. IHSS may include household and related chores (laundry, cooking, cleaning, shopping), personal care services (bathing, dressing, bowel and bladder care, feeding), paramedical services, protective supervision, and accompaniment to medical appointments.

ELIGIBILITY

A Social Worker determines eligibility for IHSS and the number of hours a recipient may receive each month for specific tasks. The recipient is the employer of the care provider, choosing who works for them. Payroll is done through Trinity County Health & Human Services (TCHHS).

WORK SCHEDULES

Both the care provider(s) and the recipient share responsibility for maintaining contact with each other, arranging an acceptable work schedule, and insuring that hours are used for authorized tasks. The recipient has a letter from IHSS that specifies what tasks are authorized to be done and how much time is authorized for each task. Payment for tasks or time not authorized by IHSS is the responsibility of the recipient. Both recipient and provider are also responsible to assure that the total hours worked per month do not exceed the recipient's authorized amount.

WAGES AND BENEFITS

The rate of pay is *\$11.50 per hour*. IHSS care providers are covered by Workers' Compensation Insurance, Social Security, and State Disability as applicable. If you are injured on the job you must contact IHSS at 623-8257 immediately.

CARE PROVIDER RESPONSIBILITIES

Care providers are expected to be professional on the job. They are to respect the recipient's rights to privacy and confidentiality and are not to discuss their personal affairs with anyone else. They should NEVER be in the recipient's home without the recipient being there and should always give the recipient as much notice as possible when unable to work as scheduled. It is also your responsibility to report fraud if you suspect it. To report fraud call IHSS Quality Assurance 1-800-851-5658 or 623-8269 or Call the Bureau of Medi-Cal Fraud & Elder Abuse toll-free 1-800-722-0432 or report on-line <http://caag.state.ca.us/bmfea/reporting.php>

CARE PROVIDER REWARDS

Being a care provider can be difficult and demanding. Wages are low and benefits are small. Care Providers help the elderly and disabled remain safely in their homes and live a life with as much dignity and personal freedom as possible.

IHSS Rules and Regulations Regarding Recipient Services and Payroll

- **Authorized hours need to be spread out to cover the entire month.** The 1st of the month to the 15th of the month (first pay period) **CANNOT BE OVER 70%** of the authorized hours for the entire month.
- As a provider of IHSS, you are hired and supervised by the Recipient.
- Unless arrangements have been made ahead of time with the IHSS Social Worker, the Recipient **must be home** when you are providing services. It is considered fraud if you turn in time when the Recipient is in the hospital, rehab, vacation, etc...
- If you are unable to begin work at your scheduled time, contact the Recipient. If for some reason you cannot work for a few days (sick, vacation), please let the Recipient know so they can make arrangements to have someone else work.
- **Please let the IHSS Office know if you are no longer working for a Recipient.**
- **Any changes in your address or phone number needs to be reported to the IHSS Office.**
- If a Recipient asks the provider to perform services not authorized by IHSS or to work more hours than IHSS has granted, the Recipient is responsible to pay for the extra services or hours.
- IHSS does not pay for care of the Recipient's pets.
- If grocery shopping is to be done for a Recipient please keep in mind that IHSS does not pay for gas mileage. If you choose to transport a Recipient, it is at your own risk.
- Although the IHSS program may authorize hours for "accompaniment" of a Recipient to the doctor, IHSS does not authorize payment for "transportation" of a Recipient to the doctor or the store or anywhere else. Should you choose to transport a Recipient anywhere, you do so at your own risk.
- You agree to work for \$11.50 per hour.
- **IMPORTANT: You and the Recipient must sign and date the timesheet AFTER the hours have been worked. Timesheets will be returned for correction if they are turned in early or if not properly filled out. This will cause a delay in your paycheck.**
- **DO NOT USE PENCIL, BLACK INK only, when completing your timesheet and DO NOT USE white out to make corrections. If you do, your timesheet will be rejected.**
- **TIMESHEET CONVERSION CHART** – When filling out your timesheets, please use the minute's system on the back of this page for decimals worked. **DO NOT** use fractions and use only one number after the decimal point.
- If you did not work for a whole 2 week pay period, **DO NOT** mail timesheet to Chico. If you work the following pay period, contact your IHSS office to have the next pay period timesheet mailed to you.
- You should expect to receive your paycheck approximately 7 to 12 days after you turn in your timesheet.
- Paychecks are mailed from Sacramento by the State. Paychecks cannot be picked up at the IHSS Office.

CMIPS II Conversion to Hours and Minutes

| Decimal | Rounded Minutes | Decimal | Rounded Minutes | Decimal | Rounded Minutes |
|---------|-----------------|---------|-----------------|---------|-----------------|
| 0.00 | 0 | 0.41 | 25 | 0.81 | 49 |
| 0.01 | 1 | 0.42 | 25 | 0.82 | 49 |
| 0.02 | 1 | 0.43 | 26 | 0.83 | 50 |
| 0.03 | 2 | 0.44 | 26 | 0.84 | 50 |
| 0.04 | 2 | 0.45 | 27 | 0.85 | 51 |
| 0.05 | 3 | 0.46 | 28 | 0.86 | 52 |
| 0.06 | 4 | 0.47 | 28 | 0.87 | 52 |
| 0.07 | 4 | 0.48 | 29 | 0.88 | 53 |
| 0.08 | 5 | 0.49 | 29 | 0.89 | 53 |
| 0.09 | 5 | 0.50 | 30 | 0.90 | 54 |
| 0.10 | 6 | 0.51 | 31 | 0.91 | 55 |
| 0.11 | 7 | 0.52 | 31 | 0.92 | 55 |
| 0.12 | 7 | 0.53 | 32 | 0.93 | 56 |
| 0.13 | 8 | 0.54 | 32 | 0.94 | 56 |
| 0.14 | 8 | 0.55 | 33 | 0.95 | 57 |
| 0.15 | 9 | 0.56 | 34 | 0.96 | 58 |
| 0.16 | 10 | 0.57 | 34 | 0.97 | 58 |
| 0.17 | 10 | 0.58 | 35 | 0.98 | 59 |
| 0.18 | 11 | 0.59 | 35 | 0.99 | 59 |
| 0.19 | 11 | 0.60 | 36 | | |
| 0.20 | 12 | 0.61 | 37 | | |
| 0.21 | 13 | 0.62 | 37 | | |
| 0.22 | 13 | 0.63 | 38 | | |
| 0.23 | 14 | 0.64 | 38 | | |
| 0.24 | 14 | 0.65 | 39 | | |
| 0.25 | 15 | 0.66 | 40 | | |
| 0.26 | 16 | 0.67 | 40 | | |
| 0.27 | 16 | 0.68 | 41 | | |
| 0.28 | 17 | 0.69 | 41 | | |
| 0.29 | 17 | 0.70 | 42 | | |
| 0.30 | 18 | 0.71 | 43 | | |
| 0.31 | 19 | 0.72 | 43 | | |
| 0.32 | 19 | 0.73 | 44 | | |
| 0.33 | 20 | 0.74 | 44 | | |
| 0.34 | 20 | 0.75 | 45 | | |
| 0.35 | 21 | 0.76 | 46 | | |
| 0.36 | 22 | 0.77 | 46 | | |
| 0.37 | 22 | 0.78 | 47 | | |
| 0.38 | 23 | 0.79 | 47 | | |
| 0.39 | 23 | 0.80 | 48 | | |
| 0.40 | 24 | | | | |

**WELCOME TO YOUR JOB AS
AN IN-HOME SUPPORTIVE
SERVICES (IHSS)
INDIVIDUAL PROVIDER**

This notice briefly describes benefits that may be available to you and your income tax responsibilities. Please read this pamphlet carefully. Also, remember that your employer is the IHSS recipient that hired you, not the State of California nor the County Welfare Department (CWD). The State of California issues this pamphlet and your paychecks on behalf of your employer and the CWD handles all the paper work.

Please contact the CWD whenever you have any questions about your paycheck or timesheet. Always sign and date your timesheet after the pay period ends (not before), also have your employer sign and date it, then mail your timesheet to the CWD address that appears in the lower right-hand corner of the timesheet to avoid any delay in receiving your paycheck. Remember: always keep the CWD notified of any change to your address and/or telephone number.

My County Service Worker is:

Name Liz Ritz

Address 51 Industrial Park Way
 PO Box 1470

 Weaverville, CA 96093

Phone: (530) 623-8257

 County of: Trinity

For information about IHSS
call the local
county welfare department



STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

**IN-HOME
SUPPORTIVE
SERVICES**

**INDIVIDUAL
PROVIDER
BENEFITS
AND
SERVICES
INFORMATION**



SOCIAL SECURITY

Social Security benefits are available to individual providers who are 18 years old or older and not the parent of the employer/recipient. The benefits are available if you become totally disabled or retire and meet certain eligibility requirements. There is a deduction from your paycheck for Social Security (FICA). The benefits include monthly retirement or disability payments to you or your dependents. You should contact your local Social Security Administration Office for information and/or to apply for Social Security. The telephone number and address of this office are listed in the white pages of your telephone book under "United States Government, Social Security Administration."

MEDICARE TAX

Medicare is the health and medical benefits received as part of the total Social Security benefits package. In the past, the Medicare tax deduction was a part of the Social Security (FICA) tax deduction. Federal law now requires that the tax and the amount deducted be reported separately. Questions regarding the Medicare tax should be directed to the Social Security Administration.

STATE DISABILITY INSURANCE (SDI)

State Disability Insurance benefits are available to you if you become disabled and are prevented from doing your regular work and you meet certain eligibility requirements. There is a deduction from your paycheck for SDI. State Disability Insurance benefits are available for a maximum of 52 weeks. You should contact your local California Employment Development Department (EDD) office for information and/or to apply for State Disability Insurance. The telephone number and address of this office are listed in the white pages of your telephone book under "California State of, Employment Development Department."

If you are the parent, spouse or child of the person you are providing services to you may choose to participate in the SDI program by applying for Elective State Disability Insurance. The forms for Elective SDI coverage are available from the county social services worker. If you want this optional coverage, the cost will be deducted from your paycheck. All other Individual Providers are automatically covered for SDI if they have IHSS quarterly wages in excess of \$750.

UNEMPLOYMENT INSURANCE (UI)

Unemployment Insurance (UI) benefits may be available to you if you are not the parent or spouse of your employer/recipient and become unemployed, able and available to work and you meet certain eligibility requirements. There is no deduction from your paycheck for UI. Unemployment Insurance benefits are available for a maximum of 26 weeks. You should contact your local California Employment Development Department office for information and/or to apply for Unemployment Insurance. The telephone number and address of this office are listed in the white pages of your telephone book under "California State of, Employment Development Department."

WORKERS' COMPENSATION

Workers' Compensation benefits are available to you if you are injured on the job or become ill due to your job, and you meet certain eligibility requirements. There is no deduction from your paycheck for Workers' Compensation. If you are injured on the job, you should seek medical attention immediately and then notify your employer/recipient's county social services worker. Claim forms to apply for Workers' Compensation are available from the county social services worker and should be returned to the County Welfare Department when completed. For more information about Workers' Compensation, you may call an Information and Assistance Officer at 1-800-736-7401.

INCOME TAX WITHHOLDING

You may have state and federal income tax withheld from your paycheck if you apply and you meet certain eligibility requirements. Income tax withholding for individual providers is strictly voluntary. If you wish to have state and federal income tax withheld from your paycheck please complete the Income Tax Withholding Form (W-4) and mail it to your county welfare department. If you do not have state and/or federal income tax withheld from your paycheck, you are still required to file a tax return at the end of the year and possibly pay taxes on your earnings. You should contact your employer/recipient's county social service worker if you require additional W-4s, need to change your withholding, or need to determine the status of your withholding.

You should contact your local California Franchise Tax Board (FTB) office for information about state income tax withholding. The telephone number and address of this office are listed in the white pages of your telephone book under "California, State of, Franchise Tax Board." You should contact your local Internal Revenue Service (IRS) office for information about federal income tax withholding. The telephone number and address of this office are listed in the white pages of your telephone book under "United States Government, Internal Revenue Service."

EARNED INCOME CREDIT (EIC)

You may be eligible for the Earned Income Credit (EIC). To find out about EIC and if you are eligible, carefully read the instructions for completing a form W-5 (Earned Income Credit Advance Payment Certificate). If you are eligible for EIC you can choose to get the credit in advance with your pay instead of waiting until you file your tax return. You should contact your local Internal Revenue Service office or your tax consultant for information about EIC.

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
PROVIDER ENROLLMENT FORM****READ THE INFORMATION BELOW CAREFULLY BEFORE
YOU BEGIN TO COMPLETE THIS FORM**

Under state law, if you have been convicted of or incarcerated following a conviction for certain exclusionary crimes within the past 10 years, you are not eligible to be enrolled as a provider or to receive payment from the IHSS program for providing supportive services except as specified below. There are two categories of exclusionary crimes.

- **Tier 1 crimes, as set forth in Welfare and Institutions Code (W&IC) section 12305.81, include the following:**
 1. Specified abuse of a child (Penal Code [PC] section 273a[a]*),
 2. Abuse of an elder or dependent adult (PC section 368*), and
 3. Fraud against a government health care or supportive services program.
- **Tier 2 crimes, as set forth in W&IC section 12305.87, include the following:**
 1. A violent or serious felony, as specified in PC section 667.5(c)*, and PC section 1192.7(c)*,
 2. A felony offense for which a person is required to register as a sex offender pursuant to PC section 290(c)*, and
 3. A felony offense for fraud against a public social services program, as defined in W&IC sections 10980(c)(2)* and (g)(2)*.

A complete listing of Tier 2 crimes is available upon request from the County IHSS Office or IHSS Public Authority.

*See attached form SOC 426C for the text of these PC and W&IC sections.

- As part of the IHSS provider enrollment process, you must submit fingerprints and undergo a criminal background check conducted by the California Department of Justice.
- If your responses on this form or the results of the criminal background check show that you have been convicted of, or incarcerated following a conviction for, either a Tier 1 or Tier 2 crime within the last 10 years, you will not be eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing supportive services.
- For Tier 2 crimes, if you have obtained a certificate of rehabilitation or an expungement (dismissal pursuant to PC section 1203.4), the conviction will not disqualify you from working as an IHSS provider.
- If your conviction is for a Tier 2 crime, you may qualify for an individual waiver or a general exception under certain circumstances which are described below.
- ***There are no waivers or exceptions allowed for Tier 1 crimes.***

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
PROVIDER ENROLLMENT FORM**

**CONTINUE READING THE INFORMATION BELOW CAREFULLY BEFORE
YOU BEGIN TO COMPLETE THIS FORM**

Individual Waiver of an Exclusion for Conviction for a Tier 2 Crime

If you are found ineligible based on a conviction for a Tier 2 exclusionary crime but an IHSS recipient (or his/her authorized representative) wishes to hire you as his/her provider in spite of your criminal background, you may obtain a waiver as follows:

- The IHSS recipient who wishes to hire you (or his/her authorized representative) will be informed of your conviction and will be directed to keep the information confidential.
- The recipient who wishes to hire you as his/her provider (or his/her authorized representative) must submit an IHSS Recipient Request for Provider Waiver (SOC 862) to the County IHSS Office or IHSS Public Authority.
- The waiver will allow you to be enrolled to provide services only for the recipient who requested the waiver and only in the county in which the waiver was filed.
- If you, as the provider, are also the recipients' authorized representative, you are NOT allowed to sign the waiver on behalf of the recipient to waive crimes for which you have been convicted. In this case, the waiver must either be signed directly by the recipient or, if that is not possible, another individual must be declared an authorized representative for purposes of signing this waiver.
- For more information about requesting a waiver, the IHSS recipient who wishes to hire you as his/her provider should contact the County IHSS Office or IHSS Public Authority.

General Exception of an Exclusion for Conviction for a Tier 2 Crime

If you are found ineligible based on a conviction for a Tier 2 exclusionary crime and you want to be listed on a provider registry or to provide services for a recipient who has not requested an individual waiver.

- You may apply for a general exception of the exclusion by completing the IHSS Applicant Provider Request for General Exception (SOC 863).
- You will be required to provide backup documentation, e.g., employment history, personal references, etc., to support your request for a general exception.
- For more information about requesting a general exception, contact the County IHSS Office or IHSS Public Authority.

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IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM PROVIDER ENROLLMENT FORM

INSTRUCTIONS:

- Use black or blue ink to fill out. Print information clearly.
- Fill out, sign and return this form in person to the office or location designated by the county. Bring original federal or state government-issued identification and your original Social Security card when returning this form.
- Complete all items in PART A, answer the questions in PART B, and read and sign the declaration in PART C.
- The county will: 1) Review the form to make sure it is complete; 2) Make photocopies of your identification and Social Security card; and 3) Provide you with a copy of the completed form for your records.
- You **MUST** let the county know if anything you report on this form changes within 10 calendar days of the change.

PART A: PROVIDER INFORMATION

| | | |
|---|---|--|
| <p>1. Full Name (First Name, Middle Initial, Last Name):</p> | <p>2. Date of Birth:</p> | <p>3. Gender:</p> <p style="text-align: center;"><input type="checkbox"/> M <input type="checkbox"/> F</p> |
| If you are under 18 years of age, you must submit a valid Work Permit with this form. | | |
| <p>4. Home Address (Must be physical address, <u>not</u> a Post Office Box*):</p> | <p>City:</p> | <p>State: Zip:</p> |
| <p>5. Mailing Address (if different from home address):</p> | <p>City:</p> | <p>State: Zip:</p> |
| <p>6. Telephone Number (with Area Code):</p> | <p>7. Social Security Number**:</p> | |
| <p>8. E-Mail Address (if any):</p> | | |
| <p>9. a. Driver's License # or Government Issued ID #:</p> | <p>b. Expiration Date:</p> <p>c. Issuing State:</p> | |
| <p>10. a. Primary Spoken Language:</p> | <p>b. Primary Written Language:</p> | |

NOTES:

- * A paycheck for a provider cannot be mailed to a P.O. Box unless the county has approved a request from the provider.
- ** The collection of the Social Security Number is required pursuant to W&IC 12305.81(a), and the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a), for the purposes of verifying the individual's identity and authorization to work in the United States.

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
PROVIDER ENROLLMENT FORM**

PROVIDER'S NAME: _____

PART B: PROVIDER DISCLOSURE

ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX:

1. WITHIN THE PAST 10 YEARS, HAVE YOU BEEN –

- a. Convicted of or incarcerated following a conviction for a Tier 1* crime?..... YES NO
- b. Convicted of or incarcerated following a conviction for a Tier 2* crime?..... YES NO

**See Page 1 of this form for a definition of Tier 1 and Tier 2 crimes.*

2. IF YOU ANSWERED “YES” TO QUESTION 1.b. ABOVE, have you obtained a certificate of rehabilitation or expungement (dismissal pursuant to PC section 1203.4) of the Tier 2 crime?..... YES NO

If YES, you must provide the county with a copy of the certificate of rehabilitation or documentation of the expungement along with this completed form.

PART C: PROVIDER DECLARATION

I UNDERSTAND AND AGREE THAT –

- I cannot receive IHSS program funds as payment for authorized services I provide to any eligible recipient of IHSS until I have completed the entire provider enrollment process and I have been officially enrolled as a provider by the county.
- I have 90 calendar days from the date I first began the provider enrollment process to complete all of the enrollment requirements. If I do not complete all of the enrollment requirements within 90 calendar days, I shall be deemed ineligible to serve as a provider in the IHSS program and cannot be paid by the IHSS program for providing authorized services to an IHSS recipient.
- As a part of the provider enrollment process, I must provide fingerprints and undergo a criminal background check. I am responsible for paying the costs of fingerprinting and the background check.
- If it is found, either through my responses on this form, the results of the criminal background check, or some other means, that within the past 10 years, I have been convicted of or incarcerated following a conviction for a Tier 1 exclusionary crime, I will not be eligible to be an IHSS provider, and the recipient who wished to hire me will be informed that I am ineligible to be a provider because of a disqualifying criminal conviction which will not be specified.

GO ON TO THE NEXT PAGE →

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
PROVIDER ENROLLMENT FORM**

PROVIDER'S NAME: _____

PART C: PROVIDER DECLARATION (Continued)

I UNDERSTAND AND AGREE THAT –

- If it is found, either through my responses on this form, the results of the criminal background check, or some other means, that within the past 10 years, I have been convicted of or incarcerated following a conviction for a Tier 2 exclusionary crime, and I have not received a certificate of rehabilitation or had the conviction expunged –
 - I will not be eligible to be an IHSS provider, unless an IHSS recipient who wishes to hire me to provide his/her services, requests an individual waiver, or I apply for and I am granted a general exception; and
 - The IHSS recipient who wishes to hire me as his/her provider will be informed of my conviction and the types of crimes for which I was convicted, and he/she will be directed to keep the information confidential.

**IF I AM ENROLLED BY THE COUNTY AS AN IHSS PROVIDER,
I UNDERSTAND AND AGREE THAT –**

- If the person I provide services for receives IHSS through the Medi-Cal program, I will be considered to be a Medi-Cal provider of personal care services. Therefore, I will be required to comply with all Medi-Cal program rules relating to the provision of services.
- Payment for the authorized services I provide to an IHSS recipient will be from federal, state and/or county IHSS funds and any false statement I provide, including false entries on the timesheet, or withholding of information may be prosecuted under federal and/or state laws.
- I will reimburse the IHSS program for any overpayments paid to me and any overpayment, individually or collectively, may be deducted from a future paycheck for services I provide to any recipient of IHSS.
- I will provide all services without discrimination based on race, religion, color, national or ethnic origin, gender, age, sexual orientation, or physical or mental disability.

I declare, UNDER PENALTY OF PERJURY, that all of the information I have provided on this form is true and correct to the best of my knowledge, and that I agree to the declaration and agreements listed above.

Signature: _____ Date: _____

Printed Name: _____

County Representative's Signature (Optional): _____

DATE: _____

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM CALIFORNIA CODE SECTIONS

CALIFORNIA PENAL CODE SECTION 273a, SUBDIVISION (a)

- (a) Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of that child to be injured, or willfully causes or permits that child to be placed in a situation where his or her person or health is endangered, shall be punished by imprisonment in a county jail not exceeding one year, or in the state prison for two, four, or six years.

CALIFORNIA PENAL CODE SECTION 368

- (a) The Legislature finds and declares that crimes against elders and dependent adults are deserving of special consideration and protection, not unlike the special protections provided for minor children, because elders and dependent adults may be confused, on various medications, mentally or physically impaired, or incompetent, and therefore less able to protect themselves, to understand or report criminal conduct, or to testify in court proceedings on their own behalf.
- (b) (1) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars (\$6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.
- (2) If in the commission of an offense described in paragraph (1), the victim suffers great bodily injury, as defined in Section 12022.7, the defendant shall receive an additional term in the state prison as follows:
- (A) Three years if the victim is under 70 years of age.
- (B) Five years if the victim is 70 years of age or older.
- (3) If in the commission of an offense described in paragraph (1), the defendant proximately causes the death of the victim, the defendant shall receive an additional term in the state prison as follows:
- (A) Five years if the victim is under 70 years of age.
- (B) Seven years if the victim is 70 years of age or older.
- (c) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars (\$2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.
- (d) Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is punishable by Imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars (\$400); and by a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM CALIFORNIA CODE SECTIONS

moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars (\$400).

- (e) Any caretaker of an elder or a dependent adult who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of that elder or dependent adult, is punishable by imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars (\$400), and by a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars (\$400).
- (f) Any person who commits the false imprisonment of an elder or a dependent adult by the use of violence, menace, fraud, or deceit is punishable by imprisonment in the state prison for two, three, or four years.
- (g) As used in this section, "elder" means any person who is 65 years of age or older.
- (h) As used in this section, "dependent adult" means any person who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. "Dependent adult" includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.
- (i) As used in this section, "caretaker" means any person who has the care, custody, or control of, or who stands in a position of trust with, an elder or a dependent adult.
- (j) Nothing in this section shall preclude prosecution under both this section and Section 187 or 12022.7 or any other provision of law. However, a person shall not receive an additional term of imprisonment under both paragraphs (2) and (3) of subdivision (b) for any single offense, nor shall a person receive an additional term of imprisonment under both Section 12022.7 and paragraph (2) or (3) of subdivision (b) for any single offense.
- (k) In any case in which a person is convicted of violating these provisions, the court may require him or her to receive appropriate counseling as a condition of probation. Any defendant ordered to be placed in a counseling program shall be responsible for paying the expense of his or her participation in the counseling program as determined by the court. The court shall take into consideration the ability of the defendant to pay, and no defendant shall be denied probation because of his or her inability to pay.

CALIFORNIA PENAL CODE SECTION 290, SUBDIVISION (c)

(c) The following persons shall be required to register:

Any person who, since July 1, 1944, has been or is hereafter convicted in any court in this state or in any federal or military court of a violation of Section 187 committed in the perpetration, or an attempt to perpetrate, rape or any act punishable under Section 286, 288, 288a, or 289, Section 207 or 209 committed with intent to violate Section 261, 286, 288, 288a, or 289, Section 220, except assault to commit mayhem, Section 243.4, paragraph (1), (2), (3), (4), or (6) of subdivision (a) of Section 261, paragraph (1) of subdivision (a) of Section 262 involving the use of force or violence for which the person is sentenced to the state prison, Section 264.1, 266, or 266c, subdivision (b) of Section 266h, subdivision (b) of Section 266i, Section 266j, 267, 269, 285, 286, 288, 288a, 288.3, 288.4, 288.5, 288.7, 289, or 311.1, subdivision (b), (c), or (d) of Section 311.2, Section 311.3, 311.4, 311.10, 311.11, or 647.6, former Section 647a, subdivision (c) of Section 653f, subdivision 1 or 2 of Section 314, any offense involving lewd or lascivious conduct under Section 272, or any felony violation of Section 288.2; any statutory predecessor that includes all elements of one of the above-mentioned offenses; or any person who since that date has been or is hereafter convicted of the attempt or conspiracy to commit any of the above-mentioned offenses.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM CALIFORNIA CODE SECTIONS

CALIFORNIA PENAL CODE SECTION 667.5, SUBDIVISION (c)

- (c) For the purpose of this section, "violent felony" shall mean any of the following:
- (1) Murder or voluntary manslaughter.
 - (2) Mayhem.
 - (3) Rape as defined in paragraph (2) or (6) of subdivision (a) of Section 261 or paragraph (1) or (4) of subdivision (a) of Section 262.
 - (4) Sodomy as defined in subdivision (c) or (d) of Section 286.
 - (5) Oral copulation as defined in subdivision (c) or (d) of Section 288a.
 - (6) Lewd or lascivious act as defined in subdivision (a) or (b) of Section 288.
 - (7) Any felony punishable by death or imprisonment in the state prison for life.
 - (8) Any felony in which the defendant inflicts great bodily injury on any person other than an accomplice which has been charged and proved as provided for in Section 12022.7, 12022.8, or 12022.9 on or after July 1, 1977, or as specified prior to July 1, 1977, in Sections 213, 264, and 461, or any felony in which the defendant uses a firearm which use has been charged and proved as provided in subdivision (a) of Section 12022.3, or Section 12022.5 or 12022.55.
 - (9) Any robbery.
 - (10) Arson, in violation of subdivision (a) or (b) of Section 451.
 - (11) Sexual penetration as defined in subdivision (a) or (j) of Section 289.
 - (12) Attempted murder.
 - (13) A violation of Section 12308, 12309, or 12310.
 - (14) Kidnapping.
 - (15) Assault with the intent to commit a specified felony, in violation of Section 220.
 - (16) Continuous sexual abuse of a child, in violation of Section 288.5.
 - (17) Carjacking, as defined in subdivision (a) of Section 215.
 - (18) Rape, spousal rape, or sexual penetration, in concert, in violation of Section 264.1.
 - (19) Extortion, as defined in Section 518, which would constitute a felony violation of Section 186.22 of the Penal Code.
 - (20) Threats to victims or witnesses, as defined in Section 136.1, which would constitute a felony violation of Section 186.22 of the Penal Code.
 - (21) Any burglary of the first degree, as defined in subdivision (a) of Section 460, wherein it is charged and proved that another person, other than an accomplice, was present in the residence during the commission of the burglary.
 - (22) Any violation of Section 12022.53.
 - (23) A violation of subdivision (b) or (c) of Section 11418. The Legislature finds and declares that these specified crimes merit special consideration when imposing a sentence to display society's condemnation for these extraordinary crimes of violence against the person.

CALIFORNIA PENAL CODE SECTION 1192.7, SUBDIVISION (c)

- (c) As used in this section, "serious felony" means any of the following:
- (1) Murder or voluntary manslaughter; (2) mayhem; (3) rape; (4) sodomy by force, violence, duress, menace, threat of great bodily injury, or fear of immediate and unlawful bodily injury on the victim or another person; (5) oral copulation by force, violence, duress, menace, threat of great bodily injury, or fear of immediate and unlawful bodily injury on the victim or another person; (6) lewd or lascivious act on a child under 14 years of age; (7) any felony punishable by death or imprisonment in the state prison for life; (8) any felony in which the defendant personally inflicts great bodily injury on any person, other than an accomplice, or any felony in which the defendant personally uses a firearm; (9) attempted murder; (10) assault with intent to commit rape or robbery; (11) assault with a deadly weapon or instrument on a peace officer; (12) assault by a life prisoner on a noninmate; (13) assault with a deadly weapon by an inmate; (14) arson; (15) exploding a destructive device or any explosive

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM CALIFORNIA CODE SECTIONS

with intent to injure; (16) exploding a destructive device or any explosive causing bodily injury, great bodily injury, or mayhem; (17) exploding a destructive device or any explosive with intent to murder; (18) any burglary of the first degree; (19) robbery or bank robbery; (20) kidnapping; (21) holding of a hostage by a person confined in a state prison; (22) attempt to commit a felony punishable by death or imprisonment in the state prison for life; (23) any felony in which the defendant personally used a dangerous or deadly weapon; (24) selling, furnishing, administering, giving, or offering to sell, furnish, administer, or give to a minor any heroin, cocaine, phencyclidine (PCP), or any methamphetamine-related drug, as described in paragraph (2) of subdivision (d) of Section 11055 of the Health and Safety Code, or any of the precursors of methamphetamines, as described in subparagraph (A) of paragraph (1) of subdivision (f) of Section 11055 or subdivision (a) of Section 11100 of the Health and Safety Code; (25) any violation of subdivision (a) of Section 289 where the act is accomplished against the victim's will by force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person; (26) grand theft involving a firearm; (27) carjacking; (28) any felony offense, which would also constitute a felony violation of Section 186.22; (29) assault with the intent to commit mayhem, rape, sodomy, or oral copulation, in violation of Section 220; (30) throwing acid or flammable substances, in violation of Section 244; (31) assault with a deadly weapon, firearm, machinegun, assault weapon, or semiautomatic firearm or assault on a peace officer or firefighter, in violation of Section 245; (32) assault with a deadly weapon against a public transit employee, custodial officer, or school employee, in violation of Sections 245.2, 245.3, or 245.5; (33) discharge of a firearm at an inhabited dwelling, vehicle, or aircraft, in violation of Section 246; (34) commission of rape or sexual penetration in concert with another person, in violation of Section 264.1; (35) continuous sexual abuse of a child, in violation of Section 288.5; (36) shooting from a vehicle, in violation of subdivision (c) or (d) of Section 12034; (37) intimidation of victims or witnesses, in violation of Section 136.1; (38) criminal threats, in violation of Section 422; (39) any attempt to commit a crime listed in this subdivision other than an assault; (40) any violation of Section 12022.53; (41) a violation of subdivision (b) or (c) of Section 11418; and (42) any conspiracy to commit an offense described in this subdivision.

CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 10980, PARAGRAPH (2) OF SUBDIVISIONS (c) AND (g)

(c) Whenever any person has, willfully and knowingly, with the intent to deceive, by means of false statement or representation, or by failing to disclose a material fact, or by impersonation or other fraudulent device, obtained or retained aid under the provisions of this division for himself or herself or for a child not in fact entitled thereto, the person obtaining this aid shall be punished as follows:

(2) If the total amount of the aid obtained or retained is more than nine hundred fifty dollars (\$950), by imprisonment in the state prison for a period of 16 months, two years, or three years, by a fine of not more than five thousand dollars (\$5,000), or by both that imprisonment and fine; or by imprisonment in the county jail for a period of not more than one year, by a fine of not more than one thousand dollars (\$1,000), or by both imprisonment and fine.

(g) Any person who knowingly uses, transfers, sells, purchases, or possesses food stamps, electronically transferred benefits, or authorizations to participate in the federal Supplemental Nutrition Assistance Program in any manner not authorized by Chapter 10 (commencing with Section 18900), of Part 6, or by the federal Food Stamp Act of 1977 (Public Law 95-113 and all amendments thereto) or the Food and Nutrition Act of 2008 (7 U.S.C. Sec. 2011 et seq.)

(2) is guilty of a felony if the face value of the food stamps or the authorizations to participate exceeds nine hundred fifty dollars (\$950), and shall be punished by imprisonment in the state prison for a period of 16 months, two years, or three years, by a fine of not more than five thousand dollars (\$5,000), or by both that imprisonment and fine, or by imprisonment in the county jail for a period of not more than one year, or by a fine of not more than one thousand dollars (\$1,000), or by both imprisonment and fine.

**TRINITY COUNTY
IHSS PROVIDER WAIVER**

I _____ HAVE SELECTED _____
IHSS RECIPIENT NAME PROVIDER NAME

TO BE MY IHSS PROVIDER AS OF _____ (Date Care Provider began working.)

ATTENTION CARE PROVIDER AND IHSS RECIPIENT:

I UNDERSTAND THAT AS THE IHSS RECIPIENT, I AM RESPONSIBLE FOR MAKING SURE MY CARE PROVIDER (S) DO NOT WORK MORE HOURS THAN I HAVE AUTHORIZED.

IHSS staff will not make reference or background checks on new care providers.

(Recipient Signature) (Date)

(OR Legal Representative) (Date)

We must have the following information in order for the Care Provider to be paid.

