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)