APPLICATION FOR VARIANCE TO EXCEED THE TWO RESIDENT LIMIT

Submit to a certifying agent for the admission or continuing retention of the third and/or fourth residents

1. CFH Provider and Home Information.

Full Legal Name:	Certificate No.:
Phone Number:	Email:
Training/Education/Experience of the Provider to Meet Needs of CFH Residents:	
If the provider works outside the home, is he/she available to consult with staff? ☐ Yes ☐ No ☐ N/A Employer: _____Work Phone:_____	
Excluding residents, number of people who live in the home: Adults:_____ Children:_____ Do any of these people, excluding residents, require care from the CFH provider? ☐ Yes ☐ No If so, please describe:	

Rooms For CFH Residents	Square Footage	Names of Proposed/Current Occupants
Sleeping Room #1		
Sleeping Room #2		
Sleeping Room #3		
Sleeping Room #4		

☐ Attach a copy of the floor plan that identifies rooms and any potential barriers to egress/ingress.

2. Substitute Caregivers. *Must be adults with current qualifications.*

Substitute Caregiver Name	Age	Expiration Date of CPR	Expiration Date of First Aid	Date of DHW Background Clearance	Date of Medication Course

3. Resident Information. *For each <u>prospective</u> resident, <u>attach</u> the results of their current history and physical examination conducted within past 12 months and, if transferring from another residential healthcare setting, the plan of service from their previous setting.*

Resident #1 ☐ Current Resident ☐ Prospective Resident

Full Legal Name:	Date of Birth:
Sex: ☐ Male ☐ Female	Relationship to Provider:

Diagnoses/Behaviors:
Hours of Daily Direct Care Needed (i.e., 1:1 services—excludes passive supervision):
Care Payment: ☐ DD Waiver ☐ Self-Directed ☐ A&D Waiver/MMCP/IMPlus ☐ Private Pay
Any unstable health issues that require 24-hour ongoing care from a licensed nurse? ☐ Yes ☐ No
Does the resident have a legal guardian or power of attorney for healthcare? ☐ Yes ☐ No If Yes, Representative Name: _____ Phone:_____
Does the resident have any physical impairments? (non-ambulatory, blind, etc.): ☐ Yes ☐ No If so, please describe and how the home can accommodate them:

Resident #2 ☐ Current Resident ☐ Prospective Resident

Full Legal Name:	Date of Birth:
Sex: ☐ Male ☐ Female	Relationship to Provider:
Diagnoses/Behaviors:	
Hours of Daily Direct Care Needed (i.e., 1:1 services—excludes passive supervision):	
Care Payment: ☐ DD Waiver ☐ Self-Directed ☐ A&D Waiver/MMCP/IMPlus ☐ Private Pay	
Any unstable health issues that require 24-hour ongoing care from a licensed nurse? ☐ Yes ☐ No	
Does the resident have a legal guardian or power of attorney for healthcare? ☐ Yes ☐ No If Yes, Representative Name: _____ Phone:_____	
Does the resident have any physical impairments? (non-ambulatory, blind, etc.): ☐ Yes ☐ No If so, please describe and how the home can accommodate them:	

Resident #3 ☐ Current Resident ☐ Prospective Resident

Full Legal Name:	Date of Birth:
Sex: ☐ Male ☐ Female	Relationship to Provider:
Diagnoses/Behaviors:	
Hours of Daily Direct Care Needed (i.e., 1:1 services—excludes passive supervision):	
Care Payment: ☐ DD Waiver ☐ Self-Directed ☐ A&D Waiver/MMCP/IMPlus ☐ Private Pay	
Any unstable health issues that require 24-hour ongoing care from a licensed nurse? ☐ Yes ☐ No	

Does the resident have a legal guardian or power of attorney for healthcare? ☐ Yes ☐ No If Yes, Representative Name: _____ Phone:_____
Does the resident have any physical impairments? (non-ambulatory, blind, etc.): ☐ Yes ☐ No If so, please describe and how the home can accommodate them:

Resident #4 (If applicable) ☐ Current Resident ☐ Prospective Resident

Full Legal Name:	Date of Birth:
Sex: ☐ Male ☐ Female	Relationship to Provider:
Diagnoses/Behaviors:	
Hours of Daily Direct Care Needed (i.e., 1:1 services—excludes passive supervision):	
Care Payment: ☐ DD Waiver ☐ Self-Directed ☐ A&D Waiver/MMCP/IMPlus ☐ Private Pay	
Any unstable health issues that require 24-hour ongoing care from a licensed nurse? ☐ Yes ☐ No	
Does the resident have a legal guardian or power of attorney for healthcare? ☐ Yes ☐ No If Yes, Representative Name: _____ Phone:_____	
Does the resident have any physical impairments? (non-ambulatory, blind, etc.): ☐ Yes ☐ No If so, please describe and how the home can accommodate them:	

4. Justification. *What is the CFH provider proposing that will give the third and/or fourth resident(s) substantially equal protection of their health, safety, and welfare as that of the first and second residents? What compensating factors exist in the certified family home (e.g., additional staff, space, training, etc.)?*

5. Application Verification.

I am requesting a variance to IDAPA 16.03.19.140, which limits a CFH to admitting and retaining a maximum of two (2) residents. I propose to admit and retain no more than four (4) residents.
In requesting this variance, I am assuring the department, the residents, and their representatives that the health and safety of the residents will not be jeopardized if the variance is granted.
I agree to abide by any special conditions the department attaches to granting this variance and notify

the residents and their representatives, if applicable, of these special conditions.
I understand that this variance expires as indicated in Section 7, and I must submit a new request to apply for a renewal. If a variance granted to me expires without renewal, I will comply with IDAPA 16.03.19.140 by giving 30-day notices to terminate admission agreements and discharge residents such that I retain no more than two (2) residents.
I understand that, should the department grant this variance, it is not considered a precedent and will not be given any force or effect in any other proceeding.

Provider/Applicant Signature:	Date:

6. Resident Acknowledgment.

My signature indicates the following:

- I have been informed of the provider's request to exceed the two-resident limit, including how it may affect my living arrangement or the living arrangement of the person I represent;
- I am competent to make choices about my living arrangement or the living arrangement of the person I represent;
- I request this specific living arrangement; and
- I have not been coerced into signing this request.

Resident Name	Resident or Representative Signature

7. Department Decision.

Completed by Department of Health and Welfare Staff		
This request for an exception is	☐ Approved	Effective Date:
	☐ Denied	Expiration Date*:
*This variance, if approved, is effective as indicated above unless it is revoked by the department.		
Comments (including Special Conditions if approved):		
Program Manager Signature and Date:		