NOTICE OF ACTION

IN-HOME SUPPORTIVE SERVICES (IHSS)
SHARE OF COST

COUNTY OF

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

Notice Date: _____
Case Name: _____
Case Number: _____

Here's how your share of cost for IHSS was determined:

	WAS	**NOW**
Your countable income	$_____	$_____
Minus SSI/SSP benefit	$_____	$_____
IHSS Share of Cost	**$_____**	**$_____**

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 back of this page tells how.