

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
EXEMPTION FROM WORKWEEK LIMITS FOR EXTRAORDINARY CIRCUMSTANCES  
REFERRAL JUSTIFICATION**

|                                     |  |  |  |
|-------------------------------------|--|--|--|
| <input type="checkbox"/> <b>NEW</b> |  | <input type="checkbox"/> <b>Renewal</b> <i>(Must be same provider, recipients, and criteria as initial referral justification)</i> |  |
| <b>County Name:</b>                 |  |  |  |
| <b>Provider Name:</b>               |  | <b>Provider #:</b>   |  |

To be considered for an Extraordinary Circumstances Exemption (Exemption 2), the provider must work for two or more IHSS recipients and ALL of the recipients the provider works for must meet AT LEAST ONE of the following conditions which puts them at serious risk of placement in out-of-home care:

- Criteria A:** Have complex medical and/or behavioral needs that must be met by a provider who lives in the same home as the recipient;
- Criteria B:** Live in a rural or remote area where available providers are limited and as a result the recipient is unable to hire another provider; and/or
- Criteria C:** Be unable to hire a provider who speaks his/her same language in order to direct his/her own care.

*Note: The provider need not live in the same home as the recipients to qualify for Criteria B and C*

|  |  |   |  |
|--|--|---|--|
| <b>Recipient #1 Name:</b>  |  | <b>Case #:</b>  |  |
| <b>Meets the Following Referral Condition(s): (Check all that apply)</b>   |  |   |  |
| <input type="checkbox"/> <b>Complex Medical/Behavioral Needs</b> <input type="checkbox"/> <b>Rural/Remote</b> <input type="checkbox"/> <b>Language/Communication</b> |  |   |  |
| <b>Is the provider an Authorized Representative/Conservator for this recipient?</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>           |  |   |  |
| <b>Relationship to Provider:</b>   |  |   |  |
| <b>Did provider apply for Exemption 1 for this recipient?</b><br><input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>                              |  | <b>If yes, was the provider:</b><br><input type="checkbox"/> <b>APPROVED</b> <input type="checkbox"/> <b>DENIED</b> |  |
| <b>If approved, why is an Exemption 2 being requested?</b>   |  |   |  |

|  |  |   |  |
|--|--|---|--|
| <b>Recipient #2 Name:</b>  |  | <b>Case #:</b>  |  |
| <b>Meets the Following Referral Condition(s): (Check all that apply)</b>   |  |   |  |
| <input type="checkbox"/> <b>Complex Medical/Behavioral Needs</b> <input type="checkbox"/> <b>Rural/Remote</b> <input type="checkbox"/> <b>Language/Communication</b> |  |   |  |
| <b>Is the provider an Authorized Representative/Conservator for this recipient?</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>           |  |   |  |
| <b>Relationship to Provider:</b>   |  |   |  |
| <b>Did provider apply for Exemption 1 for this recipient?</b><br><input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>                              |  | <b>If yes, was the provider:</b><br><input type="checkbox"/> <b>APPROVED</b> <input type="checkbox"/> <b>DENIED</b> |  |
| <b>If approved, why is an Exemption 2 being requested?</b>   |  |   |  |

|  |  |   |  |
|--|--|---|--|
| <b>Recipient #3 Name:</b>  |  | <b>Case #:</b>  |  |
| <b>Meets the Following Referral Condition(s):</b> (Check all that apply)   |  |   |  |
| <input type="checkbox"/> <b>Complex Medical/Behavioral Needs</b> <input type="checkbox"/> <b>Rural/Remote</b> <input type="checkbox"/> <b>Language/Communication</b> |  |   |  |
| Is the provider an Authorized Representative/Conservator for this recipient? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>                  |  |   |  |
| <b>Relationship to Provider:</b>   |  |   |  |
| Did provider apply for Exemption 1 for this recipient?   |  | If yes, was the provider:   |  |
| <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>   |  | <input type="checkbox"/> <b>APPROVED</b> <input type="checkbox"/> <b>DENIED</b> |  |
| If approved, why is an Exemption 2 being requested?  |  |   |  |

**FOR RENEWAL ONLY**

**Have any circumstances changed since the initial referral justification approval?**

**YES**     **NO**

*If YES, complete as a new referral justification (General Questions Section and appropriate Section for criteria).*

*If NO, complete General Questions Section and sign/approve Section D).*

**GENERAL QUESTIONS** *(New and Renewal)*

|           |   |
|-----------|---|
| <b>1.</b> | <p><b>Has the county inquired whether other adults living in the home would be able and willing to be a paid provider for both or either recipient?</b></p> <p style="text-align: center;"><input type="checkbox"/> <b>YES</b>    <input type="checkbox"/> <b>NO</b></p> <p><b>If YES, explain why this is not a viable option. If NO, explain why the county has not explored this option.</b></p>   |
|           |   |
| <b>2.</b> | <p><b>Has the county inquired whether an IHSS recipient in the home would be eligible to be a provider?</b> <i>(Note: an IHSS recipient can be an IHSS provider as long as they are not providing the same services they are authorized.)</i></p> <p style="text-align: center;"><input type="checkbox"/> <b>YES</b>    <input type="checkbox"/> <b>NO</b></p> <p><b>If YES, explain why this is not a viable option. If NO, explain why the county has not explored this option.</b></p> |
|           |   |
| <b>3.</b> | <p><b>Has the county inquired whether other relatives, friends or neighbors living outside</b></p>  |

