DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-62548 (01/2020)

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 or contact the Division of Quality Assurance (DQA) Regional Office that serves the facility.
- Return this completed and signed form to the appropriate DQA Regional Office email address.

Name – Facility	Type of Facility ☐ ADC ☐ 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 ➢

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

This approval may be rescinded at any time upon a determination by the Department.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)*