IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE OF PROVIDER INELIGIBILITY

COUNTY OF

(ADDRESSEE)

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider Applicant

As of the date of this notice, you are no longer eligible to be an IHSS provider or to receive payment from the IHSS Program for providing services. Here's why:

> On _____, we sent you a notice telling you that the Provider Enrollment Form (SOC 426) you submitted to the county was incomplete. We asked you to provide the missing information within 15 business days. You did not submit the requested information by the date we requested it.

If you have any questions about this letter, call _____ .