IN-HOME SUPPORTIVE SERVICES
INTER-COUNTY TRANSFER

Date: _____

TO: County of

RE: Name SSN: DOB:

The above named IHSS recipient moved to your county during the month of January.
The recipient is requesting a transfer of his/her In-Home Support services in accordance with Welfare and Institutions Code, Sections 10553, 11102 and Manual of Policy and Procedures Section 30-759.9.

The recipient's new address is:
Street or P.O. Box:
City: California Zip code:
Phone:

☐ This is an Income Eligible recipient.
Eligibility Worker Name: EW Code:
Phone: ( )

☐ Documents included with this letter:

☐ SOC 293 Needs Assessment	☐ NA 690 Notice of Action
☐ SOC 293A Face Sheet	☐ SOC 821 Protective Supervision
☐ SOC 295 Application for Social Services	☐ Assessment Worksheet
☐ SOC 311 IHSS Provider Information	☐ Medical/Nursing Information
☐ SOC 326 Paramedical Services Consent	☐ Comment/Contact Sheet
☐ SOC 426 PCSP Provider Agreement	☐ Other Forms/Comments

The County of will pay for IHSS services until the discontinuance date of: _____
I may be reached at ( ) for additional information.

Sincerely,

Social Service Worker
Receiving County: Please sign and return a copy of this document which will verify that your County will accept responsibility for this case effective: _____
Social Worker: Phone: Comments: