

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal Form

CMS 1135 General Waiver Request

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal 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 **0938-1384 (Expires 05/31/2024)**. 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.**

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

What would you like to do? ?

- I want to submit a waiver / flexibility request ?
- I want to submit an inquiry request ?
- I want to provide a status on my healthcare facility, patients and or residents ?

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 do not have to apply for an individual waiver. If there is no blanket waiver, providers can ask for an individual Section 1135 waiver.

Submit a waiver / flexibility request

1 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 | |
|-----------------------|-------------------------|
| 2023 Hurricane Idalia | 08/27/2023 - 11/28/2023 |
| 2023 Hawaii Wildfires | 08/08/2023 - 02/03/2024 |

2 Provide Your Contact Information

This will help keep you updated on your request's progress

Point of Contact [?](#)

Who should CMS contact in response to this waiver request?

Email address (required) *

Confirm 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 / Supplier Types | Other |
|---|--|--|
| <input type="checkbox"/> Advocacy Group | <input type="checkbox"/> Department of Health and Human Services | <input type="checkbox"/> State Medicaid or CHIP Agency |
| <input type="checkbox"/> Association | <input type="checkbox"/> Medicare Advantage Plan | <input type="checkbox"/> State Survey Agency |
| <input type="checkbox"/> Congressional Office | <input type="checkbox"/> Part D Prescription Plan | <input type="checkbox"/> Tribal Nation |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> State Government | |

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

| General | Emergency Provider / Supplier Types | Other |
|--|-------------------------------------|--|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Palliative | |
| <input type="checkbox"/> Durable Medical Equipment (DME) | <input type="checkbox"/> Physician | |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Other | <input type="text" value="Other Organization Category"/> |

Organization Identification Numbers ?

What are the identification numbers for your organization?

Please include all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

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

IDENTIFICATION NUMBER ?

Separate multiple identification numbers with a comma.

3 Describe your 1135 Waiver / Flexibility Request ?

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) * ?

Click here if you do not see your waiver type

Regulation Related to this Request ?

Request Description (required) * ?

Detail a brief summary of why the waiver is needed (For example: CAH is sole community provider without reasonable transfer options at this point during the specified emergent event (e.g. flooding, tornado, fires, or flu outbreak). CAH needs a waiver to exceed its bed limit by X number of beds for Y days/weeks (be specific)) and the type of relief you are seeking.

[+ Add another waiver request](#)

4 Submit your request

Submit

Thank You! Your request has been successfully submitted.

Your case number is <Case#>

You will also receive an email confirmation summarizing your request and providing you with additional guidance.

To report technical issues please email qnetsupport@cms.hhs.gov and note "1135 Waiver/Flexibility" in the subject line.

If you are requesting an 1135 waiver or making an Inquiry about a public health emergency, please submit your request at the [CMS PHE Emergency Web Portal](#). For all other questions, please contact Emergencies@cms.hhs.gov.

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 safeguarding protected healthcare information or data, please refer to the "HIPAA Security Rule" (<https://www.hhs.gov/hipaa/for-professionals/index.html>).

INFORMATION NOT TO BE RELEASED TO PUBLIC UNLESS AUTHORIZED BY LAW. This information is for internal Government use only and has not been publicly disclosed. It may contain information that is privileged, confidential, or otherwise protected from disclosure under public law. Do not share Personally Identifiable Information (PII) and/or Protected Health Information (PHI). Unauthorized disclosure may result in prosecution to the full extent of the law.



Drop down options

PHE

2023 Hurricane Idalia 08/27/2023 - 11/28/2023
2023 Hawaii Wildfires 08/08/2023 - 02/03/2024

State/US Territory/Federal District

| | | |
|----------------|--------------------------|-----------------|
| Alabama | Maine | Oklahoma |
| Alaska | Marshall Islands | Oregon |
| American Samoa | Maryland | Palau |
| Arizona | Massachusetts | Pennsylvania |
| Arkansas | Michigan | Rhode Island |
| California | Micronesia | South Carolina |
| Colorado | Minnesota | South Dakota |
| Connecticut | Mississippi | Tennessee |
| Delaware | Missouri | Texas |
| Florida | Montana | Utah |
| Georgia | Nebraska | Vermont |
| Guam | Nevada | Virginia |
| Hawaii | New Hampshire | Washington |
| Idaho | New Jersey | Washington D.C. |
| Illinois | New Mexico | West Virginia |
| Indiana | New York | Wisconsin |
| Iowa | North Carolina | Wyoming |
| Kansas | North Dakota | |
| Kentucky | Northern Mariana Islands | |
| Louisiana | Ohio | |

Waiver/Flexibility Request Type

| | | |
|--|--|---|
| Accreditation Organizations: Survey, Certification, Quality and Enforcement | EMTALA: Survey, Certification, Quality and Enforcement | Certification, Quality and Enforcement |
| Ambulatory Surgery Center (ASC): Survey, Certification, Quality and Enforcement | End Stage Renal Disease (ESRD): Payment | OASIS: Payment |
| Ambulatory Surgical Center (ASC): Payment | End Stage Renal Disease (ESRD): Survey, Certification, Quality and Enforcement | OASIS: Survey, Certification, Quality and Enforcement |
| Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital | Ensuring Correct Processing of Home Health Disaster Related Claims | Organ Procurement Organizations: Survey, Certification, Quality and Enforcement |
| Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital | Extension for Medicare Geographic Classification Review Board (MGCRB) Applications | Outpatient Physical Therapy/Outpatient Speech Pathology: Payment |
| Certified Nursing Assistants: Survey, Certification, Quality and Enforcement | Federally Qualified Health Center (FQHC): Payment | Outpatient Physical Therapy/Outpatient Speech Pathology: Survey, Certification, Quality and Enforcement |
| Clinical Laboratory Improvement Amendments (CLIA): Survey, Certification, Quality and Enforcement | Federally Qualified Health Center (FQHC): Survey, Certification, Quality and Enforcement | Portable X-Ray: Payment |
| Community Health Center (CHC): Payment | Home Health Agency (HHA): Timeframe for OASIS transmission | Portable X-Ray: Survey, Certification, Quality and Enforcement |
| Community Mental Health Center (CMHC): Survey, Certification, Quality and Enforcement | Home Health Agency (HHA): Payment | Preadmission Screen and Resident Review (PASARR): Survey, Certification, Quality and Enforcement |
| Comprehensive Outpatient Rehabilitation Facilities (CORF): Payment | Home Health Agency (HHA): Survey, Certification, Quality and Enforcement | Psychiatric Residential Treatment Facility (PRTF): Survey, Certification, Quality and Enforcement |
| Comprehensive Outpatient Rehabilitation facilities (CORF): Survey, Certification, Quality and Enforcement | Home Infusion Therapy: Survey, Certification, Quality and Enforcement | Quality |
| Conditions of Participation (COP) | Hospice: Payment | Religious Nonmedical Health Care Institution Coverage (RNHCI): Payment |
| Critical Access Hospital (CAH): Survey, Certification, Quality and Enforcement | Hospice: Survey, Certification, Quality and Enforcement | Religious Nonmedical Health Care Institution Coverage (RNHCI): Survey, Certification, Quality and Enforcement |
| Critical Access Hospital (CAH): Waive the requirements that limit the number of beds to 25 and the length of stay to 96 hours | Hospital Inpatient: Payment | Replacement Prescription Fills: Permit Medicare payment for replacement prescription fills (for a quantity up to the amount originally dispensed) |
| Critical Access Hospital (CAH): Payment | Hospital Outpatient: Payment | Rural Health Clinic: Payment |
| Diabetes Self-Management: Survey, Certification, Quality and Enforcement | Hospital: Survey, Certification, Quality and Enforcement | Rural Health Clinic: Survey, Certification, Quality and Enforcement |
| Durable Medical Equipment (DME): If lost, destroyed, irreparably damaged or otherwise rendered unusable, waive requirements such that face-to-face requirements, a new physician's order and new medical necessity doc | Housing Acute Care Patients in Excluded Distinct Part Units | Safety |
| Emergency Preparedness | Inpatient Rehab Facility (IRF): Survey, Certification, Quality and Enforcement | Skilled Nursing Facility (SNF): 3-day Prior Hospitalization |
| EMTALA: Payment | Inpatient Rehab Facility (IRF): Payment | Skilled Nursing Facility (SNF): For beneficiaries who exhausted their SNF benefits, renewed SNF coverage without first having to start a new benefit period |
| | Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID): Survey, Certification, Quality and Enforcement | Skilled Nursing Facility (SNF): Timeframe for MDS assessments and transmission |
| | Intermediate Care Facility (ICF): Payment | Transplant: Payment |
| | Lab: Payment | Transplant: Survey, Certification, Quality and Enforcement |
| | Life Safety Code (LSC) | |
| | Minimum Data Set (MDS): Payment | |
| | Minimum Data Set (MDS): Survey, Certification, Quality and Enforcement | |
| | Nursing Homes (SNF/NF): Survey, | |

Help tooltips

What would you like to do?

Choose the applicable option below.

I want to submit a waiver/flexibility request [option](#)

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

"Waiver" refers to a waiver or modification of a statutory requirement of the Social Security Act (Act) or its implementing regulations that may be waived or modified under the authority of §1135 of the Act or §1812(t). A "flexibility" is an agency policy or procedure that can be adjusted under current authority - and generally speaking can be adjusted without reprogramming CMS's systems. CMS will implement these waivers and flexibilities as necessary and appropriate to accommodate the needs of those impacted by an emergency or disaster.

I want to submit an inquiry request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

I want to provide a status update on my patients and/or healthcare facility residents

You may use this option to report any impact on normal operations.

Select a Public Health Emergency

Select the applicable Public Health Emergency from the dropdown list.

Provide Your Contact Information - Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

Organization Information

An organization is an organized body of people with a particular purpose (e.g., State, Corporation, Health System, etc.). Please provide the required information for your organization.

Organization Information - State/US Territory/Federal District dropdown

Choose all applicable States, US Territories and/or Federal Districts where your healthcare facilities are located.

Organization Information - Organization Categories

This provides CMS additional information on the type of organization requesting a waiver. Please select all applicable organizations by reviewing the data on all three tabs (At least one category must be selected).

Organization Information - Identification Number

Indicate all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

Describe Your 1135 Waiver / Flexibility Request

CMS uses this information to route your request to the appropriate area for faster response.

Describe Your 1135 Waiver / Flexibility Request - Waiver Request Type dropdown

Start typing key words for your request. A list of waiver option(s) that match your key word(s) will appear to choose from.

Describe Your 1135 Waiver / Flexibility Request - Regulation Related to this Request dropdown

Cite the regulation(s) you are requesting be waived (if applicable).

Describe Your 1135 Waiver / Flexibility Request - Description

CMS uses this information to route your request to the appropriate area for faster response.

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal Form

CMS 1135 Inquiry Request

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What would you like to do? [?](#)

- I want to submit a waiver / flexibility request [?](#)
- I want to submit an inquiry request [?](#)
- I want to provide a status on my healthcare facility, patients and or residents [?](#)

Submit an inquiry

1 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 | |
|-----------------------|-------------------------|
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2 Provide Your Contact Information

This will help keep you updated on your request's progress

Point of Contact [?](#)

Who should CMS contact in response to this waiver request?

Email address (required) *

Confirm email address (required) *

First name (required) *

Last name (required) *

Zip code (required) * [?](#)

Phone number

Organization Information ?

Who is the organization making this request?

Organization name (required) *

Organization Categories ?

