IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
PROVIDER PAID SICK LEAVE REQUEST FORM

PROVIDER REQUIREMENTS:

- You can only request paid sick leave if you have earned paid sick leave. Your sick leave balance is shown on your pay warrant.
- You can use paid sick leave for yourself or to care for a family member who is sick or has a medical appointment.
- If you are going to be using paid sick leave for a planned medical appointment, you must notify your recipient(s) at least **48 hours prior** to using the sick leave.
- If you need to use paid sick leave for an unplanned medical need, you must notify your recipient **immediately or within two (2.0) hours prior** to your start time.
- You must determine how many hours of paid sick leave you need to take for each occurrence; the minimum amount of paid sick leave that may be used for each occurrence is one (1.0) hour with additional time used in increments of 30 minutes.

INSTRUCTIONS:

- This form must be completed, signed, and dated by the provider.
- You must complete a separate Provider Sick Leave Request Form for each recipient you work for during the sick leave hours you are requesting.
- You must submit the completed second page of the Provider Sick Leave Request Form to the address indicated on the form prior to or at the same time as your submission of the timesheet for the pay period during which you requested the paid sick time.
- Failure to sign and/or timely submit a Sick Leave Request Form may result in your sick leave pay being delayed.
- Use black ink only and press firmly. Numbers must be readable.

Provider Information:

Provider Name (Print):		
Street Address:		
City:	State:	Zip Code:

Provider Number (9 digits): | | | | | | | | | |

Recipient Information: Recipient the provider works for during the sick leave time.

Recipient Name:

_____

Recipient Case Number (7 digits):

The minimum amount of paid sick leave that may be used for each occurrence is one (1.0) hour with additional time used in increments of 30 minutes. I am requesting paid sick leave for pay period _____for the following date(s):

	M M	D D	Y Y Y Y		H H	M M
Absence Date:	/	/		Total Hours Requested:	:	
Absence Date:	/	/		Total Hours Requested:	:	
Absence Date:	/	/		Total Hours Requested:	:	

I hereby acknowledge that

- **The information provided above is true and correct.**
- **I have spoken to my recipient(s), and he/she/they know that I will be taking sick leave on the dates and for the amount of time indicated above.**

Provider's Signature:	Date:

Please submit this completed form to the following address for processing:

Sick Leave Processing Center
P.O. Box 989700
West Sacramento, CA 95798-9700