

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REQUEST FOR WAIVER FROM OASAS REGULATIONS

<p><u>INSTRUCTIONS:</u></p> <p>OASAS regulations are minimum requirements. Waiver requests must contain complete information to justify regulatory relief. Please submit clear and complete justification, with attachments if needed. Unclear/ incomplete submissions will be returned without being processed for consideration. Completed Waiver Request forms must be sent simultaneously to the Waiver Committee Chair and the appropriate OASAS Field Office Regional Coordinator.</p>	<p align="center"><u>THIS SPACE FOR OASAS USE</u></p>
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PROVIDER INFORMATION

Provider Name			
Street Address	City	State	Zip Code
		NY	
Name and Title of Contact Person	Telephone Number	Fax Number	
Provider No.	Service Type:	Is this a Renewal Request? Yes <input type="checkbox"/> No <input type="checkbox"/>	
PRU No.	Operating Certificate No.:	If "YES", enter the number of the previous waiver request and attach copy of prior approval.	
	Certified Capacity (if applicable):		
	Current Census:		
Field Office Regional Coordinator:		Field Office:	

WAIVER REQUEST INFORMATION

<p>REGULATION(S) REQUESTED TO BE WAIVED</p>	<p>Correctly cite regulation [for example: 814.3(d)(1)]. Include full text (e.g., Fire drills shall be conducted at least monthly at varying times. All such drills shall be held at times when the building is occupied).</p>
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JUSTIFICATION FOR REQUESTED WAIVER	Justify why regulation should be waived. Be clear.
	<p>Is this request a result of a citation made during an OASAS recertification review? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please include the Review # and the Regulatory Compliance Inspector's name who conducted the review.</p> <p>Review # _____ Name _____</p>

IMPACT OF THE WAIVER	Describe the purpose of the regulation, including patient impact.
	Describe how waiving regulation will not diminish its purpose nor negatively impact the health or safety of the patients. Include how patients will receive comparable services.

OTHER RELEVANT INFORMATION	Only if necessary, identify other relevant factors for consideration, such as: special needs of the population served; relevant geographic and/or transportation problems; staff availability; long-range plans of the service; and any alternatives to the waiver.
	Other relevant information, if any. For example, all waiver requests for staffing relief must include, as is applicable: resumes; staffing pattern; staff roster; staff schedules; substituted services; etc.

Signature	Date
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SUBMIT COMPLETED FORM VIA MAIL OR FAX TO:

**Chair
Waiver Review Committee
New York State Office of Alcoholism
and Substance Abuse Services
1450 Western Avenue
Albany, NY 12203-3526
FAX: 518-485-2335**

COPY TO: _____ at _____ **Field Office**
Field Office Regional Coordinator

NOTE TO FIELD OFFICE: PLEASE REVIEW THIS WAIVER REQUEST AND SEND YOUR RECOMMENDATION TO APPROVE OR DENY, WITH REASONS, TO THE WAIVER COMMITTEE CHAIR WITHIN 20 DAYS OF RECEIPT.