Who is the organization making this request?

| General | Emergency Provider / Supplier Types | Other |
|---|--|--|
| <input type="checkbox"/> Advocacy Group | <input type="checkbox"/> Department of Health and Human Services | <input type="checkbox"/> State Medicaid or CHIP Agency |
| <input type="checkbox"/> Association | <input type="checkbox"/> Medicare Advantage Plan | <input type="checkbox"/> State Survey Agency |
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| General | Emergency Provider / Supplier Types | Other |
|--|---|-------|
| <input type="checkbox"/> Ambulatory Surgical Center (ASC) | <input type="checkbox"/> Nursing Homes (SNF/NP) | |
| <input type="checkbox"/> Community Mental Health Center (CMHC) | <input type="checkbox"/> Organ Procurement Organization (DPO) | |
| <input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility (CORF) | <input type="checkbox"/> Outpatient Physical Therapy/Speech Therapy (OPT/ST) | |
| <input type="checkbox"/> Critical Access Hospital (CAH) | <input type="checkbox"/> Programs of All-Inclusive Care for Elderly (PACE) | |
| <input type="checkbox"/> End Stage Renal Disease (ESRD) | <input type="checkbox"/> Psychiatric Residential Treatment Facility (PRTF) | |
| <input type="checkbox"/> Home Health Agencies (HHA) | <input type="checkbox"/> Religious Non-Medical Health Care Institution (RNCHI) | |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC) | |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Transplant Center | |
| <input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) | | |

| General | Emergency Provider / Supplier Types | Other |
|--|-------------------------------------|--|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Palliative | |
| <input type="checkbox"/> Durable Medical Equipment (DME) | <input type="checkbox"/> Physician | |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Other | <input type="text" value="Other Organization Category"/> |

Organization Identification Numbers ?

What are the identification numbers for your organization?

Please include all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

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


IDENTIFICATION NUMBER ?

Separate multiple identification numbers with a comma.

3 Inquiry

Request #1

Topic (required) * ?

Type (required) * 

Please select a topic 

Click here if you do not see your type

Description (required) *

Provide a comprehensive description of your inquiry (including regulation citations if applicable).

 [Add another inquiry request](#)

4 Submit your inquiry

Submit

Thank You! Your request has been successfully submitted.

Your case number is <Case#>

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Drop down options

PHE

| | |
|-----------------------|-------------------------|
| 2023 Hurricane Idalia | 08/27/2023 - 11/28/2023 |
| 2023 Hawaii Wildfires | 08/08/2023 - 02/03/2024 |

Topic

Medicaid/CHIP
Medicare Advantage/Prescription Drug Plan
Original Medicare (Part A or B)
Qualified Health Plans

Type

683 Tribal Clinics
Access to Care
Academia
Advocate
Ambulatory Care Center
Ambulance
Association/Society for Provider/Facility
Appeals
Appendix K
Attorney for Provider/Facility
Billing Agency
Consultant for Provider/Facility
Critical Access Hospital
Denials
Dialysis Facility
Eligibility
Facility
Fair Hearings
Federally Qualified Health Center (FQHC)
General Public
Home Health
Hospice
Hospital
Long Term Care Services and Supports
Managed Care
Medical Supplier/DME
Nurse/Nurse Practitioner
Payment Methodology/Rates
Pharmacists/Pharmacy
Physical/Occupational Therapy
Physician
Physician Assistant
Provider Enrollment
Provider - Mental Health
Provider - Other
Respite
Rural Health Clinic
Skilled Nursing Facility
State Agency
Telehealth

Help tooltips

What would you like to do?

Choose the applicable option below.

I want to submit a waiver / flexibility request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

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I want to provide a status update on my patients and/or healthcare facility residents

You may use this option to report any impact on normal operations.

Select a Public Health Emergency

Select the applicable Public Health Emergency from the dropdown list.

Provide Your Contact Information - Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

Provide Your Contact Information - Zip Code

Please enter your five digit zip code.

Organization Information

An organization is an organized body of people with a particular purpose (e.g., State, Corporation, Health System, etc.). Please provide the required information for your organization.

Organization Information - Organization Categories

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Organization Information - Identification Number

Indicate all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

Topic

Choose your topic from the dropdown list below.

Type

Choose your inquiry type from the dropdown list below.

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal Form

CMS 1135 Medicaid/CHIP Waiver Request
Standard Waiver

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal Form

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Submit a waiver / flexibility request

1 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 ▼ | |
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| 2023 Hawaii Wildfires | 08/08/2023 - 02/03/2024 |

2 Provide Your Contact Information

This will help keep you updated on your request's progress

Point of Contact [?](#)

Who should CMS contact in response to this waiver request?

Email address (required) *

Confirm 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 x California x Ne

- Nebraska
- Nevada
- New York

Organization Categories [?](#)

Who is the organization making this request?

| General | Emergency Provider / Supplier Types | Other |
|---|--|---|
| <input type="checkbox"/> Advocacy Group | <input type="checkbox"/> Department of Health and Human Services | <input checked="" type="checkbox"/> State Medicaid or CHIP Agency |
| <input type="checkbox"/> Association | <input type="checkbox"/> Medicare Advantage Plan | <input type="checkbox"/> State Survey Agency |
| <input type="checkbox"/> Congressional Office | <input type="checkbox"/> Part D Prescription Plan | <input type="checkbox"/> Tribal Nation |
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| General | Emergency Provider / Supplier Types | Other |
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| <input type="checkbox"/> Ambulatory Surgical Center (ASC) <input type="checkbox"/> Community Mental Health Center (CMHC) <input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility (CORF) <input type="checkbox"/> Critical Access Hospital (CAH) <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> Home Health Agencies (HHA) <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital <input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) | <input type="checkbox"/> Nursing Homes (SNF/NF) <input type="checkbox"/> Organ Procurement Organization (OPO) <input type="checkbox"/> Outpatient Physical Therapy/Speech Therapy (OPT/ST) <input type="checkbox"/> Programs of All-Inclusive Care for Elderly (PACE) <input type="checkbox"/> Psychiatric Residential Treatment Facility (PRTF) <input type="checkbox"/> Religious Non-Medical Health Care Institution (RNCHI) <input type="checkbox"/> Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC) <input type="checkbox"/> Transplant Center | |

| General | Emergency Provider / Supplier Types | Other |
|--|---|--|
| <input type="checkbox"/> Ambulance <input type="checkbox"/> Durable Medical Equipment (DME) <input type="checkbox"/> Lab | <input type="checkbox"/> Palliative <input type="checkbox"/> Physician <input type="checkbox"/> Other | <input type="text" value="Other Organization Category"/> |

Background

Under section 1135 of the Social Security Act (the Act), the Secretary has the authority to temporarily waive or modify certain Medicare, Medicaid, and CHIP requirements to ensure that sufficient health care items and services are available to meet the needs of enrollees in an area affected by a federally-declared PHE. Section 1135 authority enables providers to furnish needed items and services in good faith during times of a PHE or disaster and be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

Please select all that apply


- I want to submit a general waiver
- I want to submit a Medicaid / CHIP waiver
-  Please click the above option to request a Medicaid / CHIP waiver. For all other waivers, use the 'general waiver' option.

Organization Identification Numbers

What are the identification numbers for your organization?

Please include all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

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

IDENTIFICATION NUMBER 

Separate multiple identification numbers with a comma.


3 Describe your 1135 Medicaid Waiver / Flexibility Request

Please note that unless otherwise indicated in the descriptions below, flexibilities operationalized under section 1135 authority terminate at the conclusion of the PHE.

Request #1

Waiver Request Type (required) * 

Click here if you do not see your waiver type

Description of waiver Request (required) * 

Please provide a description of the additional 1135 Medicaid 1135 waiver or modification requested by the state or territory.

4 Submit your request

Submit

Thank You! Your request has been successfully submitted.

Your Medicaid / CHIP waiver case number is <Case#>

You will also receive an email confirmation summarizing your request and providing you with additional guidance.

To report technical issues please email qnetsupport@cms.hhs.gov and note "1135 Waiver/Flexibility" in the subject line.

If you are requesting an 1135 waiver or making an Inquiry about a public health emergency, please submit your request at the [CMS PHE Emergency Web Portal](#). For all other questions, please contact Emergencies@cms.hhs.gov.

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 safeguarding protected healthcare information or data, please refer to the "HIPAA Security Rule" (<https://www.hhs.gov/hipaa/for-professionals/index.html>).

