IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO PROVIDER
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) Provider

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

Your recipient will authorize you or any other of his/her providers to work these hours. Do not work these hours without first obtaining permission from your recipient.

Your recipient will need to adjust your work hours by reducing an amount equal to the number of approved exception hours before the end of the month. This is to make sure you, and any other providers the recipient may have, do not exceed his/her monthly authorized hours. If your recipient does not adjust your work hours before the end of the month, you will not be paid for the excess hours by the IHSS program. Instead, your recipient will be responsible for the payment of any service hours you work beyond his/her authorized monthly hours.

Also, please note that if you work for more than one recipient, you cannot work more than 66 hours in a workweek. Therefore, if the adjustment to your recipient's maximum weekly hours would result in you working more than 66 hours in a workweek, you will not be able to work those additional hours or you may have to adjust the hours you work for another recipient.

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