

Office of Health Care Quality

Resident Specific Level of Care Waiver Application

(Use one form for each resident requiring a waiver)

(10.07.14.22 - Resident-Specific Level of Care Waiver)

Name of Assisted Living Manager _____

Name of Assisted Living Program _____

Address of Assisted Living Program _____

Licensed capacity: _____ Licensed level of care: _____

Census: _____ Number of resident-specific waivers in effect: _____

I am currently: (check if applicable)

Authorized to provide a level of care beyond current licensure

Authorized to provide the level of services described in 10.07.14.22I

This is to request a resident-specific level of care waiver in accordance with **COMAR 10.07.14.22** to permit _____ (resident's name) to continue to reside in the facility. I certify that the program is capable of and wishes to care for this resident and that in doing so the needs of other residents will not be jeopardized.

I am requesting this waiver, with the consent of the resident's representative, because:
(check if applicable)

The level of care required by the resident exceeds the level of care for which the facility has authority to provide. The level of care the resident requires is _____.

The resident requires services described in **COMAR 10.07.14.22I**. List service(s) required: _____

In support of my request for a waiver, I offer the following:

1. A copy of the completed form on which information concerning the resident's physical condition and medical status is documented in accordance with **COMAR 10.07.14.21A**.
2. A copy of the resident's functional assessment conducted in accordance with **COMAR 10.07.14.21B**.

3. A detailed description of how the program intends to meet the needs of the resident without jeopardizing the needs of the other residents.

4. A description of how the program complies with applicable fire and building codes as detailed in **COMAR 10.07.14.46A**. (Describe your program's life safety equipment.)

5. If my request for a waiver involves the continuation of services to a resident whose needs fall within one of the categories set forth in **COMAR 10.07.14.22I**, the following is a description of how the program will comply with the Medicare requirements for home health agencies set forth in 42 CFR §§ 484.18 (plan of care), 484.30 (duties of the nurse), and 484.32 (therapy services).

Other comments:

Signature of Applicant

Date

Title

Telephone