IN-HOME SUPPORTIVE SERVICES PROGRAM
RECIPIENT REQUEST FOR PROVIDER WAIVER

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____
Applicant Provider Name: _____
Recipient Name: _____
Recipient Case Number: _____
IHSS Office Address: _____

_____
IHSS Office Telephone Number: _____

I, _____, am submitting this waiver request to the _____ in order to hire the person
COUNTY/PUBLIC AUTHORITY/NON-PROFIT CONSORTIUM

named below to be my In-Home Supportive Services (IHSS) provider. I understand he/she has been denied eligibility to be paid from the IHSS program, due to a felony criminal conviction(s). Despite this information, I accept the responsibility for my decision, and the possible risks involved, in allowing this person to work in my home as an IHSS provider.

I have chosen to hire _____ to be my IHSS provider and acknowledge that he/she has been convicted of the following crime(s):

Date of Conviction	Penal Code Section	Felony Conviction Description
1.		
2.		
3.		
4.		
5.		

IN-HOME SUPPORTIVE SERVICES (IHSS)
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AS THE IHSS RECIPIENT WHO WILL HIRE THIS PERSON TO PROVIDE IN-HOME SUPPORTIVE SERVICES, I UNDERSTAND AND AGREE TO THE FOLLOWING STATEMENTS AND ACTIVITIES LISTED BELOW

- I am hiring a person who has been convicted of the felony crime(s) listed on this form.
- I am required to keep this person's criminal conviction information confidential, and I am prohibited, by law, from sharing any part of it with any other individual or entity.
- I am completing this waiver request form, which applies only to the crime(s) listed on this form.
- This waiver only applies in the county to which I am sending it. If I move to a new county, the person I am hiring as my provider will have to go through another criminal background check and I will have to complete and submit another waiver request form in the new county before he/she can work and be paid for providing services to me as my provider.
- If the county notifies me that this person is convicted of an additional disqualifying felony crime(s) in the future, I will be required to complete and submit another waiver if I wish to continue receiving services from this person.
- A notice will be sent to me when the county has accepted this waiver.
- The county will send a timesheet to the provider I have chosen to hire only after this waiver has been accepted.

By signing this form, I accept the responsibility for hiring the person named on this form to work in my home. I understand the County and the State of California are immune from any liability, due to the risk of any actions that may occur, because of my decision to hire him/her as my IHSS provider.

This document may only be signed by the recipient or by an authorized representative who is not the provider named on this form.

_____
SIGNATURE OF RECIPIENT OR RECIPIENT'S AUTHORIZED REPRESENTATIVE

_____ _____
PRINT NAME DATE

Without an approved waiver to hire the person named on this form, you will be responsible for paying him/her with your own money for any services provided.

Submit this form within ten (10) calendar days from the "Notice Date" listed on the upper right corner of Page 1. You may submit this form by mail or in person to your IHSS county, Public Authority, or Non-Profit Consortium at the following address:

By mail: _____
_____
_____

In person: _____
_____
_____