STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND CERTIFICATION

Home and Community Services Program

Request for Waiver

SECTION 1: Agency Information			
Agency Name:			
License Number:		License Expiration Date:	
Administrator:			
Physical Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.:			
Email Address:			
Sites for which this waiver is requested:			

Instructions for requesting a waiver: The Department may waive or modify any provision(s) of these rules as long as the provision is not mandated by state or federal law and does not violate client rights described in Section 10 of these rules. The applicant/licensee shall indicate, in writing, what alternative method will comply with the intent of the rule for which the waiver is sought. This waiver will have an expiration date.

Send this application or any questions regarding this program and/or application to HCS.DLC@maine.gov.

SECTION 2: Waiver Information
Rule Number:
Describe the Rule requirement:

Describe in detail the alternative method for compliance:

SECTION 3: Declaration

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

- I/We certify that all information provided herein is true and correct to the best of my/our knowledge.

Print name of Administrator	**Signature of Administrator**	**Date**

Office Use Only:

Action taken by Department: ☐ Approved ☐Not Approved

Program Manager's Signature:_____

Comments:

Waiver Expiration Date:_____