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

Personal Care Agency
Request for Waiver

SECTION 1: Program Information			
Agency Name:			
License Number		License Expiration Date	
Administrator:			
Mailing Address:			
City:	State: ME	Zip:	County:
Physical Address:			
City:	State: ME	Zip:	County:
Telephone No.:			
Email Address:			

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 or agency expectations as described in Section 7 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 be time limited.

Send this application or any questions to AH-PCA.dlc@maine.gov

Section 2: Waiver Information
Rule Number:
Describe the rule requirement and the reason for the requested modification of the provision:
Describe in detail the alternative method for compliance:

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

SECTION 3: Declaration

The Department of Health and Human Services reserves the right to request/review any additional information that willbe 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

Comments:_____

Manager:_____ Waiver Expiration Date:_____