Alameda County
Social Services Agency

Department of Adult and Aging Services
In-Home Supportive Services
Office Address: 6955 Foothill Blvd., Suite 143
Oakland, CA 94605
Mailing Address: 6955 Foothill Blvd., Suite 300
Oakland, CA 94605

Provider Enrollment Instructions

To become an In-Home Supportive Services (IHSS) provider, you must:

- ✓ Complete the IHSS Provider Enrollment Packet;
- ✓ Attend a mandatory new provider orientation; **and**
- ✓ Be fingerprinted and complete a criminal background check.

All of these requirements must be completed within 90 days from the date you begin the provider enrollment process. In order to be paid as a provider by the IHSS Program, you must be enrolled and approved as a provider. If you do not complete these requirements within the timeframe, you will be found ineligible to work and will not be paid by the IHSS Program.

If you begin providing services prior to completing the enrollment requirements and is ultimately determined to be an eligible provider, you may be eligible to receive retroactive payments for services provided up to a maximum of 90 calendar days from the date you completed the provider enrollment requirements.

If you begin providing services prior to completing the enrollment requirements and is ultimately determined NOT an eligible provider, the IHSS recipient is responsible for paying you for your services.

Existing Providers

If you are an existing or returning provider who has completed the provider orientation **AND** it has been less than one (1) year since you cleared the background check, please e-mail, fax, mail or submit in person to the IHSS office at the address listed above the following:

- ❒ Completed Provider Enrollment Packet. See instructions on page 2.
- ❒ Copy of your signed social security card and your original Resident Alien or Employment Authorization Card **if your Social Security Card states, "Authorization Needed".**

If you moved here from another county and are a current provider, provide a copy of your valid photo identification and social security card.

New Providers

If you are a new provider (not previously enrolled OR it has been 12 months or more since you last worked), please submit/complete:

- ❒ Completed Provider Enrollment Packet. See instructions on page 2.
- ❒ Original signed Social Security Card. Include your original Resident Alien or Employment Authorization Card if your Social Security Card states, "Authorization Needed". **Submit in person at provider orientation**
- ❒ Original valid/unexpired government issued photo identification (CA Driver License or Identification Card, U.S Passport or Military Identification). **Submit in person at provider orientation**

~CONTINUED (FLIP) ~

- ❒ IHSS New Provider Orientation.
  - To attend and complete a remote orientation (online), visit IHSS Provider Enrollment (acgov.org)
  - New Provider Orientation Calendar information is available:
    - On the IHSS Website: https://alamedasocialservices.org/public/services/elders_and_disabled_adults/in_home_Supportive_services.cfm;
    - In the IHSS office located at 6955 Foothill Blvd., 1st Floor Suite 143, Oakland, Ca 94605; or
    - The IHSS Payroll Call Center at 510.577.1877
    - Orientations are for providers only – No guests including recipients and children will be permitted.

- ❒ Information regarding Live Scan fingerprinting sites will be provided to you in order for you to complete the criminal background check. **You are responsible for paying for the fees.**

Instructions for Completing the Provider Enrollment Packet

New and Existing Providers

1. **If you are a new or existing provider, complete the following forms:**
   - SOC 426A IHSS Recipient Designation of Provider *(provider portion required)*
   - W-4, Employee's Withholding Allowance Certificate *(optional)*
   - DE-4 Employee's Withholding Allowance Certificate State *(optional)*
2. **Submit all required enrollment forms (packet) in one of the following ways:**
   - Email to: IHSSProviderEnrollment@acgov.org
   - Fax to: (510) 577-1803
   - Mail to: In-Home Supportive Services
     6955 Foothill Blvd., Suite 300
     Oakland, CA 94605
   - Drop-off to: Office Lobby at Suite 143
3. **Keep the following forms for your records:**
   - PUB 104, IHSS Individual Provider Benefits and Services Information
   - SOC 426C, IHSS California Code Sections
   - SOC 847, Important Information for Prospective Providers About the IHSS Provider Enrollment Process
   - Facts about Workers' Compensation
   - 72-16, Universal Precautions Notification

IHSS Recipients

1. **If you are the recipient, complete the following forms:**
   - SOC 426A, IHSS Recipient Designation of Provider *(required)*
   - **If you are terminating a former provider:**
     - 70-19, Provider Leave or Discontinuance *(optional)*

For assistance, please call (510) 577-1877. Thank you.

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.

Tier 1 crimes include: • 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.	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. • You are **NOT** eligible even if you had a **Tier 1** crime that was expunged from your record.
Tier 2 crimes include: • 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). *You can ask the County IHSS Office or IHSS Public Authority for a list of the Tier 2 crimes.*	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: • 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. *Read the sections below for more information.*

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.

