

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE OF PROVIDER ELIGIBILITY**

(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

As of the date of this notice, you have been officially enrolled as an IHSS provider. You can now begin providing services for an IHSS recipient(s) and receiving payment from the IHSS program for providing services.

If you have already begun providing IHSS services to a recipient, you may be eligible to receive retroactive payments for any authorized services you provided for 90 days prior to the date of this notice.

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