

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO PROVIDER
APPROVAL TO WORK ALTERNATE SCHEDULE DUE TO RECURRING EVENT**

(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 to adjust his/her maximum weekly hours for a specified week of the month due to a monthly recurring event has been approved. You may work the additional hours during the specified week of each month. Do not work these hours without first obtaining permission from your recipient.

This means that your maximum weekly hours for one week of each month will be different from the other weeks of the month.

You may continue to work this weekly schedule in all later months as long as your recipient continues to have the need for the adjustment resulting from a recurring event. Your recipient must notify the county immediately if the situation changes and he/she no longer has the need for this adjustment.

Also, please note that if you work for more than one recipient, you cannot work more than 66 hours in a workweek. Therefore, if the adjustment to your recipient's maximum weekly hours would result in you working more than 66 hours in a workweek, you will not be able to work those additional hours or you may have to adjust the hours you work for another recipient.

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