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):	☐ Male ☐ Female
9.	Provider's Relationship to Recipient (if any):	☐ Parent ☐ Child ☐ Spouse/Domestic Partner ☐ Conservator ☐ Guardian ☐ 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 <u>maximum weekly hours</u>. 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:

Alameda County
Social Services Agency

Department of Adult, Aging and Medi-Cal Services
In-Home Supportive Services
6955 Foothill Blvd., Suite 300
Oakland, CA 94605

PROVIDER LEAVE OR DISCONTINUANCE

Provider Name (Last, First)	
Address	City, State and Zip code
Telephone Number	Social Security Number

This form will serve as written request to:

☐ **Discontinue the provider's employment with the following recipient:**
☐ **Place the provider in Leave status (suspend my employment) for the following recipient:**

Recipient Information	
Name (Last, First)	
Case Number or Social Security Number	Telephone Number
Last day the provider worked	Total number of hours authorized from the first day of the month to the last day worked.

Reason(s) for discontinuance or Leave request:

☐ Quit/ Fired	☐ Recipient is in the hospital.
☐ Disability/Workers' Compensation injury	☐ Recipient is deceased.
☐ Recipient is no longer eligible for services.	
☐ Recipient is on vacation/out of County/State/Country. Anticipated Return Date .	
☐ Other reasons	

Person Completing Form: ☐ Recipient ☐ Provider ☐ Recipient's Authorized Representative	
Print Name	Date
Signature	

County Use Section

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 retum. You should contact your local Internal Revenue Service office or your tax consultant for information about EIC.

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 _____

_____

Address _____

_____

_____

Phone: _____

_____

County of:

For information about IHSS
call the local
county welfare department

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES

PUB 104 (12/06)

IN-HOME SUPPORTIVE SERVICES

INDIVIDUAL PROVIDER BENEFITS AND SERVICES INFORMATION

CDSS
CALIFORNIA
DEPARTMENT OF
SOCIAL SERVICES

Pre-designation Of Personal Physician

In the event you sustain an injury or illness related to your employment, you may be treated for such injury/illness by your personal medical doctor (M.D) or doctor of osteopathic medicine (D.O.) or medical group if: You have health care insurance for injuries/illness that are not work related, the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records; your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries; prior to the injury your doctor agrees to treat you for work injuries or illnesses; prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury/illness, and (2) your personal doctor's name and business address.

You may use this form, a form provided by your employer or provide all the information in writing to notify your employer if you wish to have your personal medical doctor or a doctor osteopathic medicine treat you for a work-related injury/illness and the above requirements are met.

Notice Of Pre-designation Of Personal Physician

Employee: Complete this section

Employer _____

If I have a work-related injury or illness, I choose to be treated by:

_____
(Name of doctor) (M.D., D.O., or medical group)

_____
(street address, city, state, zip)

_____
(telephone number)

Employee Name (please print): _____

Employee's Address:_____

Employee Signature:_____Date_____

Note to Employee: Unless you agree in writing, neither your employer or York may contact your personal physician to confirm a pre-designation. If your physician does not sign this form, other documentation that they agreed to be pre-designated prior to the injury will be required. If you agree, your employer or York may contact your personal physician to confirm this pre-designation, sign and date below:

Employee Signature_____

Employee #_____ Date_____

Physician: I agree to this Pre-designation:

Signature:_____Date_____

(Physician or Designated Employee of the Physician)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Notice Of Personal Chiropractic Or Personal Acupuncturist

If your employer or your employer's insurer does not have a Medical Provider Network (MPN), you may be able to change your treating physician to your personal chiropractor (D.C.) or acupuncturist (L.AC.) following a work-related injury/illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal D.C. or L.AC. in writing prior to the injury/illness. York generally has the right to select your treating physician within the first 30 days after your employer knows of your injury/illness. After your employer or York has initiated your treatment with another physician during this period, you may then, upon request, have your treatment transferred to your personal D.C. or L.AC. You may use this form to notify your employer of your personal D.C. or L.AC., or your employer may have their own form. The D.C. or L.AC. must be your regular D.C. or L.AC. who has directed your treatment and retains your chiropractic records and history. If your employer has an MPN, you may only switch to a D.C. or L.AC. within the MPN. A chiropractor cannot be your treating physician after 24 visits. If you still require medical treatment thereafter, you will have to select a physician who is not a chiropractor.

_____ _____
Name of chiropractor or acupuncturist (D.C., L.AC.)

_____
(street address, city, state, zip code)

_____
(telephone number)

Employee Name (Please Print):_____

Employee's Address:_____

_____

Employee's Signature:_____

Date:_____

WHEN A WORK INJURY OCCURS…

- **Quickly seek first aid. Call 9-1-1 for help immediately**
- **If emergency medical care is needed.**
- **Immediately report injuries to your supervisor or employer representative at** _____

_____

_____

Information & Assistance Office:_____

_____

_____

Employer MUST complete this information

The Facts About Workers' Compensation

For dates of injury on or after January 1, 2013

York Risk Services Group, Inc.
P.O. Box 619079
Roseville, CA 95661
Phone (866) 221-2402
Fax (866) 548-2637

Approved by Division of Workers' Compensation

What is workers' compensation? Its purpose is to insure that an employee who is found to sustain an industrial injury or illness will be provided with benefits to medically cure or relieve them from the effects of the injury/illness, provide temporary compensation when they are medically unable to perform any occupational function, compensation for any residual handicap and/or impairment of bodily function, benefits for dependents if an employee dies as a result of an injury/illness, protection from discrimination by his/her employer because of the injury/illness.

Am I Covered? Nearly every person employed in California is protected by workers' compensation, however there are a few exceptions. People that are self-employed or volunteer workers may not be covered. Similar laws cover federal and maritime workers. York Risk Services Group (York) is your employer's claims administrator. Your employer or York can answer any questions you might have about coverage.

What Does Workers' Compensation Cover? If you have an injury/illness due to your job, it is covered. The cause can be a single event, like a fall or it can be due to repeated exposures, such as hearing loss due to constant loud noise. Injuries ranging from first-aid to serious accidents are covered. Even injuries related to a workplace crime, such as psychological or physical injuries, are covered under workers' compensation. Some injuries that result from voluntary activity, such as off duty social or athletic activities may not be covered. Check with your employer or York if you have questions. Coverage begins the moment you start your job. There is no probationary period or wage rate.

Duty Of The Employee. Immediately notify your employer or York so you can get the medical help that you need without delay. If your injury is greater than a first-aid injury, your supervisor will give you a Claim Form (Form DWC-1) for you to describe where, when and how it happened. To submit a claim, fill out the "Employee" section of the DWC-1. Keep one copy of this form and give the remaining pages to your supervisor. Your employer will fill out the "Employer" section and return a signed and dated copy of the form to you. Your employer will keep a copy of this form and forward another to York. York is in charge of handling your claim and informing you about your eligibility for benefits.

Your claim benefits do not start until your employer knows about your injury, so report and file the DWC-1 as quickly as possible. California law requires your employer to authorize medical treatment within one working day of receipt of your Claim Form. Employers are liable for up to $10,000 in treatment pending a decision by York for a claim to be accepted or rejected. Waiting to report may delay workers' compensation benefits. You may not receive benefits if you fail to file a claim within one year of the date of injury, the date you know the injury was work related, or the date benefits were last provided.

Duty of the Employer: Provide this form to every employee at the time of hire or by the end of their first pay period.

Within one working day, upon knowledge or notice from any source of a work injury/illness greater than first-aid, provide the employee with a Claim Form (DWC-1) and authorize medical treatment and report the claim to York Risk Services Group.

What are the benefits? You may be entitled to various kinds of benefits under California workers' compensation law including:

Medical Care: Medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the injury/illness. There is no deductible or co-payment. These medical benefits may include lab tests, physical therapy, hospital services, medication and treatment by a doctor.

State law limits certain medical services as of January 1, 2004. You should never receive a medical bill. If additional treatment is necessary, York will coordinate medical care that meets applicable treatment guidelines for the injury. The doctor may be a specialist for your specific type of injury, and he or she will be familiar with workers' compensation requirements and will report promptly to York so your benefits can be paid.

The physician with overall responsibility for treating your injury/illness is your primary treating physician (PTP). The PTP decides what kind of medical care you need and if you have work restrictions. If necessary, the PTP will review your job description with you and your employer to define any limitation or restrictions that you may have. This doctor also is responsible for coordinating care between other medical providers and will write reports about any permanent impairment of bodily function(s) or the need for future medical care. Generally, your employer selects the PTP you will see for the first 30 days, but if you want to change doctors for any reason, ask your employer or York. They're as interested as you are in your prompt recovery and return to work and will select a different doctor for you. If your employer has a Medical Provider Network (MPN) you will be directed to treat with a physician within the MPN and different rules apply regarding changing your physician.

