IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER ELIGIBILITY
ACKNOWLEDGEMENT OF RECEIPT OF WAIVER

(ADDRESSEE)

COUNTY OF: ______________________

Notice Date: ______________________
Applicant Provider Name: ______________________
Recipient Name: ______________________
Recipient Case Number: ______________________
IHSS Office Address: ______________________

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IHSS Office Telephone Number: ______________________

To: In-Home Supportive Services (IHSS) Recipient

On ______________, you were informed that, based on Welfare and Institutions Code,
MM/DD/YYYY

Section 12305.87, _________________________ was denied eligibility to work as an IHSS provider because he/she had been convicted of a felony crime.

On _______________________, the IHSS office received your signed waiver request. By signing the waiver, you confirmed that you understand that you are employing the above-named individual to work for you as an IHSS provider with the knowledge of his/her criminal conviction(s) and that the State of California and the County of ________________ are not liable for the actions of this individual while in your employ as an IHSS provider.

He/she may begin work as an IHSS provider for you as of the date of this notice. If this individual has already begun providing IHSS services to you, he/she may be eligible to receive retroactive payments for any authorized services he/she provided up to 90 days prior to the date of this notice.

If you move to a different county and wish to retain the above-named individual as your provider, he/she must go through another criminal background check through the California Department of Justice to be your provider in that county and you must complete and submit another IHSS Recipient Request for Provider Waiver (SOC 862) to that county.

If you have any questions about this notice, call the IHSS office at the telephone number listed at the top of this document.