INSTRUCTIONS FOR COMPLETION OF
DOM CARE REQUEST FOR WAIVER OF REGULATION

1. NAME OF AREA AGENCY ON AGING: Indicate name of the Area Agency on Aging.

2. NAME OF PERSON COMPLETING FORM: Indicate name of the Area Agency on Aging staff person completing this Request for Waiver of Regulation form.

3. NAME OF DOM CARE PROVIDER: Indicate the full name of the Dom Care home provider for which this regulatory waiver form is being submitted.

4. CERTIFICATION DATE OF HOME: Indicate the date the Dom Care home was first certified.

5. NAME OF DOM CARE HOME (IF APPLICABLE): If the Dom Care home as an identifiable name, enter it here.

6. CERTIFIED CAPACITY: Indicate the total certified capacity (# of beds) of the Dom Care home.

7. ADDRESS OF DOM CARE HOME: Indicate the complete mailing address of the Dom Care home.

8. NUMBER OF CLIENTS IN THE HOME: Indicate the number of Dom Care clients residing in the Dom Care home as of the date of the waiver request. Also indicate the number of other care-dependent persons residing in the home that are not relatives of the Dom Care provider.

9. COUNTY IN WHICH DOM CARE HOME IS LOCATED: Indicate the county where the Dom Care home is located.

10. DATE OF WAIVER REQUEST: Indicate the date this waiver request was submitted to the Department.

11. INDICATE WHETHER THIS IS FOR A NEW WAIVER OR A RENEWAL OF WAIVER.

12. 6 PA CODE CH. 21 SECTION NUMBER/SUBSECTION NUMBER: Indicate the regulatory section/subsection (i.e. 21.21(a)). If requesting a waiver of multiple regulations for one situation, complete a separate form for each regulation.

13. WHAT IS THE REASON FOR THIS REQUEST: Indicate the reason for the request. Be specific. Explain what other options were considered prior to making this request.

August 26, 2010
14. **EXPLAIN WHY THERE IS NO JEOPARDY TO THE CLIENT(S) IF THIS WAIVER IS GRANTED**: Indicate why there is no jeopardy to the client(s) relative to this request.

15. **EXPLAIN HOW ONE OR MORE CLIENTS WILL BENEFIT FROM THE WAIVER OF THIS REGULATION**: How will the approval of this waiver benefit the client(s)? Be specific.

16. **HAVE ANY OTHER WAIVERS BEEN GRANTED IN THIS DOM CARE HOME UNDER CHAPTER 21 REGULATIONS?** Indicate yes or no

17. **SECTION(S) OR SUBSECTION(S) PREVIOUSLY WAIVED**: Answer if applicable. **IS (ARE) WAIVER(S) STILL VALID?** Answer if applicable.

18. **IF REQUESTING A WAIVER OF 21.21, SUBMIT THE FOLLOWING MATERIALS**: Submit the three items indicated. In addition, ensure the LOCA and CMI are posted and accessible in SAMS for Department review.

**ATTACHMENTS**: Attach additional pages as necessary.