TO REQUEST APPEAL OF PROVIDER ENROLLMENT DENIAL:

- This request for appeal must be received within sixty (60) calendar days of the date of the notice informing you that the county has denied your eligibility to serve as an IHSS provider.
- Fill out and sign the second page of this form.
- Provide a copy of your notice from the county denying your eligibility.
- Provide any supporting documentation for your appeal request. You may provide, for example, certified court documents.
- Make a copy of the front and back of this page for your records.
- Send this page to:

California Department of Social Services
Policy and Litigation Branch, Litigation and Appeals Bureau
Attn: PEAU, MS 9-9-04
PO Box 944243
Sacramento, CA 94244-2430

- The California Department of Social Servicers (CDSS), IHSS Provider Enrollment Appeals Unit (PEAU), will review the information contained with this request (including both information you provided and all information provided by the county/Public Authority/ Non-Profit Consortium) to make the decision regarding your eligibility. Upon completion of this review of all materials, the PEAU will make a determination of eligibility.
- If you have any questions, call the CDSS PEAU at (916) 651-3488.

TO REQUEST APPEAL OF PROVIDER ENROLLMENT DENIAL

APPEAL REQUEST

I want to appeal the determination of _____ County about my ineligibility to be a provider of In-Home Supportive Services. I believe that the County's decision is not correct. Here's why:

☐ If you need more space, check the box at left and attach a page.

PRINT NAME:

STREET ADDRESS:

CITY:	**STATE:**	**ZIP CODE:**
TELEPHONE NUMBER:	**DATE OF BIRTH:**	
SIGNATURE OF APPLICANT PROVIDER:	**DATE:**	