NOTICE OF ACTION

COUNTY OF

IN-HOME SUPPORTIVE SERVICES (IHSS) CHANGE

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)

As of ________ the services you can get and/or the amount of time you can get for services has changed.

Here why: MMDDYYYY

Total Hours:Minutes of IHSS you can get each month is now:_____. This is a/an increase/decrease of______.

You will now get the services shown below for amount of time shown in the column “Authorized Amount of Service You can Get.” That column shows the hours/minutes you got before, the hours/minutes you will get from now on, and the difference. If you are getting less time for a service, the reason(s) is shown on the next page.

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 NOW	WAS	+/-
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.