

NOTICE OF ACTION

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

COUNTY OF

Notice Date:

Case Name:

Case Number:

NOTICE OF ACTION

STATE OF CALIFORNIA HEALTH AND
HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF
SOCIAL SERVICES

COUNTY OF:

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 Procedures (MPP) sections are shown above and may be reviewed 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 State Hearing Rights included with this notice tells how.
