IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT
APPROVAL OF EXCEPTION TO EXCEED WEEKLY HOURS

(ADDRESSEE)

COUNTY OF: _____
Notice Date: _____
Provider Name: _____
IHSS Office Address: _____

_____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

This notice is to inform you that your request for an exception to exceed your maximum weekly hours has been approved for the service month of _____.
MONTH

You may have your provider(s) work these additional hours.

You will need to adjust your providers' work hours by reducing an amount equal to the number of approved exception hours before the end of the month to make sure your monthly authorized hours are not exceeded. If you do not adjust your providers' work hours before the end of the month, your provider(s) will not be paid for the excess hours by the IHSS program, and you will be responsible for the payment of any service hours beyond your authorized monthly hours.

If you have any further questions about this notice, you may contact your county IHSS office at the phone number above.