# NH Bureau of Developmental Services

## Request for Waiver to He-M 1201

<table>
<thead>
<tr>
<th>Responsible Area Agency (check one)</th>
<th>Date: ____________</th>
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Request is for an **Initial** ☐ or **Renewal** ☐ waiver?

### Provider agency name and address (if applicable):

### Residence or Day Service name and address:

Indicate specific section of **He-M 1201** for which a waiver is being sought: **He-M 1201**.

Provide an explanation of why a waiver to this standard is sought:

### What alternative is proposed to satisfy regulatory intent?

### Number of staff/providers authorized to administer medications: _____ Nurse Trainer phone # ________________

Number of people receiving medication within certified service: _____

I certify that policies and procedures are in place for:
- Nurse Trainer oversight of authorized staff
- Communication protocols between Day and Residential Services

Nurse Trainer signature: __________________________ Date: ____________

Individual/Guardian (if applicable) signature: __________________________ Date: ____________

AA Executive Director or designee signature: __________________________ Date: ____________

Medication Committee: Approved ☐ Denied ☐

Waiver will be effective from ____________ until ____________ *(duration not to exceed 5 years)*

Medication Committee Chair signature: __________________________ Date: ____________

Submit completed request to:
- BDS
  - ATTN: Medication Committee
  - State Office Park South
  - 105 Pleasant St - Main Building
  - Concord, NH 03301

Waiver Form He-M 1201

NH DHHS

Bureau of Developmental Services

August 2017