Waiver Personal Care Services (WPCS)
Workweek Overtime Exemption Request

Beginning in 2016, state law (Welfare and Institutions Code (WIC) section 12300.4) limited the maximum weekly number of hours Waiver Personal Care Services (WPCS) and In-Home Supportive Services (IHSS) providers can work in a workweek. A provider providing authorized WPCS and/or IHSS to waiver participant(s) will be paid overtime if they work more than 40 hours per week, up to a maximum of:

- 70 hours and 45 minutes per workweek for combined IHSS and WPCS, if the provider is serving only one participant; or
- 66 hours per workweek for combined WPCS and IHSS, if the provider is serving more than one participant.

WPCS providers and/or participants can request an exemption to the workweek overtime limits for a provider. **The WPCS Workweek Overtime Exemption will allow a provider to work and be paid for up to a maximum of 12 hours per day, or 360 hours per month, of WPCS and IHSS combined hours.**

Participants approved for more than 360 combined IHSS/WPCS hours per month must have at least two active IHSS/WPCS providers in order for the participant and/or the providers to request an overtime exemption.

Provider Information	
1. Provider Name (Last, First, MI)	2. Provider Number
3. Does this provider have an active IHSS/WPCS exemption in place on another case?	
WPCS Participant Information	
4. WPCS Participant Name (Last, First, MI)	5. Participant Date of Birth/Age
6. Participant Client Index Number (CIN)	7. Waiver Care Agency
8. How many exemptions have been granted for this case?	
9. Number of IHSS only providers	10. Number of IHSS authorized hours
11. Number of WPCS only providers	12. Number of WPCS authorized hours
13. Number of IHSS/WPCS providers	14. Total number of providers

In order to request a WPCS Workweek Overtime Exemption, the participant and/or provider must work with the participant's assigned Waiver Agency Care Management Team (CMT) to complete the form and obtain the necessary documentation supporting the need for an overtime exemption.

- If the CMT determines the exemption requirements are met, the CMT will approve the exemption and submit it to the Department of Health Care Services (DHCS).
- If the CMT determines the exemption requirements are not met, the CMT will send a letter to the participant and provider denying the exemption, and explaining how to ask DHCS for a secondary review of the denial.

EXEMPTION REQUIREMENTS

Waiver Participants Enrolled On or Before January 31, 2016

For Waiver participants who enrolled in the In-Home Operations (IHO) Waiver or the Nursing Facility/Acute Hospital (NF/AH) Waiver ***on or before*** **January 31, 2016**, and whose functional or behavioral needs require that the IHSS and/or WPCS services be provided by a specific provider, an exemption from the regular overtime rules will be granted, on a case by case basis, if one or more of the following is shown to be true:

(i) The provider lives in the same home as the waiver participant, at least 5 days and nights per week on a regular basis, even if the provider is not a family member.

(ii) The provider currently provides care to the waiver participant at least eight hours per day, five days per week, and has done so for two or more years continuously.

(iii) The waiver participant is unable to find an additional local caregiver who speaks the same language as the participant, resulting in the participant being unable to direct his or her own care.

Waiver Participants Enrolled After January 31, 2016

For participants who were enrolled in the NF/AH or IHO Waiver ***after*** **January 31, 2016,** or were originally enrolled in the Home and Community-Based Alternatives (HCBA) Waiver (which was effective January 1, 2017), an exemption from the regular overtime rules will be approved, on a case-by-case basis, if both (a) and (b) are present:

(a) At least one of the following is true:

(1) The care provider lives in the same home as the waiver applicant or participant at least 5 days and nights per week on a regular basis. They do not have to be a family member;

OR

(2) The care provider is now furnishing consistent care to the Waiver participant at least 8 hours per day, five days per week, and has done so for two or more years, without a break;

OR

(3) The waiver applicant or participant is unable to find an additional local caregiver who speaks the same language as the applicant or participant, resulting in the applicant or participant being unable to direct his or her own care;

OR

(4) The provider provides WPCS for more than one **Waiver** participant;

AND

(b) DHCS agrees that there are no other possible care providers to assist with the Waiver participant's care. Possible reasons that a participant may not be able to find a new provider include, but are not limited to:

- The Waiver participant lives in a rural area;
- No providers are available who speak the Waiver participant's primary language;
- The participant's functional and/or behavioral care needs are such that they require the assistance of a specific provider.

The Waiver participant must work closely with the Waiver Agency CMT, or DHCS nurses when there is no Waiver Agency, to attempt to find other care providers. DHCS will require documentation of reasonable attempts to locate and hire other providers.

If granted, the overtime exemption is valid for one year. If the participant and provider would like the exemption to continue, before the one year has ended, they must work with the Waiver Agency CMT to search for other providers. If other providers cannot be located, the participants and/or providers will need to work with the CMT to submit a new DHCS 2279 form with supporting documentation demonstrating the continued need for the overtime exemption.

WPCS OVERTIME EXEMPTION EVALUATION INFORMATION

Exemption 1: Waiver Participants Enrolled On or Before January 31, 2016

Please answer all questions. You may be requested to provide supporting documentation. If you need more space, please include additional pages.

A. The WPCS participant was enrolled in either the IHO Waiver or NF/AH Waiver prior to or on **January 31, 2016**.

☐Yes ☐No

B. If known, provide the date of enrollment.

If enrolled *after* January 31, 2016, please stop here and complete the Exemption 2 section to request an exemption.

C. The WPCS participant's medical or behavioral needs require the services of the requested provider. ☐Yes ☐No

If "Yes," please briefly describe.

D. The provider lives in the same home as the WPCS participant at least 5 days and nights per week on a regular basis. ☐Yes ☐No

E. The provider has an established and active working relationship for two or more years with the participant, working at least 8 hours a day, 5 days per week **without a break in service**. ☐Yes ☐No

If "Yes," please briefly describe the active working relationship.

