

NOTICE OF ACTION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES (IHSS) APPROVAL (CONTINUED)

Notice Date: _____
Case Name: _____
Case Number: _____

You must immediately tell the county about any changes that might affect your eligibility or need for IHSS, including changes in income, property, living arrangements, medical conditions or the ability to work. If you have any questions or think more facts should be considered, call your social worker.

Rules: The applicable Manual of Policies and Procedure (MPP) sections are shown above and on the previous page in parentheses. You may review the MPP at your local IHSS office.

Questions?: Please contact your IHSS social worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of the first page of this notice tells how.