EXCEPTION REQUEST FORM

PROVIDER

The provider is the adult responsible for ensuring compliance with rules governing certified family homes.

Provider Name:		Telephone:
Address:		
City:	State:	ZIP:

RULE

The rule for which the provider is requesting an exception.

Rule Reference: IDAPA 16, Title 03, Chapter 19, Section/Subsection:

JUSTIFICATION

Narratives that justify to the Department reasons for granting an exception to the rule identified above.

Good Cause/Extenuating Circumstance:
Compensating Factors:

SPECIAL CONDITIONS (To be completed by Department staff only)

Requirements that will be in place as conditions for the provider to operate the certified family home in non-compliance with the rule identified above.

RESIDENT ACKNOWLEDGEMENT

Confirmation that the residents have been made aware of and agree in principle to the request for this exception.

My signature indicates the following:

- I have been informed of this exception request;
- I understand an exception to this rule may affect my living arrangement;
- I have been informed or will be informed of any special conditions in connection to this exception;
- I am competent to make choices about my living arrangement;
- I request this specific living arrangement; and
- I have not been coerced into making this request.

RESIDENT NAME(S)	RESIDENT OR REPRESENTATIVE SIGNATURE(S)

APPLICATION VERIFICATION

Confirmation that the provider agrees to abide by the special conditions and ensure the health and safety of residents.

In requesting this exception, I am assuring that the health and safety of the residents will not be jeopardized if the exception is granted.	
I agree to abide by any special conditions the Department attaches to granting this exception.	
I understand that this exception expires as indicated below, and I must submit a new request to extend this exception upon its expiration. If an exception expires without renewal, I will comply with the rule.	
I understand that should the Department grant this exception, it is not considered a precedent and will not be given any force or effect in any other proceeding.	
Provider Signature:	Date:

DEPARTMENT DETERMINATION (To be completed by Department staff only)

The Department's review and determination of whether or not to grant this request for an exception

Determination: This request for an exception is ☐ Approved ☐ Denied	
Effective Date:	Expiration Date*:
*If there is no expiration date, the Department is granting a permanent waiver to the provider for this rule.	
This exception is effective as indicated above unless the Department revokes this variance or waiver.	
Program Manager Signature:	Date: