

# NOTICE OF ACTION

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

IN-HOME SUPPORTIVE SERVICES  
(IHSS) SHARE OF COST

COUNTY OF \_\_\_\_\_

Notice Date: \_\_\_\_\_

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

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

	<u>WAS</u>	<u>NOW</u>
Your countable income	\$ _____	\$ _____
Minus SSI/SSP benefit	\$ _____	\$ _____
<b>IHSS Share of Cost</b>	<b>\$ _____</b>	<b>\$ _____</b>

**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. Please see the State Hearing Rights insert included with this notice.

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