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:

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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.

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SECTION D: ***FOR DOH USE ONLY***

Regional Office RO Log #: **Central Office Log #:**

Name of Facility:

Date received from: Facility **Regional Office**

Decentralized Waiver

RO Program Manager Disposition: ☐ Approved ☐ Disapproved

Reason:

Centralized Waiver

RO Recommendation: ☐ Approved ☐ Disapproved ☐ Conditional Approval ☐ Withdrawn

Reason:

Regional Office:

RO Reviewer (include title) Date:

RO Program Manager (signature) Date:

Architect:

Date to Architect: Architect Recommendation: ☐ Approved ☐ Disapproved

Architect (signature): Date:

Comments:

Central Office:

Central Office Reviewer: Title: Date:

Division Director Recommendation: ☐ Approved ☐ Disapproved ☐ Conditional Approval ☐ Withdrawn

Division Director (signature): Date:

Comments:

cc: R.O. Program Manager with attachments
DACF/ALS Project File
ACF Application Manager with attachments (only for pending applications)