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|  | **WAIVER REQUEST FORM**  **DPH – BHCSQ - DHCFLC, 250 Washington Street, 3rd Floor, Boston, MA 02108**  Note: (1) A separate waiver request form must be submitted for each regulation or FGI Guidelines requirement for which a waiver is requested; and (2) all information pertaining to this waiver request must be contained in this form to allow the waiver determination to be made without the need to refer to other plan review documentation. |

Facility's Licensed Name or Proposed Name Address, including zip code

If Hospital/Clinic Satellite, Name Address, including zip code

Hospital/Clinic Department Building/Floor Location

**I HEREBY REQUEST THE DEPARTMENT WAIVE COMPLIANCE WITH THE REGULATION OR REQUIREMENT:**

**1.A: REGULATION/FGI GUIDELINES NUMBER:**

**1.B: RELEVANT TEXT OF REGULATION/FGI GUIDELINES REQUIREMENT:**

**2.A: DESCRIBE WHAT IS PROPOSED IN LIEU OF COMPLIANCE WITH THE REQUIREMENT:**

**2.B: HOSPITAL, LONG TERM CARE FACILITY & ADULT DAY HEALTH PROGRAM – DESCRIBE COMPENSATING FEATURES; CLINIC & HOSPICE – DESCRIBE HOW THE PROVIDER WILL REMAIN IN SUBSTANTIAL COMPLIANCE:**

Facility's Licensed Name or Proposed Name Address, including zip code

**Regulation/Requirement Citation:**

**3. PROVIDER’S DETAILED EXPLANATION OF HOW MEETING THE REQUIREMENT WOULD CAUSE UNDUE HARDSHIP:**

**(Indicate excessive cost implications associated with compliance or potential patient care improvements associated with waiver)**

**4. PROVIDER’S DETAILED EXPLANATION OF HOW APPROVAL OF THE WAIVER: (A) WILL NOT LIMIT THE CAPACITY TO PROVIDE ADEQUATE CARE; AND, (B) DOES NOT JEOPARDIZE/AFFECT PATIENT OR RESIDENT HEALTH AND SAFETY:**

**5. A FLOOR PLAN OR PLAN DETAIL IN 8½ X 11 FORMAT IS ATTACHED TO THIS FORM TO SHOW WHAT IS PROPOSED IN LIEU OF COMPLIANCE WITH THE REQUIREMENT.**

**FACILITY AUTHORIZED REPRESENTATIVE: FACILITY CLINICAL REPRESENTATIVE:**

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| Name: |  | Name: |  |
| Title: |  | Title: |  |
| Organization: |  | Telephone: |  |
| Mailing Address: |  |  |  |
|  |  |  |  |
| Email: |  | Email: |  |
| Signature/Date: |  | Signature/Date: |  |

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| **For DPH Use Only:** The waiver identified above is approved, approved with conditions or denied as indicated below.  Evaluated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ /\_\_\_  Approved Approved w/Conditions  Denied  Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ /\_\_\_  Approved Approved w/Conditions  Denied  WAIVER APPROVAL CONDITIONS OR REASONS FOR DENIAL: |
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| Note: This waiver may be evaluated during on-site visits by Department staff at the facility. The Department reserves the right to revoke the waiver approvals if deficiencies are cited that indicate that the waivers adversely affect patient or resident health and safety. |