IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
EXEMPTION FROM WORKWEEK LIMITS FOR EXTRAORDINARY CIRCUMSTANCES
APPROVED EXEMPTION PROVIDER AGREEMENT

Provider Name:		Provider Number:	

Recipient #1 Name:		Case #:	
Recipient #2 Name:		Case #:	
Recipient #3 Name:		Case #:	

By signing below, I acknowledge, understand and agree that, as a condition of being granted an exemption from the IHSS Program workweek limits, I hereby certify to abide by all of the following conditions:

- The exemption applies only to the services I provide for the above-named recipients.
- I may not work for an individual recipient more hours than that recipient is authorized in a month.
- The maximum combined total number of authorized hours I can work for the above-named recipients shall not exceed 360 hours per month.
- Working over 360 authorized hours per month may lead to me being ineligible to be a provider in the IHSS Program.
- If my recipients' combined authorized hours total more than 360 per month, one or more of my recipients will need to hire another provider to work the hours above 360 per month.
- I will notify the county of any changes in my employment arrangements within 15 days. If I no longer work for the above-named recipients, the exemption will be rescinded and I will be subject to the standard workweek limits. In that case, the maximum number of hours I will be able to work for two or more recipients combined is 66 hours in a workweek.

Provider Signature:		Date:	

Please keep a copy of this signed agreement for your records and return the original to:

<County IHSS Agency>
<County IHSS Agency Address>
<City>, CA <ZIP Code>

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