**Instructions for Completing the Facility Waiver Request**

1. Enter Facility Name in the header above.
2. Enter the Plan Review Project Number (if applicable) in the header above. The Plan Review Project Number begins with DH and is listed on the Office of State Fire Marshal Plan Review Report on the upper right side of page one. (**example: DH-19-000000**)
3. Fill out all applicable sections below in entirety. Not all sections may apply to your request.
4. If you are requesting a waiver for multiple items, please describe each requested waiver item separately in **Section C** of this form.
5. All waiver requests shall be approved by the HSS Director. Decisions regarding waiver requests will be made on a case-by-case basis and will be forwarded to the requestor in writing.
6. If applicable, please attach a copy of the Office of State Fire Marshal Plan Review Report (this report lists the “DH” Plan Review Project Number and Review Type: LDH Licensed Facility Review on the upper right side of page one). Also, attach a copy of any cautionary codes associated with this plan review.
7. Please attach a copy of the floor plan showing the Office of State Fire Marshal’s stamp of approval, as applicable.
8. Please attach photographs as appropriate to assist in determination of request.
9. Email the completed waiver request to the applicable program mailbox. A listing of the program email addresses is located on the HSS webpage at <http://www.ldh.la.gov/index.cfm/directory/detail/14452>.

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| **SECTION A** | |
| **Waiver Application Date:** Click or tap to enter a date. | |
| **Facility doing business as Name as it Appears on the License:** Click or tap here to enter text. | |
| **Facility Address:** Click or tap here to enter text. | |
| **Is this waiver request a result of a Change of Ownership (CHOW)? Yes No** | |
| **Is this waiver for an offsite/branch? Yes No**  **If yes, provide the offsite/branch name and address:** Click or tap here to enter text. | |
| **Facility Telephone Number, including area code:** Click or tap here to enter text. | |
| ***ADMINISTRATOR, or DESIGNEE, CONTACT INFORMATION:*** | ***ARCHITECT CONTACT INFORMATION:*** |
| **Name:** Click or tap here to enter text. | **Name:** Click or tap here to enter text. |
| **Telephone number:** Click or tap here to enter text. | **Telephone number:** Click or tap here to enter text. |
| **Email address:** Click or tap here to enter text. | **Email address:** Click or tap here to enter text. |

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| **SECTION B** |
| **Provide a description of the project or the variance of the regulation(s) & why the waiver is being requested (i.e., renovating an existing space, requesting existing physical space be continued, etc.)**  Click or tap here to enter text. |

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| **SECTION C** |
| **Item Number on the Plan Review Report:** Click or tap here to enter text. |
| **FGI Reference Number or Licensing Standard Number and the specific requirement:** Click or tap here to enter text. |
| **Waivers are granted at the discretion of the department. Waivers are subject to review or revocation upon any change in the circumstances related to the waiver as described in this section and in section B.**  **The facility shall demonstrate how patient safety and quality of care offered are not compromised by the waiver. The facility must demonstrate their ability to completely fulfill all other requirements of the service. Please address this from all perspectives, including the clinical/medical perspective.**  Click or tap here to enter text. |
| **SECTION D** |
| **Attention:** **Read the Following Information Carefully Before Signing. This form must be signed by the Administrator, or Designee, and Architect of the Facility, as applicable.**  **Statements or Entries Generally: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes false, fictitious or fraudulent statement or entry, shall be fined or imprisoned or both. (18 U.S.C., Sec. 1001)**  ***I certify that the information listed above is true. I understand this waiver request is only applicable to that which is stated in SECTION C. I agree that I will notify the LDH Health Standards Section of changes immediately in order to permit a valid determination of the facility’s compliance to the regulations regarding this action. I understand that the LDH Health Standards Section, or its representative, has the right to conduct an on-site survey at any time to validate whether the information provided is true.***  **Signature (Administrator or Designee): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date (Month/Day/Year):** Click or tap to enter a date.  **Signature (Architect of Record on the Plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date (Month/Day/Year):** Click or tap to enter a date. |

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| **SECTION E** *(for HSS use only)* |
| **Approved Expires:  Yes  No  N/A** *Expiration Date****:*** Click or tap to enter a date.  **Comments:**  Click or tap here to enter text.  **Date:** Click or tap to enter a date.    **Denied.** Please see attached letter.  **Comments:**  Click or tap here to enter text.  **Date:** Click or tap to enter a date.  **Deputy Assistant Secretary, HSS Signature:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      LDH/HSS Stamp of Approval |