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

COUNTY OF

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

Notice Date :_____
Case Name :_____
Case Number :_____
Social Worker Name :_____
Social Worker Number :_____
Social Worker Telephone :_____
Social Worker Address :_____
_____

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.**

(ADDRESSEE)

Total Hours:Minutes of IHSS you can get each month: _____.

Based on an assessment done on _____ (MM/DD/YY), you can get the services shown below for the amount of time shown in the column "Authorized Amount of Service You Can Get."

1) If there is a zero in the "Authorized Amount of Service You Can Get" column or the amount is less than the "Total Amount of Service Needed" column, the reason is explained on the next page(s).
2) "Not Needed" means that your social worker found that you do not require assistance with this task. (MPP 30-756.11)
3) "Pending" means the county is waiting for more information to see if you need that service. See the next page(s) for more information.

SERVICES **Note:** *See the back of the next page for a short description of each service.*	TOTAL AMOUNT OF SERVICE NEEDED (HOURS: MINUTES)	ADJUSTMENT FOR OTHERS WHO SHARE THE HOME (PRORATION)	AMOUNT OF SERVICE YOU NEED (HOURS: MINUTES)	SERVICES YOU REFUSED OR YOU GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET (HOURS: MINUTES)
DOMESTIC SERVICES (per MONTH):					
RELATED SERVICES (per WEEK):					
Prepare Meals					
Meal Clean-up					
Routine Laundry					
Shopping for Food					
Other Shopping/Errands					
NON-MEDICAL PERSONAL SERVICES (per WEEK):					
Respiration Assistance (Help with Breathing)					
Bowel, Bladder Care					
Feeding					
Routine Bed Bath					
Dressing					
Menstrual Care					
Ambulation (Help with Walking, including Getting In/Out of Vehicles)					
Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)					
Bathing, Oral Hygiene, Grooming					
Rubbing Skin, Repositioning					
Help with Prosthesis (Artificial Limb, Visual/ Hearing Aid) and/or Setting up Medications					
ACCOMPANIMENT (per WEEK):					
To/From Medical Appointments					
To/From Places You Get Services in Place of IHSS					
PROTECTIVE SUPERVISION (per WEEK):					
PARAMEDICAL SERVICES (per WEEK):					

TOTAL WEEKLY HOURS:MINUTES OF SERVICE YOU CAN GET:	
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS:MINUTES:	**x 4.33 =**
SUBTOTAL MONTHLY HOURS:MINUTES OF SERVICE YOU CAN GET:	
ADD MONTHLY DOMESTIC HOURS:MINUTES OF SERVICE YOU CAN GET (from above):	
TOTAL HOURS:MINUTES OF SERVICE YOU CAN GET PER MONTH:	

TIME LIMITED SERVICES (per MONTH):					
Heavy Cleaning:					
Yard Hazard Abatement					
Remove Ice, Snow					
Teaching and Demonstration					
TOTAL HOURS:MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:					

Questions?: Please contact your IHSS social worker. See top of page for phone number.
State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.