NEW YORK STATE | Department of Health

Medical Equipment Waiver

REVISED Submission Process & Content Refresher Training

Division of Adult Care Facility and Assisted Living Surveillance

Background & Purpose

When do I need a Medical Equipment Waiver?

Approved Medical Equipment Waivers are required for:

- Hospital, hi/low, height adjustable beds;
- ½ side rail;
- Enabling devices (including med. poles); and
- Trapeze devices.

Non-hospital electric beds (I.e., TempurPedic, Beautyrest, or SleepNumber, etc.) fall under the existing equivalency for bed substitution. Accordingly, no waiver request is currently required to deploy these beds. The existing equivalency interpretive guidelines are applicable.

Non-medical equipment waivers should continue to be submitted via the Regional Office until otherwise advised. Any changes to this requirement will be widely broadcast.

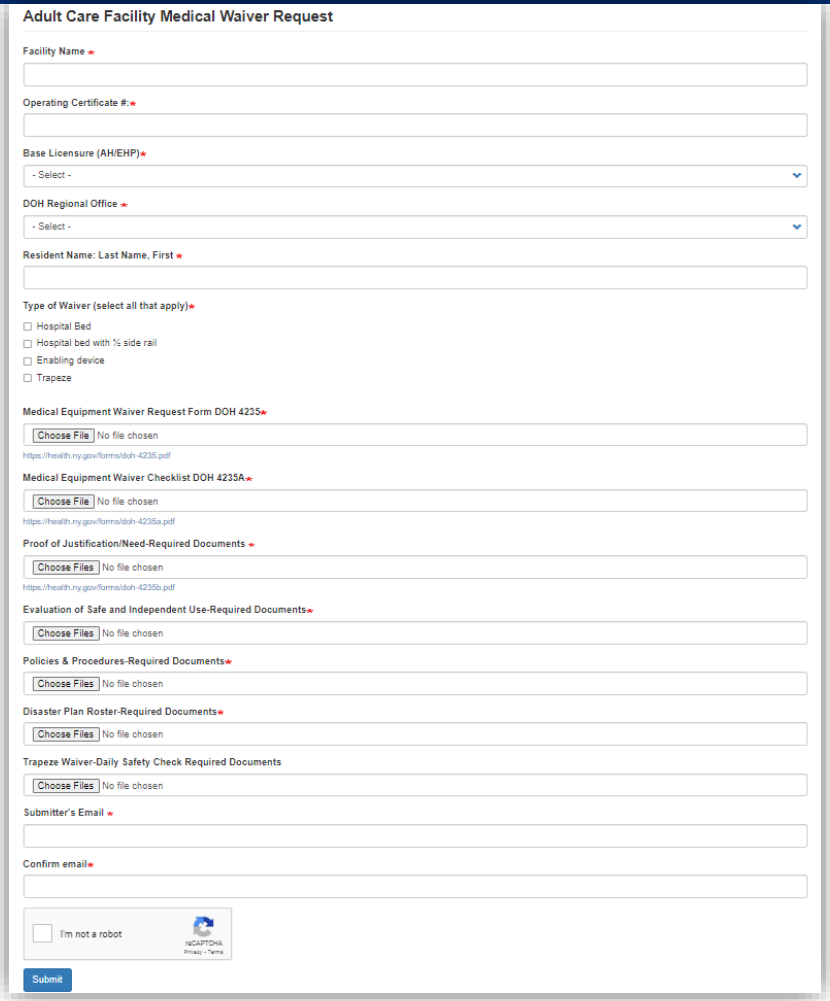
Waivers/Equivalencies are not required items such as oxygen concentrators or orthopedic shoes with brace(s). Facilities must ensure that, when necessary, physician orders are on file; appropriate policies and procedures are in place; and proper case management and personal care planning are completed and implemented.

Waiver Submission

New Medical Equipment Waiver Submission Process

- Medical equipment waiver requests **already in queue** will be processed pursuant to the workflow described in DAL #22-22.

- Effective September 1, 2022
  - All new medical equipment waiver submissions must be submitted via the secured Drupal survey which will be provided in DAL #22-34



Adult Care Facility Medical Waiver Request

Facility Name *

Operating Certificate #:*

Base Licensure (AH/EHP)*

- Select -

DOH Regional Office *

- Select -

Resident Name: Last Name, First *

Type of Waiver (select all that apply)*

- ☐ Hospital Bed
- ☐ Hospital bed with ½ side rail
- ☐ Enabling device
- ☐ Trapeze

Medical Equipment Waiver Request Form DOH 4235*

Choose File No file chosen

https://health.ny.gov/forms/doh-4235.pdf

Medical Equipment Waiver Checklist DOH 4235A*

Choose File No file chosen

https://health.ny.gov/forms/doh-4235a.pdf

Proof of Justification/Need-Required Documents *

Choose Files No file chosen

https://health.ny.gov/forms/doh-4235b.pdf

Evaluation of Safe and Independent Use-Required Documents*

Choose Files No file chosen

Policies & Procedures-Required Documents*

Choose Files No file chosen

Disaster Plan Roster-Required Documents*

Choose Files No file chosen

Trapeze Waiver-Daily Safety Check Required Documents

Choose Files No file chosen

Submitter's Email *

Confirm email*

I'm not a robot reCAPTCHA Privacy - Terms

Submit

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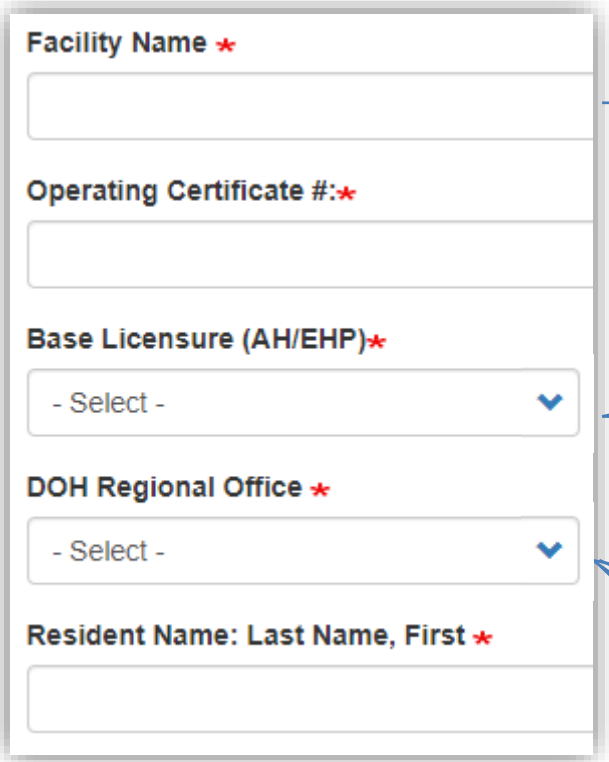

Full Facility Name

Adult Home (AH)
Enriched Housing Program (EHP)

Capital District Regional Office
Central New York Regional Office
Metropolitan Area Regional Office
Western Regional Office

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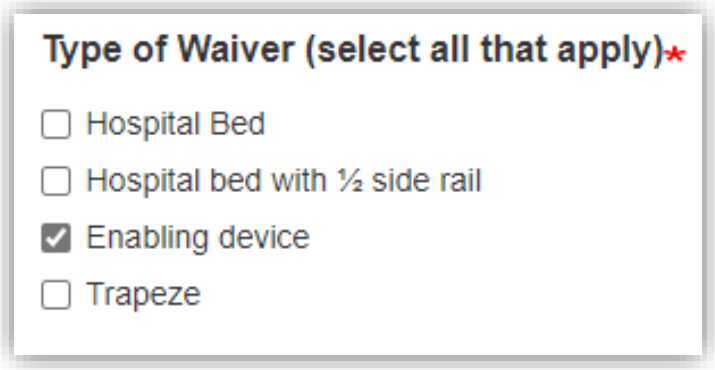
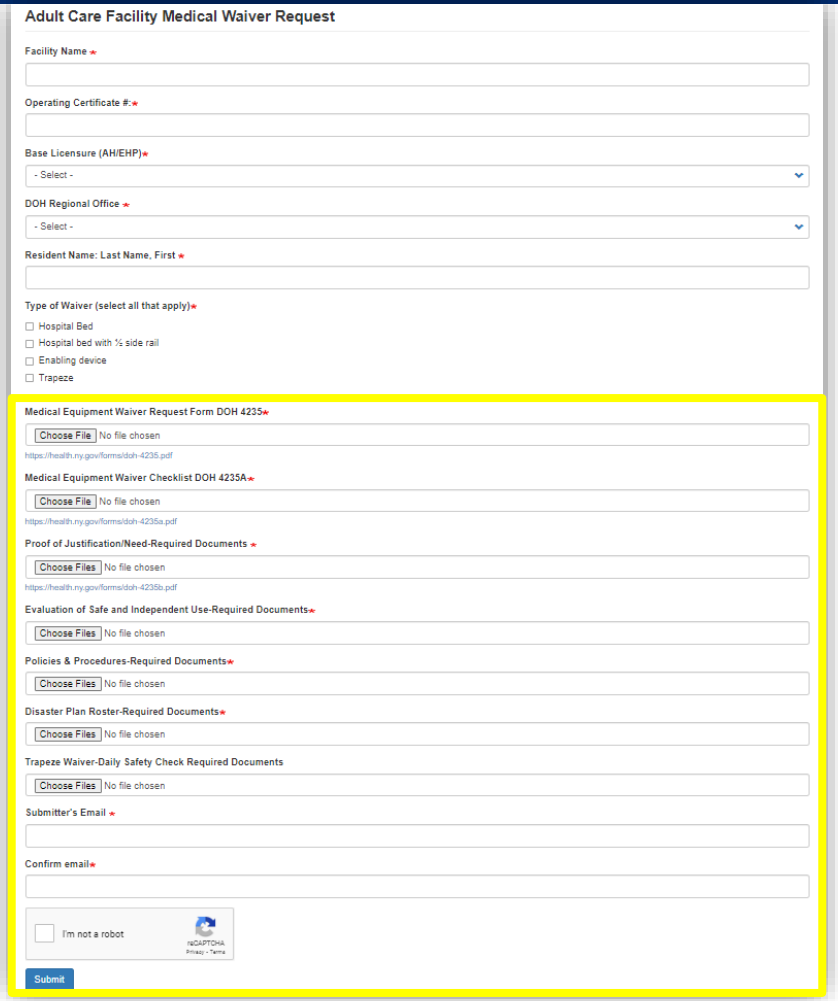


For enabling device, please be specific and consistent on DOH-4235a and supporting documentation.



Adult Care Facility Medical Waiver Request

Facility Name *

Operating Certificate #:*

Base Licensure (AH/EHP)*

- Select -

DOH Regional Office *

- Select -

Resident Name: Last Name, First *

Type of Waiver (select all that apply)*

- ☐ Hospital Bed
- ☐ Hospital bed with ½ side rail
- ☐ Enabling device
- ☐ Trapeze

Medical Equipment Waiver Request Form DOH 4235*

Choose File No file chosen

https://health.ny.gov/forms/doh-4235.pdf

Medical Equipment Waiver Checklist DOH 4235A*

Choose File No file chosen

https://health.ny.gov/forms/doh-4235a.pdf

Proof of Justification/Need-Required Documents *

Choose Files No file chosen

https://health.ny.gov/forms/doh-4235b.pdf

Evaluation of Safe and Independent Use-Required Documents*

Choose Files No file chosen

Policies & Procedures-Required Documents*

Choose Files No file chosen

Disaster Plan Roster-Required Documents*

Choose Files No file chosen

Trapeze Waiver-Daily Safety Check Required Documents

Choose Files No file chosen

Submitter's Email *

Confirm email*

I'm not a robot reCAPTCHA Privacy - Terms

Submit

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Home

Application Received

The completed application has been successfully received.
Your Submission ID is: [redacted]
Please keep this submission ID for your records.

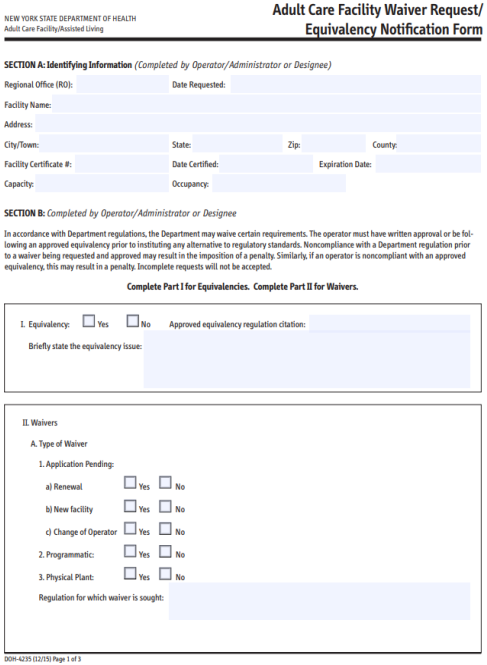
Back to survey

Content Overview

Medical Equipment Waiver Request Form DOH 4235 *

Choose File No file chosen

https://health.ny.gov/forms/doh-4235.pdf



NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facility Waiver Request/ Equivalency Notification Form

SECTION A: Identifying Information *(Completed by Operator/Administrator or Designee)*

Regional Office (RO): Date Requested:

Facility Name:

Address:

City/Town: State: Zip: County:

Facility Certificate #: Date Certified: Expiration Date:

Capacity: Occupancy:

SECTION B: *Completed by Operator/Administrator or Designee*

In accordance with Department regulations, the Department may waive certain requirements. The operator must have written approval or be following an approved equivalency prior to instituting any alternative to regulatory standards. Noncompliance with a Department regulation prior to a waiver being requested and approved may result in the imposition of a penalty. Similarly, if an operator is noncompliant with an approved equivalency, this may result in a penalty. Incomplete requests will not be accepted.

Complete Part I for Equivalencies. Complete Part II for Waivers.

I. Equivalency: ☐ Yes ☐ No Approved equivalency regulation citation:

Briefly state the equivalency issue:

II. Waivers

A. Type of Waiver

1. Application Pending:

a) Renewal ☐ Yes ☐ No

b) New facility ☐ Yes ☐ No

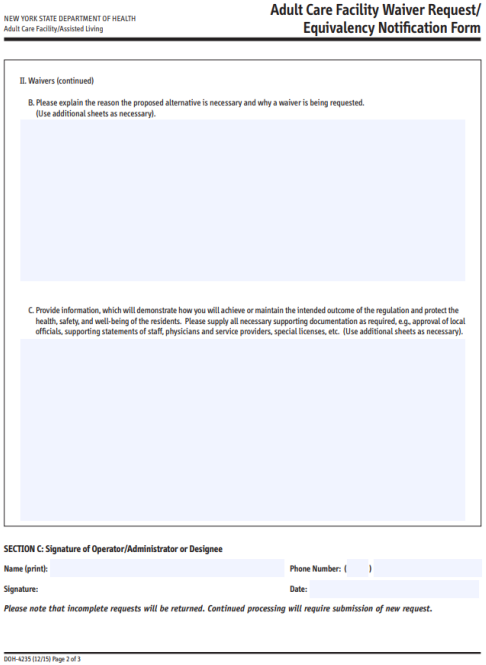
c) Change of Operator ☐ Yes ☐ No

2. Programmatic: ☐ Yes ☐ No

3. Physical Plant: ☐ Yes ☐ No

Regulation for which waiver is sought:

DOH-4235 (12/15) Page 1 of 3



NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facility Waiver Request/ Equivalency Notification Form

II. Waivers (continued)

B. Please explain the reason the proposed alternative is necessary and why a waiver is being requested. (Use additional sheets as necessary).

C. Provide information, which will demonstrate how you will achieve or maintain the intended outcome of the regulation and protect the health, safety, and well-being of the residents. Please supply all necessary supporting documentation as required, e.g., approval of local officials, supporting statements of staff, physicians and service providers, special licenses, etc. (Use additional sheets as necessary).

SECTION C: Signature of Operator/Administrator or Designee

Name (print): Phone Number: ( )

Signature: Date:

Please note that incomplete requests will be returned. Continued processing will require submission of new request.

DOH-4235 (12/15) Page 2 of 3

Please complete sections A-C , save, and upload file.

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DOH-4235 Awareness

Regulation for which waiver is sought:	Commonly left Incomplete/Incorrect

ME Equipment Requested	Adult Home	Enriched Housing Program	Residents for Adults
Hospital Bed	487.11(i) (4)(i) (a,b)	488.11 (f)(4)(i)	490.11(j)(4)(i)(a,b)
Hospital Bed with ½ side rail	487.11(i)(4)(i) (a,b) 487.11(i)(6)	488.11 (f)(4)(i)	490.11(j)(4)(i)(a,b) 490.11(j)(6)
Enabling Device (on standard bed)	487.11(i)(6)	488.11 (f)(4)(i)	490.11(j)(6)
Hospital Bed with Enabling Device	487.11(i)(4)(i)(a,b) 487.11(i)(6)	488.11(f)(4)(i)	490.11(j)(4)(i)(a,b) 490.11(j)(6)

Hint: Find your operating certificate. If you are an Enriched Housing Program, your license number will have an "S" (xxx-S-xxx). Anything else you're an Adult Home!

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Regulations

- 18 NYCRR § 487.11(i)(4)

Each operator shall furnish each resident with the following minimum bedroom equipment:
(i) a standard single bed, well constructed, in good repair, and equipped with:
(a) clean springs maintained in good condition;
(b) a clean, comfortable, well-constructed mattress, standard in size for the bed...

- 18 NYCRR § 487.11 (i)(6)

Beds with side rails or beds in excess of 36 inches high shall not be used, except in sick bays...

Adult Home

- 18 NYCRR § 488.11(f)(4)

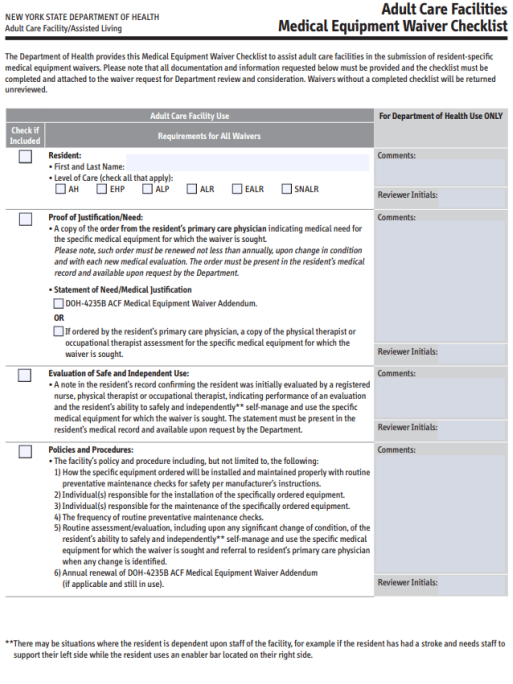
When not supplied by the resident, the operator must provide each resident with the following minimum household equipment:
(i) a standard, single bed in good repair, a chair, a lamp...

Enriched Housing Program

Medical Equipment Waiver Checklist DOH 4235A*

Choose File No file chosen

https://health.ny.gov/forms/doh-4235a.pdf



NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facilities
Medical Equipment Waiver Checklist

The Department of Health provides this Medical Equipment Waiver Checklist to assist adult care facilities in the submission of resident-specific medical equipment waivers. Please note that all documentation and information requested below must be provided and the checklist must be completed and attached to the waiver request for Department review and consideration. Waivers without a completed checklist will be returned unreviewed.

Adult Care Facility Use: Check if Included	Requirements for All Waivers	For Department of Health Use ONLY
☐	**Resident:** • First and Last Name: • Level of Care (check all that apply): ☐ AH ☐ EHP ☐ ALP ☐ ALR ☐ EALR ☐ SNALR	Comments: Reviewer Initials:
☐	**Proof of Justification/Need:** • A copy of the **order from the resident's primary care physician** indicating medical need for the specific medical equipment for which the waiver is sought. *Please note, such order must be renewed not less than annually, upon change in condition and with each new medical evaluation. The order must be present in the resident's medical record and available upon request by the Department.* • **Statement of Need/Medical Justification** ☐ DOH-4235B ACF Medical Equipment Waiver Addendum. **OR** ☐ If ordered by the resident's primary care physician, a copy of the physical therapist or occupational therapist assessment for the specific medical equipment for which the waiver is sought.	Comments: Reviewer Initials:
☐	**Evaluation of Safe and Independent Use:** • A note in the resident's record confirming the resident was initially evaluated by a registered nurse, physical therapist or occupational therapist, indicating performance of an evaluation and the resident's ability to safely and independently** self-manage and use the specific medical equipment for which the waiver is sought. The statement must be present in the resident's medical record and available upon request by the Department.	Comments: Reviewer Initials:
☐	**Policies and Procedures:** • The facility's policy and procedure including, but not limited to, the following: 1) How the specific equipment ordered will be installed and maintained properly with routine preventative maintenance checks for safety per manufacturer's instructions. 2) Individual(s) responsible for the installation of the specifically ordered equipment. 3) Individual(s) responsible for the maintenance of the specifically ordered equipment. 4) The frequency of routine preventative maintenance checks. 5) Routine assessment/evaluation, including upon any significant change of condition, of the resident's ability to safely and independently** self-manage and use the specific medical equipment for which the waiver is sought and referral to resident's primary care physician when any change is identified. 6) Annual renewal of DOH-4235B ACF Medical Equipment Waiver Addendum (if applicable and still in use).	Comments: Reviewer Initials:

**There may be situations where the resident is dependent upon staff of the facility, for example if the resident has had a stroke and needs staff to support their left side while the resident uses an enabler bar located on their right side.

DOH-4235a (02/22) p 2 of 3

For Adult Care Facility Use: Check if Included	Requirements for All Waivers	For Department of Health Use ONLY
☐	**Disaster Plan Roster:** A copy of the facility's current disaster plan roster of residents with transfer assistance levels clearly identified for all residents and specifying residents in need of assistance with evacuation. Please note, facilities must have specific and current procedures for evacuation of residents needing individual procedures documented and available upon request by the Department.	Comments: Reviewer Initials:

For Adult Care Facility Use: Check if Included	Additional Requirements for Hospital Bed Waivers	For Department of Health Use ONLY
☐	**Check all those that apply:** ☐ No wheels. ☐ Wheels are locked. ☐ Bed height is no more than 36 inches as measured from the floor to the top of the mattress, not the footboard and not the headboard. Bed Measurement:	Comments: Reviewer Initials:

For Adult Care Facility Use: Check if Included	Additional Requirements for Hospital Beds with ½ side rail Waivers	For Department of Health Use ONLY
☐	**Check to confirm:** ☐ Only one side rail will be in use ☐ ½ side rail will not be placed in the middle of the bed. ☐ ½ side rail cannot be used as restraints.	Comments: Reviewer Initials:

For Adult Care Facility Use: Check if Included	Additional Requirements for Enabling Device Waivers	For Department of Health Use ONLY
☐	**Type of enabling device:** **Check to confirm:** ☐ Only one type of enabling device per bed is permitted. ☐ Enabling devices may not be used as a restraint.	Comments: Reviewer Initials:

For Adult Care Facility Use: Check if Included	Additional Requirements for Trapeze Waivers	For Department of Health Use ONLY
☐	**Emergency Evacuation:** **Check to confirm:** ☐ Bed can be rolled through the door with the attached apparatus if/when required for emergency evacuation. Resident's bedroom door measurement Bed w/ apparatus width measurement	Comments: Reviewer Initials:
☐	**Daily Safety Checks:** • Provide documentation that confirms, at minimum, daily safety checks of the trapeze device.	Comments: Reviewer Initials:

The New York State Department of Health reserves the right to request any information as deemed necessary to make a determination on the waiver request.

