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| He-M 1201 Waiver Request nh 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\*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 ServiceCertificate #: 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 onlyMedication Committee Chair Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |