Variance Request Form for Paying Employees Overtime
DOL "Home Care" Rule

- **Instructions**: Complete this form if you are:
  - A Case Manager or Consultant for a consumer/surrogate-directed program participant; or
  - A program participant and a consumer-directed employer; or
  - A surrogate employer for a program participant.

  By filling out this form:
  - You have already determined that your employee is not exempt from overtime
  - You are requesting an exception to have an employee paid overtime (by X Program) for working more than 40 hours in one workweek; and
  - You will describe why you need this employee to work overtime.

- **Variance Criteria:** DAIL may grant a variance to the Department of Labor "Home Care" Rule to allow your employee to be paid an overtime rate if you show that the variance is needed to avoid placing the participant at risk of harm or at serious risk of institutionalization.

Program: ☐ Attendant Services Program ☐ Choices for Care High/Highest

Completed by Case Manager, Consultant, Individual or Surrogate:

1. **Individual/Participant Employer Name:** _____
2. **Date of Birth**: _____
3. **Surrogate Employer Name:** _____
4. **Number of employees working over 40 hours providing "care" in one workweek?** _____
5. **How many hours over 40 in one workweek (Sunday to Saturday) is each employee working?**

   Employee #1
   *Full Name***:** _____ # hours worked *over* 40: _____

   Requested Start Date for Overtime hours:_____ Base Hourly Wage: $_____
   (not including employer tax)

   Employee #2
   Full Name: _____ # hours worked *over* 40: _____

   Requested Start Date for Overtime hours: _____ Base Hourly Wage: $_____
   (not including employer tax)

6. **Have you tried to hire additional caregivers?** ☐ Yes ☐ No
   a. **If no**, please explain why?

   b. **If yes,** have you scheduled your employees to work no more than 40 hours in one workweek?

7. **Are you able to use Home Health Agency caregivers to provide your care?** ☐ Yes ☐ No
   a. **If no**, please explain why?

8. **Is the program participant at risk of harm or serious risk of institutionalization if overtime is not approved?** ☐ Yes ☐ No
   a. **If yes**, please explain why?

Case Manager/Consultant Name (*if applicable*): _____

Agency: _____ **Phone number:** _____

Employer Name: _____

Email: _____

Signature: _____

Date: _____

***Send request to*:** Requests will be reviewed by the Adult Services Division (ASD) at the Department of Disabilities, Aging and Independent Living (DAIL).

Mail: Department of Disabilities, Aging and Independent Living, ASD
280 State Drive
HC 2 South
Waterbury, VT 05671-2070

FAX: (802) 241-0385 Attention: ASD.

ASD Team Decision: ☐ Approve ☐ Deny ☐ Partial Approval ☐ Copy to ARIS

LTCCC: _____ Effective Date: _____
Comments:

DAIL Authorized Signature: _____ Date: _____

NOTE: A notice must be sent to ARIS, the individual or Surrogate and case manager (if applicable).