For Department of Health Use ONLY		
☐ Incomplete ☐ Missing Checklist	Notified On:	By:
☐ Denied	Notified On:	By:
☐ Conditionally Approved	Notified On:	By:

DOH-4235a (02/22) p 3 of 3

Please complete, save, and upload file.

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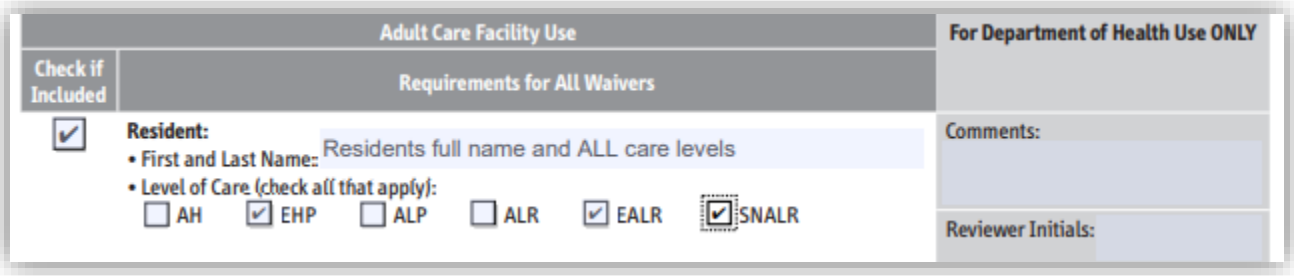
DOH-4235a Awareness



Adult Care Facility Use		For Department of Health Use ONLY
Check if Included	Requirements for All Waivers	
☑	**Resident:** • First and Last Name: Residents full name and ALL care levels • Level of Care (check all that apply): ☐ AH ☑ EHP ☐ ALP ☐ ALR ☑ EALR ☑ SNALR	Comments: Reviewer Initials:

*Residents receiving Assisted Living Program (ALP) or Enhanced Assisted Living Residence (EALR) services may require special consideration for assistance needed with medical equipment. Appropriate supporting information is required.

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Proof of Justification/Need-Required Documents *

Choose Files No file chosen

https://health.ny.gov/forms/doh-4235b.pdf

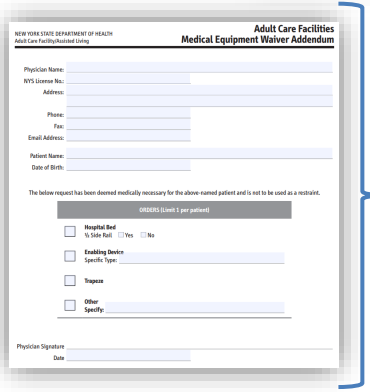
☑ **Proof of Justification/Need:**

- A copy of the **order from the resident's primary care physician** indicating medical need for the specific medical equipment for which the waiver is sought.
  Please note, such order must be renewed not less than annually, upon change in condition and with each new medical evaluation. The order must be present in the resident's medical record and available upon request by the Department.
- **Statement of Need/Medical Justification**
  - ☑ DOH-4235B ACF Medical Equipment Waiver Addendum.

  OR
  - ☐ If ordered by the resident's primary care physician, a copy of the physical therapist or occupational therapist assessment for the specific medical equipment for which the waiver is sought.

Comments:

Reviewer Initials:



NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facilities
Medical Equipment Waiver Addendum

Physician Name:
NYS License No.:
Address:
Phone:
Fax:
Email Address:
Patient Name:
Date of Birth:

The below request has been deemed medically necessary for the above-named patient and is not to be used as a restraint.

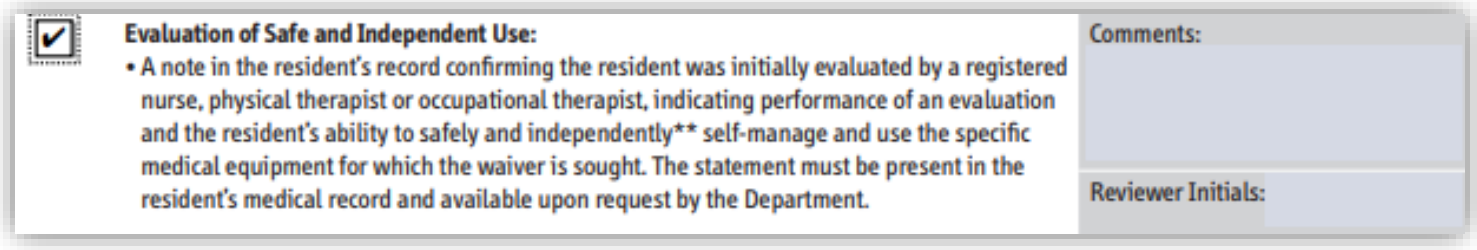
ORDERS (Limit 1 per patient)

- ☐ Hospital Bed — ½ Side Rail ☐ Yes ☐ No
- ☐ Enabling Device — Specific Type:
- ☐ Trapeze
- ☐ Other — Specify:

Physician Signature
Date

DOH 4235b: Please ensure fully completed and signed, dated, and correspond to remaining documents

NEW YORK STATE Department of Health



If you would like special consideration for residents of assisted living programs/enhanced assisted living residences/special needs assisted living residences: **please include information attesting to the resident's capacity to understand need and use of equipment, extent/frequency of assistance needed, who is responsible for providing assistance, and staff training regarding equipment and assistance guidelines.**

