Orange County In-Home Supportive Services Public Authority

1505 East Warner Avenue, Santa Ana, California 92705-5419

IHSS Provider Affidavit for Retroactive Payment(s) Over Six (6) Months

Date: _____

Recipient's Name: _____

Recipient's Case #: _____

Under penalties of perjury, my Recipient (or Recipient's Authorized Representative, Guardian, or Conservator), _____ (Recipient or Authorized Representative Name), and I, _____ (Provider Name) declare through our signatures below that I have been providing ***continuous*** care beginning

_____ (*Indicate Provider's Start Date Here*) to ☐ _____ (*Indicate Provider's End Date Here*) **OR** ☐ am still presently working. (*Only check above box if still working*)

However, IF I have not provided continuous care and the Recipient or I have been hospitalized or on vacation, I will include those dates accordingly and state them here:

_____

_____

I understand that I am not eligible to receive IHSS payments during the days in which my Recipient or I have been hospitalized.

- Any person who signs this statement and who willfully states as true any material matter which he or she knows to be false is subject to the penalties prescribed for perjury in the penal code by the State of California, WIC Section 11054.

Provider Name *(print):* _____ **Phone #**: _____

Provider Signature: _____ **Date**: _____

Recipient or Authorized Representative Name *(print):* _____

Signature: _____ **Date**: _____