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| He-M 1201 Waiver Requestnh bureau of Developmental Services | | | | |
| **Submit completed requests to:** Bureau of Developmental Services  105 Pleasant St. – Main Bldg, Concord, NH 03301  Phone#: (603) 271-5034 Fax#: (603) 271-5166 email: [bds@dhhs.nh.gov](mailto:bds@dhhs.nh.gov)  \*Waivers are to be submitted by the Area Agency **ONLY** | | | | |
| **Responsible Area Agency**: | | | | Date: |
| Indicate:  - Initial  - Renewal | | If **Renewal**  Indicate Waiver Number:  Expiration Date: | | |
| Provider Agency Name and Address: | | Consumer Name (if applicable): | Staff/Home Provider Name (if applicable): | |
| .  Waiver for:  - Residence  - Day Service | Provide Name and Address (*as it appears on the certificate)*: | | Residence or Day Service  Certificate #:  Expiration Date: | |
| Indicate specific standard from which you request a waiver: **He-M** | | | | |
| Provide a full explanation of why a waiver to this standard is sought: | | | | |
| Describe proposed alternative to satisfy regulatory intent: | | | | |
| Number of staff/providers authorized to administer medications: Nurse Trainer Phone #:  Number of people receiving medication within certified service: | | | | |
| I certify that policies and procedures are in place for:   * Nurse Trainer oversight of authorized staff * Communication protocols between Day and Residential Services   Nurse Trainer Signature: Date:  Individual/Guardian signature (if applicable): Date:  Signature of AA Executive Director / Designee: Date:  Requested number of years for waiver to be effective (check one):  1 2 3  4 5 | | | | |
| Medication Committee: Approved  Denied  Waiver is approved for       years only  Medication Committee Chair Signature: Date: | | | | |