pennsylvania
DEPARTMENT OF AGING

COMMONWEALTH OF PENNSYLVANIA
PA DEPARTMENT OF AGING
DOMICILIARY CARE
REQUEST FOR WAIVER OF REGULATION

NAME OF AREA AGENCY ON AGING:	**NAME OF PERSON COMPLETING FORM:**
NAME OF DOM CARE PROVIDER:	**CERTIFICATION DATE OF HOME:**
NAME OF DOM CARE HOME (if applicable):	**CERTIFIED CAPACITY:**
ADDRESS OF DOM CARE HOME:	**NUMBER OF CLIENTS IN HOME:**
COUNTY IN WHICH DOM CARE HOME IS LOCATED:	

DATE OF WAIVER REQUEST:	☐ **NEW WAIVER** ☐ **RENEWAL OF WAIVER**
6 PA. CODE CH. 21 SECTION NUMBER/SUBSECTION NUMBER (Complete a separate form for each section/subsection):	
WHAT IS THE REASON FOR THIS REQUEST*	
EXPLAIN WHY THERE IS NO JEOPARDY TO THE CLIENT(S) IF THIS WAIVER IS GRANTED *	
EXPLAIN HOW ONE OR MORE CLIENTS WILL BENEFIT FROM THE WAIVER OF THIS REGULATION*	
HAVE ANY OTHER WAIVERS BEEN GRANTED IN THIS DOM CARE HOME UNDER CHAPTER 21 REGULATIONS? ☐ **YES** ☐ **NO**	**SECTION(S) OR SUBSECTION(S) PREVIOUSLY WAIVED:** **IS (ARE) WAIVER(S) STILL VALID?** ☐ **YES** ☐ **NO**

IF REQUESTING A WAIVER OF 21.21, SUBMIT THE FOLLOWING MATERIALS:
☐ **COVER LETTER**
☐ **NURSE CONSULTANT REPORT**
☐ **MA-51**

***ATTACH ADDITIONAL PAGES IF NECESSARY**