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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-60289 (09/2023) | **STATE OF WISCONSIN**Page 1 of 2 |
| **WAIVER OR VARIANCE REQUEST****Community Mental Health and Substance Abuse Treatment Services****INSTRUCTIONS*** Refer to DQA publication [P-02328, Community Mental Health and Substance Abuse Treatment Services Waiver and Variance Process.](https://www.dhs.wisconsin.gov/publications/p02328.pdf)
* When this request is submitted, **all information is required.**
* If spaces allotted are not sufficient for your response, **attach additional pages as needed.**
* Return this completed and signed form to: DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov

**DEFINITIONS*** **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 in a manner different than what the regulation requires.
 |
| Certification No.      | Name – Program      |
| Address – Street      | City      | State   | Zip Code      | County      |
| Type of Request [ ]  Variance [ ]  Waiver [ ]  Extension of Current Approved Request  |
| Time Period of Request | **From** *(MM/dd/yyy*y): |       | **To** *(MM/dd/yyyy):* |       |
| Administrative Code Requested for Waiver or Variance      |
| **Description of Waiver or Variance** *(Describe the specific situation. All sections must be completed.)* |
| 1. Reason for the Request
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|  |       |
| 1. Steps facility/clinic will implement to ensure the waiver or variance will not adversely affect the health, safety, or welfare of any client for the requested action.
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|  |       |
| 1. If requesting a variance, describe the specific alternative action proposed.
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|  |       |
| Name – Person Completing Form *(Type or print.)*      | Email Address      | Phone 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| **This approval may be rescinded at any time upon a determination by the Department.** |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** –Section Manager | Date Signed *(MM/dd/yyyy)*      |