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 Email Address: ______________________________

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

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CEO Address Line 2: ______________________________

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* CEO City: ______________________________

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

* CEO Telephone Number: ___-___-____ ext. __________

Additional Contact Last Name: ______________________________

Additional Contact First Name: ______________________________

Additional Contact Email Address: ______________________________

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

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Additional Contact Address Line 2: ______________________________

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Additional Contact City: ______________________________

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

Additional Contact Telephone Number: ___-___-____ ext. __________

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Disaster Waiver Request Information

* Submission quarter(s) affected (Please state “None” if not applicable): ______________________________

* Validation quarter(s) affected (Please state “None” if not applicable): _______________________________

* Date facility will re-start data submission (MM/DD/YYYY): ____/____/___

* Justification for the submission re-start date: ____

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*** Reason(s) for requesting an extension or waiver – Please include the specific requirement or data that should be waived (attach additional documentation when necessary to include details):**

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*** Please provide evidence of the impact of the disaster or extraordinary event including (not limited to) photographs, web links, newspaper and other media articles (attach supporting documentation when necessary):**

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Additional Comments:

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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.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1171**. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.