**REQUEST FOR WAIVER OF ADMINISTRATIVE RULE (HEALTH-RELATED)**

**NOTE: PRIOR TO SUBMITTING FORM, READ IAC 481 CHAPTER 67.7(1-4) AND THE APPLICABLE ADMINISTRATIVE RULE:**

**Please check appropriate program:**

**Assisted Living Program (ALP)(69.23(1)) a-j \_\_\_\_**

**Adult Day Services (ADS)(70.23(1)) a-c \_\_\_\_\_\_\_\_**

**Elder Group Home (EGH) (68.14(1))a-j \_\_\_\_\_\_\_\_**

1. **Specific rule for which waiver is being requested: (For example: 69.23(1)(a).**

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1. **Name of the program, RN, email address, address and phone number where the tenant resides.**

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1. **Tenant name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Date of admission to program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Date of admission to hospice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **Current GDS or mini-mental score and date assessed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
6. **Functionality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
7. **Care needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **Evacuation Plans: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Tenant’s weight history for the last 6 months in pounds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **List any adverse impact on the program or other tenants or participants as**

**a result of this waiver being granted.**

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1. **List any previous waivers granted or denied (include dates).**

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1. **Name of Hospice RN and phone number. Include any applicable**

**Home Health Agencies, Hospices or other providers involved in this request.**

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1. **Tenant’s physician and phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Name of legal representative. Describe the level of family/friend involvement.**

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1. **Current program census: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Signs/symptoms of active dying, if on Hospice:**

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1. **What precipitated Hospice admission? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\*\*\*20. Include a copy of the physician orders for Hospice and current Hospice nursing**

**assessment if requesting a waiver for a tenant receiving Hospice services.**

**I authorize all individuals with knowledge of relevant or important facts relating to this request to release any information to the Department of Inspections and Appeals. I hereby attest to the accuracy and truthfulness of the information contained herein.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Requestor’s Signature and Title Date**

**For additional information contact the Adult Services Bureau at 515/281-7624**

**Mail or fax this request:**

**Department of Inspections & Appeals**

**Adult Services Bureau**

**321 E. 12th Street, 3rd Floor**

**Des Moines, IA 50319**

**(515) 242-5022 (fax)**