

ASSISTED LIVING FACILITY WAIVER, APPROVAL, VARIANCE OR EXCEPTION REQUEST

- When this request is submitted, **all information is required**.
- If spaces allotted are not sufficient for your response, **attach additional pages as needed**.
- Personal information collected on this form will be used during the review process and for no other purpose.
- For questions about completion of this form, refer to the [Waivers, Approval, Variances and Exceptions: Assisted Living webpage](#) or contact the Division of Quality Assurance (DQA) [Regional Office](#) that serves the facility.
- Return this completed and signed form to the appropriate DQA Regional Office email address.

Name – Facility		Type of Facility <input type="checkbox"/> ADC <input type="checkbox"/> AFH <input type="checkbox"/> CBRF <input type="checkbox"/> RCAC		License No.
Address - Street	City	Zip Code	County	

Type of Request: ☐ Waiver ☐ Approval ☒ Variance ☐ Exception

Time Period of Request

☐ Permanent ☐ Temporary – **From** (MM/dd/yyyy): _____ **To** (MM/dd/yyyy): _____

Applicable Codes

DHS 88.04(2)(g) Screening for illness detrimental to residents including TB

Name – Resident (if applicable)

FOR RESTRAINT USE ONLY

Is resident a Family Care or IRIS member? ☐ Yes ☐ No If “yes,” complete the following:

Name – Case Manager (Print or type.)

SIGNATURE – Case Manager

➤

Specific Action Requested

The facility is requesting a variance to the requirement for licensee and service provider screening for illness detrimental to residents including TB 90 days before the start of employment. The facility will test the licensee and new employee once clinics are conducting such testing again following the COVID-19 situation. Resident safety will be ensured in lieu of a TB Test by conducting a TB/communicable disease screening on the licensee/new employee using the Wisconsin Communicable Disease/Tuberculosis Screening Questionnaire found at dhs.wisconsin.gov/library/f-01679.htm in addition to the daily employee COVID-19 screening take place at the facility.

Steps Facility Will Implement to Ensure Resident Safety (Failure to include this information may result in denial or delayed approval.)

If request is for use of a restraint device, describe other alternatives attempted. *(Attach any relevant assessments.)*

Name – Person Completing Form <i>(Print or type.)</i>	Email Address	Telephone No.
SIGNATURE – Person Completing Form ➤	Title	Date Signed <i>(MM/dd/yyyy)</i>
DQA USE ONLY		
<input type="checkbox"/> Deny Request <input type="checkbox"/> Approve Request – Expiration Date <i>(MM/dd/yyyy)</i> : _____		
Comments		
This approval may be rescinded at any time upon a determination by the Department.		
SIGNATURE – Assisted Living Regional Director (ALRD) ➤		Date Signed <i>(MM/dd/yyyy)</i>