

**Ohio Department of Health
Bureau of Survey and Certification**

Registered/Licensed Nurse Staffing Waiver Application

Facility Name:		Provider Number:	
Street Address:			
City:	Zip:	County:	
Telephone (including Area Code):	FAX (including Area Code):	E-mail:	
Maximum Licensed Capacity of this Facility:	Does this facility operate a Nurse Aide Training and Competency Evaluation Program (NATCEP)? <div style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>		

Name of Administrator:	LNHA Number:
Name of Director of Nursing (DON):	License Number:
Name of Medical Director:	License Number:
Name of Designated Contact Person for this Waiver:	Telephone (including Area Code):

Type of Waiver Requested (Check One): <input type="checkbox"/> 24 hour coverage by a licensed nurse (Medicaid) <input type="checkbox"/> Licensed nurse as charge nurse (Medicaid) <input type="checkbox"/> Registered Nurse coverage, 8 hours per day, 7 days per week (Medicare/Medicaid) <input type="checkbox"/> Registered Nurse as Director of Nursing (Medicare/Medicaid) <input type="checkbox"/> Other (please describe) _____	
Number of Licensed Nurse Staffing Hours to be Waived (if applicable): <div style="display: flex; justify-content: space-between;"> _____ per day _____ per week </div>	Days Waiver Requested (if applicable): <div style="text-align: center;"> Sun Mon Tue Wed Thu Fri Sat </div>

Your signature below indicates the facility's acceptance of all obligations associated with this waiver, including compliance with all staffing requirements during the waiver consideration period.

Administrator's Signature:	Date:	Administrator's Name:
DON's Signature:	Date:	DON's Name:
Medical Director's Signature:	Date:	Medical Director's Name:

I. The following information must be provided so that ODH may approve or deny the NF licensed nurse waiver request (for SNFs, the information must be provided for ODH to review in making a recommendation to CMS):

- A. Payroll records for the last four (4) weeks indicating wages paid to all LPNs, RNs, and the DON, including hourly rate of pay;
- B. Facility time schedules for the last four (4) weeks showing the number of LPNs, RNs and the DON, including days, hours and shifts scheduled;
- C. The hourly wage or salary being offered in the recruitment of LPNs and RNs and any additional benefits being offered during the recruitment process (i.e., flexible schedule, child care, scholarship program, sign-on bonus);
- D. Copies of all published advertisements (e.g., newsletters, newspaper classifieds, etc.) for full- and part-time LPNs and RNs for the past four (4) months. Also include copies of letters written to state-approved nursing schools notifying them of employment opportunities;

E. A proposed letter notifying residents (or, where appropriate, the guardians or legal representatives of the residents) and the members of their immediate families of such a waiver; and

F. An explanation from the Medical Director on why granting this waiver will not jeopardize the health and safety of the residents.

II. In addition to the above information, Medicare certified facilities (SNFs) must also submit the following information to ODH for review in making a recommendation to CMS:

- A. Documentation that all residents do not require skilled nursing services for a 48-hour period (this may be in the form of physician notes or admission records signed by the physician – any document used to fulfill this requirement must be signed by a physician);

OR

- B. Plan to have either an RN or MD at the facility to provide skilled nursing services (the RN or MD must be on-site, not on call).

REMINDER: The facility must comply with all staffing requirements while the facility's waiver request is being considered. A plan must be submitted outlining how the facility will meet the staffing requirements during this time as part of the waiver request.

To the requestor:

Please ensure that all necessary documentation is attached. Any request not containing the necessary documentation will be returned. Every request must indicate how the facility will meet the required staffing levels while the waiver request is being considered. Please send your request to the Ohio Department of Health Regional Office that surveys your facility. Information is available at www.odh.ohio.gov.

Akron District:
Ohio Department of Health
Bureau of Survey and Certification
246 N. High St., 2nd Floor
Columbus, Ohio 43215

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Toledo District:
Ohio Department of Health
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246 N. High St., 2nd Floor
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