COUNTY OF

**NOTICE OF ACTION**

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

(ADDRESSEE)

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

**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:

**Total HRS:MINS of IHSS you can get each month: _____.**

Based on an assessment done on_____, you can get the services shown on the next pages 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**<br>***Note:* See the "Description of Services" insert for a short description of each service.** | **TOTAL AMOUNT OF THE SERVICE NEEDED**<br>HRS:MINS | **ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME**<br>(PRORATION) | **AMOUNT OF THE SERVICE YOU NEED**<br>HRS:MINS | **SERVICES YOU REFUSED OR GET FROM OTHERS** | **AUTHORIZED AMOUNT OF SERVICE YOU CAN GET**<br>HRS:MINS |
|---|---|---|---|---|---|
| **DOMESTIC SERVICES (per MONTH)** | | | | | |
| **RELATED SERVICES (per WEEK)** | | | | | |
| Prepare Meals | | | | | |
| Meal Clean-up | | | | | |
| Routine Laundry | | | | | |
| Shopping for Food | | | | | |
| Other Shopping/Errands/Reading Svcs. | | | | | |
| **NON-MEDICAL PERSONAL SERVICES (per WEEK)** | | | | | |
| Respiration Assistance (Help with Breathing) | | | | | |
| Bowel, Bladder Care | | | | | |
| Feeding | | | | | |
| Routine Bed Bath | | | | | |
| Dressing | | | | | |
| Menstrual Care | | | | | |
| Ambulation (Help w/Walking, including Getting In/Out of Vehicles) | | | | | |
| Transferring (Help Moving In/Out of | | | | | |

| **SERVICES**<br>***Note:* See the "Description of Services" insert for a short description of each service.** | **TOTAL AMOUNT OF THE SERVICE NEEDED**<br>HRS:MINS | **ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME**<br>(PRORATION) | **AMOUNT OF THE SERVICE YOU NEED**<br>HRS:MINS | **SERVICES YOU REFUSED OR GET FROM OTHERS** | **AUTHORIZED AMOUNT OF SERVICE YOU CAN GET**<br>HRS:MINS |
|---|---|---|---|---|---|
| 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 | | | | | |
| | | | | | |
| To/From Medical Appointments | | | | | |
| To/From Places You Get Services in Place of IHSS | | | | | |
| **PROTECTIVE SUPERVISION (per WEEK)** | | | | | |
| **PARAMEDICAL SERVICES (per WEEK)** | | | | | |
| TOTAL WEEKLY HRS:MINS OF SERVICE YOU CAN GET: | | | | | |
| MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HRS:MINS: | | | | | **x 4.33 =** |
| SUBTOTAL MONTHLY HRS:MINS OF SERVICE YOU CAN GET: | | | | | |
| ADD MONTHLY DOMESTIC HRS:MINS OF SERVICE YOU CAN GET (from above): | | | | | |
| **TOTAL HRS:MINS OF SERVICE YOU CAN GET PER MONTH:** | | | | | |

| **TIME LIMITED SERVICES (per MONTH)** | | | | | |
|---|---|---|---|---|---|
| **SERVICES** *Note:* **See the "Description of Services" insert for a short description of each service.** | **TOTAL AMOUNT OF THE SERVICE NEEDED** HRS:MINS | **ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME** (PRORATION) | **AMOUNT OF THE SERVICE YOU NEED** HRS:MINS | **SERVICES YOU REFUSED OR GET FROM OTHERS** | **AUTHORIZED AMOUNT OF SERVICE YOU CAN GET** HRS:MINS |
| Heavy Cleaning | | | | | |
| Yard Hazard Abatement | | | | | |
| Remove Ice, Snow | | | | | |
| Teaching and Demonstration | | | | | |
| **TOTAL HRS:MINS OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:** | | | | | |

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**Questions?** Please contact your IHSS social worker. See top of page 1 for phone number.
**State Hearing:** If you think this action is wrong, you can ask for a hearing. The State Hearing Rights included in this notice tells how.