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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-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 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| ***This approval may be rescinded as determined by the Department.*** | **SIGNATURE** – BHS Director | Date Approved |