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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-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](mailto: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 | | | | | | | | | | | | | | | |
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| **This approval may be rescinded at any time upon a determination by the Department.** | | | | | | | | | | | | | | | |
| **SIGNATURE** –Section Manager | | | | | | | | | | | | Date Signed *(MM/dd/yyyy)* | | | |