This form is required in the preparation of a waiver request in accordance with the **Section 711.9 of 10** **NYCRR,**. All regulatory requirements, applicable building codes and standards of construction shall be referenced. For sections that are not applicable, indicate “N/A”. Provide attachments where indicated. Note, a waiver cannot be issued in conjunction with a self certification or notification.

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| **Date of Waiver Request:**  **November 6, 2019** | | | | **County:** Choose an item. | | | **BAER Assigned Waiver Number:** | | | | | | | |
| **Applicant/Operator Name:** | | | | | **Mailing Address:** | | | | | | | | | |
| Click here to enter applicant/operator. | | | | | **Street Address:**Click here to enter street address. | | | | | | | | | |
| **City:** Click here to enter city. | | | | | **New York** | | **Zip Code:**XXXXXX | | |
| **Email:** Enter e-mail address. | | | | | | | | | |
| **Facility Name:** | | | | | **Facility Address/Site Location:** | | | | | | | | | |
| Facility name. | | | | | **Street Address:** Click to enter street address | | | | | | | | | |
| **City:** Click here to enter city. | | | | | | **New York** | **Zip Code:** XXXXXX | | |
| **Phone Number:** | | | XXX-XXX-XXXX | | **Email:** Click here to enter text. | | | | | | | | | |
| **Contact Type:** Choose an item. | | | | | **Medicare Provider #:** 33-0000 | | | | **Operating Certificate Number:** 0000000N | | | | | **FacID (PFI)-**0000 |
| **Contact Name: Ms.** Enter name here. | | | | | **CMS K-Tag:** K-XXX. | | | | **Survey Date:**  **2016-05-06** | | | | | **CON Number:**  XXXXXX |
| **Contact E-mail:**Enter e-mail here. | | | | | **NYCRR: Article 28** | | | | **Facility Type: SNF/NH** | | | | | **Design Professional:**  **Architect** |
| **Contact Phone:**Enter phone number here. | | | | | **Waiver Type:** Choose an item. | | | | **Trades:** Choose an item. | | | | |
| **1.** | Cite the pertinent regulatory standards, codes and edition for which the waiver is sought as indicated in [10NYCRR:](http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/56cf2e25d626f9f785256538006c3ed7/2d301c80ad36bd658525677c006aaf50?OpenDocument&Highlight=0,711.2)  Part 711 General Standards of Construction, **Part 713-Standards of Construction for Nursing Home Facilities** and **Subpart 713-1 Standards for Nursing Home Construction Projects Completed or Approved prior to August 25, 1975** | | | | | | | | | | | | | |
| **Referenced standard cited** from Part 711.2 Pertinent technical standards is **FGI 2018 Edition. Insert Reference Paragraph** | | | | | | | | | | | | | |
| **2.** | Describe the deficiency. | | | Click here to enter deficiency. | | | | | | | | | | |
| **3.** | Indicate the reason for the prescribed standard to be waived? | | | Click here to enter reason for waiver. | | | | | | | | | | |
| **4.** | Will an approval of the requested waiver cause the facility to be out of compliance with any **health and safety standards**?  Federal: State: Local: | | | | | | | | | | | | | |
| **5.** | Will an approval of the requested waiver cause the facility to be out of compliance with any **building construction codes & referenced standards**? Federal: State: Local: | | | | | | | | | | | | | |
| **6.** | If time limited waiver is requested, indicate the period of time requested to correct the deficiency (include start and finish dates and provide attachments such as schedules and phasing plans). | | | | | | | | | | | | | |
| **Task:** | | | **Start Date:** | | | | **End Date:** | | | | **Duration:** | | |
| Selection of Design Professional | | | 2016-04-21 | | | | 2016-04-21 | | | | **0 years** and **0 months** | | |
| Evaluation of Deficiency & Recommendation of Corrective Action Required | | | 2016-04-15 | | | | 2016-04-21 | | | | **0 years** and **0 months** | | |
| Preparation of Contract Documents | | | 2016-04-21 | | | | 2016-04-21 | | | | **0 years** and **0 months** | | |
| Obtaining Local Permits & Approvals | | | 2016-04-21 | | | | 2016-04-21 | | | | **0 years** and **0 months** | | |
| Duration of Construction (Please include phasing.) | | | 2016-04-21 | | | | 2016-04-21 | | | | **0 years** and **0 months** | | |
| Overall Time Limited Waiver Duration (Not to exceed (3) three years.) | | | 2016-04-21 | | | | 2016-04-21 | | | | **0 years** and **0 months** | | |
| **7.** | Extension of Time Limited Waiver | | | **Approved Completion Date:** | | | | **Revised Completion**  **Date:** | | | | | **Duration:** | |
| 2016-04-21 | | | | 2016-04-21 | | | | | **0 years** and **0 months** | |
| Reason for extension request. | | | Click here to enter text. | | | | | | | | | | |
| **8.** | What is the facility going to provide as an **alternative** to protect the health and safety of facility occupants? | | | | | | | | | | | | | |
| **A**. | Describe alternative **design features**. Provide attachments such as drawings, cut sheets, etc. | | Click here to enter design features. | | | | | | | | | | |
| **B.** | Describe alternative **equipment and systems** to be used. | | Click here to enter equipment and systems. | | | | | | | | | | |
| **C.** | Indicate the alternative arrangements such as **policies, procedures and protocols** to be implemented to mitigate risks associated with the deficiency. | | Click here to enter policy and procedures. | | | | | | | | | | |
| **D.** | Describe the **risks** to the health and safety of facility occupants presented by the deficiency. | | Click here to enter risk. | | | | | | | | | | |
| **9.** | Indicate **areas affected** by the deficiency. Provide floor plans per the submission requirements described in DSG appropriate for the facility. | | | Click here to enter areas affected. | | | | | | | | | | |
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| **10.** | Describe the **financial impact** of the design alternative. | | | | | | | | | | | | | |
| **A.** | Initial Costs | | Click here to initial costs. | | | | | | | | | | |
| **B.** | Operations & Maintenance Costs | | Click here to enter operations and maintenance. | | | | | | | | | | |
| **11.** | Alternatives that impact facility functions require a letter from the **medical director** confirming that the proposed alternative will not adversely affect facility functions. **Included as Attachment:** | | | | | | | | | | | | | |
| **12.** | Alternatives that impact facility infection controls require a letter from the **infection control professional** confirming that the proposed alternative will not adversely affect infection controls. **Included as Attachment:** | | | | | | | | | | | | | |
| **13.** | The work will be implemented in accord with an approved Plan of Correction (POC) from the Regional Office. **Yes** | | | | | | | | | | | | | |
| **14.** | Attach a copy of an Architectural and Engineering Certification letter **identifying the above deficiency and the proposed alternative** in a format stipulated by the Department.  **Included as Attachment:** | | | | | | | | | | | | | |
| **15.** | Has a copy been provided to the Regional Office if this waiver request originates from a Survey (deficiency)? **Yes** | | | | | | | | | | | | | |
| **16.** | * All new work and equipment is to be provided in accordance with NYS Hospital Code, Title 10, Part 711 General Standards of Construction and/or **Part 713-Standards of Construction for Nursing Home Facilities** and **SubPart 713-3 - Standards for nursing home construction projects completed or approved between July 2, 1990 and December 31, 2010** * The evacuation and/or protection of the occupants of the facility, shall be assessed. The existing policies and procedures shall be modified accordingly. Such policies shall be acceptable to the Regional Office, prior to starting any corrective work. * The facility shall maintain the current level of patient and staff safety. Patient and Staff safety shall not be diminished.   The facility shall provide additional safeguards, as required to allow patients and staff to be evacuated in a safe and orderly manner. | | | | | | | | | | | | | |
| **17.** | Print Name: Click here to enter name. | | | | | Title: Click here to enter text. | | | | | | | | |
| Signature: | | | | | Date: 2016-05-06 | | | | | | | | |
|  | **Submit To**: **New York State Department of Health**  **Center for Health Care Facility Planning, Bureau of Architecture & Engineering Review**  **Empire State Plaza, Corning Tower, Room 1861**  **Albany, New York 12237** | | | | | | | | | | | | | |