IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO PROVIDER OF EXPIRATION OF EXEMPTION FROM WORKWEEK LIMITS

(ADDRESSEE)

County of:_____
IHSS Office Address:_____
_____
IHSS Office Telephone:_____
Notice Date:_____

Provider Name:_____
Provider Number:_____

To: In-Home Supportive Services (IHSS) Provider

As of _____, you were approved for an Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) for the IHSS recipients listed below:

Recipient #1: <Recipient Name> Case Number: <Recipient Case #>
Recipient #2: <Recipient Name> Case Number: <Recipient Case #>
Recipient #3: <Recipient Name> Case Number: <Recipient Case #>
Recipient #4: <Recipient Name> Case Number: <Recipient Case #>

This notice is to inform you that your Exemption 2 will be expiring on _____.

Prior to the expiration of your Exemption 2, we will review the recipients' cases to determine whether the circumstances the exemption was based on continue to exist and, if so, we will initiate a renewal of the Exemption 2 on your behalf.

If you have any questions about this notice, please contact the IHSS Office at the telephone number listed above.