



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:	
<input type="checkbox"/> a. Bed bound	<input type="checkbox"/> e. Is under the age of 18
<input type="checkbox"/> b. Requires routine, two-person assistance with standing, transfer or evacuation	<input type="checkbox"/> f. Requires more than part-time or intermittent health-related care;
<input type="checkbox"/> c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who:	<input type="checkbox"/> g. Has unmanageable incontinence on a routine basis despite an individualized toileting program
<input type="checkbox"/> (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression	<input type="checkbox"/> h. Is medically unstable
<input type="checkbox"/> (2) Displays behavior that places another tenant at risk;	<input type="checkbox"/> i. Requires maximal assistance with activities of daily living
<input type="checkbox"/> d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness;	<input type="checkbox"/> 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 Health, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For Assisted Living Only:		
Tenant Resides in: <input type="checkbox"/> General Population Unit <input type="checkbox"/> 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