State of Illinois
Department of Human Services - Home Services Program/Division of Rehabilitation Services

POST-APPROVAL REQUEST FOR OVERTIME EXCEPTION

To request post-approval for an exception of Individual Provider Overtime, the Home Services Program (HSP) Customer must complete and submit this form to the local HSP office where he or she is served. Use of Individual Provider Overtime under the requested exception should be submitted as soon as the need is known or no later than 5 business days thereafter. Incomplete forms will be returned to the Customer. Please note that medical or other required documentation must be attached. The Customer will receive written notification of a decision within 30 days of HSP's receipt of the completed form. Unauthorized overtime will result in an occurrence as defined under the HSP Individual Provider Overtime policy with progressive consequences for the Individual Provider (IP).

Customer Name: _____

Street Address: _____

City/State/Zip Code: _____

HSP Case Number: _____

HSP Local Office: _____

Individual Provider Name: _____

Overtime Exception Category:
Please choose ONE Exception Category and complete the Section for that category in full.

☐ Provider Unable to Work - HSP may approve up to 120 days.

- ☐ IP has quit, was unfunded, no longer meets qualifications, or has expired credentials.
- ☐ The back-up IP is unable to work.
- ☐ Homemaker agency in the Customer's service area is at capacity or otherwise not available.
- ☐ There is no CIL in the Customer's service area or;
- ☐ HSP Customer has contacted the CIL in his or her service area to identify additional IPs.

_____ _____
CIL Staff Person Printed Name and Signature Date

☐ Emergency Need - HSP may approve up to 4 additional hours each pay period with a maximum of 30 hours/year.

*** No approval is needed for the first 4 hours per pay period with a maximum of 30 hours per year under this exception category.**

☐ Number of additional hours and pay period dates are identified below.

HSP Customer has an emergency need for: _____ (number of hours) hours for pay period ending on _____ (mm/dd/yyyy)

Reason for Emergency Exception Request:

_____ _____
HSP Customer Signature Date

For Internal State Use Only:	
Date Received in Local HSP Office:	Date Entered in WebCM:
Name:	Title: