

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY
ACKNOWLEDGEMENT OF RECEIPT OF INVALID
REQUEST FOR PROVIDER WAIVER**

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

On _____, you were notified that, based on state law*, _____,

(DATE)

(PROVIDER APPLICANT NAME)

the person you chose to be your IHSS provider, was ineligible because he/she had been convicted of a disqualifying crime in the last 10 years. The notice explained that if you wanted him/her to be your provider, even though he/she had been convicted of a disqualifying crime, you could submit a signed request for a provider waiver to the county/Public Authority (PA)/Non-Profit Consortium (NPC) IHSS office.

On _____, the county/PA/NPC IHSS program office received an invalid request

(DATE)

for a provider waiver. The waiver request is invalid because it was signed by _____

(PROVIDER APPLICANT NAME)

as your authorized representative. State law* does not allow your authorized representative to sign the waiver request to be your provider unless he/she is:

- Your parent, guardian or person having legal custody (if you are a minor), or
- Your conservator, spouse or registered domestic partner (if you are an adult).

County/PA/NPC records show that _____ is NOT your parent, guardian

(PROVIDER APPLICANT NAME)

or a person having legal custody (if you are a minor), or your conservator, spouse or registered domestic partner (if you are an adult). If he/she IS your parent, guardian or a person having legal custody (if you are a minor), or if he/she is your conservator, spouse or registered domestic partner (if you are an adult), call your IHSS worker at the number shown at the top of this notice.

If you still want _____ to be your provider, you can either:
(PROVIDER APPLICANT NAME)

- Sign the attached waiver request yourself if you are able, or
- Name another person to be your authorized representative, who will not be your provider, and ask him/her to sign the Recipient Request for Provider Waiver (form SOC 862).

Once the waiver request has been signed, you must return it to the county/PA/NPC IHSS program office, either in person or by mail.

If this person provides services for you without a valid waiver request, you will be responsible for paying him/her with your own money for any services he/she provides.

As an alternative, you may choose someone else to be your provider. If you need help finding a provider, call _____.

If you have any questions about this notice, call your IHSS worker at the number listed at the top of the first page of this notice.

*Welfare and Institutions Code Section 12305.87