INFORMATION NOT TO BE RELEASED TO PUBLIC UNLESS AUTHORIZED BY LAW: This information is for internal Government use only and has not been publicly disclosed. It may contain information that is privileged, confidential, or otherwise protected from disclosure under public law. Do not share Personally Identifiable Information (PII) and/or Protected Health Information (PHI). Unauthorized disclosure may result in prosecution to the full extent of the law.



Drop down options

PHE

2023 Hurricane Idalia 08/27/2023 - 11/28/2023
2023 Hawaii Wildfires 08/08/2023 - 02/03/2024

State/US Territory/Federal District

| | | |
|----------------|--------------------------|-----------------|
| Alabama | Maine | Oklahoma |
| Alaska | Marshall Islands | Oregon |
| American Samoa | Maryland | Palau |
| Arizona | Massachusetts | Pennsylvania |
| Arkansas | Michigan | Rhode Island |
| California | Micronesia | South Carolina |
| Colorado | Minnesota | South Dakota |
| Connecticut | Mississippi | Tennessee |
| Delaware | Missouri | Texas |
| Florida | Montana | Utah |
| Georgia | Nebraska | Vermont |
| Guam | Nevada | Virginia |
| Hawaii | New Hampshire | Washington |
| Idaho | New Jersey | Washington D.C. |
| Illinois | New Mexico | West Virginia |
| Indiana | New York | Wisconsin |
| Iowa | North Carolina | Wyoming |
| Kansas | North Dakota | |
| Kentucky | Northern Mariana Islands | |
| Louisiana | Ohio | |

Waiver/Flexibility Request Type

| | | |
|--|---|---|
| Medicaid Authorizations-Suspend fee-for-service prior authorizations | and Provider Signatures-191 S(c) | Evaluations, Assessments and Person-Centered Service Plans-Reevaluation of 191 S(i) Eligibility |
| Medicaid Authorizations-Extend pre-existing authorizations | Long Term Services and Supports (LTSS)-Person-Centered Plan Beneficiary and Provider Signatures-191 S(i) | Long Term Services and Supports (LTSSJ-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Independent Assessment of Need |
| Long Term Services and Supports (LTSS)-PASRR | Long Term Services and Supports (LTSSJ)-Person-Centered Plan Beneficiary and Provider Signatures-191 S(k) | Long Term Services and Supports (LTSS)-1915(i) Evaluations, Assessments and Person-Centered Service Plans |
| Long Term Services and Supports (L TSSJ)-HCBS Settings Requirements-191 S(c) | Long Term Services and Supports (LTSSJ-Person-Centered Plan Beneficiary and Provider Signatures-HCBS services in approved 1115 Demonstration | Reassessments of Need Long Term Services and Supports (LTSS), 1915 (i) Evaluations, Assessments and Person-Centered Service Plans-Review and Revision of the Person-Centered Service Plan |
| Long Term Services and Supports (LTSSJ)-HCBS Settings Requirements-191 S(i) | Long Term Services and Supports (LTSS)-1915(c) Level of Care and Person-Centered Service Plan Timelines-Initial Evaluation of Need | Long Term Services and Supports (LTSSJ-1915(i) State Plan Benefit-Use of Representatives |
| Long Term Services and Supports (LTSS)-HCBS Settings Requirements-191 S(k) | Long Term Services and Supports (LTSSJ-1915(c) Level of Care and Person-Centered Service Plan Timelines-Reevaluation | Long Term Services and Supports (LTSS)-1915(i) State Plan Benefit-Initial Assessments |
| Long Term Services and Supports (LTSSJ)-HCBS Settings Requirements-HCBS services.in approved 11.15 Demonstration | Long Term Services and Supports (LTSSJ-1915(c) Level of Care and Person-Centered Service Plan Timelines-Review and Revision of Person-Centered Service Plan | Long Term Services and Supports (LTSSJ-1915(i) State Plan Benefit-Annual Reviews |
| Long Term Services and Supports (L TSSJ)-Conflict of Interest Requirements-191 S(c) | Long Term Services and Supports (LTSS)-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Evaluation of 191 S(i) Eligibility | Long Term Services and Supports (LTSSJ-1915(k) State Plan Benefit-Use of Representatives |
| Long Term Services and Supports (L TSS)-Conflict of Interest Requirements-191 S(i) | Long Term Services and Supports (LTSSJ-1915(c) Level of Care and Person-Centered Service Plan Timelines-Review and Revision of Person-Centered Service Plan | Long Term Services and Supports (LTSS)-1915(k) State Plan Benefit-Initial Assessments |
| Long Term Services and Supports (L TSSJ)-Conflict of Interest Requirements-191 S(k) | Long Term Services and Supports (LTSS)-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Evaluation of 191 S(i) Eligibility | |
| Long Term Services and Supports (LTSSJ)-Person-Centered Plan Beneficiary | Long Term Services and Supports (LTSSJ-1915(i) | |

Help tooltips

What would you like to do?

Choose the applicable option below.

I want to submit a waiver/flexibility request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

"Waiver" refers to a waiver or modification of a statutory requirement of the Social Security Act (Act) or its implementing regulations that may be waived or modified under the authority of §1135 of the Act or §1812(t). A "flexibility" is an agency policy or procedure that can be adjusted under current authority - and generally speaking can be adjusted without reprogramming CMS's systems. CMS will implement these waivers and flexibilities as necessary and appropriate to accommodate the needs of those impacted by an emergency or disaster.

I want to submit an inquiry request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

I want to provide a status update on my patients and/or healthcare facility residents

You may use this option to report any impact on normal operations.

Select a Public Health Emergency

Select the applicable Public Health Emergency from the dropdown list.

Provide Your Contact Information - Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

Medicaid or CHIP State Contact Information

This is contact information for official CMS communications.

Organization Information

An organization is an organized body of people with a particular purpose (e.g., State, Corporation, Health System, etc.). Please provide the required information for your organization.

Organization Information - State/US Territory/Federal District dropdown

Choose all applicable States, US Territories and/or Federal Districts where your healthcare facilities are located.

Provide Your Contact Information - Organization Categories

This provides CMS additional information on the type of organization requesting a waiver. Please select all applicable organizations by reviewing the data on all three tabs (At least one category must be selected).

Provide Your Contact Information - Identification Number

Indicate all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

Describe Your 1135 Medicaid Waiver / Flexibility Request

CMS uses this information to route your request to the appropriate area for faster response.

Describe Your 1135 Waiver / Flexibility Request - Waiver / Flexibility Request Type dropdown

Start typing key words for your request. A list of waiver option(s) that match your key word(s) will appear to choose from.

Describe Your 1135 Waiver / Flexibility Request - Description of Waiver Request

This description is auto-populated based on waiver type selected above. If this does not meet your needs, please select "Click here if you do not see your "Waiver Request Type" and enter your Waiver Request Type.

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal Form

CMS 1135 Medicaid/CHIP Waiver Request
Standard Waiver with Additional Information

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal 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 **0938-1384 (Expires 05/31/2024)**. 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.**

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

What would you like to do?

- I want to submit a waiver / flexibility request
- I want to submit an inquiry request
- I want to provide a status on my healthcare facility, patients and or residents

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 do not have to apply for an individual waiver. If there is no blanket waiver, providers can ask for an individual Section 1135 waiver.

Submit a waiver / flexibility request

1 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 | |
|-----------------------|-------------------------|
| 2023 Hurricane Idalia | 08/27/2023 - 11/28/2023 |
| 2023 Hawaii Wildfires | 08/08/2023 - 02/03/2024 |

2 Provide Your Contact Information

This will help keep you updated on your request's progress

Point of Contact

Who should CMS contact in response to this waiver request?