The Care Provider completes the box below.

| |
|--|
| 1. Print the name of the Care Provider: _____ |
| 2. Mailing Address of Care Provider: _____ _____ _____ |
| 3. Telephone or Message Number: _____ |
| 4. Social Security Number: _____ |
| 5. Driver's License Number: _____ |
| 6. Care Provider's Birth Date: _____ |
| 7. Care Provider Relationship to IHSS Recipient: Are You: A HUSBAND or WIFE to the IHSS Recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No A SON or DAUGHTER to the IHSS Recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No A MOTHER or FATHER to the IHSS Recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Signature of Care Provider: _____ Date: _____ |

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM RECIPIENT DESIGNATION OF PROVIDER

INSTRUCTIONS:

- Use black or blue ink. Print information clearly.
- You (or your authorized representative) must complete PART A of this form to let the county know who you have chosen to provide your authorized services.
- If you have multiple providers, you must fill out a separate form for each person who will be providing authorized services for you.
- You must sign the acknowledgement in PART C of this form.
- Please return this completed and signed form to the county. The county will keep the original form and give you a copy.

PART A. RECIPIENT DESIGNATION OF PROVIDER

| | | |
|-----|--|---|
| 1. | Recipient's Name: | |
| 2. | County IHSS Case #: | |
| 3. | Provider's Name: | |
| 4. | Provider's Address: | |
| | City, State, ZIP Code: | |
| 5. | Provider's Telephone Number: | |
| 6. | Provider's Date of Birth | |
| 7. | Provider's Social Security #*: | |
| 8. | Provider's Gender (check box): | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 9. | Provider's Relationship to Recipient (if any): | <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Conservator <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____ |
| 10. | Provider's Start Date: | |

*NOTE: The collection of the Social Security Number is required by the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a), for the purposes of verifying the individual's identity and authorization to work in the United States.

I choose the person listed above to be my IHSS provider. This person will provide some or all of the services authorized by the county.

PART B. RECIPIENT AGREEMENT

I UNDERSTAND AND AGREE THAT:

- The person I have chosen to be my provider cannot be paid federal and/or state money for providing services to me until he/she completes all of the provider enrollment requirements. These requirements include completing, signing, and returning (in person) the Provider Enrollment Form (SOC 426), submitting fingerprints and being cleared of disqualifying crimes through a criminal background check, completing a provider orientation, and returning a signed Provider Enrollment Agreement (SOC 846).
- The county will send me a notice telling me if the person I have chosen as my provider does not complete the provider enrollment requirements or if he/she is not eligible to be an IHSS provider.
- If I choose to have this person provide services for me before he/she is enrolled as an IHSS provider, and the county sends me a notice telling me that he/she is not eligible to be an IHSS provider, I will have to pay him/her with my own money for the services that he/she provided before he/she was determined ineligible to be a provider and for any services he/she provides after the county notifies me that he/she is ineligible.
- Neither the county nor the State will be held responsible for any claims and/or losses caused by the above-named person I choose to hire as my IHSS provider. I agree to hold harmless the State and county, their officers, agents, and employees, and to take responsibility for any and all claims and/or losses to any person caused by the named person I choose to hire as my IHSS provider.
- The county can provide information about my authorized services and service hours to the person I have chosen as my provider. The county will send my provider the IHSS Provider Notice of Recipient Authorized Hours and Services (SOC 2271).
- My total monthly authorized hours will be divided by 4 to determine my maximum weekly hours. The maximum weekly hours is a guideline telling me the highest number of hours my provider(s) will be able to work for me during a workweek. However, since most months are slightly longer than 4 weeks, I will work with my provider(s) to spread his/her hours throughout the month in order to make sure I have all the service hours I need for the month.
- Sometimes I may need my provider to work more than my maximum weekly hours. I must ask for county approval to adjust my maximum weekly hours only if the change requires my provider to work:
 1. More overtime hours in the month than he/she would normally work.

- 2. More than 40 hours for me in a workweek if my maximum weekly hours are 40 hours or less in a workweek.
- If I do not get an approved exception, my provider will get a violation for working more than my maximum weekly hours.
- I can **never** authorize my provider to work more than my total authorized monthly service hours. Therefore, when I authorize my provider to work extra hours in one week, I must have the provider work fewer hours in the other week(s) of the month.
- **If my provider works for another recipient**, the maximum number of hours that he/she may claim in a workweek for all of the time he/she works for his/her recipients combined is **66** hours. **I must make a work schedule for my provider to determine how many hours he/she will be working for me each week to make sure he/she does not work more than 66 hours per workweek.** I will get a Recipient Notification of Maximum Weekly Hours (SOC 2271A) which will include information on my maximum weekly hours so I can use it to make the work schedule for my provider(s). In order to make the schedule, my provider must tell me how many hours he/she is available to work for me each workweek. If my provider cannot work all of my authorized hours, I will need to hire additional provider(s). **If I need help finding and hiring another provider(s), I can call my county IHSS Public Authority to obtain a provider from the registry or my county IHSS office.**
- The county will send me a notice each time my provider gets a violation. If my provider gets three violations, he/she will be suspended from providing IHSS for three months. If he/she gets another violation after being reinstated from the three-month suspension, he/she will be terminated as a provider for one year.

PART C. RECIPIENT ACKNOWLEDGMENT

I understand and agree to follow all of the requirements listed in this form.

| | |
|--|-------|
| RECIPIENT'S SIGNATURE: | DATE: |
| PRINTED NAME: | |
| AUTHORIZED REPRESENTATIVE'S SIGNATURE: | DATE: |
| PRINTED NAME: | |

FOR COUNTY USE ONLY

| | |
|--------------|-------|
| WORKER NAME: | DATE: |
| | |

**WORKERS COMPENSATION AND CONFIDENTIALITY
FOR IHSS CARE PROVIDERS**

You need to report all IHSS work-related accidents and injuries immediately to (530) 623-8229. Within 24 hours of reporting a work-related accident or injury to us, we are required to provide you with an Employee Claim for Worker's Compensation Benefits (SOC 412).

You should be aware that Worker's Compensation would not pay if you were injured doing tasks that are not authorized for the client (recipient). Always ask to see the client's "Notice of Action" so you will know exactly what tasks you should be doing for that particular client. The following is a list of tasks that are **not** authorized for any client:

1. Washing windows inside or outside unless specifically authorized as a one time heavy cleaning by an IHSS Social Worker.
2. Washing walls or ceilings or shampooing carpets unless specifically authorized as a one time heavy cleaning by an IHSS Social Worker.
3. Washing cupboards inside or out unless specifically authorized as a one time heavy cleaning by an IHSS Social Worker.
4. Moving heavy furniture.
5. Stripping and waxing floors.
6. Helping pack up or unpack a client to move.
7. Painting inside or outside.
8. Paneling walls.
9. Yard work unless specifically authorized as a one time yard hazard abatement by an IHSS Social Worker.
10. Planting a garden of any kind.
11. Any type of pet care or pet clean up (litter box cleaning, bird cages, etc.)
12. Cleaning up after client's friends and/or relatives.

Also remember that anything you learn or are told about the client's personal and private affairs is confidential and should not be discussed with anyone other than the IHSS staff.

When the client is in the hospital or goes to a skilled nursing facility (SNF) you need to call and report to IHSS staff immediately. You may not claim hours while the client is in the hospital or in a SNF facility. You may not be in their home unless they are there.

If you have any questions about whether or not an activity or task is authorized for a client call an IHSS worker before doing it.

Signing this form means you understand and agree to follow the above rules and regulations.

Recipient Signature

Date

Care Provider Signature

Date



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (*Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.*)

| | | | | | | |
|---|--|----------------------------------|---------------------------|----------------|---|----------------|
| Last Name (<i>Family Name</i>) | | First Name (<i>Given Name</i>) | | Middle Initial | Other Last Names Used (<i>if any</i>) | |
| Address (<i>Street Number and Name</i>) | | | Apt. Number | City or Town | | State ZIP Code |
| Date of Birth (<i>mm/dd/yyyy</i>) | U.S. Social Security Number <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px;"> - - </div> | | Employee's E-mail Address | | Employee's Telephone Number | |

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

| | |
|---|--|
| <input type="checkbox"/> 1. A citizen of the United States | |
| <input type="checkbox"/> 2. A noncitizen national of the United States (<i>See instructions</i>) | |
| <input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____ | |
| <input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (<i>See instructions</i>) | |
| <p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p> | |
| <div style="border: 1px solid black; width: 150px; height: 100px; margin: auto; padding: 5px;"> QR Code - Section 1 Do Not Write In This Space </div> | |

| | |
|-----------------------|------------------------------------|
| Signature of Employee | Today's Date (<i>mm/dd/yyyy</i>) |
|-----------------------|------------------------------------|

Preparer and/or Translator Certification (check one):

I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

| | | | |
|---|--|------------------------------------|----------------|
| Signature of Preparer or Translator | | Today's Date (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | | First Name (<i>Given Name</i>) | |
| Address (<i>Street Number and Name</i>) | | City or Town | State ZIP Code |



