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

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)

Your eligibility for the In-Home for Supportive Services will stop as of _____. Here's why:
MMDDYYYY

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.