REQUEST FOR SUSPENSION OF MEDI-CAL PAYMENT ELIGIBILITY

Of In-Home Supportive Services (IHSS) Medi-Cal Providers
Under Welfare and Institutions Code Sections 14043.6 and 14123

1. Requestor | Job Title | Organization

2. Street Address | City | State | Zip Code

3. Telephone No.

The agency above hereby requests suspension of the following providers from Medi-Cal:

4. Name	5. Address	6. SSN / TIN	7. Second Identifier	8. S/R
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9. Printed Name of Requestor	10. Signature	11. Date

I have reviewed this form and the attached documents, and verified their accuracy. For every provider bearing a mark in Column 8, I hereby verify that Department of Social Services has formally determined that the provider committed a crime(s) substantially related to the practice of providing In-Home Supportive Services. **(To be completed by DSS Only)**:

12. Printed Name of DSS Employee	13. Signature	14. Date

INSTRUCTIONS

In-Home Supportive Services (IHSS) is a program administered by the Department of Social Services (DSS), in cooperation with county governments, to provide in-home care services to the eligible clients. Services are performed by "providers" who are paid by DSS, usually through the local county government. For the claims of many (but not all) IHSS providers, DSS is in turn reimbursed by the Medi-Cal program (Medi-Cal). Medi-Cal, administered by the Department of Health Care Services (DHCS), is funded by a blend of state and Federal funds under the Federal Medicaid program.

IHSS providers must follow DSS rules and regulations to qualify for payment. They must also follow DHCS rules and regulations in order for DSS to be eligible to be reimbursed with Medi-Cal funds. A "suspension" of the provider from IHSS is a determination that the provider has failed to follow DSS rules and regulations, and can no longer be paid by DSS. A "suspension" of the provider from Medi-Cal is a determination that the provider has failed to follow DHCS rules and regulations; the provider may still be paid by DSS, but DSS cannot be reimbursed for the provider's services with Medi-Cal money.

This form is designed to request suspension of a provider or providers from Medi-Cal. It cannot be used to request a suspension from IHSS. It must be fully completed and accompanied by sufficient supporting documentation. The final decision to suspend from Medi-Cal will be made by DHCS. Any questions about suspension from IHSS should be directed to DSS. Fields must be completed as follows:

1. Requestor: In this field put the name of the individual requesting the suspension, followed by job title and the entity or organization that the requestor works for.
2. The requestor should list a mailing address where he or she can be contacted and to which documents can be returned.
3. Telephone Number: In this field, the requestor should put a telephone number where her or she can be reached during normal business hours.
4. Name: In this column, the requestor should list the full name of each provider to be suspended from Medi-Cal. If the individual uses more than one name, attach a document, such as a court filing, showing other names used.
5. Address: In this column, the requestor should list the most current address for the provider. If the individual uses more than one address, additional addresses should be noted in the attachments.
6. SSN/TIN: In this column, the requestor should list the Social Security Number (SSN) or Tax Identification Number (TIN) used to issue Form 1099 tax statements to the provider.
7. Second Identifier: The requestor must include a second piece of personal information to identify the individual to be suspended, and distinguish that individual from any other person of the same name. Please indicate the type of identifier with the following initials:
   DL: Driver's License or state ID card number GC: INS Green Card number
   DOB: Date of Birth MIL: Military ID Card number
   OTH: Other (Describe)
8. Substantially Related Crime: Check this box only if DSS has formally determined that one or more of the crimes of which the provider was convicted are substantially related to the practice of providing In-Home Supportive Serivces. DSS must keep the formal determination on file and provide it upon request.
9. Printed Name of Requestor: The name of the requestor should be printed in this box.
10. Signature: The requestor must sign this box.
11. Date: The requestor must write the date that the signature in Box 8 was executed.

    Attachments: When the requestor submits the form, he or she must include court minute orders showing the conviction(s) for each listed provider.

    Once the attachments are complete and boxes 1-9 have been filled out, the requestor must submit the form to: In-Home Supportive Services Program, Department of Social Services, 744 P St., Sacramento, CA 95814. The Department of Social Services will complete boxes 12-14.

12. Printed Name of DSS Employee: A DSS employee must review the form and attached documents, and verify their accuracy. The employee who performed this task must print his or her name in this box.
13. Signature: The DSS employee whose name appears in box 10 must sign here.
14. Date: The DSS employee must write the date that the signature in box 11 was executed.

Once the DSS employee has completed boxes 12-14, DSS will forward the form and attachments to: Mandatory Suspension Desk, Department of Health Care Services, MS 0010, PO Box 997413, Sacramento, CA 95899-7413.

The information requested on this form is required by the Department of Health Care Services, Office of Legal Services, Mandatory Suspension Desk, for purposes of processing suspensions of Medi-Cal payment. Furnishing the information requested on this form is voluntary. Information requested on this form is used to determine the Department of Social Services' eligibility to request payment on behalf of IHSS providers who have been convicted of crimes.