You can be treated by your personal physician or medical group immediately if you have health care insurance for injuries or illness that are not work related, and your physician agrees in advance to treat you for any work injuries/illnesses and has previously directed your treatment and retains your medical records and agrees, prior to your injury/illness, to treat you for workplace injuries/illnesses and you gave your employer your physician's name and address in writing before the injury. You may use the form inside of this pamphlet or your employer may have a form for you to use.

If you give the name of your personal chiropractor or acupuncturist, different rules apply, and you may need to see an employer-selected physician first.

Temporary Disability Benefits: If you are not medically able to work for more than three days due to your work-related injury, counting weekends, you have a right to temporary disability (TD) payments to assist substituting your lost wages. After two weeks from reporting the injury, you will receive a check. If your employer has a salary continuation plan, your benefit may be included in your regular paycheck. TD is payable every 14 days until the doctor states you can return to work (Payments won't be made for the first three days, though, unless you're hospitalized as an inpatient or unable to work more than 14 days). The amount of the payments will be two-thirds of your average wage, subject to minimums and maximums set by the state legislature. Although the TD payment will not be the full amount of your regular paycheck, there are no deductions and the payments are tax-free. For injuries occurring on or after January 1, 2008, TD payments are limited to 104 compensable weeks within five years of date of injury. For a few long-term injuries such as chronic lung disease or severe burns, TD payments can last up to 240 weeks within five years from the date of injury. If you reach the maximum TD payment period before you can return to work or before your condition becomes permanent and stationary. See the "Other Benefits" section of this pamphlet for additional in information. A timely filing with Employment Development Department may result in additional State Disability benefits when TD benefits are delayed, denied, or terminated.

Permanent Disability: If your doctor says your injury will always leave you with some permanent impairment of bodily function(s), you may receive permanent disability (PD) payments. The amount depends on the doctor's report, how much of the PD was directly caused by your work, and factors such as your age, occupation, type of injury, and date of injury. State law determines minimum and maximum amounts, and they vary by injury date. If you are entitled to PD, York will send you a letter explaining how the benefit was calculated. If the injury causes PD, the first payment of PD benefits is made within 14 days after the last payment of TD, unless your employer has offered you a position that pays at least 85% of your date of injury wages or if you are returned to a position that pays you 100% of the wages and, compensation paid to you on the date of injury, the PD would be paid after an Award issues.

Supplemental Job Displacement Benefit (SJDB): If you have a permanent whole person impairment, the eligibility for SJDB begins when your employer does not offer regular work, permanent, modified, or alternative work within 60 days of the receipt of a doctor's Medical Maximum Improvement (MMI) report. This is a nontransferable voucher for education-related retraining and/or skill development at state-approved schools, tools, licensing, certification fees and other resources as possible benefits. If you qualify for the supplemental job displacement benefit, York will provide a voucher up to a maximum of $6,000.

Death Benefits: If the injury/illness causes death, payments may be made to your dependents. State law sets these benefits and the total benefit depends on the number of dependents. The payments are made at the same rate as TD payments. In addition, workers' compensation provides a burial allowance.

Discrimination: It a violation of Labor Code Section 132(a) and illegal for your employer to punish or fire you for having a workplace injury/illness, for filing a claim or for testifying in another person's workers' compensation case. If your employer is found guilty of discrimination, you would be entitled to increased benefits, reinstatement and reimbursement for lost wages and benefits.

Other Benefits: Sometimes people confuse workers' compensation with State Disability Insurance (SDI). Workers' compensation covers on-the-job injuries/ illnesses and is paid for by your employer or their insurance. On the other hand, SDI covers off-the-job injuries or sicknesses, and is paid for by deductions from your paycheck. If you are not getting workers' compensation benefits, you may be able to get State Disability benefits. Contact the local office of the State Employment Development Department listed in the government pages of your phone book for more information.

You may be eligible to access the return-to-work fund, for the purposes of making supplemental payments to injured worker's whose PD benefits are disproportionately low in comparison to their earnings loss. If you have questions or think you qualify, contact the Information & Assistance office listed in this pamphlet or visit the DIR website at: www.dir.ca.gov.

If You Still Have Questions…ask your supervisor or employer representative. Or contact York at the number indicated on workers' compensation posters at work and on this brochure. You can also contact the State Division of Workers' Compensation (DWC) and speak with an Information and Assistance Officer. These officers are available to review problems, answer questions and provide additional written information about workers' compensation at no charge. The local office is listed below and posted at your workplace. You can also call 800-736-7401 or visit the DWC website at: http://www.dir.ca.gov/dwc.

WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. Fines can be up to $150,000 and imprisonment up to five years.