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

| | | | | |
|-------------------------------------|-------------------------|-------------------------|------|--------------------------------|
| Employee Info from Section 1 | Last Name (Family Name) | First Name (Given Name) | M.I. | Citizenship/Immigration Status |
|-------------------------------------|-------------------------|-------------------------|------|--------------------------------|

| List A Identity and Employment Authorization | OR | List B Identity | AND | List C Employment Authorization |
|---|----|--------------------------------------|-----|--|
| Document Title | | Document Title | | Document Title |
| Issuing Authority | | Issuing Authority | | Issuing Authority |
| Document Number | | Document Number | | Document Number |
| Expiration Date (if any)(mm/dd/yyyy) | | Expiration Date (if any)(mm/dd/yyyy) | | Expiration Date (if any)(mm/dd/yyyy) |
| Document Title | | Additional Information | | QR Code - Sections 2 & 3 Do Not Write In This Space |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date (if any)(mm/dd/yyyy) | | | | |

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

| | | | | |
|--|---|--|----------|--|
| Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Title of Employer or Authorized Representative | | |
| Last Name of Employer or Authorized Representative | First Name of Employer or Authorized Representative | Employer's Business or Organization Name | | |
| Employer's Business or Organization Address (Street Number and Name) | City or Town | State | ZIP Code | |

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

| | | | | |
|------------------------------------|-------------------------|----------------|--|--|
| A. New Name (if applicable) | | | B. Date of Rehire (if applicable) | |
| Last Name (Family Name) | First Name (Given Name) | Middle Initial | Date (mm/dd/yyyy) | |

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

| | | |
|----------------|-----------------|---------------------------------------|
| Document Title | Document Number | Expiration Date (if any) (mm/dd/yyyy) |
|----------------|-----------------|---------------------------------------|

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

| | | |
|--|---------------------------|---|
| Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Name of Employer or Authorized Representative |
|--|---------------------------|---|

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

| LIST A Documents that Establish Both Identity and Employment Authorization | LIST B Documents that Establish Identity | LIST C Documents that Establish Employment Authorization |
|--|---|---|
| OR | AND | |
| <ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | <ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record | <ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security |

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

IHSS TAX WITHHOLDING INFORMATION

STATE AND FEDERAL INCOME TAX WITHHOLDING

- Income tax withholding is only offered to individual providers who are paid in arrears.
- When a provider submits a W-4, it will be applied to only the recipient case(s) indicated on the form. If the provider begins working for another recipient, s/he must submit a separate W-4 for each additional recipient. Multiple recipient cases may be indicated on a single W-4. "All Recipients" is not a valid indication. The ten-digit recipient case number must be provided on the W-4 in Field 8 – Employer Name.
- When a W-4 is submitted the indications will be applied to both Federal and State Tax withholding. To have different State Tax Deduction, the provider must complete and submit a DE-4 concurrently or subsequent to the submission of the W-4. The provider must have a W-4 on file before the DE-4 can be processed. To request a DE-4 contact your IHSS Office.
- When a provider enters a dollar amount on Line 6 of a W-4, requesting additional money to be withheld, the amount will apply to both FIT and SIT withholding unless a separate DE-4 is submitted concurrently or subsequent to the W-4 submission. The indicated amount will be withheld from each paycheck.

Example: Additional amount requested from Line 6 is \$5. The first half of the month \$5 is taken out for FIT and \$5 for SIT. The second half of the month \$5 is taken out for FIT and \$5 for SIT. Therefore, the total additional amount withheld for the month is \$20, \$10 for FIT and \$10 for SIT.

SOCIAL SECURITY AND MEDICARE TAXES

- Providers who are paid less than \$1,500 annually by the State of California for In-Home Supportive (IHSS) do not have to pay Social Security and Medicare taxes also known as Federal Insurance Contribution Act (FICA).
- FICA taxes will be withheld during the year because we can't know until the end of the year if you will earn less than \$1,500. At the end of each year your wages will be reviewed. If you earn less than \$1,500 from all IHSS employers you get refunds of the FICA taxes taken from you paychecks.
- A son or daughter who provides services to a parent and who is under 21 years of age is exempt from FICA. In the year the child turns 21, all wages earned after the 21st birthday are subject to FICA as soon as the \$1,500 threshold has been met. Wages earned from January 1 to the 21st birthday count toward the \$1,500 threshold, but are not subject to FICA taxes. If you are working as an In Home Supportive Service provider for you husband or wife you are not covered by FICA.

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
 ▶ **Give Form W-4 to your employer.**
 ▶ **Your withholding is subject to review by the IRS.**

2020

| | | | |
|---|---|-----------|--|
| Step 1: Enter Personal Information | (a) First name and middle initial | Last name | (b) Social security number |
| | Address | | ▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov . |
| | City or town, state, and ZIP code | | |
| | (c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.) | | |

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

| | | | |
|---|---|-------------|----------|
| Step 3: Claim Dependents | If your income will be \$200,000 or less (\$400,000 or less if married filing jointly): | | |
| | Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____ | | |
| | Multiply the number of other dependents by \$500 ▶ \$ _____ | | |
| | Add the amounts above and enter the total here | 3 | \$ _____ |
| Step 4 (optional): Other Adjustments | (a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income | 4(a) | \$ _____ |
| | (b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here | 4(b) | \$ _____ |
| | (c) Extra withholding. Enter any additional tax you want withheld each pay period | 4(c) | \$ _____ |

| | | | |
|------------------------------------|--|------------------------|--|
| Step 5: Sign Here | Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete. | | |
| | ▶ _____ Employee's signature (This form is not valid unless you sign it.) | ▶ _____ Date | |

| | | | |
|-----------------------|-----------------------------|--------------------------|--------------------------------------|
| Employers Only | Employer's name and address | First date of employment | Employer identification number (EIN) |
| | | | |

General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b) – Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b
c Add the amounts from lines 2a and 2b and enter the result on line 2c
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)

Step 4(b) – Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income
2 Enter: { \$24,800 if you're married filing jointly or qualifying widow(er); \$18,650 if you're head of household; \$12,400 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Widow(er)

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|--|---|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|---------------------|---------------------|
| | \$0 - 9,999 | \$10,000 - 19,999 | \$20,000 - 29,999 | \$30,000 - 39,999 | \$40,000 - 49,999 | \$50,000 - 59,999 | \$60,000 - 69,999 | \$70,000 - 79,999 | \$80,000 - 89,999 | \$90,000 - 99,999 | \$100,000 - 109,999 | \$110,000 - 120,000 |
| \$0 - 9,999 | \$0 | \$220 | \$850 | \$900 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,210 | \$1,870 | \$1,870 |
| \$10,000 - 19,999 | 220 | 1,220 | 1,900 | 2,100 | 2,220 | 2,220 | 2,220 | 2,220 | 2,410 | 3,410 | 4,070 | 4,070 |
| \$20,000 - 29,999 | 850 | 1,900 | 2,730 | 2,930 | 3,050 | 3,050 | 3,050 | 3,240 | 4,240 | 5,240 | 5,900 | 5,900 |
| \$30,000 - 39,999 | 900 | 2,100 | 2,930 | 3,130 | 3,250 | 3,250 | 3,440 | 4,440 | 5,440 | 6,440 | 7,100 | 7,100 |
| \$40,000 - 49,999 | 1,020 | 2,220 | 3,050 | 3,250 | 3,370 | 3,570 | 4,570 | 5,570 | 6,570 | 7,570 | 8,220 | 8,220 |
| \$50,000 - 59,999 | 1,020 | 2,220 | 3,050 | 3,250 | 3,570 | 4,570 | 5,570 | 6,570 | 7,570 | 8,570 | 9,220 | 9,220 |
| \$60,000 - 69,999 | 1,020 | 2,220 | 3,050 | 3,440 | 4,570 | 5,570 | 6,570 | 7,570 | 8,570 | 9,570 | 10,220 | 10,220 |
| \$70,000 - 79,999 | 1,020 | 2,220 | 3,240 | 4,440 | 5,570 | 6,570 | 7,570 | 8,570 | 9,570 | 10,570 | 11,220 | 11,240 |
| \$80,000 - 99,999 | 1,060 | 3,260 | 5,090 | 6,290 | 7,420 | 8,420 | 9,420 | 10,420 | 11,420 | 12,420 | 13,260 | 13,460 |
| \$100,000 - 149,999 | 1,870 | 4,070 | 5,900 | 7,100 | 8,220 | 9,320 | 10,520 | 11,720 | 12,920 | 14,120 | 14,980 | 15,180 |
| \$150,000 - 239,999 | 2,040 | 4,440 | 6,470 | 7,870 | 9,190 | 10,390 | 11,590 | 12,790 | 13,990 | 15,190 | 16,050 | 16,250 |
| \$240,000 - 259,999 | 2,040 | 4,440 | 6,470 | 7,870 | 9,190 | 10,390 | 11,590 | 12,790 | 13,990 | 15,520 | 17,170 | 18,170 |
| \$260,000 - 279,999 | 2,040 | 4,440 | 6,470 | 7,870 | 9,190 | 10,390 | 11,590 | 13,120 | 15,120 | 17,120 | 18,770 | 19,770 |
| \$280,000 - 299,999 | 2,040 | 4,440 | 6,470 | 7,870 | 9,190 | 10,720 | 12,720 | 14,720 | 16,720 | 18,720 | 20,370 | 21,370 |
| \$300,000 - 319,999 | 2,040 | 4,440 | 6,470 | 8,200 | 10,320 | 12,320 | 14,320 | 16,320 | 18,320 | 20,320 | 21,970 | 22,970 |
| \$320,000 - 364,999 | 2,720 | 5,920 | 8,750 | 10,950 | 13,070 | 15,070 | 17,070 | 19,070 | 21,290 | 23,590 | 25,540 | 26,840 |
| \$365,000 - 524,999 | 2,970 | 6,470 | 9,600 | 12,100 | 14,530 | 16,830 | 19,130 | 21,430 | 23,730 | 26,030 | 27,980 | 29,280 |
| \$525,000 and over | 3,140 | 6,840 | 10,170 | 12,870 | 15,500 | 18,000 | 20,500 | 23,000 | 25,500 | 28,000 | 30,150 | 31,650 |

