

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

(ADDRESSEE)

County of: _____

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider

This notice is to inform you that your recipient’s request to adjust his/her maximum weekly hours for a specified week of each month due to a monthly recurring event has been cancelled. As of _____, you may no longer work additional hours during the specified week of each month.
CANCELLATION DATE

This means that your recipient’s 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.