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 83.29(2)(h) Admission agreement notice of transfer within the CBRF requirement	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 waiver of the requirement that a resident has to be given written advance notice pursuant to its admission agreement for a facility wanting to transfer a resident to an isolation room or area of the CBRF related to COVID-19 and facility needs due to COVID-19. To ensure resident safety, the facility will do everything possible to give the resident and legal representative as much advance notice as possible and will make every attempt to hold the prior room for the resident to return to.

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This approval may be rescinded at any time upon a determination by the Department.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