IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT
CANCELLATION OF ALTERNATE SCHEDULE DUE TO RECURRING EVENT

(ADDRESSEE)

County of: _____

Notice Date: _____
Recipient Name: _____
Recipient Case Number: _____
IHSS Office Address: _____
_____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

This notice is to inform you that your request to adjust your maximum weekly hours for a specified week of each month due to a monthly recurring event has been cancelled. As of _____, your provider may not work additional hours during the specified week of each month.
CANCELLATION DATE

This means that your maximum weekly hours will now be the same for each week of the month.

If you have any further questions about this notice, you may contact your county IHSS office at the phone number above.