

TO ASK FOR AN APPEAL:

- You must ask for an appeal within 60 days of the day the county tells you that you are not eligible to be an IHSS provider.
- Fill out and sign this page.
- Make a copy of the front and back of this page for your records.
- For questions about the request to appeal: (916) 556-1156
- Send this page to:

California Department of Social Services
 Adult Programs Branch
 IHSS Provider Enrollment Appeals Unit, MS 19-04
 PO Box 944243
 Sacramento, CA 94244-2430

APPEAL REQUEST		
I want to appeal the decision of _____ County about my ineligibility to be a provider of In-Home Supportive Services. I believe that the County's decision is not correct. Here's why:		
<input type="checkbox"/> If you need more space, check the box at left and attach a page.		
NAME:		
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER:	DATE OF BIRTH:	
SIGNATURE:	DATE:	