IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER ELIGIBILITY

(ADDRESSEE)

County of: _____

Notice Date: _____

Provider Name: _____

Recipient Name: _____

Recipient Case Number: _____

IHSS Office Address: _____

_____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

As of the date of this notice, _____, has been officially enrolled as a provider. He/she can now begin providing services for you.

If you have any questions, call _____ .