Employment Development Department
State of California

Clear Form

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 City, State, and ZIP Code	Filing Status ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (Worksheet A) 0
   - 1b. Number of allowances from the Estimated Deductions (Worksheet B, if applicable.) 0
   - 1c. Total Number of Allowances you are claiming 0
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)**

OR

Exemption from Withholding

3. I claim exemption from withholding for 2021, and I certify I meet both of the conditions for exemption. (Check box here) ☐

OR

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 withholding 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) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting Payroll Taxes - Forms and Publications (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the Franchise Tax Board (FTB) (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the 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) (govt.westlaw.com/calregs/Search/Index), 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 (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes).xhtml).

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 1a of the DE 4	(F)	0

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 $9,202 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $4,601 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.	0
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+ 4.	
5.	Add line 4 to line 3, enter sum	= 5.	0
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.	0
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**.	8.	0
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.	0
11.	Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.	11.	0

*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.

WORKSHEET C **ADDITIONAL TAX WITHHOLDING AND ESTIMATED TAX**

1.	Enter estimate of total wages for tax year 2021.	1.	
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2.	
3.	Add line 1 and line 2. Enter sum.	3.	0
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.	0
7.	Subtract line 6 from line 3. Enter difference.	7.	0
8.	Figure your tax liability for the amount on line 7 by using the 2021 tax rate schedules below.	8.	
9.	Enter personal exemptions (line F of Worksheet A x $136.40).	9.	0
10.	Subtract line 9 from line 8. Enter difference.	10.	0
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.	0
13.	Calculate the tax withheld and estimated to be withheld during 2021. 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 2021. 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 2021.	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.	0
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 2021 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	$8,932	1.100%	$0	$0.00
$8,932	$21,175	2.200%	$8,932	$98.25
$21,175	$33,421	4.400%	$21,175	$367.60
$33,421	$46,394	6.600%	$33,421	$906.42
$46,394	$58,634	8.800%	$46,394	$1,762.64
$58,634	$299,508	10.230%	$58,634	$2,839.76
$299,508	$359,407	11.330%	$299,508	$27,481.17
$359,407	$599,012	12.430%	$359,407	$34,267.73
$599,012	$1,000,000	13.530%	$599,012	$64,050.63
$1,000,000	and over	14.630%	$1,000,000	$118,304.31

UNMARRIED HEAD OF HOUSEHOLD

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER		OF AMOUNT OVER...	PLUS
$0	$17,876	1.100%	$0	$0.00
$17,876	$42,353	2.200%	$17,876	$196.64
$42,353	$54,597	4.400%	$42,353	$735.13
$54,597	$67,569	6.600%	$54,597	$1,273.87
$67,569	$79,812	8.800%	$67,569	$2,130.02
$79,812	$407,329	10.230%	$79,812	$3,207.40
$407,329	$488,796	11.330%	$407,329	$36,712.39
$488,796	$814,658	12.430%	$488,796	$45,942.60
$814,658	$1,000,000	13.530%	$814,658	$86,447.25
$1,000,000	and over	14.630%	$1,000,000	$111,524.02

MARRIED PERSONS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER		OF AMOUNT OVER...	PLUS
$0	$17,864	1.100%	$0	$0.00
$17,864	$42,350	2.200%	$17,864	$196.50
$42,350	$66,842	4.400%	$42,350	$735.19
$66,842	$92,788	6.600%	$66,842	$1,812.84
$92,788	$117,268	8.800%	$92,788	$3,525.28
$117,268	$599,016	10.230%	$117,268	$5,679.52
$599,016	$718,814	11.330%	$599,016	$54,962.34
$718,814	$1,000,000	12.430%	$718,814	$68,535.45
$1,000,000	$1,198,024	13.530%	$1,000,000	$103,486.87
$1,198,024	and over	14.630%	$1,198,024	$130,279.52

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit (FTB) (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.

Employment Development Department
State of California

Clear Form

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 City, State, and ZIP Code	Filing Status ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ 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. ☐ Write "Exempt" here
   OR

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)** (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting **Forms and Publications** (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the **Franchise Tax Board (FTB)** (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)	0

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.	0
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+ 4.	
5.	Add line 4 to line 3, enter sum	= 5.	0
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.	0
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number	8.	0
	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**.		
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.	0
11.	Subtract line 10 from line 9, enter difference	11.	0

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.

WORKSHEET C **ADDITIONAL TAX WITHHOLDING AND ESTIMATED TAX**

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.	0
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.	0
7.	Subtract line 6 from line 3. Enter difference.	7.	0
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.	0
10.	Subtract line 9 from line 8. Enter difference.	10.	0
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.	0
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.	0
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

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

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

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