

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO PROVIDER OF PROVIDER ELIGIBILITY
ACKNOWLEDGEMENT OF RECEIPT OF WAIVER**

(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) Provider

On _____, you were informed that, based on Welfare and Institutions Code,
MM/DD/YYYY

Section 12305.87, you were denied eligibility to work as an IHSS provider because you have been convicted of a felony crime.

On _____, the county/Public Authority/Non-Profit Consortium
IHSS program office received the signed waiver request from _____.

You may begin work as an IHSS provider for this recipient as of the date of this notice. This waiver allows you to work for the above-named recipient only and only in the county referenced above. If you wish to work for additional recipients, you will need to obtain a waiver from each of those individuals, or you may request a general exception. If you have already begun providing IHSS services for this individual, you may be eligible to receive retroactive payments for any authorized services you provided up to 90 days prior to the date of this notice.

If the recipient for whom you work moves to a different county or you choose to work as an IHSS provider for a recipient in a different county, you must go through another criminal background check through the California Department of Justice to be used in that county and the recipient for whom you work or will work must complete and submit another IHSS Recipient Request for Provider Waiver (SOC 862) to that county.

If you have any questions about this notice, call the IHSS office at the telephone number listed at the top of this document.