Single or Married Filing Separately

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|--|---|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|---------------------|---------------------|
| | \$0 - 9,999 | \$10,000 - 19,999 | \$20,000 - 29,999 | \$30,000 - 39,999 | \$40,000 - 49,999 | \$50,000 - 59,999 | \$60,000 - 69,999 | \$70,000 - 79,999 | \$80,000 - 89,999 | \$90,000 - 99,999 | \$100,000 - 109,999 | \$110,000 - 120,000 |
| \$0 - 9,999 | \$460 | \$940 | \$1,020 | \$1,020 | \$1,470 | \$1,870 | \$1,870 | \$1,870 | \$1,870 | \$2,040 | \$2,040 | \$2,040 |
| \$10,000 - 19,999 | 940 | 1,530 | 1,610 | 2,060 | 3,060 | 3,460 | 3,460 | 3,460 | 3,640 | 3,830 | 3,830 | 3,830 |
| \$20,000 - 29,999 | 1,020 | 1,610 | 2,130 | 3,130 | 4,130 | 4,540 | 4,540 | 4,720 | 4,920 | 5,110 | 5,110 | 5,110 |
| \$30,000 - 39,999 | 1,020 | 2,060 | 3,130 | 4,130 | 5,130 | 5,540 | 5,720 | 5,920 | 6,120 | 6,310 | 6,310 | 6,310 |
| \$40,000 - 59,999 | 1,870 | 3,460 | 4,540 | 5,540 | 6,690 | 7,290 | 7,490 | 7,690 | 7,890 | 8,080 | 8,080 | 8,080 |
| \$60,000 - 79,999 | 1,870 | 3,460 | 4,690 | 5,890 | 7,090 | 7,690 | 7,890 | 8,090 | 8,290 | 8,480 | 9,260 | 10,060 |
| \$80,000 - 99,999 | 2,020 | 3,810 | 5,090 | 6,290 | 7,490 | 8,090 | 8,290 | 8,490 | 9,470 | 10,460 | 11,260 | 12,060 |
| \$100,000 - 124,999 | 2,040 | 3,830 | 5,110 | 6,310 | 7,510 | 8,430 | 9,430 | 10,430 | 11,430 | 12,420 | 13,520 | 14,620 |
| \$125,000 - 149,999 | 2,040 | 3,830 | 5,110 | 7,030 | 9,030 | 10,430 | 11,430 | 12,580 | 13,880 | 15,170 | 16,270 | 17,370 |
| \$150,000 - 174,999 | 2,360 | 4,950 | 7,030 | 9,030 | 11,030 | 12,730 | 14,030 | 15,330 | 16,630 | 17,920 | 19,020 | 20,120 |
| \$175,000 - 199,999 | 2,720 | 5,310 | 7,540 | 9,840 | 12,140 | 13,840 | 15,140 | 16,440 | 17,740 | 19,030 | 20,130 | 21,230 |
| \$200,000 - 249,999 | 2,970 | 5,860 | 8,240 | 10,540 | 12,840 | 14,540 | 15,840 | 17,140 | 18,440 | 19,730 | 20,830 | 21,930 |
| \$250,000 - 399,999 | 2,970 | 5,860 | 8,240 | 10,540 | 12,840 | 14,540 | 15,840 | 17,140 | 18,440 | 19,730 | 20,830 | 21,930 |
| \$400,000 - 449,999 | 2,970 | 5,860 | 8,240 | 10,540 | 12,840 | 14,540 | 15,840 | 17,140 | 18,450 | 19,940 | 21,240 | 22,540 |
| \$450,000 and over | 3,140 | 6,230 | 8,810 | 11,310 | 13,810 | 15,710 | 17,210 | 18,710 | 20,210 | 21,700 | 23,000 | 24,300 |

Head of Household

| Higher Paying Job Annual Taxable Wage & Salary | Lower Paying Job Annual Taxable Wage & Salary | | | | | | | | | | | |
|--|---|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|---------------------|---------------------|
| | \$0 - 9,999 | \$10,000 - 19,999 | \$20,000 - 29,999 | \$30,000 - 39,999 | \$40,000 - 49,999 | \$50,000 - 59,999 | \$60,000 - 69,999 | \$70,000 - 79,999 | \$80,000 - 89,999 | \$90,000 - 99,999 | \$100,000 - 109,999 | \$110,000 - 120,000 |
| \$0 - 9,999 | \$0 | \$830 | \$930 | \$1,020 | \$1,020 | \$1,020 | \$1,480 | \$1,870 | \$1,870 | \$1,930 | \$2,040 | \$2,040 |
| \$10,000 - 19,999 | 830 | 1,920 | 2,130 | 2,220 | 2,220 | 2,680 | 3,680 | 4,070 | 4,130 | 4,330 | 4,440 | 4,440 |
| \$20,000 - 29,999 | 930 | 2,130 | 2,350 | 2,430 | 2,900 | 3,900 | 4,900 | 5,340 | 5,540 | 5,740 | 5,850 | 5,850 |
| \$30,000 - 39,999 | 1,020 | 2,220 | 2,430 | 2,980 | 3,980 | 4,980 | 6,040 | 6,630 | 6,830 | 7,030 | 7,140 | 7,140 |
| \$40,000 - 59,999 | 1,020 | 2,530 | 3,750 | 4,830 | 5,860 | 7,060 | 8,260 | 8,850 | 9,050 | 9,250 | 9,360 | 9,360 |
| \$60,000 - 79,999 | 1,870 | 4,070 | 5,310 | 6,600 | 7,800 | 9,000 | 10,200 | 10,780 | 10,980 | 11,180 | 11,580 | 12,380 |
| \$80,000 - 99,999 | 1,900 | 4,300 | 5,710 | 7,000 | 8,200 | 9,400 | 10,600 | 11,180 | 11,670 | 12,670 | 13,580 | 14,380 |
| \$100,000 - 124,999 | 2,040 | 4,440 | 5,850 | 7,140 | 8,340 | 9,540 | 11,360 | 12,750 | 13,750 | 14,750 | 15,770 | 16,870 |
| \$125,000 - 149,999 | 2,040 | 4,440 | 5,850 | 7,360 | 9,360 | 11,360 | 13,360 | 14,750 | 16,010 | 17,310 | 18,520 | 19,620 |
| \$150,000 - 174,999 | 2,040 | 5,060 | 7,280 | 9,360 | 11,360 | 13,480 | 15,780 | 17,460 | 18,760 | 20,060 | 21,270 | 22,370 |
| \$175,000 - 199,999 | 2,720 | 5,920 | 8,130 | 10,480 | 12,780 | 15,080 | 17,380 | 19,070 | 20,370 | 21,670 | 22,880 | 23,980 |
| \$200,000 - 249,999 | 2,970 | 6,470 | 8,990 | 11,370 | 13,670 | 15,970 | 18,270 | 19,960 | 21,260 | 22,560 | 23,770 | 24,870 |
| \$250,000 - 349,999 | 2,970 | 6,470 | 8,990 | 11,370 | 13,670 | 15,970 | 18,270 | 19,960 | 21,260 | 22,560 | 23,770 | 24,870 |
| \$350,000 - 449,999 | 2,970 | 6,470 | 8,990 | 11,370 | 13,670 | 15,970 | 18,270 | 19,960 | 21,260 | 22,560 | 23,900 | 25,200 |
| \$450,000 and over | 3,140 | 6,840 | 9,560 | 12,140 | 14,640 | 17,140 | 19,640 | 21,530 | 23,030 | 24,530 | 25,940 | 27,240 |

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

| | |
|-----------------------------------|--|
| Enter Personal Information | |
| First, Middle, Last Name | Social Security Number |
| Address | Filing Status |
| City, State, and ZIP Code | <input type="checkbox"/> SINGLE or MARRIED (with two or more incomes) <input type="checkbox"/> MARRIED (one income) <input type="checkbox"/> HEAD OF HOUSEHOLD |

1. Total Number of Allowances you're claiming (Use Worksheet A for regular withholding allowances. Use other worksheets on the following pages as applicable, Worksheet A+B). _____
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet B and C)** _____
OR

Exemption from Withholding

3. I claim exemption from withholding for 2020, and I certify I meet both of the conditions for exemption.
OR Write "Exempt" here
4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here)

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

| | |
|--|--|
| Employer's Section: Employer's Name and Address | California Employer Payroll Tax Account Number |
|--|--|

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only**. You must file the state form *Employee's Withholding Allowance Certificate* (DE 4) to determine the appropriate California Personal Income Tax (PIT) withholding.

