REQUEST FOR WAIVER OF ADMINISTRATIVE RULE

IAC 481-69.23 Criteria for Retention of Tenants in an Assisted Living Program
IAC 481-68.14 Criteria for Retention of Tenants in an Elder Group Home
IAC 481 – 70.23 Criteria for Retention of Participants in an Adult Day Service

Program Information			
Program Name:			
Address:		Date of Request:	
City:	Zip Code:	County:	Phone:
Program Director:		Email:	
Registered Nurse:		Email:	

Tenant/Participant Information			
Name:		Age:	Date of Admission:
Diagnoses:			
Current Cognitive Score:	Tool used:		Date Assessed:
Date of Previously Granted Waiver:			
Hospice Provider:		Date of Admission to Hospice:	
Hospice RN:		Phone:	
Physician:		Phone:	
Legal Representative:		Phone:	
Describe Family/Friend involvement:			

Criteria for Which Waiver is Requested (69.23) *please check all that apply:*	
☐ a. Bed bound	☐ e. Is under the age of 18
☐ b. Requires routine, two-person assistance with standing, transfer or evacuation	☐ f. Requires more than part-time or intermittent health-related care;
☐ c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who:	☐ g. Has unmanageable incontinence on a routine basis despite an individualized toileting program
☐ (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression	☐ h. Is medically unstable
☐ (2) Displays behavior that places another tenant at risk;	☐ i. Requires maximal assistance with activities of daily living
☐ d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness;	☐ j. Despite intervention, chronically urinates or defecates in places that are not considered acceptable according to societal norms

Additional Tenant/Participant Information
Additional Services Provided (Home Heath, PT, etc.):
What Precipitated Hospice Admission:
Is the tenant exhibiting any signs/symptoms of actively dying? If so, please list:
Functionality:
Care Needs:
Evacuation Plans:
Weight History (past six months):
List any adverse impact on the program or other tenants as a result of granting this waiver:
Is the Program able to meet the needs of the tenant/participant, as well as all other tenants/participants in the program? ☐ Yes ☐ No

For Assisted Living Only:		
Tenant Resides in:	☐ General Population Unit	☐ Dementia Unit
Program Census:	General Population Unit:	Dementia Unit:

Staffing Patterns (# of Scheduled Staff)	General Population Unit	Dementia Unit
AM Shift		
PM Shift		
NOC Shift		

Please attach the following additional information:

- ☐ Physician Orders for Hospice
- ☐ Current Hospice Nursing Assessment
- ☐ Current service plan

I hereby attest to the accuracy and truthfulness of the above information.	
Signature:	Date:

Submit all waiver requests via email to: catie.campbell@dia.iowa.gov