

WAIVER PERSONAL CARE SERVICES
WORKWEEK TEMPORARY OR PERMANENT EXEMPTION FOR WPCS CARE PROVIDERS

(WPCS Participants enrolled in NF/AH or IHO Waiver after January 31, 2016)

WPCS Participants enrolled in NFAH or IHO Waiver after January 31 2016

PROVIDER NAME:

PROVIDER NUMBER:

Part A: REQUIREMENTS

Beginning February 1, 2016, state law (Welfare and Institutions Code section 12300.4) went into effect and put limits on the maximum weekly number of hours a WPCS/IHSS provider can work in a workweek. A provider providing authorized services to one participant in the WPCS/IHSS program will be paid overtime if they work more than 40 hours a week, not to exceed a 70-hour and 45-minute workweek for WPCS and IHSS combined.

The WPCS program has created a Temporary or Permanent Exemption to Senate Bill (SB) 855 and SB 873 for WPCS providers. The Temporary Exemption allows providers to work up to a maximum of 12 hours per day, or 360 hours per month of WPCS and IHSS combined for a period of sixty (60) days.

The following criteria must be met to receive a Temporary Exemption:

- The NF/AH Waiver participant lost their primary care provider (their provider that worked the most hours in a work week or month) and
- The Waiver participant is working closely with their IHO care manager to find more care providers.

A Temporary Exemption can be granted for a period of sixty (60) days if the above requirements are met.

Permanent Exemption: If the participant could not find an additional provider during the 60-day Temporary Exemption period, the participant may request a permanent exemption for their IHO care manager. Reasons for requesting a permanent exemption may include:

- Proof that a participant lives in a rural area
- A participant could not find an available provider who speaks the participant's primary language; or
- A participant can have other reasons which cause undue hardship to their living dynamics that will be considered

Provider Number _____

on a case-by-case basis.

IHO care managers will work with the WPCS participants and providers to approve exemptions on a case-by-case basis.

Please **complete Part B** of this form and provide all information to verify that you meet the requirements for either a Temporary or Permanent Exemption.

Part B: PROVIDER AND PARTICIPANT INFORMATION

INSTRUCTIONS: Fill in your residential and mailing addresses, and complete the information below for the participant that you provide services to. Then select one of the boxes on page two (2) for the type of Exemption you are requesting based on the requirements in Part A.

1. Provider residential address: _____

2. Provider mailing address: _____

PARTICIPANT NAME	PARTICIPANT CASE NUMBER	PARTICIPANT'S SIGNATURE

Check one of the boxes below for the type of Exemption you are requesting based on the requirements in Part A of this form:

TEMPORARY EXEMPTION

PERMANENT EXEMPTION

Provider Number _____

I declare that I meet the requirements to qualify for the above selected exemption and am interested in the above selected exemption. I further declare that all of the information I have provided on this form is true and correct to the best of my knowledge. I agree to adhere to all requirements for overtime under this exemption. If I no longer meet the requirements for this exemption, I will notify the IHO care manager immediately and will no longer qualify for the exemption. I understand that I will then be subject to the existing overtime limitation restrictions.

PROVIDER SIGNATURE:

DATE:

PROVIDER'S PRINTED NAME:

Please mail completed form to:
Department of Health Care Services
Long-Term Care Division
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437
ATTN: WPCS

FOR STATE USE ONLY

IHO NURSE
EVALUATOR
NAME

DATE:

APPROVED

DENIED

REASON FOR DENIAL: