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

Based on the information you provided on the Provider Enrollment Form (SOC 426), you are not eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing services. Here's why:

- ☐ You were suspended as a provider from the Medicare, Medicaid or Medi-Cal programs, and you were not reinstated. Any provider who has been suspended from the Medicare, Medicaid or Medi-Cal program and who has not been reinstated is ineligible to be enrolled as a provider or to receive payment for providing supportive services.
- ☐ A licensing authority took disciplinary action against your professional license, certificate or other authorization to provide health care. We reviewed the terms and conditions of the licensing authority's decision(s) and found that the terms and conditions prohibit you from providing supportive services.

Because you are not eligible to be an IHSS provider, we will forward this information to the California Department of Health Care Services (CDHCS) and ask that your name be placed on the Medi-Cal Suspended and Ineligible Providers list. You will get a letter from CDHCS when your name is added to the list.

If you disagree with this decision, the back of this page explains how you can request an appeal. You must submit your appeal request within 60 calendar days from the date of this letter.

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