DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-62548 (01/2020)

STATE OF WISCONSIN

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 ☐ ADC ☐ AFH ☐ CBRF ☐ 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 83.17(2)(a) Screening for clinically apparent communicable disease 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 screening new employees for clinically apparent communicable disease including TB within 90 days before the the start of employment. The facility will test the 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 new employee using the Wisconsin Communicable Disease/Tuberculosis Screening Questionnaire found at www.dhs.wisconsin.gov/library/f-01679.htm in addition to the daily employee screening for COVID-19 the facility is conducting.

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 *(Print or type.)*	Email Address	Telephone No.
SIGNATURE – Person Completing Form ➢	Title	Date Signed *(MM/dd/yyyy)*

DQA USE ONLY

☐ Deny Request ☐ Approve Request – Expiration Date *(MM/dd/yyyy):* _____

Comments

This approval may be rescinded at any time upon a determination by the Department.

SIGNATURE – Assisted Living Regional Director (ALRD) ➢	Date Signed *(MM/dd/yyyy)*