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

# 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<br>☐ 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<br>DHS 83.22 Employee Task-Specific Training | 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<br>➢ |

Specific Action Requested

The facility is requesting a variance to the requirement for employee task-specific training prior to assuming job duties. The facility requests that it be allowed to train new employees within 21 days of employment in the areas of (1) assessment of residents; (2) ISP development; (3) provision of personal care; and (4) dietary training. To ensure resident safety, the new employee will be given job duties at work that do not involve (1)-(4) until such time as the employee receives the task specific training described in DHS 83.22.

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<br>➢ | 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)<br>➢ | Date Signed *(MM/dd/yyyy)* |
|---|---|