

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

Provider Name:	Provider Number:
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County:

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 need which must be met by the applying provider who lives in the same home as the recipient;
- **Criteria B:** Live in an area with a population equal to or less than 2,500 people and is unable to hire another provider because providers are not available; 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.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you work with two or more recipients? YES NO

Do you live in the same home as all recipients you currently serve? YES NO

How many total hours do you currently provide to your recipients? _____ hours

LIST ALL RECIPIENTS CURRENTLY SERVED BY THE PROVIDER:

Recipient #1 Name:	Case Number:
Recipient #2 Name:	Case Number:
Recipient #3 Name:	Case Number:
Recipient #4 Name:	Case Number:
Provider Signature:	Date:

ONCE YOU COMPLETE AND SIGN THIS FORM, PLEASE SEND TO THE COUNTY IHSS OFFICE.

FOR COUNTY USE ONLY	
Received By:	Received Date: