

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO PROVIDER
ACKNOWLEDGEMENT OF RECEIPT OF COUNTY VIOLATION REVIEW
FOR EXCEEDING WORKWEEK AND/OR TRAVEL TIME LIMITS**

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider

This notice is to inform you that the IHSS office has received your request to review the violation you received.

The county now has ten (10) business days to conduct the county review and issue a decision on your request to review the violation. If you are requesting the review of your third or fourth violation, your ineligibility to provide and be paid to provide authorized IHSS to your current recipient or any other person will not begin until after the county has made a decision on your request. You will receive notification of the outcome of your dispute request.

If you have any questions about this notice, you may contact your IHSS office at the phone number above.