

Quality Reporting Program

Extraordinary Circumstance/Disaster Extension or Waiver Request Form

A facility can request an extension or waiver of various Quality Reporting Program requirements due to extraordinary circumstances beyond the control of the facility. To request an extension or waiver, complete and submit this form **within 30 days of the disaster or extraordinary circumstance**.

ALL sections must be complete and specific in order for Centers for Medicare and Medicaid Services to consider the request.

*Indicates required fields

Facility Contact Information

*Program Requesting Waiver: Inpatient __ Outpatient __ Psych __ Cancer __ ASC __

*Date of Request (MM/DD/YYYY): ___/___/___

*Date of Extraordinary Circumstance/Disaster (MM/DD/YYYY): ___/___/___

*CMS Certification Number (CCN): _____

*Facility Name: _____

*CEO Last Name: _____

*CEO First Name: _____

*CEO E-Mail Address: _____

*CEO Address Line 1: (must include physical street address): _____

CEO Address Line 2: _____

*CEO City: _____

*CEO State: __ *CEO Zip Code: _____ - _____

*CEO Telephone Number: ___ - ___ - ___ ext. _____

Additional Contact Last Name: _____

Additional Contact First Name: _____

Additional Contact E-Mail Address: _____

Additional Contact Address Line 1: (must include physical street address): _____

Additional Contact Address Line 2: _____

Additional Contact City: _____

Additional Contact State: __ Additional Contact Zip Code: _____ - _____

Additional Contact Telephone Number: ___ - ___ - ___ ext. _____

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Additional Comments:

Disaster Waiver Request Form Submission

In the event the facility is unable to submit the form electronically, it can be submitted by fax or mailed to your QIO or CMS designee.