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| **Telehealth Regulatory Waiver Request** | | |
| 1. **NAME OF LEGAL ENTITY:**   Click or tap here to enter text. | 1. **NAME OF ADMINISTRATOR/DIRECTOR/CEO:**   Click or tap here to enter text. | |
| 1. **ADDRESS OF LEGAL ENTITY:**   Click or tap here to enter text. | | 1. **COUNTY:**   Click or tap here to enter text. |
| 1. **NAME OF FACILITY (if different from Legal Entity):**   Click or tap here to enter text. | | 1. **LICENSE or APPROVAL #**   Click or tap here to enter text. |
| 1. **ADDRESS OF FACILITY (if different from Legal Entity):**   Click or tap here to enter text. | | 1. **LICENSED CAPACITY:**   Click or tap here to enter text. |
| 1. **NAME, PHYSICAL ADDRESS, EMAIL ADDRESS, AND PHONE NUMBER OF CONTACT FOR WAIVER:**   Click or tap here to enter text. | | |
| 1. **REGULATIONS SUBJECT TO OMHSAS AUTHORITY WHICH APPLY (55 Pa. Code Chapter) TO THIS REQUEST FOR WAIVER (Check all that apply):**   **Mental Health Intensive Case Management** 55 Pa. Code § 5221.33(4)(iii)  **Outpatient Psychiatric Services** 55 Pa. Code § 1153.14(1)  **Outpatient Drug and Alcohol Clinic Services** 55 Pa. Code § 1223.14(2) | | |
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| 1. **DATE OF WAIVER REQUEST:  NEW WAIVER  RENEWAL OF WAIVER** | | |
| 1. **THE PERIOD OF TIME COVERED BY THE REQUESTED WAIVER:** 1 year   *(all waivers granted for telehealth continuity will be issued for 1 year unless the agency/facility specifically requests less than 1 year)* | | |
| 1. **THE REASON AND DETAILED JUSTIFICATION FOR THE WAIVER REQUEST:**   This waiver is requested to ensure continuity of telehealth delivery of services by allowing this agency/facility to accept verbal consent/verification for documentation where a signature cannot be obtained when delivering **Mental Health Intensive Case Management Services**.    This waiver is requested to ensure continuity of telehealth delivery of services by allowing this agency/facility to use audio-only service delivery for **Outpatient Psychiatric Services** when the individual served does not have access to video capability or for an urgent medical situation.  This waiver is requested to ensure continuity of telehealth delivery of services by allowing this agency/facility to use audio-only service delivery for **Outpatient Drug and Alcohol Clinic Services** when the individual served does not have access to video capability or for an urgent medical situation. | | |
| 1. **EXPLANATION WITH CONCRETE ASSURANCES HOW THE HEALTH, SAFETY, AND WELFARE OF INDIVIDUALS WILL BE SAFEGUARDED DURING THE PROPOSED PERIOD OF THE WAIVER:**   This agency/facility has in place policies that ensure that services are delivered through telehealth only when it is clinically appropriate to do so.  This agency/facility has in place policies to address emergency situations during telehealth delivery of services, such as risk of harm to self or others.  Additional *(specify):* Click or tap here to enter text. | | |
| 1. **MEASURES TAKEN TO MEET THE PURPOSE OF THE REGULATION OR STANDARD THROUGHOUT THE PROPOSED PERIOD OF THE WAIVER (PLEASE BE AS SPECIFIC AS POSSIBLE TO SHOW HOW THE PURPOSE OF THE POLICY WILL BE MET, INCLUDING WHAT STEPS WILL BE TAKEN):**   This licensed **Mental Health Intensive Case Management Services** agency/facility will make a good faith effort to obtain signatures whenever possible to verify the delivery of services and have policy in place for all staff regarding expectations on documenting service delivery.  This licensed **Outpatient Psychiatric Services** or **Outpatient Drug & Alcohol Clinic** agency/facility will offer reasonable support to individuals receiving services in order to facilitate the use of audio-video telehealth whenever possible. This may include providing educational materials to assist clients in navigating the telehealth platform and linking to community resources for internet access and internet capable devices. | | |
| **16. REGION:**  **CENTRAL  NORTHEAST  SOUTHEAST  WEST** | | |
| **USE AS MUCH SPACE AS NECESSARY TO FILL-IN INFORMATION COMPLETELY** | | |