

COUNTY OF

**NOTICE OF ACTION  
IN-HOME SUPPORTIVE  
SERVICES (IHSS)**

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

(ADDRESSEE)

[ ]

**NOTE:** This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

Notice Date:

Case Name:

Case Number:

Social Worker Name:

Social Worker Number:

Social Worker

Telephone:

Social Worker Address:

**You must immediately tell the county about any changes that might affect your eligibility or need for IHSS, including any 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 rules noted above in parentheses apply; you may review the Manual of Policy and Procedures (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 State Hearing Rights insert included with this notice tells how.