Provider Number_____

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
LIVE-IN FAMILY CARE PROVIDER OVERTIME EXEMPTION

PROVIDER NAME:

Part A: PROVIDER REQUIREMENTS

Beginning February 1, 2016, state law (Welfare and Institutions Code section 12300.4) limits the maximum weekly number of hours an IHSS/Waiver Personal Care Services (WPCS) provider can work in a workweek. A provider in the IHSS/WPCS program will be paid overtime if they work more than 40 hours a week, but providers shall not work more than 66 hours a week for IHSS and WPCS recipients combined.

The IHSS program has created a family-member exemption to the workweek maximum of 66 hours for IHSS providers to allow them to work up to a maximum of 90 hours per workweek and up to a maximum of 360 hours a month. In order to be eligible for this exemption, you must meet the three (3) following conditions on or before January 31, 2016:

- You must provide IHSS services to two or more IHSS recipients.
- You must currently live in the same home as the IHSS recipients that you provide services to.
- You must be related to the IHSS recipients to whom you provide services as his/her parent, stepparent, adoptive parent or grandparent or be his/her legal guardian.

With this exemption, you cannot work more than 90 hours per workweek or more than 360 hours per month. If you work up to these maximum hours for your recipients and your IHSS recipients still have IHSS hours left, then your IHSS recipients will have to hire another IHSS provider to work the rest of their IHSS hours.

Please complete **Part B** of this form and provide all information to verify that you meet the three (3) requirements above to qualify for this exemption as a Live-in Family Care Provider.

Provider Number_____

Part B: PROVIDER & RECIPIENTS' INFORMATION

INSTRUCTIONS: You must complete the information below about your residential and mailing addresses and then complete the chart below for the recipients you provide services to.

1. Your residential address: _____

_____

2. Your mailing address: _____

_____

A		B	C
Recipient Information **Name**	**Case Number**	**Relationship to Recipient**	**Does this recipient live with you in the same residence? Please answer Yes or No**
1.		1.	1.
2.		2.	2.
3.		3.	3.
4.		4.	4.

Provider Number_____

I declare that I meet all of the requirements to qualify for this exemption. I further declare that all of the information I have provided on this form is true and correct to the best of my knowledge. I understand that verification of this information will occur at the time of my IHSS recipient's reassessment to determine if I still qualify for this exemption. I agree to adhere to all requirements for overtime under this exemption. If I no longer meet the three (3) requirements for this exemption I will no longer qualify for this exemption and I must notify the county immediately. I understand that I will then be subject to the existing overtime limitation restrictions.

PROVIDER SIGNATURE:	DATE:

PROVIDER'S PRINTED NAME:

FOR STATE USE ONLY

STAFF NAME:	DATE:

NOTES: