



**Department
of Health**

MEDICAL EQUIPMENT WAIVER SUBMISSION PROCESS

ACHIEVING SUCCESS ON THE FIRST SUBMISSION

DIVISION OF ADULT CARE FACILITY AND ASSISTED LIVING SURVEILLANCE - 2025

GOALS

Adult care facility participants will be able to:

- Understand the need for a medical equipment regulatory waiver.
- Understand the intent of each waiver and associated expectations.
- Be able to submit a complete waiver request package.

BACKGROUND AND PURPOSE

As described in DAL #[22-22](#), to accommodate residents' health and safety, adult care facilities may request to waive certain regulations related to the use of hospital beds or beds with half side rails, or an enabling device on a standard bed. Successful submissions are individualized to the specific resident's needs and specific equipment requested and include specific criteria.

Based on recent dialogue with waiver submitters, this overview is provided as a guide to help facilities achieve successful waiver submissions.



When is a Medical Equipment Waiver Required?

Approved Medical Equipment Waivers are required for:

Device	Adult Home Regulation	Enriched Housing Program Regulation
Hospital, hi/low, height adjustable beds	487.11(i)(4)(a,b)	488.11(f)(4)(i)
Hospital, hi/low, height adjustable beds with ½ side rail	487.11(i)(4)(i)(a,b) & 487.11(i)(6)	488.11(f)(4)(i)
Enabling devices on a standard bed (including medical poles, U-bars, etc.)	487.11(i)(6)	488.11(f)(4)(i)
Trapeze, Hospital Bed with Enabling Device	487.11(i)(4)(i)(a,b) & 487.11(i)(6)	488.11(f)(4)(i)

Non-hospital electric beds (example: TempurPedic, BeautyRest, or SleepNumber) fall under the existing equivalency for bed substitution. Accordingly, no waiver request is currently required to use these beds. The existing equivalency interpretive guidelines are in effect.

Waivers are not required for items such as oxygen concentrators or orthopedic shoes with brace(s).

Facilities must ensure that, when necessary, medical provider orders are on file; appropriate policies and procedures are in place; and proper case management and personalized care planning are completed and implemented.

WAIVER SUBMISSION

Non-medical equipment waivers must continue to be submitted to the applicable Regional Office until otherwise advised. Any changes to this requirement will be widely broadcast.

The next several slides will provide an overview of the submission process.

MEDICAL EQUIPMENT WAIVER INTAKE PROCESS

1. Submission is received electronically at <https://apps.health.ny.gov/pubpal/builder/survey/adult-care-facility-medical-waiv>.
2. Department of Health reviews the submitted documents for:
 - Adult Care Facility Waiver Request/Equivalency Notification Form DOH-4235 – **all 3 pages must be submitted.**
 - Adult Care Facilities Medical Equipment Waiver Checklist Form DOH-4235a – **all 3 pages must be submitted.**
 - Medical Equipment Waiver Addendum Form DOH-4235B, or a Primary Care Provider order– **must be signed and dated.**
 - Resident name on the documents match the resident name on the Medical Equipment Waiver Submission.
3. All documents referenced in step 2 are complete and have the required number of pages.
4. Waiver request passes intake, and submitter receives an automatic status notification.

MEDICAL EQUIPMENT WAIVER FAILED INTAKE PROCESS

If the Medical Equipment Waiver Submission failed on intake, the submitter will:

1. Receive a system-generated email stating that the submission failed. The appropriate Regional Office receives a copy of the email, as well.
2. Receive an email from acfmewaivers@health.ny.gov including:
 - The specific reason the submission failed (for example, failure to submit DOH 4235, DOH 4235a and/or DOH 4235b; resident name missing or unclear, etc.);
 - The requirement to resubmit the Medical Equipment Waiver Request;
 - The link to the forms to complete.
3. Resubmit the Medical Equipment Request.

BEST PRACTICES

1. Ensure your submission includes:
 - Adult Care Facility Waiver Request/Equivalency Notification Form DOH 4235 – all 3 pages are submitted.
 - Adult Care Facilities Medical Equipment Waiver Checklist Form DOH 4235a – all 3 pages are submitted
 - DOH-4235b- Medical Provider Order – signed and dated
2. Ensure the documents you are submitting match the name of the resident you are submitting the request.
3. The submitted documents have a clear and consistent naming convention (i.e., “name” 4235, “name” 4235a, “name” 4235b).
4. The submitted documents do not contain any special characters in the name (i.e., Do not use #, @, !, etc.).

Facility Name is the name as licensed and as listed on the facility Operating Certificate. *Abbreviated names, nicknames, marketing names, or Operator Names are not acceptable.* The Operating Certificate should be displayed prominently within each facility.

Facility Name, Operating Certificate Number, and the Department of Health Regional Office can also be found on the Department's webpage: [NYS Adult Care Facility Profiles](#)

Adult Care Facility Medical Waiver Request

Facility Name ★

Operating Certificate #: ★

Base Licensure (AH/EHP) ★

- Select -

DOH Regional Office ★

- Select -

Resident Name: Last Name, First ★



Department
of Health

NYS Health Profiles

Find and Compare New York Health Care Providers

Hospitals ▼

Nursing Homes ▼

Home Care ▼

Hospice ▼

Adult Care ▼

Other Providers ▼

Find a Provider by Name:

Begin by typing a provider's name

Search

Find Providers Near You:

+

-

Search for Zip, City, Name

Resident Name: Last Name, First *

Type of Waiver (select all that apply) *

- ☐ Hospital Bed
- ☐ Hospital bed with ½ side rail
- ☐ Enabling device
- ☐ Trapeze

Resident Name should be consistent on all documentation provided.

If requesting an enabling device, specify the type and ensure it is consistent with all submitted forms.

Medical Equipment Waiver Request Form DOH 4235★

No file chosen

<https://health.ny.gov/forms/doh-4235.pdf>

Medical Equipment Waiver Checklist DOH 4235A★

No file chosen

<https://health.ny.gov/forms/doh-4235a.pdf>

All 3 pages of both the Medical Equipment Waiver Request Form DOH-4235 and Medical Equipment Waiver Checklist DOH-4235a must be submitted.

Failure to submit all pages of either document will result in a failed intake and a new waiver submission will be required.

Proof of Justification/Need-Required Documents ★

No file chosen

<https://health.ny.gov/forms/doh-4235b.pdf>

Evaluation of Safe and Independent Use-Required Documents★

No file chosen

Proof of Justification/Need - DOH-4235B ACF Medical Equipment Waiver Addendum or a Primary Care Medical Provider order.

Evaluation of Safe and Independent Use - Must be completed by a Registered Nurse, Physical Therapist, or Occupational Therapist. The evaluator must sign the document including their professional title. Mandatory language must include the “resident’s ability to safely and independently **self-manage and can use the specific medical equipment for which the waiver is sought.” Refer to DOH 4235a (Checklist).

Policies & Procedures-Required Documents★

No file chosen

Disaster Plan Roster-Required Documents★

No file chosen

Policies & Procedures- Must indicate medical equipment will be installed per manufacturer guidelines and specifications, frequency of safety checks, and include the staff responsible for safety checks, and where safety checks will be documented.

*The policy must also include “routine assessment/evaluation, including upon any significant change of condition, of the resident’s ability to safely and independently** self-manage and use the specific medical equipment and referral to the resident’s primary care physician [provider] when such change is identified.”*

Refer to DOH-4235a for additional requirements.

Disaster Plan Roster- A copy of the facility’s current disaster plan roster of residents with transfer assistance levels clearly identified for all residents and specifying residents in need of assistance with evacuation.

Choose Files No file chosen

Trapeze Waiver- Daily Safety Check: *Required if a waiver is being sought for a trapeze.*

Provide documentation that confirms, at minimum, daily safety checks of the trapeze device. Additional documentation required on **DOH-4235a** regarding confirmation the Resident's bed can be rolled through the door with the apparatus attached during an emergency evacuation. Door and bed measurements must be included, as well.

Submitter's Email *

Confirm email *

☐

I'm not a robot



Submit

Submitter must complete this page and click “Submit” to send the waiver request to the Department for review.



Department
of Health

[Home](#)

Application Received

The completed application has been successfully received.

Your Submission ID is: [REDACTED]

Please keep this submission ID for your records.

[Back to survey](#)

After successfully submitting the waiver request, the message above will appear.

ADULT CARE FACILITY WAIVER REQUEST/EQUIVALENCY NOTIFICATION FORM 4235
SECTION A, PAGE 1 OF 3, TOP OF PAGE

Include all three pages of DOH-4235 with submission, complete Sections A-C, save, then upload file. Failure to include all three pages will result in failed intake.

NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facility Waiver Request/
Equivalency Notification Form

SECTION A: Identifying Information *(Completed by Operator/Administrator or Designee)*

Regional Office (RO):

Date Requested:

Facility Name: Complete name as facility licensed

Address:

City/Town:

State:

Zip:

County:

Facility Certificate #:

Date Certified:

Expiration Date:

Capacity:

Occupancy:

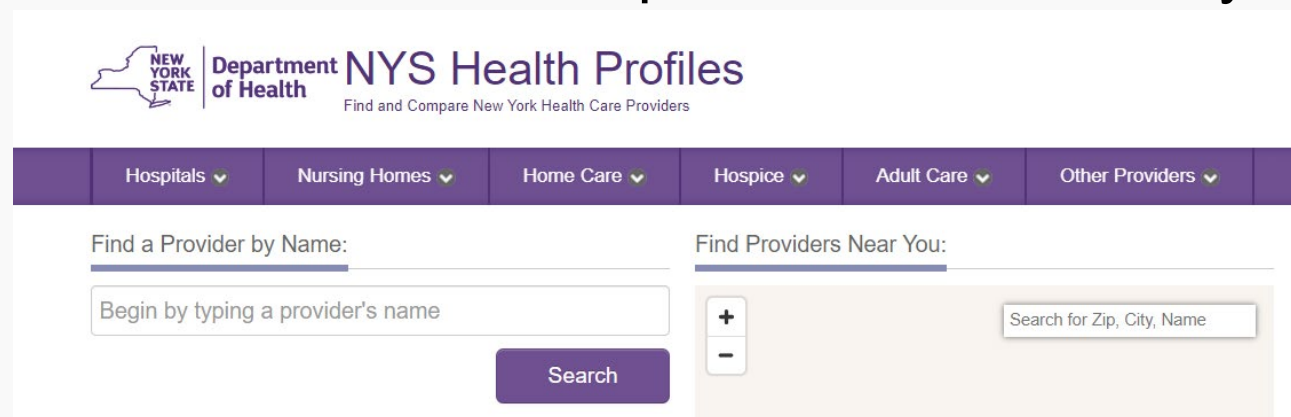


DOH-4235 - COMPLETING SECTION A

Facility Name should be identical to the Facility Operating Certificate. *Abbreviated names, nicknames, marketing names, or Operator Names are not acceptable.* The Operating Certificate should be displayed prominently within each facility.

Facility Name, Operating Certificate Number, and the Department of Health Regional Office can also be found on the Department's "NYS Health Profiles" webpage.

Incomplete or inaccurate submissions will not be accepted. Please carefully review all entries for accuracy.



The screenshot shows the NYS Health Profiles website. At the top, there is a header with the New York State Department of Health logo and the text "NYS Health Profiles" and "Find and Compare New York Health Care Providers". Below the header is a navigation bar with tabs for "Hospitals", "Nursing Homes", "Home Care", "Hospice", "Adult Care", and "Other Providers". The main content area has two search sections. The first section, "Find a Provider by Name:", has a text input field with the placeholder "Begin by typing a provider's name" and a "Search" button. The second section, "Find Providers Near You:", has a vertical zoom control with "+" and "-" buttons and a text input field with the placeholder "Search for Zip, City, Name".

ADULT CARE FACILITY WAIVER REQUEST/EQUIVALENCY NOTIFICATION FORM 4235, SECTION B, PART I, PAGE 1 OF 3

SECTION B: *Completed by Operator/Administrator or Designee*

In accordance with Department regulations, the Department may waive certain requirements. The operator must have written approval or be following an approved equivalency prior to instituting any alternative to regulatory standards. Noncompliance with a Department regulation prior to a waiver being requested and approved may result in the imposition of a penalty. Similarly, if an operator is noncompliant with an approved equivalency, this may result in a penalty. Incomplete requests will not be accepted.

Complete Part I for Equivalencies. Complete Part II for Waivers.

I. Equivalency:

☒ Yes

☐ No

Approved equivalency regulation citation:

Briefly state the equivalency issue:

Medical Equipment Waiver Requests are not Equivalencies, therefore “No” should be selected.

ADULT CARE FACILITY WAIVER REQUEST/EQUIVALENCY NOTIFICATION FORM 4235, SECTION B, PART II- A, PAGE 1 OF 3

II. Waivers

A. Type of Waiver

1. Application Pending:

a) Renewal ☐ Yes ☐ No

b) New facility ☐ Yes ☐ No

c) Change of Operator ☐ Yes ☐ No

2. Programmatic: ☒ Yes ☐ No

3. Physical Plant: ☐ Yes ☐ No

Regulation for which waiver is sought:

DOH-4235 (12/15) Page 1 of 3

Typical submission is **Programmatic**. Waiver renewal is not necessary, only initial approval is required. The facility would maintain all appropriate annual/semi-annual evaluations and annual medical provider orders on-site for Surveyor review upon request.

DOH-4235 –THE APPROPRIATE REGULATION(S)

Regulation for which waiver is sought:

Commonly left Incomplete/Incorrect

Medical Equipment Waiver Requested	Adult Home	Enriched Housing Program	Residence for Adults
Hospital Bed	487.11(i)(4)(i)(a,b)	488.11(f)(4)(i)	490.11(j)(4)(i)(a,b)
Hospital Bed with ½ side rail	487.11(i)(4)(i)(a,b) 487.11(i)(6)	488.11(f)(4)(i)	490.11(j)(4)(i)(a,b) 490.11(j)(6)
Enabling Device (standard bed)	487.11(i)(6)	488.11(f)(4)(i)	490.11(j)(6)
Hospital Bed + Enabling Device	487.11(i)(4)(i)(a,b) 487.11(i)(6)	488.11(f)(4)(i)	490.11(j)(4)(i)(a,b) 490.11(j)(6)

Select the appropriate regulation based on the facility license and equipment for which you are seeking a waiver.



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REGULATIONS

18 NYCRR § 487.11(i)(4)(i)(a,b)

Each operator shall furnish each resident with the following minimum bedroom equipment:

(i) a standard single bed, well constructed, in good repair, and equipped with:

(a) clean springs maintained in good condition;

(b) a clean, comfortable, well-constructed mattress, standard in size for the bed...

18 NYCRR § 487.11(i)(6)

Beds with side rails or beds in excess of 36 inches high shall not be used, except in sick bays

18 NYCRR § 488.11(f)(4)(i)

When not supplied by the resident, the operator must provide each resident with the following minimum household equipment:

(i) a standard, single bed in good repair, a chair, a lamp...

Adult
Home

Enriched
Housing
Program



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ADULT CARE FACILITY WAIVER REQUEST/EQUIVALENCY NOTIFICATION FORM 4235, SECTION B, PART II- B, PAGE 2 OF 3

II. Waivers (continued)

B. Please explain the reason the proposed alternative is necessary and why a waiver is being requested.
(Use additional sheets as necessary).

Resident specific reason for request (example: to increase independence with transfers into/out of bed, promote improved range of motion, for repositioning, etcetera).
Seeking use of (specific equipment sought) to promote independence when getting in and out of bed.
See attachments

The information provided must be resident-specific and describe the reason a waiver is being requested. See example above.

NOTIFICATION FORM 4235, SECTION B, PART II- C, PAGE 2 OF 3

C. Provide information, which will demonstrate how you will achieve or maintain the intended outcome of the regulation and protect the health, safety, and well-being of the residents. Please supply all necessary supporting documentation as required, e.g., approval of local officials, supporting statements of staff, physicians and service providers, special licenses, etc. (Use additional sheets as necessary).

Resident specific

Seeking use of (specific equipment sought) to promote/maintain independence when getting in and out of bed or repositioning in bed.

See attachments

Include resident specific information describing how the facility will achieve the intended outcomes while protecting the health, safety, and well-being of the resident. See example above.



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ADULT CARE FACILITY WAIVER REQUEST/EQUIVALENCY NOTIFICATION
FORM 4235, SECTION C, PAGE 2 OF 3

SECTION C: Signature of Operator/Administrator or Designee

Name (print):

Phone Number: (

)

Signature:

PRINT NAME

Date:

Please note that incomplete requests will be returned. Continued processing will require submission of new request.

Section 3 must be completed in its entirety. Incomplete forms will not pass the intake process.

ADULT CARE FACILITY WAIVER REQUEST/EQUIVALENCY NOTIFICATION FORM 4235, SECTION D, PAGE 3 OF 3: FOR DOH USE ONLY

The entire DOH-4235 form, including page 3, must be submitted with each waiver request.

NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facility Waiver Request/
Equivalency Notification Form

SECTION D: FOR DOH USE ONLY

Regional Office RO Log #: [text] Central Office Log #: [text]

Name of Facility: [text]

Date received from: Facility [text] Regional Office [text]

Decentralized Waiver

RO Program Manager Disposition: ☐ Approved ☐ Disapproved

Reason: [text]

Centralized Waiver

RO Recommendation: ☐ Approved ☐ Disapproved ☐ Conditional Approval ☐ Withdrawn

Reason: [text]

Regional Office:

RO Reviewer (include title) [text] Date: [text]

RO Program Manager (signature) [text] Date: [text]

Architect:

Date to Architect: [text] Architect Recommendation: ☐ Approved ☐ Disapproved

Architect (signature) [text] Date: [text]

Comments: [text]

Central Office:

Central Office Reviewer: [text] Title: [text] Date: [text]

Division Director Recommendation: ☐ Approved ☐ Disapproved ☐ Conditional Approval ☐ Withdrawn

Division Director (signature): [text] Date: [text]

Comments: [text]

cc: R.O. Program Manager with attachments
DACF/ALS Project File
ACF Application Manager with attachments (only for pending applications)

DOH-4235 (12/15) Page 3 of 3



Adult Care Facilities Medical Equipment Waiver checklist Form 4235a

Page 1 of 3

The DOH-4235a form provides a checklist to assist the facility in preparing an approvable Medical Equipment Waiver submission. All appropriate areas must be completed with supporting documentation attached. Be sure to review each requirement thoroughly.

NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facilities Medical Equipment Waiver Checklist

The Department of Health provides this Medical Equipment Waiver Checklist to assist adult care facilities in the submission of resident-specific medical equipment waivers. Please note that all documentation and information requested below must be provided and the checklist must be completed and attached to the waiver request for Department review and consideration. Waivers without a completed checklist will be returned unreviewed.

ADULT CARE FACILITIES MEDICAL EQUIPMENT WAIVER CHECKLIST

FORM 4235A, PAGE 1 OF 3, CONTINUED

Adult Care Facility Use	
Check if Included	Requirements for All Waivers
☐	Resident: • First and Last Name: • Level of Care (check all that apply): ☐ AH ☐ EHP ☐ ALP ☐ ALR ☐ EALR ☐ SNALR

The facility's base license information is found on the Operating Certificate.
AH=Adult Home
EHP=Enriched Housing Program

All appropriate boxes must be checked.
ALP=Assisted Living Program
ALR=Assisted Living Residence
EALR=Enhanced Assisted Living Residence
SNALR=Special Needs Assisted Living Residence



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ADULT CARE FACILITIES MEDICAL EQUIPMENT WAIVER CHECKLIST

FORM 4235A, PAGE 1 OF 3, CONTINUED

☐

Proof of Justification/Need:

- A copy of the order from the resident's primary care physician indicating medical need for the specific medical equipment for which the waiver is sought.

Please note, such order must be renewed not less than annually, upon change in condition and with each new medical evaluation. The order must be present in the resident's medical record and available upon request by the Department.

- Statement of Need/Medical Justification

☐ DOH-4235B ACF Medical Equipment Waiver Addendum.

OR

☐ If ordered by the resident's primary care physician, a copy of the physical therapist or occupational therapist assessment for the specific medical equipment for which the waiver is sought.

A completed form DOH-4235B ACF Medical Equipment Waiver Addendum or a Primary Care Medical Provider order must be submitted, with provider signature. The order must specify the Medical Equipment for which the waiver is being sought and be consistent with all submitted waiver request documents. See the next pages for more information.



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ADULT CARE FACILITIES MEDICAL EQUIPMENT WAIVER ADDENDUM

DOH-4235B

This form must be completed, signed by the resident's primary care provider, and dated.

The type of medical equipment requested must be consistent with all submitted documentation.

If requesting a waiver for an Enabling Device, be sure to included the specific type, e.g., U-bar, bed cane.

Physician Name: _____

NYS License No.: _____

Address: _____

Phone: _____

Fax: _____

Email Address: _____

Patient Name: _____

Date of Birth: _____

The below request has been deemed medically necessary for the above-named patient and is not to be used as a restraint.

ORDERS (Limit 1 per patient)

☐ **Hospital Bed**
½ Side Rail ☐ Yes ☐ No

☐ **Enabling Device**
Specific Type: _____

☐ **Trapeze**

☐ **Other**
Specify: _____

Physician Signature _____

Date _____

ADULT CARE FACILITIES MEDICAL EQUIPMENT WAIVER CHECKLIST

FORM 4235A PAGE 1 OF 3, CONTINUED

If seeking special consideration for residents of Assisted Living Programs, Enhanced or Special Needs Assisted Living Residences, please include information attesting to the resident's capacity to understand the need and use of equipment, extent and frequency of assistance needed, who is responsible for providing this assistance, and staff training regarding equipment and assistance guidelines.



Evaluation of Safe and Independent Use:

- A note in the resident's record confirming the resident was initially evaluated by a registered nurse, physical therapist or occupational therapist, indicating performance of an evaluation and the resident's ability to safely and independently** self-manage and use the specific medical equipment for which the waiver is sought. The statement must be present in the resident's medical record and available upon request by the Department.



ADULT CARE FACILITIES MEDICAL EQUIPMENT WAIVER CHECKLIST

FORM 4235A PAGE 1 OF 3, CONTINUED

Submit the facility's formal policy & procedure. A waiver attachment alone does not suffice.

Policies & Procedures must reflect all 6 qualifiers listed on the DOH-4235a form.

If submitting Policies & Procedures and waiver attachment, information must be consistent on all documentation submitted. The Policies & Procedures must contain the required information regardless of waiver attachment.



Policies and Procedures:

- The facility's policy and procedure including, but not limited to, the following:
 - 1) How the specific equipment ordered will be installed and maintained properly with routine preventative maintenance checks for safety per manufacturer's instructions.
 - 2) Individual(s) responsible for the installation of the specifically ordered equipment.
 - 3) Individual(s) responsible for the maintenance of the specifically ordered equipment.
 - 4) The frequency of routine preventative maintenance checks.
 - 5) Routine assessment/evaluation, including upon any significant change of condition, of the resident's ability to safely and independently** self-manage and use the specific medical equipment for which the waiver is sought and referral to resident's primary care physician when any change is identified.
 - 6) Annual renewal of DOH-4235B ACF Medical Equipment Waiver Addendum (if applicable and still in use).



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ADULT CARE FACILITIES MEDICAL EQUIPMENT WAIVER CHECKLIST

FORM 4235A PAGE 2 OF 3

A current roster must be provided for all facility residents.

The Disaster Plan must clearly identify Transfer Assistance Levels (TALs) and residents in need of assistance with evacuation. A TAL key must be included.

**Disaster Plan Roster:**

A copy of the facility's current disaster plan roster of residents with transfer assistance levels clearly identified for all residents and specifying residents in need of assistance with evacuation. Please note, facilities must have specific and current procedures for evacuation of residents needing individual procedures documented and available upon request by the Department.



ADULT CARE FACILITIES MEDICAL EQUIPMENT WAIVER CHECKLIST

FORM 4235A PAGE 2 OF 3, CONTINUED

Check if Included	Additional Requirements for Hospital Bed Waivers
☐	Check all those that apply: ☐ No wheels. ☐ Wheels are locked. ☐ Bed height is no more than 36 inches as measured from the floor to the top of the mattress, not the footboard and not the headboard. Bed Measurement:
For Adult Care Facility Use	
Check if Included	Additional Requirements for Hospital Beds with ½ side rail Waivers
☐	Check to confirm: ☐ Only one side rail will be in use ☐ ½ side rail will not be placed in the middle of the bed. ☐ ½ side rail cannot be used as restraints.
For Adult Care Facility Use	
Check if Included	Additional Requirements for Enabling Device Waivers
☐	Type of enabling device: Check to confirm: ☐ Only one type of enabling device per bed is permitted. ☐ Enabling devices may not be used as a restraint.