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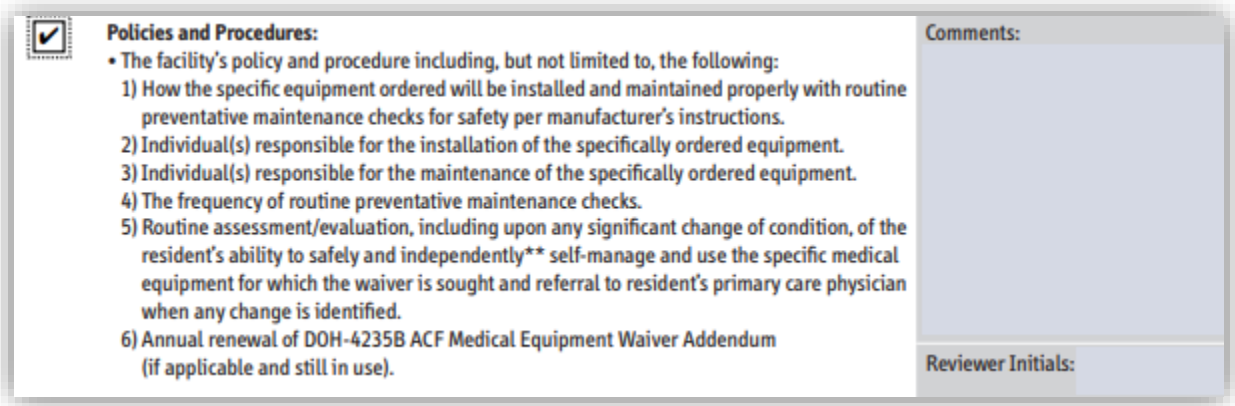
Policies & Procedures-Required Documents*

Choose Files No file chosen



☑ **Policies and Procedures:**

- The facility's policy and procedure including, but not limited to, the following:
  1) How the specific equipment ordered will be installed and maintained properly with routine preventative maintenance checks for safety per manufacturer's instructions.
  2) Individual(s) responsible for the installation of the specifically ordered equipment.
  3) Individual(s) responsible for the maintenance of the specifically ordered equipment.
  4) The frequency of routine preventative maintenance checks.
  5) Routine assessment/evaluation, including upon any significant change of condition, of the resident's ability to safely and independently** self-manage and use the specific medical equipment for which the waiver is sought and referral to resident's primary care physician when any change is identified.
  6) Annual renewal of DOH-4235B ACF Medical Equipment Waiver Addendum (if applicable and still in use).

Comments:

Reviewer Initials:

-Must submit formal policy & procedure, a waiver attachment does not qualify alone.
-Policy & procedure must reflect all 6 qualifiers in DOH-4235a.
-If submitting policy and procedure and waiver attachment, information must be consistent on all documentation submitted.

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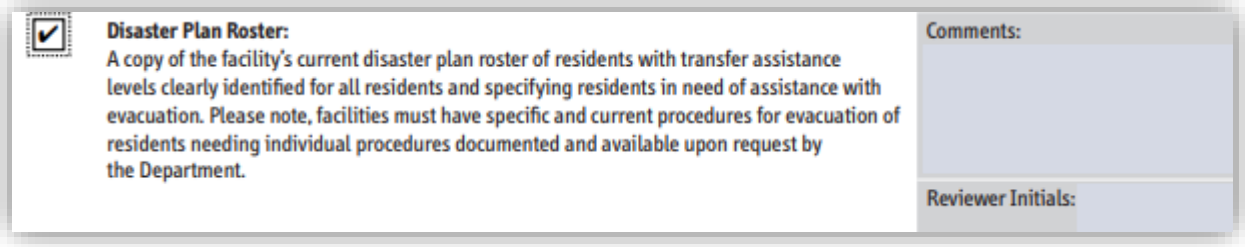
Disaster Plan Roster-Required Documents*

Choose Files No file chosen



Disaster Plan Roster:
A copy of the facility's current disaster plan roster of residents with transfer assistance levels clearly identified for all residents and specifying residents in need of assistance with evacuation. Please note, facilities must have specific and current procedures for evacuation of residents needing individual procedures documented and available upon request by the Department.

Comments:

Reviewer Initials:

- Roster must be provided for all facility residents.
- Plan must clearly identify transfer assistance levels/residents in need of assistance with evacuation.
- If using Transfer Assistance Levels, please include a key.

