IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM REQUEST FOR EXEMPTION FROM WORKWEEK LIMITS FOR EXTRAORDINARY CIRCUMSTANCES (EXEMPTION 2)

Provider Name:	Provider Number:
County:	

To be considered for an Exemption 2, you must work for two or more IHSS recipients and **ALL** the recipients you work 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** – He or she has complex medical and/or behavioral needs that must be met by a provider who lives in the same home as the recipient.
- **Criteria B** – He or she lives in a rural or remote area where available providers are limited and as a result, he or she is unable to hire another provider.
- **Criteria C** – He or she is unable to hire another provider who speaks the same language, and as a result, he or she is unable to direct his or her own care.

Note: The provider does not have to live in the same home as the recipients to qualify under Criteria B and C.

To be approved for an Exemption 2, the recipients (or their authorized representative(s)) with the assistance of the county, as needed, must have tried to hire an additional provider(s) so that their authorized service hours can be worked within the workweek limits. Prior documented attempts to hire and/or have services provided by other providers may be considered in meeting this requirement.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Do you work for two or more recipients? ☐ YES ☐ NO

2. Do you live in the same home as all recipients applying under Criteria A? ☐ YES ☐ NO

3. How many total combined monthly hours do you currently work for all your recipients? _____ hours

4. Have the recipients (or their authorized representatives) tried to hire an additional provider(s)? ☐ YES ☐ NO

   If YES, briefly describe the efforts to hire an additional provider(s):

   _____

   _____

   _____

   If NO, briefly explain why no efforts were made to hire an additional provider(s):

   _____

   _____

   _____

LIST ALL RECIPIENTS YOU ARE CURRENTLY SERVING:

Recipient #1 Name:	Case Number:
Please evaluate recipient under exemption criteria: ☐ Criteria A ☐ Criteria B ☐ Criteria C	
Recipient #2 Name:	Case Number:
Please evaluate recipient under exemption criteria: ☐ Criteria A ☐ Criteria B ☐ Criteria C	
Recipient #3 Name:	Case Number:
Please evaluate recipient under exemption criteria: ☐ Criteria A ☐ Criteria B ☐ Criteria C	
Recipient #4 Name:	Case Number:
Please evaluate recipient under exemption criteria: ☐ Criteria A ☐ Criteria B ☐ Criteria C	

Provider Name:	**Provider Number:**
Provider Signature:	**Date:**

ONCE YOU COMPLETE AND SIGN THIS FORM,
PLEASE SUBMIT TO YOUR COUNTY IHSS OFFICE.

FOR COUNTY USE ONLY	
Received By:	**Received Date:**