SECTION A: Identifying Information (Completed by Operator/Administrator or Designee)

Regional Office (RO): __________________________ Date Requested: ________________________________

Facility Name: ____________________________________________________________

Address: ___________________________________________________________________

City/Town: __________________________ State: __________________ Zip: __________ County: __________

Facility Certificate #: __________________________ Date Certified: __________________ Expiration Date: __________________

Capacity: __________________________ Occupancy: __________________________

SECTION B: Completed by Operator/Administrator or Designee

In accordance with Department regulations, the Department may waive certain requirements. The operator must have written approval or be following an approved equivalency prior to instituting any alternative to regulatory standards. Noncompliance with a Department regulation prior to a waiver being requested and approved may result in the imposition of a penalty. Similarly, if an operator is noncompliant with an approved equivalency, this may result in a penalty. Incomplete requests will not be accepted.

Complete Part I for Equivalencies. Complete Part II for Waivers.

I. Equivalency: □ Yes □ No Approved equivalency regulation citation: ________________________________

Briefly state the equivalency issue: _____________________________________________________________________________

II. Waivers

A. Type of Waiver

1. Application Pending:

   a) Renewal □ Yes □ No

   b) New facility □ Yes □ No

   c) Change of Operator □ Yes □ No

2. Programmatic: □ Yes □ No

3. Physical Plant: □ Yes □ No

Regulation for which waiver is sought: ___________________________________________________________________________
II. Waivers (continued)

B. Please explain the reason the proposed alternative is necessary and why a waiver is being requested. (Use additional sheets as necessary).

C. Provide information, which will demonstrate how you will achieve or maintain the intended outcome of the regulation and protect the health, safety, and well-being of the residents. Please supply all necessary supporting documentation as required, e.g., approval of local officials, supporting statements of staff, physicians and service providers, special licenses, etc. (Use additional sheets as necessary).

SECTION C: Signature of Operator/Administrator or Designee

Name (print): ____________________________ Phone Number: (________) ____________________________

Signature: ____________________________ Date: ____________________________

Please note that incomplete requests will be returned. Continued processing will require submission of new request.
SECTION D: FOR DOH USE ONLY

Regional Office RO Log #: ___________________________ Central Office Log #: ___________________________

Name of Facility: ____________________________________________

Date received from: Facility ___________________________ Regional Office ___________________________

Decentralized Waiver

RO Program Manager Disposition: [ ] Approved [ ] Disapproved

Reason: __________________________________________________

Centralized Waiver

RO Recommendation: [ ] Approved [ ] Disapproved [ ] Conditional Approval [ ] Withdrawn

Reason: __________________________________________________

Regional Office:

RO Reviewer (include title) ___________________________ Date: ___________________________

RO Program Manager (signature) ___________________________ Date: ___________________________

Architect:

Date to Architect: ___________________________ Architect Recommendation: [ ] Approved [ ] Disapproved

Architect (signature): ___________________________ Date: ___________________________

Comments: ____________________________________________

Central Office:

Central Office Reviewer: ___________________________ Title: ___________________________ Date: ___________________________

Division Director Recommendation: [ ] Approved [ ] Disapproved [ ] Conditional Approval [ ] Withdrawn

Division Director (signature): ___________________________ Date: ___________________________

Comments: ____________________________________________

cc: R.O. Program Manager with attachments
    DACF/ALS Project File
    ACF Application Manager with attachments (only for pending applications)