

IHO Nurse Evaluator Name _____

Provider Number _____

WAIVER PERSONAL CARE SERVICES WORKWEEK EXEMPTION FOR WPCS CARE PROVIDERS

PROVIDER NAME:	PROVIDER NUMBER:
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Part A: PROVIDER 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 an exemption to Senate Bill (SB) 855 and SB 873 for WPCS providers to allow them to work up to a maximum of 12 hours per day, or 360 hours per month of WPCS and IHSS combined. **The WPCS provider must meet one of the three (3) following criteria below on January 31, 2016:**

- The care provider lives in the same home as the waiver participant. They do not have to be a family member; or
- The care provider is now giving care to the waiver participant and has done so for two or more years without a break; or
- DHCS agrees that there are no other possible care providers near the waiver participant’s home. The waiver participant must work closely with DHCS care managers to try to find more care providers.

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Please complete **Part B** of this form and **provide all information to verify that you meet one of the three (3) requirements to qualify for this exemption.**

Part B: PROVIDER & PARTICIPANT INFORMATION

INSTRUCTIONS: Provider must complete the information below. Mark an X under any of the criteria in the table below, which applies to you and the participant.

1. Participant Name: _____

2. Participant Case Number: _____

3. Participant's Signature: _____

You live in the same home as the Participant.	You have an established and active working relationship for two or more years with the Participant.	There are no other available providers in the area.

I declare that I meet all of the requirements to qualify for this exemption and am interested in this 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 one of the three requirements for this exemption I will notify IHO immediately and will no longer qualify for this 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: