



**Distribution:**

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

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

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

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

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

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

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

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

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

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

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

**STATE  
 COMPENSATION  
 INSURANCE  
 FUND**