Use this form for survey citations involving Facility Guidelines Institute (FGI), Americans with Disabilities Act (ADA), or provisions under State Hospital Code, NYCRR Title 10, Parts 711-717.

**Provide a separate request form completed in its entirety for each citation for which a waiver is requested.**

A permanent waiver may be granted due to structural infeasibility or demonstrated hardship and where the deficiency is not detrimental to the health and safety of the occupants. Time limited waivers will not be granted for FGI, ADA and state regulation citations as corrective work must be promptly provided.

For a federal waiver or equivalency request for survey citations involving NFPA 101 or NFPA 99, see the *Waiver and Equivalency Submission Guidelines* at [www.health.ny.gov/facilities/cons/](http://www.health.ny.gov/facilities/cons/).

|  |  |  |  |
| --- | --- | --- | --- |
| Date: click to enter date |  | Survey Exit Date:click to enter date | |
| Licensed Operator: |  | Medicare Provider #: 33-0000 | NYS Facility ID #: 0000 |
| Facility Contact Name: |  | Facility Name: | |
| Contact Title: |  | Street Address: | |
| Contact Email: |  | City: | Zip Code: |
| Contact Phone: |  | County: | |

|  |  |
| --- | --- |
| **Tag** from Survey |  |
| **Regulation Part** or **Code Section** with edition year | Example: 10 NYCRR Part 713-4.8(b)(1)  2018 FGI Design and Construction of Outpatient Facilities, Section 2.1-6.4.2  2010 ADA Standards, Part 610.2 |
| State the **Regulation** or **Code Requirement** |  |
| Describe the **deficient condition** and **areas affected** |  |
| Specify the **reason** for the standard to be waived |  |
| Describe the **alternative proposal** or **policy** to ensure occupant health and safety |  |

|  |  |  |
| --- | --- | --- |
| **Signature of**  **Licensed Operator** | Signature is the provider’s assurance that the approved waiver will not limit the capacity to provide adequate care, and does not jeopardize patient or resident health and safety. | |
|  | |
| **Required Documents** | Submit all documentation (PDF format) in one email:   * Plan of Correction CMS-2567, approved by the NYSDOH Regional Office * This form (DOH-5223) * Supporting documentation and floor plans where applicable | |
| **Submit to** | **HOSPITAL, ASC, ESRD:**  [BAERwaivers1861@health.ny.gov](mailto:BAERwaivers1861@health.ny.gov)  Include the facility name in the email subject line. | **NURSING HOME:**  [LTCLSCwaivers@health.ny.gov](mailto:LTCLSCwaivers@health.ny.gov) and  [BAERwaivers1861@health.ny.gov](mailto:BAERwaivers1861@health.ny.gov)  Include the facility name in the email subject line. |

**Information below to be completed by the Department.**

|  |  |  |  |
| --- | --- | --- | --- |
| **NYSDOH Waiver #** |  | | |
| **Waiver Determination** |  |  |  |
| **Conditions:** | | |
| **Waiver Requirements** | * The facility must retain this waiver approval documentation. * Approved waivers are subject to subsequent surveys that will revisit circumstances as presented in the waiver request. * Future alterations affecting the waived provision must be brought to the Department’s attention. * This waiver approval remains valid for the duration of the operating certificate. * The Department may revoke this approval if deficiencies are cited that indicate that the waiver adversely affects occupant health and safety or conditions affecting the waiver have changed. | | |
| **NYSDOH Signature** | Director, Bureau of Architecture and Engineering Review | | Date |