REQUEST FOR IHSS REASSESSMENT

TO: County of _____

Name of Social Worker: _____

IHSS Case # _____

I, _____
Name of IHSS Recipient

request a reassessment because my needs for services has changed and I need more hours.

Thank you for your consideration of my request for reassessment.

Dated:_____ _____

Signature of IHSS Recipient/Representative

FORM INSTRUCTION: This form should be mailed to the IHSS recipient's social worker anytime the IHSS recipient believes that he or she has a change and in needs more hours.

If the county does not act on this request within 30 days file for a state hearing at: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

IHSS State Regulation Number §30-761.219

The county shall reassess the recipient's need for services:
(a) Any time the recipient notifies the county of a need to adjust the service hours authorized due to a change in circumstances; or

(b) When there is other pertinent information which indicates a change in circumstances affecting the recipient's need for supportive services.

For Assistance contact CCWRO at 916-712-0071 or email
kevin.aslanian@ccwro.org

Additional Areas of Services Requested

Type of Service	Current hours per week	Hours requested per week	Rank	Reason for request
Domestic Services				
Respiration				
Bowel/bladder care				
Feeding				
Be bath				
Dressing				
Min. Care				
Ambulation				
Transfer				
Bathing				
Medical Appointment				
Protective superviusion				