

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

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____

Recipient Name: _____

Recipient Case Number: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

This notice is to inform you that the IHSS office has received your provider’s request to review the violation he/she received.

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

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