If you do not provide your employer with a withholding certificate, the employer must use Single with Zero withholding allowance.

CHECK YOUR WITHHOLDING: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating EXEMPT must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax on your wages if

- (i) your spouse is a member of the armed forces present in California in compliance with military orders;
- (ii) you are present in California solely to be with your spouse; and
- (iii) you maintain your domicile in another state.

If you claim exemption under **this act**, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

The [California Employer's Guide \(DE 44\) \(PDF, 2.4 MB\)](http://edd.ca.gov/pdf_pub_ctr/de44.pdf) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting [Forms and Publications](http://edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm) (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the [Franchise Tax Board \(FTB\)](http://ftb.ca.gov) (ftb.ca.gov).

If you need information on your last California Resident Income Tax Return (FTB Form 540), visit the Franchise Tax Board (FTB) (ftb.ca.gov).

NOTIFICATION: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of [Title 22, California Code of Regulations \(CCR\)](#), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

PENALTY: You may be fined \$500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the [California Unemployment Insurance Code](#) and section 19176 of the [Revenue and Taxation Code](#).

WORKSHEETS

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:

- Do you claim allowances for dependents or blindness?
- Will you itemize your deductions?
- Do you have more than one income coming into the household?

TWO-EARNERS/MULTIPLE INCOMES: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet all of the following tests:

- (1) Your spouse will not live with you **at any time** during the year;
- (2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
- (3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A

REGULAR WITHHOLDING ALLOWANCES

- | | |
|--|-----------|
| (A) Allowance for yourself — enter 1 | (A) _____ |
| (B) Allowance for your spouse (if not separately claimed by your spouse) — enter 1 | (B) _____ |
| (C) Allowance for blindness — yourself — enter 1 | (C) _____ |
| (D) Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1 | (D) _____ |
| (E) Allowance(s) for dependent(s) — do not include yourself or your spouse | (E) _____ |
| (F) Total — add lines (A) through (E) above and enter on line 1 of the DE 4 | (F) _____ |

INSTRUCTIONS — 2 — (OPTIONAL) ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each \$1,000, or fraction of \$1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

WORKSHEET B

ESTIMATED DEDUCTIONS

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

- | | |
|---|------------|
| 1. Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540 | 1. _____ |
| 2. Enter \$9,074 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or \$4,537 if single or married filing separately, dual income married, or married with multiple employers | – 2. _____ |
| 3. Subtract line 2 from line 1, enter difference | = 3. _____ |
| 4. Enter an estimate of your adjustments to income (alimony payments, IRA deposits) | + 4. _____ |
| 5. Add line 4 to line 3, enter sum | = 5. _____ |
| 6. Enter an estimate of your nonwage income (dividends, interest income, alimony receipts) | – 6. _____ |
| 7. If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference | = 7. _____ |
| 8. Divide the amount on line 7 by \$1,000, round any fraction to the nearest whole number Add this number to Line F of Worksheet A and enter it on line 1 of the DE 4. Complete Worksheet C, if needed, otherwise stop here . | 8. _____ |
| 9. If line 6 is greater than line 5; Enter amount from line 6 (nonwage income) | 9. _____ |
| 10. Enter amount from line 5 (deductions) | 10. _____ |
| 11. Subtract line 10 from line 9, enter difference | 11. _____ |

Complete Worksheet C

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

1. Enter estimate of total wages for tax year 2020. 1. _____
2. Enter estimate of nonwage income (line 6 of Worksheet B). 2. _____
3. Add line 1 and line 2. Enter sum. 3. _____
4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest). 4. _____
5. Enter adjustments to income (line 4 of Worksheet B). 5. _____
6. Add line 4 and line 5. Enter sum. 6. _____
7. Subtract line 6 from line 3. Enter difference. 7. _____
8. Figure your tax liability for the amount on line 7 by using the 2020 tax rate schedules below. 8. _____
9. Enter personal exemptions (line F of Worksheet A x \$134.20). 9. _____
10. Subtract line 9 from line 8. Enter difference. 10. _____
11. Enter any tax credits. (See FTB Form 540). 11. _____
12. Subtract line 11 from line 10. Enter difference. This is your total tax liability. 12. _____
13. Calculate the tax withheld and estimated to be withheld during 2020. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2020. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2020. 13. _____
14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld. 14. _____
15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4. 15. _____

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2020 ONLY

**SINGLE PERSONS, DUAL INCOME
MARRIED WITH MULTIPLE EMPLOYERS**

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|--------------------------|--------------|-------------------|-------------|--------------|
| OVER | BUT NOT OVER | OF AMOUNT OVER... | | PLUS |
| \$0 | \$8,809 | 1.100% | \$0 | \$0.00 |
| \$8,809 | \$20,883 | 2.200% | \$8,809 | \$96.90 |
| \$20,883 | \$32,960 | 4.400% | \$20,883 | \$362.53 |
| \$32,960 | \$45,753 | 6.600% | \$32,960 | \$893.92 |
| \$45,753 | \$57,824 | 8.800% | \$45,753 | \$1,738.26 |
| \$57,824 | \$295,373 | 10.230% | \$57,824 | \$2,800.51 |
| \$295,373 | \$354,445 | 11.330% | \$295,373 | \$27,101.77 |
| \$354,445 | \$590,742 | 12.430% | \$354,445 | \$33,794.63 |
| \$590,742 | \$1,000,000 | 13.530% | \$590,742 | \$63,166.35 |
| \$1,000,000 | and over | 14.630% | \$1,000,000 | \$118,538.96 |

MARRIED PERSONS

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|--------------------------|--------------|-------------------|-------------|--------------|
| OVER | BUT NOT OVER | OF AMOUNT OVER... | | PLUS |
| \$0 | \$17,618 | 1.100% | \$0 | \$0.00 |
| \$17,618 | \$41,766 | 2.200% | \$17,618 | \$193.80 |
| \$41,766 | \$65,920 | 4.400% | \$41,766 | \$725.06 |
| \$65,920 | \$91,506 | 6.600% | \$65,920 | \$1,787.84 |
| \$91,506 | \$115,648 | 8.800% | \$91,506 | \$3,476.52 |
| \$115,648 | \$590,746 | 10.230% | \$115,648 | \$5,601.02 |
| \$590,746 | \$708,890 | 11.330% | \$590,746 | \$54,203.55 |
| \$708,890 | \$1,000,000 | 12.430% | \$708,890 | \$67,589.27 |
| \$1,000,000 | \$1,181,484 | 13.530% | \$1,000,000 | \$103,774.24 |
| \$1,181,484 | and over | 14.630% | \$1,181,484 | \$128,329.03 |

UNMARRIED HEAD OF HOUSEHOLD

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|--------------------------|--------------|-------------------|-------------|--------------|
| OVER | BUT NOT OVER | OF AMOUNT OVER... | | PLUS |
| \$0 | \$17,629 | 1.100% | \$0 | \$0.00 |
| \$17,629 | \$41,768 | 2.200% | \$17,629 | \$193.92 |
| \$41,768 | \$53,843 | 4.400% | \$41,768 | \$724.98 |
| \$53,843 | \$66,636 | 6.600% | \$53,843 | \$1,256.28 |
| \$66,636 | \$78,710 | 8.800% | \$66,636 | \$2,100.62 |
| \$78,710 | \$401,705 | 10.230% | \$78,710 | \$3,163.13 |
| \$401,705 | \$482,047 | 11.330% | \$401,705 | \$36,205.52 |
| \$482,047 | \$803,410 | 12.430% | \$482,047 | \$45,308.27 |
| \$803,410 | \$1,000,000 | 13.530% | \$803,410 | \$85,253.69 |
| \$1,000,000 | and over | 14.630% | \$1,000,000 | \$111,852.32 |

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit [Franchise Tax Board \(FTB\)](http://ftb.ca.gov) (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.