NEW YORK STATE OFFICE OF ADDICTION SERVICES AND SUPPORTS (NYS OASAS)

REQUEST FOR WAIVER FROM OASAS REGULATIONS

INSTRUCTIONS:	**THIS SPACE FOR OASAS USE**
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.	

PROVIDER INFORMATION

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

WAIVER REQUEST INFORMATION

REGULATION(S) REQUESTED TO BE WAIVED	**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).**

JUSTIFICATION FOR REQUESTED WAIVER	**Justify why regulation should be waived. Be clear.**
	Is this request a result of a citation made during an OASAS recertification review? Yes ☐ No ☐ **If yes, please include the Review # and the Regulatory Compliance Inspector's name who conducted the review.** **Review #_____ Name _____**

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

SUBMIT COMPLETED FORM VIA MAIL OR FAX TO:

Chair
Waiver Review Committee
New York State Office of Addiction Services and Supports
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.