IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM AND
WAIVER PERSONAL CARE SERVICES (WPCS) PROGRAM
LIVE-IN SELF-CERTIFICATION FORM FOR FEDERAL AND
STATE TAX WAGE EXCLUSION

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Recipient Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Number</td>
<td>Recipient Case Number</td>
</tr>
<tr>
<td>County Of Residence</td>
<td></td>
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</tbody>
</table>

ALL INFORMATION MUST BE COMPLETED.
SEE BACK OF FORM FOR INSTRUCTIONS.

Provider Self-Certification

By completing this form, you are certifying that the wages you receive for providing IHSS
and/or WPCS services to the recipient named above will be excluded from your federal
and state personal income taxes.

Under penalties of perjury, I declare that I am a provider receiving payments under the
IHSS and/or WPCS programs for care I provide to _______________________,
who lives with me in the same home.

Provider Signature: Date of Signature:

RETURN COMPLETED FORM TO:
IHSS – IRS Live-In Self-Certification
P.O. Box 272854
Chico, CA 95927-2854
Instructions for filling out the Live-In Self-Certification Form

1. All requested information must be entered on the form in the designated area.

2. You must sign the form on the designated line.

3. You must provide the date the form was signed on the designated line.

4. Only use black ink and please print clearly.

5. Do not wrinkle or staple the form.

6. Provider Name: Enter your name as it appears on your IHSS paperwork.

7. Provider Number: May be found on your IHSS paperwork – (Provider Notification of Recipient Authorized Hours and Services and Maximum Weekly Hours, Provider Timesheet, etc.).

8. Recipient Case Number: May be found on your IHSS paperwork – Provider Notification of Recipient Authorized Hours and Services and Maximum Weekly Hours, Provider Timesheet, etc.

9. Recipient County of Residence: Please enter the county where you and your Recipient reside.