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| DEPARTMENT OF HEALTH SERVICESDivision of Quality AssuranceF-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  |
|       |
| 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 *(expandable field)* |
|       |
| **This approval may be rescinded at any time upon a determination by the Department.** |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)*      |