|    |   |
|----|---|
|    | <p><b>the home would be able and willing to provide services for both or either recipient?</b><br/> <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>If YES, explain why this is not a viable option. Include names of individuals contacted and outcome of discussions. If NO, explain why the county has not explored this option.</b></p>  |
|    |   |
| 4. | <p><b>Are there currently other active providers on the case(s)?</b><br/> <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>If YES, explain why the active provider(s) cannot rearrange work hours so that the 66 hour workweek limit is not exceeded.</b></p>   |
|    |   |
| 5. | <p><b>Have there been other providers on the case(s) in the past?</b><br/> <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>If YES, explain why they are no longer a viable option.</b></p>   |
|    |   |
| 6. | <p><b>Has the county explored hiring another provider to provide non-personal care services (e.g. domestic, related, protective supervision, etc.)?</b><br/> <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>If YES, explain why this is not a viable option. Include names of individuals contacted and outcome of discussions. If NO, explain why the county has not explored this option.</b></p> |
|    |   |
| 7. | <p><b>Has outreach been made to the provider registry/Public Authority to inquire about</b></p>   |

|                  |   |
|------------------|---|
|                  | <p><b>individuals willing to be a provider for both or either recipient?</b><br/> <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p><b>If YES, explain why this is not a viable option. Include names of individuals contacted and outcome of discussions. If NO, explain why the county has not explored this option.</b></p>  |
|                  |   |
| <p><b>8.</b></p> | <p><b>Do the recipients for whom the provider works have authorized hours totaling more than 360 per month?</b>   <input type="checkbox"/> YES   <input type="checkbox"/> NO</p>  |
| <p><b>a.</b></p> | <p><b>If YES, explain what arrangements have been made to hire an additional provider(s) to work those hours in excess of the 360 per month limit (if an exemption is granted) so that that all of the recipients’ authorized monthly hours are provided.</b><br/> <i>(NOTE: Counties must assist in finding an additional provider to ensure that all authorized hours are provided. Volunteering hours can result in a reduction of the recipients’ authorized IHSS hours.)</i></p> |
|                  |   |
| <p><b>b.</b></p> | <p><b>Explain why the additional provider(s) being hired to work the monthly hours in excess of 360 cannot work all of the hours that exceed the 66 hour workweek limit so that an exemption would not be necessary.</b></p>  |
|                  |   |

**FOR RECIPIENTS WHO MEET THE FOLLOWING REFERRAL CRITERIA –**

**COMPLETE ONLY QUESTIONS IN**

- Criteria A: Complex Medical/Behavioral Needs
- Criteria B: Rural/Remote
- Criteria C: Language/Communication

- Section A & D
- Section B & D
- Section C & D

*(NOTE: If multiple criteria apply, complete the appropriate section for each criterion. Additional sheets may be attached as needed to provide necessary details.)*

**SECTION A (Criteria A)**

|                  |   |
|------------------|---|
| <p><b>1.</b></p> | <p><b>Has the county verified that the provider lives in the same home as all of the recipients he/she provides services for?</b><br/> <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> |
|------------------|---|

|                              |   |
|------------------------------|---|
| <b>2.</b>                    | <b>Explain why having another provider would place the recipients at serious risk of placement in out-of-home care and how this has been determined and confirmed.</b><br><i>(Note: Please do not solely list the recipient's medical/behavioral conditions or authorized services (i.e., protective supervision, etc.), but the impact that having another provider would have on them and how this has been confirmed).</i> |
|                              | <b>Recipient #1:</b><br><br>  |
|                              | <b>Recipient #2:</b><br><br>  |
| <b>Recipient #3:</b><br><br> |   |

**SECTION B (Criteria B)**

*(NOTE: Additional sheets may be attached as needed to provide necessary details.)*

|           |   |
|-----------|---|
| <b>1.</b> | <b>Does the county consider the location where the recipient resides to be rural and/or remote?</b><br><br><input type="checkbox"/> YES <input type="checkbox"/> NO   |
| <b>2.</b> | <b>Have provider registries/Public Authorities in neighboring counties been contacted to find providers who are willing and able to travel to be a provider for both or either recipient?</b><br><br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br><b>If YES, explain why this is not a viable option. Include names of individuals contacted and outcome of discussions. If NO, explain why the county has not explored this option.</b> |
|           |   |

**SECTION C (Criteria C)**

*(NOTE: Additional sheets may be attached as needed to provide necessary details.)*

|           |  |
|-----------|--|
| <b>1.</b> | <b>Explain why the recipient(s) would be at risk of out-of-home care if authorized services are provided by a provider who does not speak their language.</b>                            |
|           |  |
| <b>2.</b> | <b>Explain why the recipient(s) cannot have their services provided by another provider with initial interpretation assistance given by someone who speaks the recipients' language.</b> |
|           |  |

**SECTION D****COMPLETED BY:**

|                         |  |                        |  |
|-------------------------|--|------------------------|--|
| <b>Signature:</b>       |  | <b>Date:</b>           |  |
| <b>Printed Name:</b>    |  | <b>Telephone #:</b>    |  |
| <b>Title:</b>           |  | <b>E-Mail Address:</b> |  |
| <b>Mailing Address:</b> |  |                        |  |

**PROGRAM MANAGER REVIEW COMPLETED BY:**

|                         |  |                        |  |
|-------------------------|--|------------------------|--|
| <b>Signature:</b>       |  | <b>Date:</b>           |  |
| <b>Printed Name:</b>    |  | <b>Telephone #:</b>    |  |
| <b>Title:</b>           |  | <b>E-mail Address:</b> |  |
| <b>Mailing Address:</b> |  |                        |  |

**MAIL COMPLETED FORM TO THE FOLLOWING ADDRESS:**

**California Department of Social Services  
 Adult Programs Division / Policy & Operations Bureau  
 744 P Street, M.S. 9-7-96  
 Sacramento, CA 95814**