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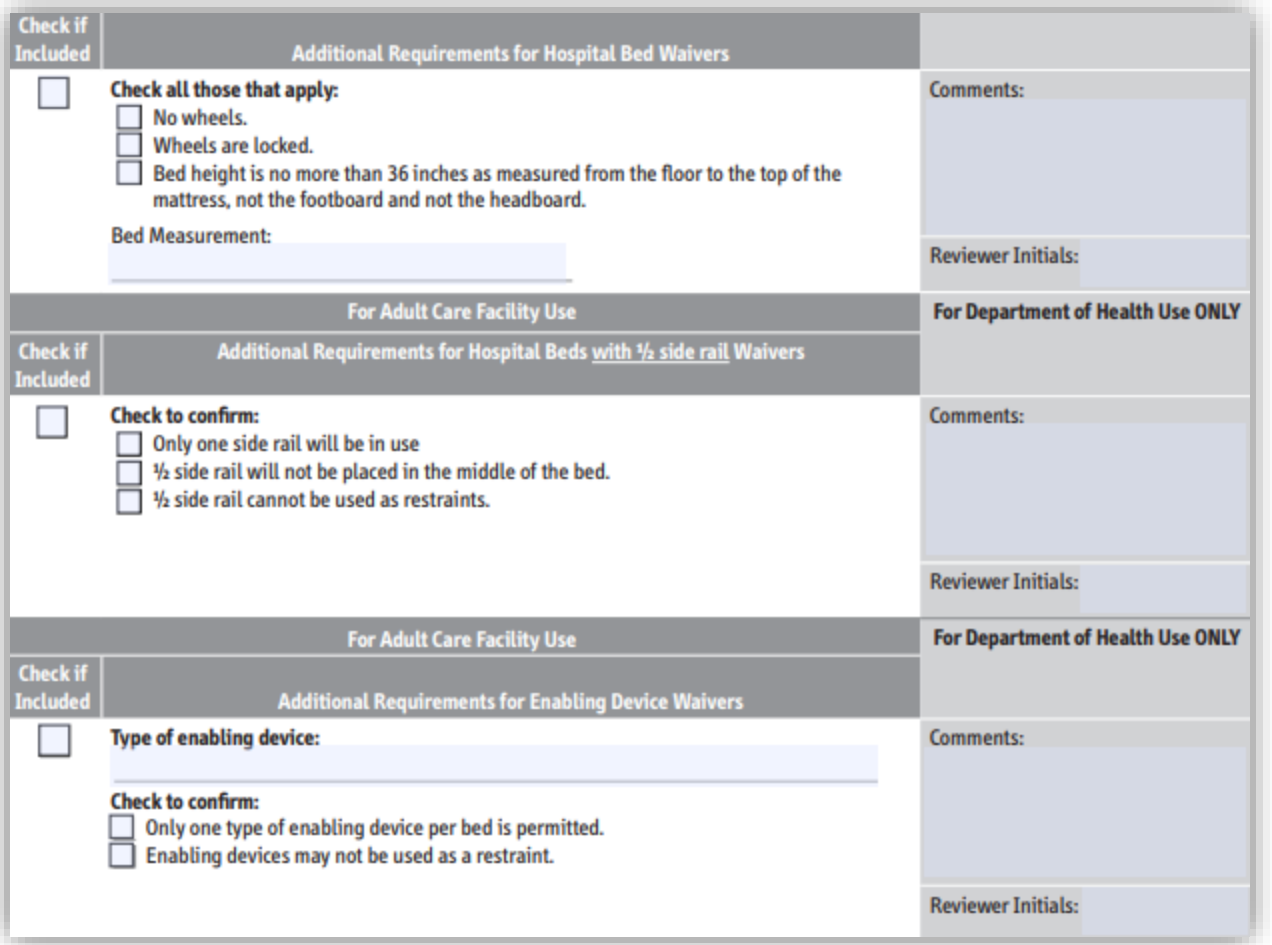

Check if Included	Additional Requirements for Hospital Bed Waivers	
☐	**Check all those that apply:** ☐ No wheels. ☐ Wheels are locked. ☐ Bed height is no more than 36 inches as measured from the floor to the top of the mattress, not the footboard and not the headboard. Bed Measurement:	Comments: Reviewer Initials:
	For Adult Care Facility Use	For Department of Health Use ONLY
Check if Included	Additional Requirements for Hospital Beds with ½ side rail Waivers	
☐	**Check to confirm:** ☐ Only one side rail will be in use ☐ ½ side rail will not be placed in the middle of the bed. ☐ ½ side rail cannot be used as restraints.	Comments: Reviewer Initials:
	For Adult Care Facility Use	For Department of Health Use ONLY
Check if Included	Additional Requirements for Enabling Device Waivers	
☐	**Type of enabling device:** **Check to confirm:** ☐ Only one type of enabling device per bed is permitted. ☐ Enabling devices may not be used as a restraint.	Comments: Reviewer Initials:

Device specific categories, select and complete all applicable areas.

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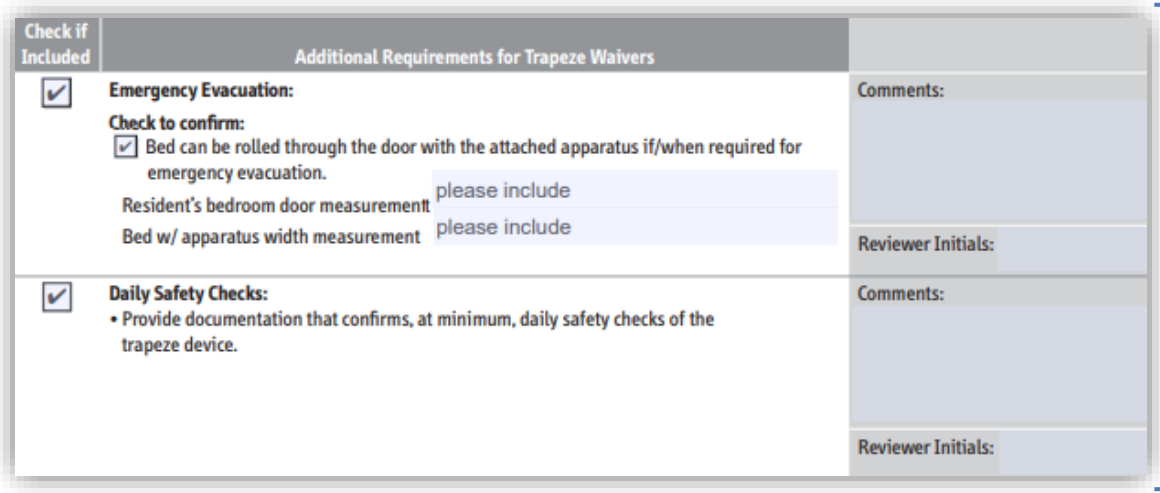
Trapeze Waiver-Daily Safety Check Required Documents

Choose Files | No file chosen



Check if Included	Additional Requirements for Trapeze Waivers	
☑	**Emergency Evacuation:** **Check to confirm:** ☑ Bed can be rolled through the door with the attached apparatus if/when required for emergency evacuation. Resident's bedroom door measurement: please include Bed w/ apparatus width measurement: please include	Comments: Reviewer Initials:
☑	**Daily Safety Checks:** • Provide documentation that confirms, at minimum, daily safety checks of the trapeze device.	Comments: Reviewer Initials:

Specific to trapeze devices, please submit corresponding information in trapeze survey selection.

