IN-HOME SUPPORTIVE SERVICES PROGRAM NOTICE OF INCOMPLETE PROVIDER ENROLLMENT FORM

COUNTY OF

(ADDRESSEE)

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

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

The County reviewed the Provider Enrollment Form (SOC 426) you submitted and has found that the information you provided is incomplete. We are not able to determine if you are eligible to be enrolled as an IHSS provider because you did not provide all of the necessary information. You must submit all of the information indicated below within 15 business days of the date of this letter.

- ☐ Response to Item Number(s) _____ on the SOC 426
- ☐ Copy of notice of reinstatement as a provider in the Medicare, Medicaid and/or Medi-Cal programs
- ☐ Copy of written confirmation from the licensing authority that your professional privileges have been restored
- ☐ Copy of the licensing authority's decision(s), including terms and conditions, regarding disciplinary action(s) taken
- ☐ Other: _____

If you do not provide all of the requested information within 15 business days, you will not be eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing services.

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