**IHSS Payroll Dispute Form**

**Date form completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Timesheets attached? 🞎 Yes 🞎 No**

**Form Completed by: 🞎 Provider 🞎 Recipient/AR 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**IHSS Provider Information:**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IHSS Recipient Information:**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IHSS Case Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

**Was this a Public Authority Registry Match? 🞎 Yes 🞎 No**

**Pay Period(s) in Dispute: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please explain actions already taken, and the nature of the conflict: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**If terminated, what date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***(If you need more room, please continue on reverse)***

**The completed form may be submitted in-person (Ste. 143), OR by mail to the address below:**

Adult & Aging Services

IHSS Payroll Disputes

6955 Foothill Blvd, Ste. 300

Oakland, CA 94605