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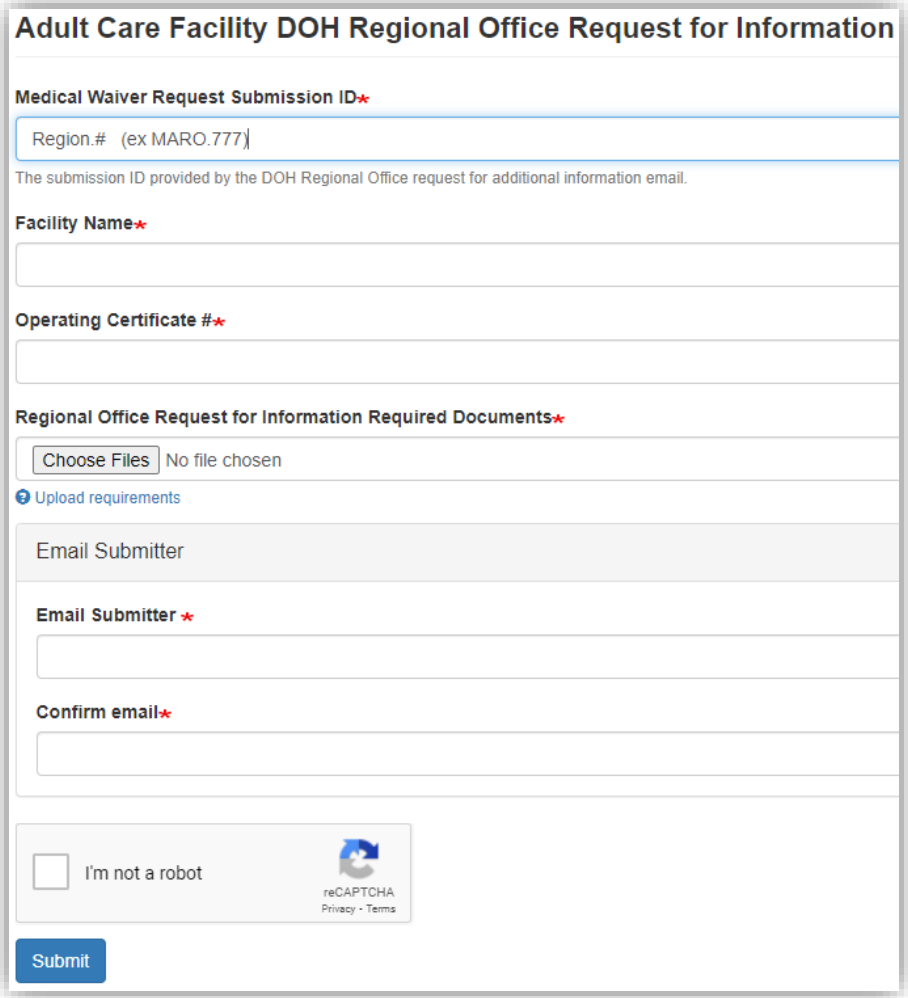
Request for information (RFI)



Adult Care Facility DOH Regional Office Request for Information

Medical Waiver Request Submission ID*

Region.# (ex MARO.777)

The submission ID provided by the DOH Regional Office request for additional information email.

Facility Name*

Operating Certificate #*

Regional Office Request for Information Required Documents*

Choose Files No file chosen

Upload requirements

Email Submitter

Email Submitter *

Confirm email*

I'm not a robot

reCAPTCHA
Privacy - Terms

Submit

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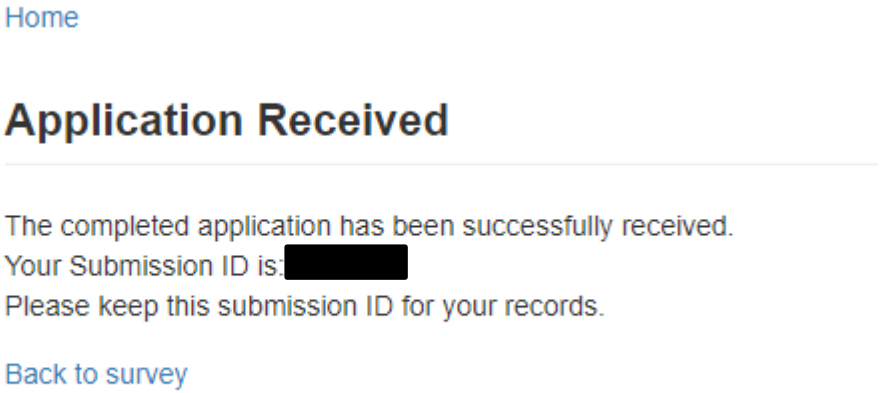
Home
Application Received
The completed application has been successfully received.
Your Submission ID is: [redacted]
Please keep this submission ID for your records.
Back to survey

Determinations & Expectations

Approvals

- Once approved, a waiver does not need to be submitted to the department annually, provided there are no changes that warrant a new submission, however:
  - Need, and ability to safely & independently use and self-manage the equipment, must be assessed annually and maintained on file
  - DOH-4235b must be completed annually and maintained on file

- Should an assessment determine that the equipment is no longer needed, the facility must ensure proper and prompt removal

Denials

- A denial letter detailing reason for denial will be sent to facility if waiver is not approved.
- If the facility has the additional information the denial letter outlined, it must resubmit a new waiver request with all attachments.

Resources

- DAL 22-34 & FAQ
- DOH 4235: DAL DAL 15-17 Attachment (ny.gov)
- DOH 4235a: DAL #22-22 DOH4235a (ny.gov)
- DOH 4235b: Medical Equipment Waiver Request Addendum (ny.gov)
- Questions may be submitted to acfinfo@health.ny.gov

Thank you!

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