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| DEPARTMENT OF HEALTH SERVICES Division of Quality Assurance  F-62548 (05/2023) | **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](https://www.dhs.wisconsin.gov/regulations/waiver-variance-assisted-living.htm) or contact the Division of Quality Assurance (DQA) [Regional Office](https://www.dhs.wisconsin.gov/dqa/bal-regionalmap.htm) that serves the facility.
* Return this completed and signed form to the appropriate DQA Regional Office email address.

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| Name – Facility | | | | | Type of Facility  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 | | | | | 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 | | | | | | | | |
| *The following three items have expandable fields.* | | | | | | | | | | | | |
| Specific Action Requested | | | | | | | | | | | | |
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| Steps Facility Will Implement to Ensure Resident Safety *(Failure to include this information may result in denial or delayed approval.)* | | | | | | | | | | | | |
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| 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 *(expandable field)* | | | | | | | | | | | | |
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| **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)* | | | |