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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-02527 (11/2022) | | | | | | | | | | **STATE OF WISCONSIN** | | | | | | | | | | |
| **WAIVER OR VARIANCE REQUEST**  **Hospital (DHS 124), Home Health Agency (DHS 133), Hospice (DHS 131), Personal Care Agency (DHS 105.17), and Adult Day Care Center (DHS 105.14)** | | | | | | | | | | | | | | | | | | | | |
| **INSTRUCTIONS AND DEFINITIONS** | | | | | | | | | | | | | | | | | | | | |
| *Return completed form via mail, fax, or email to:*  **Mail:** DHS/DQA/Bureau of Health Services **Fax:** 608-264-9847 **Email:** [DHSDQALCCS@dhs.wisconsin.gov](mailto:DHSDQALCCS@dhs.wisconsin.gov)  ATTN: BHS Director  PO Box 2969  Madison, WI 53701-2969 | | | | | | | | | | | | | | | | | | | | |
| **Waiver:** If granted, a waiver allows the provider to **not meet** the requested regulation.  **Variance:** If granted, a variance allows the provider to **meet the regulation differently** than in the manner the regulation requires. | | | | | | | | | | | | | | | | | | | | |
| **PROVIDER INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Provider Type  Hospital  Home Health Agency  Hospice  Personal Care Agency  Adult Day Care Center | | | | | | | | | | | | | | | | | | License or Certification No. | | |
| Name – Provider | | | | | | | | | | | | | | | | Phone Number | | | | |
| Address – Street | | | | | | | City | | | | | State | | | Zip Code | | | | County | |
| **WAIVER OR VARIANCE REQUEST** | | | | | | | | | | | | | | | | | | | | |
| *Describe the specific situation. Complete all sections. Attach narrative if additional space is needed.  Check if narrative is attached.* | | | | | | | | | | | | | | | | | | | | |
| **Type:**  Waiver  Variance | | | **Wis. Admin. Code for which Exception is Requested:** | | | | | | | | | | |  | | | | | | |
| **Reason for Request** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Justification** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **If requesting a variance, describe specific alternative action proposed.** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **How will provider assure there is no adverse impact to the health, safety, or welfare of patients/clients/residents?** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Time Period Requested:** | | Extension / Renewal of Current Exception  Permanent | | | | | | | | | | | | | | | | | | |
|  | | Temporary – From (*MM/dd/yyyy):* | | | | | | | |  | | | To *(MM/dd/yyyy):* | | | | | |  | |
| **REQUESTOR INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Name – Person Completing Form | | | | | | Email Address | | | | | | | | | | | Phone Number | | | |
| **SIGNATURE** – Person Completing Form | | | | | | | | | Title | | | | | | | | | Date Signed | | |
| **DQA**  **USE**  **ONLY** | Deny  Approve | | | If approved ---  Expiration Date: | | | | | | |  | | | | | | | | | or  Permanent |
| Comments/Conditions: | | | |  | | | | | | | | | | | | | | | |
| ***This approval may be rescinded as determined by the Department.*** | | | | | | | **SIGNATURE** – BHS Director | | | | | | | | | | Date Approved | | |