

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY
INCOMPLETE PROVIDER PROCESS**

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____

Applicant Provider Name: _____

Recipient Name: _____

Recipient Case Number: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

The person you have chosen to employ to provide IHSS services to you, _____, is not eligible to receive payment from the IHSS program for providing services to you or to any other person. Here's why:

He/she did not complete one or more of the required steps of the provider enrollment process listed below within 90 days of starting the provider enrollment process.

- He/she did not complete, sign and return the IHSS Provider Enrollment Form (SOC 426) to the county; and/or
- He/she did not attend an IHSS Provider Orientation; and/or
- He/she did not sign an IHSS Provider Enrollment Agreement (SOC 846); and/or
- He/she did not complete a California Department of Justice criminal background check.

Because this individual has been deemed ineligible as an IHSS provider, you must choose a different person to provide services. If you choose to continue receiving services from this individual, you will be responsible for paying him/her with your own money for any services provided.

If you need help finding a different provider, call the IHSS Office at the telephone number listed at the top of this document.