IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO PROVIDER OF THIRD VIOLATION (90-DAY SUSPENSION OF ELIGIBILITY) FOR EXCEEDING WORKWEEK AND/OR TRAVEL TIME LIMITS

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____
Provider Name: _____
IHSS Office Address: _____

_____
IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider

Effective twenty (20) days from the date of this notice, you are no longer eligible to receive payment from the IHSS program for providing authorized services to your current recipient(s) or to any other person for a period of 90 days.

In the service month of _____, you violated your workweek and travel time
MONTH
limits, for a third time, by doing one or more of the following:

- ☐ Working more than 40 hours in a workweek for a recipient without the recipient getting approval from the county when that recipient's maximum weekly hours are 40 hours or less.
- ☐ Working more than a recipient's maximum weekly hours without the recipient getting approval from the county which caused you to work more overtime hours in the month than you normally would.
- ☐ Working more than 66 hours in a workweek when you work for more than one recipient.
- ☐ Claiming more than seven (7) hours of travel time in a workweek.

If you disagree with this decision you may submit the attached county request form to the IHSS office at the address above. You have ten (10) calendar days from the date of this notice to request a county review. The county then has ten (10) business days to review and investigate and decide whether to rescind the violation.