

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO PROVIDER
DENIAL OF EXCEPTION TO EXCEED WEEKLY HOURS**

(ADDRESSEE)

County of: _____

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider

This notice is to inform you that your recipient’s request for an exception to exceed his/her maximum weekly hours has been denied for the service month of _____
MONTH. Therefore, do not work these additional hours.

If you have already worked these additional hours, you will be paid for the time worked, but you will receive a violation. The penalty for this violation will be based on the number of violations you have received. You will receive a notification informing you of the violation and any penalty given. You will also receive information about how you can request a county review of your violation.

Further, if you already worked these hours, your recipient will need to adjust your work hours, before the end of the month, by the number of exception hours worked, but not approved. This is to make sure you and any other provider(s) that the recipient may have, do not exceed his/her monthly authorized hours. If your recipient does not adjust your work hours before the end of the month, you will not be paid for the excess hours by the IHSS Program. Instead, your recipient will be responsible for the payment of any service hours you work beyond his/her authorized monthly hours.

If you have any further questions about this notice, you may contact your county IHSS office at the phone number above.