

CMS 1135 Waiver / Flexibility Request and Inquiry Form

# **Organization Workflow**

CMS 1135 Waiver / Flexibility Request

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### CMS 1135 Waiver / Flexibility Request and Inquiry Form

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-XXXX (Expires XX/XX/XXXX)**. This is a **voluntary** information collection. The time required to complete this information collection is estimated to average **1 hour** 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. \*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Adriane Saunders at Adriane.Saunders@cms.hhs.gov.

Under Section 1135 or 1812(f) of the Social Security Act, CMS can issue several blanket waivers when there's a disaster or emergency. Blanket waivers prevent gaps in the access to care for beneficiaries affected by the emergency.

When a blanket waiver is issued, providers don't have to apply for an individual waiver. If there's no blanket waiver, providers can ask for an individual Section 1135 waiver.

If you have a request or inquiry, please use this form to submit your request to CMS.

### Who are you? ?

An Organization / Provider

A Beneficiary

#### What would you like to do?

I want to submit a waiver / flexibility request

I want to submit an inquiry request

## Submit a waiver / flexibility request



### **Select a Public Health Emergency**

Select the Public Health Emergency (PHE) that applies to your waiver request

Public Health Emergency (PHE) (required) * ?					
Please select one		•			
COVID-19	3/13/20 - 10/31/2020				
California Wildfire	3/13/20 - 10/31/2020	CA			
Hurricane Laura	8/15/20 - 11/15/2020				
Hurricane Revelation	9/13/19 - 12/13/2019				



### Point of Contact (?)

Who should CMS contact in response to this waiver request?

Email address (required) \*

First name (required) \*

Last name (required) \*

**Phone number** 

### Organization Information ?

Who is the organization making this request?

**Organization name** (required) \*

State/US Territory/Federal District (required) \*

Alaska	California × Ne
	Nebraska
	Nevada
	New York

### Organization Categories 🕐

Who is the organization making this request?

General	Emergency Provider / S	Supplier Types	Other
<b>—</b>			
Associatio	n	Part D Pres	cription Plan
Advocacy	Group	State Gover	nment
Congressional Office		State Medic	aid Agency
Corporatio	on	State Surve	y Agency
Departme Services	nt of Health and Human	Tribal Natio	n

Other

Ambulatory Surgical Center (ASC)	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Community Mental Health Center (CMHC)	Nursing Homes (SNF/NF)
Comprehensive Outpatient Rehabilitation Facility (CORF)	Organ Procurement Organization
Critical Access Hospital (CAH)	Outpatient Physical Therapy/Speech Therapy (OPT/ST)
Community Mental Health Center (CMHC)	Programs of All-Inclusive Care for Elderly (PACE)
End Stage Renal Disease (ESRD)	Psychiatric Residential Treatment Facility (PRTF)
Home Health Agencies (HHA)(OPO)	Religious Non-Medical Health Care Institution (RNCHI)
Hospice(OPO)	Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC)
Hospital	Transplant Center

Ambulance Palliative Durable Medical Equipment (DME) Physician	General	Emergency Provider / S	upplier Types	Other
Durable Medical Equipment (DME)	🗖 Ambulan	nce	Palliative	
	_		_	
	Lab		Other	

### Organization Identification Numbers ?

What are the identification numbers for your organization?

These numbers will be different, depending on the categories you have selected for your organization including: CCN/Provider, Medicare Contract Number, or NPI.

For the categories selected above, use:

#### NAME-OF-IDENTIFICATION-NUMBER



Select the type of request you are making. Depending on your request type, we may ask you for additional information.

#### Request #1

Waiver Request Type (required) \*

<b>Regulation Related to this Request</b>	?
<b>Regulation Description</b> (required) *	?
+ Add another waiver request	

Submit your request 4)

Submit

**Confirmation Message (need content)** Case #

WARNING: Individually identifiable health information in this system is subject to the Health Information Portability and Accountability Act of 1996 and the Privacy Act of 1974. Submission to the 1135 Waivers System that contains Protected Health Information (PHI) is a violation of these Acts. Questions containing PHI will be deleted from the system and not processed. For detailed information regarding transmitting or receiving healthcare information or data read the <u>QualityNet System Security Policy</u> (PDF).

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### Who are you? ?

An Organization / Provider

A Beneficiary

#### What would you like to do?

) I want to submit a waiver / flexibility request

I want to submit an inquiry request

# Submit an inquiry



### Select a Public Health Emergency

Select the Public Health Emergency (PHE) that applies to your inquiry request

Public Health Emergency (PHE) (required) * ?							
	California Wildfire	3/13/20 - 10/31/20	CA	•			



### **Provide Your Contact Information**

Some explanatory text on what's in the step

Point of Contact *?* 

Who should CMS contact in response to this inquiry request?

Email address (required) \*

First name (required) \*

Last name (required) \*

**Phone number** 

### 3 Inquiry

Inquirer Type (required) \*

Please select an option

Inquiry Topic (required) \*

Please select an option

# **Inquiry Form**

Submit

### **Confirmation Message (need content)**

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# **Beneficiary Workflow**

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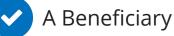
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### Who are you? ?

) An Organization / Provider



What would you like to do?

) I want to submit a waiver / flexibility request

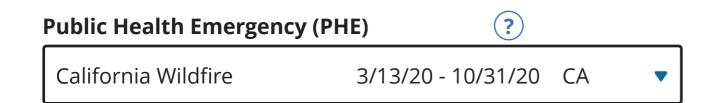
I want to submit an inquiry request

# Submit an inquiry



### Select a Public Health Emergency

Select the Public Health Emergency (PHE) that applies to your inquiry request





### **Provide Your Contact Information**

Some explanatory text on what's in the step

Point of Contact *?* 

Who should CMS contact in response to this inquiry request?

Email address (required) \*

First name (required) \*

Last name (required) \*

**Phone number** 

### 3 Inquiry

Inquirer Type (required) \*

Please select an option

Inquiry Topic (required) \*

Please select an option

# **Inquiry Form**

Submit

### **Confirmation Message (need content)**

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