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

(ADDRESSEE)

County of:_____
IHSS Office Address: _____
_____
IHSS Office Telephone: _____
Notice Date:_____
Recipient Name: _____
Case Number: _____

Provider Name:_____
Provider Number:_____

To: In-Home Supportive Services (IHSS) Recipient

As of <Exemption Begin Date>, your provider listed above was approved for an Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2).

This notice is to inform you that your provider's Exemption 2 will be expiring on <Exemption Expiration Date>.

Prior to the expiration of your provider's Exemption 2, we will review your case 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 provider's behalf.

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