Select and complete these sections based on the medical equipment for which the waiver is requested. Be sure to complete all applicable fields.

If requesting a waiver for a **Hospital Bed**, check the box for either “no wheels” or “wheels are locked”. “Bed height is no more than 36 inches” should always be checked to confirm bed height is appropriate. Bed measurements should include bed height.

If requesting a waiver for a **Hospital Bed with ½ side rail**, all boxes must be checked.

The last section should be completed if requesting and **Enabling Device**. Specific type of enabling device must match the DOH-4235b/primary care provider order. For example, if U-bar is listed on the DOH-4235b/primary care provider order, U-bar must be indicated as the enabling device type on the DOH-4235a, as well.



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ADULT CARE FACILITIES MEDICAL EQUIPMENT WAIVER CHECKLIST

FORM 4235A, PAGE 2 OF 3, CONTINUED

For Adult Care Facility Use	
Check if Included	Additional Requirements for Trapeze Waivers
☐	Emergency Evacuation: Check to confirm: ☐ Bed can be rolled through the door with the attached apparatus if/when required for emergency evacuation. Resident's bedroom door measurement Bed w/ apparatus width measurement
☐	Daily Safety Checks: • Provide documentation that confirms, at minimum, daily safety checks of the trapeze device.

Specific to waiver requests for Trapeze devices, please submit corresponding documentation as outlined on DOH-43235a and pictured above.

REQUEST FOR ADDITIONAL INFORMATION (RFAI)

Responses to all Requests for Additional Information must be received within **five (5) business days**.

REQUESTS FOR ADDITIONAL INFORMATION

Requests for Additional Information comments are entered by waiver reviewers. Typically, these are for:

- The DOH-4235b form, or Primary Care Provider order is incomplete, does not match other documents, or is not current.
- Safe and independent use resident evaluation is not completed by the appropriate licensed staff (Registered Nurse, Physical Therapist, or Occupational Therapist) or contradicts other documentation.
- Policy and Procedures do not include all qualifiers outlined on the DOH-4235a form, most often qualifier number 5.
- The facility name indicated on the DOH-4235a does not match the name as licensed.

Responses to all Requests for Additional Information must be received **within five (5) business days**. If a second request for additional information does not meet the requested criteria, a new waiver submission may be required.

MEDICAL EQUIPMENT WAIVER REQUEST DETERMINATION



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- The facility will receive a notification when a medical equipment waiver has been approved. Medical equipment cannot be implemented prior to this notification.
- After the initial approval, a waiver request does not need to be submitted to the Department annually, *provided there are no changes that warrant a new submission*. The DOH-4235b/primary care provider order and the evaluation of safe and independent use must be updated yearly as outlined on the DOH-4235a.
- DOH-4235b must be completed annually and as warranted for changes in condition, maintained onsite and made available upon request for Department review. Refer to DOH-4235a for additional information.
- Evaluation of the resident's ability to safely and independently use and self-manage the equipment must be completed at least annually, with all evaluations, and as warranted for changes in condition. Evaluations must be maintained on-site and made available for Surveyor review upon request.
- If an assessment determines that the equipment is no longer appropriate, the facility must ensure proper and prompt removal with appropriate notifications made to Regional Office.

MEDICAL EQUIPMENT WAIVER REQUEST DENIAL

- A denial letter with rationale will be sent to the facility if a medical equipment waiver request is not approvable. The letter will explain revisions necessary to make the waiver request eligible for approval.
- Once a waiver request is denied, it cannot be reopened. The facility must submit a new waiver request and include all required documentation. It is important to make the required revisions outlined in the denial letter.

RESOURCES

Please email ACFMEWaivers@health.ny.gov

DAL 22-22:

https://health.ny.gov/facilities/adult_care/dear_administrator_letters/docs/dal_22-22.pdf

DOH-4235: <https://www.health.ny.gov/forms/doh-4235.pdf>

DOH-4235a: <https://www.health.ny.gov/forms/doh-4235a.pdf>

DOH-4235b: <https://www.health.ny.gov/forms/doh-4235b.pdf>



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