F. The participant is unable to find another provider who speaks the same language.

☐Yes ☐No

List primary language of the participant.

If “Yes,” please describe the steps that were taken to obtain another provider that speaks the same language.

Exemption 2: Waiver Participants Enrolled in the NF/AH Waiver, IHO Waiver, or HCBA Waiver *After* January 31, 2016:

Please answer all questions. All information provided must be supported with documentation. If you need more space, please include additional pages.

A. The provider lives in the same home as the WPCS participant at least 5 days and nights per week on a regular basis. ☐Yes ☐No

B. The provider has an established and active working relationship for two or more years with the participant, working at least 8 hours a day, 5 days per week **without a break in service**. ☐Yes ☐No

If “Yes,” please briefly describe the active working relationship.

C. The participant is unable to find another provider who speaks the same language.

☐Yes ☐No

If “Yes,” list primary language of the participant.

If “Yes,” please describe the steps that were taken to obtain another provider that speaks the same language.

D. The provider delivers WPCS services for more than one Waiver participant.

☐Yes ☐No

If “Yes,” list the number of Waiver participants.

E. Are there other adults living in the home who are able and willing to be a paid provider for the WPCS participant? ☐Yes ☐No ☐No Other Adults in the Home

If there are other adults living in the home who are unable to be a paid provider, explain why they are unable to provide services.

If there are other adults living in the home who are unwilling to provide services in the home, please explain.

F. Does the WPCS participant live in a rural and/or remote location that makes accessing additional services challenging? ☐Yes ☐No

If “Yes,” please provide a description. Note: Include the population of the participant’s city, town, etc., any information demonstrating the remote location and difficulties encountered when attempting to access/find/hire providers.

G. Does the WPCS participant have complex functional/behavioral needs that are such that they require the assistance of this specific provider?

☐Yes ☐No

If “Yes,” please explain and provide all available supporting documentation. **If possible, provide a letter from the participant’s primary care doctor.**

H. The WPCS participant has attempted to get additional WPCS providers.
☐Yes ☐No

Please include a log of **ALL** potential providers contacted. The log should include:

- Date provider was contacted;
- Name and Phone Number of provider contacted;
- Location of provider;
- Reason why provider was not able and/or willing to provide services.

You may also include any online (i.e. Facebook, Care.com, Craigslist, etc.) or newspaper ads or postings at local community centers/United States Post Offices and the results from those ads. These documents should be submitted with this form.

Explain below any other information about the participant's efforts to obtain additional providers:

I. Other factors not listed above in the Exemption 2 section that may be considered for the exemption process:

Certification—by Provider and Waiver Participant

I declare that I meet all of the requirements to qualify for this exemption and that I 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 comply with all requirements for overtime under this exemption.

I understand that this exemption is valid for only one year, and another form with supporting documentation must be re-submitted **every year for review and approval**.

If I no longer meet the requirements for this exemption I will notify DHCS immediately because I will no longer qualify for this exemption. I understand that I will then be subject to the existing overtime limit restrictions.

I understand that providing false information may result in fraud and may incur fraud penalties pursuant to state and local laws.

Provider Signature	Date
Provider's Printed Name	

WPCS Participant Signature (or Authorized Representative)	Date
WPCS Participant's Printed Name (or Authorized Representative)	

I certify that I have reviewed this form and that the information contained here is true to the best of my knowledge.

CMT Signature (Case Manager)	Date
CMT Printed Name (Case Manager)	Contact Phone Number

Please mail this completed form to the address below:

Department of Health Care Services
Integrated Systems of Care Division
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437
ATTN: WPCS

FAX: 916-552-9149

CAREMANAGEMENT@DHCS.CA.GOV

For State Use Only

Evaluator Name	Date

Approved ☐ Denied ☐

Reason for Approval:

Reason for Denial:

Privacy Statement for Initial WPCS OT application to Waiver Agency and DHCS

This form collects information about Waiver Personal Care Services (WPCS) providers and Waiver participants to enable the provider and participant to jointly request an exemption to the workweek overtime limits established by California statute. The personal and medical information you each provide on this form is private and confidential. The assigned Waiver Agency and DHCS need the requested information to determine whether you meet the exemption requirements for workweek overtime limits.

We will share the information you provide with other state, federal, and local agencies, contractors, and health plans only to administer the WPCS and In Home Supportive Services (IHSS) programs, and with other entities as required or permitted by law.

- You must each answer all of the questions on this application directed to you unless the question is marked "optional." For questions that specify a response is required only if the information is known to you, you must respond if you know the information. If the form is missing required information about you, DHCS will contact you to obtain that information. If you do not provide the requested information, DHCS will not be able to make a decision regarding the WPCS provider's eligibility for the workweek overtime exemption. In such a case, your request for overtime may be denied and you may have to submit a new request to the Waiver Agency for the workweek overtime exemption.

If you have any questions or concerns regarding the use and/or disclosure of your information, you can contact your assigned Waiver Agency. You can also contact the DHCS Privacy Hotline or DHCS HIPAA compliance mailbox at the following:

Phone: 1-866-866-0602
TTY: 1-877-735-2929

P.O. Box 997413, MS 4721
Sacramento, CA
95899-7413

These state and federal laws give DHCS the right to collect, keep, and utilize your information:

CA Welfare and Institutions Code §§ 12300.4, 14100.2; 42 CFR § 431.300, *et seq*.; 45 CFR §§ 164.502(a)(1)(ii), 506(a).

We are required to provide you with this Privacy Statement under CA Civil Code § 1798.17. *See* DHCS's Notice of Privacy Practices here: https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx.