

COUNTY OF

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

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

(ADDRESSEE)

**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.**

Notice Date:  
Case Name:  
Case Number:  
Social Worker Name:  
Social Worker Number:  
Social Worker Telephone:  
Social Worker Address:

**Total HRS:MINS of IHSS you can get each month:** \_\_\_\_\_.

Based on an assessment done on\_\_\_\_\_, you can get the services shown on the next pages for the amount of time shown in the column "Authorized Amount of Service You Can Get."

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  <i>Note:</i> See the “Description of Services” insert for a short description of each service.	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS
DOMESTIC SERVICES (per MONTH)					
RELATED SERVICES (per WEEK)					
Prepare Meals					
Meal Clean-up					
Routine Laundry					
Shopping for Food					
Other Shopping/Errands/Reading Svcs.					
NON-MEDICAL PERSONAL SERVICES (per WEEK)					
Respiration Assistance (Help with Breathing)					
Bowel, Bladder Care					
Feeding					
Routine Bed Bath					
Dressing					
Menstrual Care					
Ambulation (Help w/Walking, including Getting In/Out of Vehicles)					
Transferring (Help Moving In/Out of					

SERVICES <i>Note: See the “Description of Services” insert for a short description of each service.</i>	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS
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					
To/From Medical Appointments					
To/From Places You Get Services in Place of IHSS					
PROTECTIVE SUPERVISION (per WEEK)					
PARAMEDICAL SERVICES (per WEEK)					
TOTAL WEEKLY HRS:MINS OF SERVICE YOU CAN GET:					
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HRS:MINS:					x 4.33 =
SUBTOTAL MONTHLY HRS:MINS OF SERVICE YOU CAN GET:					
ADD MONTHLY DOMESTIC HRS:MINS OF SERVICE YOU CAN GET (from above):					
TOTAL HRS:MINS OF SERVICE YOU CAN GET PER MONTH:					

TIME LIMITED SERVICES (per MONTH)					
SERVICES <i>Note: See the “Description of Services” insert for a short description of each service.</i>	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS
Heavy Cleaning					
Yard Hazard Abatement					
Remove Ice, Snow					
Teaching and Demonstration					
TOTAL HRS:MINS OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:					

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**Questions?** Please contact your IHSS social worker. See top of page 1 for phone number.

**State Hearing:** If you think this action is wrong, you can ask for a hearing. The State Hearing Rights included in this notice tells how.