STATE OF CALIFORNIA
HEALTH & HUMAN SERVICES AGENCY

Department of Health Care Services

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.	4. Email		

The agency above hereby requests suspension of the following provider(s) from Medi-Cal:

5. Name	6. Address	7. SSN / TIN	8. Second Identifier	9. S/R
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Checklist:

Complaint/ Indictment: ☐ Minute Order(s): ☐

I have reviewed this form and the attached documents and verified its accuracy:

10. Printed Name of Requestor	11. Signature	12. 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 eligible clients. Services are performed by "providers" who are paid by DSS. Claims of many (but not all) IHSS providers, are paid by DSS who 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 reimbursed with Medi-Cal funds. A "suspension" of the provider from the IHSS program 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 and DSS cannot be reimbursed for the suspended 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.
3. Telephone Number during normal business hours.
4. Email address.
5. 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.
6. 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.
7. SSN/TIN: List the Social Security Number (SSN) or Tax Identification Number (TIN) used to issue Form 1099 tax statements to the provider.
8. Second Identifier: The requestor must include a second identifier of individual(s) to be suspended to 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)
9. Substantially Related Crime: Check this box only if you have determined that one or more of the crimes of which the provider was convicted are substantially related to the practice of providing IHSS.
10. Printed Name of Requestor: The name of the requestor should be printed in this box.
11. Signature: The requestor must sign this box.
12. Date: The requestor must write the date that the signature in Box 11 was executed.

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

When completed, the requester must submit the form to: Office of Legal Services, MS 0010, Attn: Mandatory Suspension Desk, Department of Health Care Services, P.O. Box 997413, Sacramento, CA 95899-7413.

The information requested on this form is required by the DHCS, Office of Legal Services, for purposes of processing suspensions of Medi-Cal payment. It will also be used to determine the DSS' eligibility to request payment on behalf of IHSS providers who have been convicted of crimes. Furnishing the information requested on this form is voluntary.