WAIVER PERSONAL CARE SERVICES (WPCS) WORKWEEK OVERTIME EXEMPTION SECONDARY REVIEW REQUEST

IMPORTANT INFORMATION ABOUT THE SECONDARY REVIEW PROCESS PLEASE READ CAREFULLY

You received this form (DHCS 2280) because you requested a WPCS Workweek Overtime Exemption and your initial request was denied by the Waiver Agency or Department of Health Care Services (DHCS).

You can request a Secondary Review of the denial determination by completing, signing and mailing this form to DHCS at the address shown on the next page.

You must submit the form within 30 calendar days of the date of the Notice to Provider of Ineligibility for the WPCS Workweek Overtime Exemption you received from the Waiver Agency/DHCS. (NOTE: You must submit a copy of the notice you received along with this form completed and signed by the provider and all recipients.)

If the form is submitted (postmarked) more than 30 days from the date of the notice, it will be considered late and it will not be accepted for review. You will be sent a notice informing you that the denial will stand and you may not submit another request for a WPCS Workweek Overtime Exemption until 90 days have passed from the initial denial notice.

If the form is submitted (postmarked) on time, it will be accepted for review. DHCS will review the original request as well as any additional documentation submitted by you or the participant. Information from the case record will also be reviewed. If necessary, a telephone conference will be scheduled with you to discuss the Secondary Review Request. If the additional documentation is sufficient to authorize the request, no phone conference will be scheduled.

After considering all the information, DHCS will determine whether the initial denial determination was made in accordance with state requirements. The final decision will either uphold or overturn the denial. You will be sent a letter informing you of a final decision within 30 calendar days of the date of receipt of the DHCS 2279. If a telephone conference was held, the decision may take longer than 30 calendar days.

INSTRUCTIONS

- Use black or blue ink to fill out. Print information clearly.
- Complete all parts of this form. If you need more space to answer any of the questions, you can attach additional page(s).
- Make sure the provider and all recipients included in the WPCS Workweek Overtime Exemption request (or their authorized representative(s)) sign on the last page.
- Mail the completed and signed form to the address shown below within 30 calendar days of the date of the Notice to Provider of Ineligibility for the WPCS Workweek Overtime Exemption. **Forms submitted (postmarked) late will NOT be accepted for review.**
- **INCLUDE A COPY OF THE DENIAL NOTICE YOU RECEIVED FROM THE WAIVER AGENCY/DHCS ALONG WITH THIS FORM COMPLETED AND SIGNED BY THE PROVIDER AND ALL RECIPIENTS.**
- Include any supporting documentation. Keep a copy of the completed form and supporting documentation for your records.
- Mail the completed form to the following address. The form may also be submitted to the Waiver Agency CMT to submit to DHCS on behalf of the participant.

Department of Health Care Services
Integrated Systems of Care Division
1501 Capitol Avenue, MS 4502
P.O. Box 997413
Sacramento, CA 95899-7413
ATTN: WPCS OT Exemption Secondary Review

- It is recommended that you ask for a receipt of mailing from the Post Office and keep it for your records.
- If you have any questions, call the WPCS Hotline at (916) 552-9214

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Once completed, the Waiver Agency must submit to DHCS, upload this form to MedCompass, and make a note in the case file.

Provider Name:

Provider Number:

Please indicate the name, Client Identification Number (CIN), and waiver enrollment date for all participants for whom this exemption should be applied.

Participant 1: Name:

CIN # **Waiver Enrollment Date:**

Participant 2: Name:

CIN # **Waiver Enrollment Date:**

Note: If there are additional participants included in the exemption request, please include the name, CIN #, and waiver enrollment date of each additional participant to this request.

Please answer the questions below indicating why you are requesting a Secondary Review. Please attach any and all additional relevant supporting documentation that was not included in your original request.

☐ **The participant(s) was/were enrolled *on or before January 31, 2016* and I have additional documentation on the following category(ies), which is attached:**

- ☐ **The participant's functional or behavioral needs require that the IHSS and/or WPCS services be provided by a specific provider.**
- ☐ **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.**
- ☐ **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.**
- ☐ **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.**

☐ **The participant(s) was/were enrolled *after January 31, 2016* and I have additional documentation for the following categories, which is attached:**

- ☐ **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.**
- ☐ **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.**
- ☐ **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.**
- ☐ **The provider provides WPCS for more than one Waiver participant.**
- ☐ **The participant is unable to find additional providers because:**
  1. **The waiver participant lives in a rural area.**
  2. **No providers are available who speak the Waiver participant's primary language.**
  3. **The participant's functional and/or behavioral care needs are such that they require the assistance of a specific provider.**
  4. **Other reason.**

Please provide additional documentation to support the categories checked above. Attach additional pages, if needed.

☐ **I do not have any additional documentation to submit. I am just requesting that my initial exemption request receive a secondary review by a different entity within DHCS.**

Please provide the name and contact information for the person who completed this form:

Name:

Title:

E-Mail Address:

Date:

Telephone #:

I declare that the information that all of the information I have provided on this form is true and correct to the best of my knowledge. I understand that providing false information may result in fraud and may incur fraud penalties pursuant to state and local laws.

Provider Printed Name	Provider Signature
Member/AR/DPOA Printed Name	Member/AR/DPOA Signature
WA CMT Printed Name	WA CMT Signature

Privacy Statement for Secondary Review by DHCS of Exemption Denial

This form collects information about Waiver Personal Care Services (WPCS) providers and Waiver participants to enable the provider and participant to jointly request secondary review of a workweek overtime limit exemption denial determination by the Waiver Agency or by DHCS. The personal and medical information you each provide on this form is private and confidential. DHCS needs the requested information to complete its secondary review of the exemption denial determination.

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 complete its secondary review of the exemption denial determination. In such a case, DHCS may send you a notice stating the exemption denial determination will stand. Additionally, you may be unable to submit a new joint request for secondary review if more than 30 days have passed from the date on the "Notice to Provider of Ineligibility" you received from the Waiver Agency or DHCS.

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.