REQUEST FOR IHSS ADVANCE PAY

TO: County of _____

Name of Social Worker: _____

IHSS Case # _____

I, (name of IHSS beneficiary) _____
request "advance pay" effective immediately.

Thank you for your consideration of my request for reassessment.

Dated:_____ _____
Signature of IHSS Recipient/Representative

FORM INSTRUCTION: This form should be mailed or emailed to the IHSS beneficiary's social worker anytime the IHSS beneficiary. If the county does not act on this request within 30 days file for a state hearing at: CCWRO.ORG

IHSS Advance Pay State Regulations

MPP § 30-769.731 Severely impaired recipients as defined under Section 30-753, shall have the option of choosing to directly receive their payment at the beginning of each authorized month. Such payment shall be the net amount exclusive of the appropriate withholdings.

MPP § 30-701(s) (1) Severely Impaired Individual means a recipient with a total assessed need, as specified in Section 30-763.5, for 20 hours or more per week of service in one or more of the following areas:
(A) Any personal care service listed in Section 30-757.14.
(B) Preparation of meals.
(C) Meal cleanup when preparation of meals and consumption of food (feeding) are required.
(D) Paramedical services.

For Assistance Contact

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

OPTIONAL: If you want help with this please sign below. Thank You

I hereby authorize Kevin Aslanian to be my authorized representative.

Date Your Signature