NOTICE OF ACTION

IN-HOME SUPPORTIVE SERVICES (IHSS) SHARE OF COST

COUNTY OF
Notice Date:
Case Name:
Case Number:

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

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 Proce-dures (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. Please see the State Hearing Rights insert included with this notice.