



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)**

Empty box for provider's detailed explanation of undue hardship.

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:

Empty box for provider's detailed explanation of how approval of the waiver meets requirements.

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:

Name: _____

Name: _____

Title: _____

Title: _____

Organization: _____

Telephone: _____

Mailing Address: _____

Email: _____

Email: _____

Signature/Date: _____

Signature/Date: _____

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:

Empty lines for waiver approval conditions or reasons for denial.

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.