# IN-HOME SUPPORTIVE SERVICES PROGRAM
# NOTICE TO APPLICANT PROVIDER OF PROVIDER INELIGIBILITY
# TIER I CRIMES (ELDER OR DEPENDENT ADULT ABUSE/CHILD ABUSE & FRAUD AGAINST A GOVERNMENT HEALTH CARE OF SUPPORTIVE SERVICES PROGRAM)
# [WELFARE & INSTITUTIONS CODE SECTION 12305.81]

**(ADDRESSEE)**

County of: _____

Notice Date: _____
Applicant Provider Name: _____
Recipient Name: _____
Recipient Case Number: _____
IHSS Office Address: _____
_____
IHSS Office Telephone Number: _____

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

Due to a criminal conviction, the county/Public Authority/Non-Profit Consortium has denied your eligibility to be an IHSS provider and to receive payment from the IHSS program for providing services.

☐ As part of the provider enrollment process, you submitted fingerprints for a California Department of Justice criminal background check. The background check showed that you had been convicted of a crime(s) that makes you ineligible to be an IHSS provider and to receive payment from the IHSS Program for providing services based on Welfare and Institutions Code (W&IC), Section 12305.81.

☐ The county/Public Authority/Non-Profit Consortium has learned that you have been convicted of a crime(s) that makes you ineligible to be employed as an IHSS provider or to receive payment from the IHSS program for providing services based on Welfare and Institutions Code (W&IC), Section 12305.81. The conviction has been verified through court documents.

The crime(s) which disqualified you is/are listed below:

The recipient who has chosen to hire you has been sent a notice as well, informing him/her that you have been convicted of a crime that makes you ineligible to be employed as an IHSS provider. The recipient has been notified that this conviction information is highly sensitive and must be kept strictly confidential. The recipient is prohibited by law from sharing any part of this information with any other individual or entity.

If you disagree with this determination, the enclosed SOC 856 form, "To Request Appeal of Provider Enrollment Denial," explains how you can request an appeal. Your written appeal request must be received within sixty (60) calendar days from the date of this letter.

If you believe the information provided to the county/Public Authority/Non-Profit Consortium IHSS office is incorrect, you must contact the California Department of Justice, Records Review Unit, at (916) 227-3849, or the court clerk for the Superior Court of the County of _____ to determine the source of the information and to correct the information contained in the court documents or your criminal background check.

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