Email address (required) *

Confirm 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 x California x Ne

- Nebraska
- Nevada
- New York

Organization Categories [?](#)

Who is the organization making this request?

| General | Emergency Provider / Supplier Types | Other |
|---|--|---|
| <input type="checkbox"/> Advocacy Group | <input type="checkbox"/> Department of Health and Human Services | <input checked="" type="checkbox"/> State Medicaid or CHIP Agency |
| <input type="checkbox"/> Association | <input type="checkbox"/> Medicare Advantage Plan | <input type="checkbox"/> State Survey Agency |
| <input type="checkbox"/> Congressional Office | <input type="checkbox"/> Part D Prescription Plan | <input type="checkbox"/> Tribal Nation |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> State Government | |

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

| General | Emergency Provider / Supplier Types | Other |
|--|-------------------------------------|--|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Palliative | |
| <input type="checkbox"/> Durable Medical Equipment (DME) | <input type="checkbox"/> Physician | |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Other | |
| | | <input type="text" value="Other Organization Category"/> |

1 Background

Under section 1135 of the Social Security Act (the Act), the Secretary has the authority to temporarily waive or modify certain Medicare, Medicaid, and CHIP requirements to ensure that sufficient health care items and services are available to meet the needs of enrollees in an area affected by a federally-declared PHE. Section 1135 authority enables providers to furnish needed items and services in good faith during times of a PHE or disaster and be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

Please select all that apply

I want to submit a general waiver

I want to submit a Medicaid / CHIP waiver

1 Please click the above option to request a Medicaid / CHIP waiver. For all other waivers, use the 'general waiver' option.

Organization Identification Numbers ?

What are the identification numbers for your organization?

Please include all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

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

IDENTIFICATION NUMBER ?

Separate multiple identification numbers with a comma.

3 Describe your 1135 Medicaid Waiver / Flexibility Request

Please note that unless otherwise indicated in the descriptions below, flexibilities operationalized under section 1135 authority terminate at the conclusion of the PHE.

Request #1

Waiver Request Type (required) * ?

Click here if you do not see your waiver type

Description of waiver Request (required) * ?

Please provide a description of the additional 1135 Medicaid 1135 waiver or modification requested by the state or territory.

Additional Information (required) * ?

[+ Add another waiver request](#)

4 Submit your request

Submit

Thank You! Your request has been successfully submitted.

Your Medicaid / CHIP waiver case number is <Case#>

You will also receive an email confirmation summarizing your request and providing you with additional guidance.

To report technical issues please email qnetsupport@cms.hhs.gov and note "1135 Waiver/Flexibility" in the subject line.

If you are requesting an 1135 waiver or making an Inquiry about a public health emergency, please submit your request at the [CMS PHE Emergency Web Portal](#). For all other questions, please contact Emergencies@cms.hhs.gov.

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INFORMATION NOT TO BE RELEASED TO PUBLIC UNLESS AUTHORIZED BY LAW: This information is for internal Government use only and has not been publicly disclosed. It may contain information that is privileged, confidential, or otherwise protected from disclosure under public law. Do not share Personally Identifiable Information (PII) and/or Protected Health Information (PHI). Unauthorized disclosure may result in prosecution to the full extent of the law.

CMS 1135 Waiver/Flexibility Request and Inquiry



A federal government website managed and paid for by the U.S Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore MD 21244

Drop down options

PHE

2023 Hurricane Idalia 08/27/2023 - 11/28/2023

2023 Hawaii Wildfires 08/08/2023 - 02/03/2024

State/US Territory/Federal District

| | | |
|----------------|--------------------------|-----------------|
| Alabama | Maine | Oklahoma |
| Alaska | Marshall Islands | Oregon |
| American Samoa | Maryland | Palau |
| Arizona | Massachusetts | Pennsylvania |
| Arkansas | Michigan | Rhode Island |
| California | Micronesia | South Carolina |
| Colorado | Minnesota | South Dakota |
| Connecticut | Mississippi | Tennessee |
| Delaware | Missouri | Texas |
| Florida | Montana | Utah |
| Georgia | Nebraska | Vermont |
| Guam | Nevada | Virginia |
| Hawaii | New Hampshire | Washington |
| Idaho | New Jersey | Washington D.C. |
| Illinois | New Mexico | West Virginia |
| Indiana | New York | Wisconsin |
| Iowa | North Carolina | Wyoming |
| Kansas | North Dakota | |
| Kentucky | Northern Mariana Islands | |
| Louisiana | Ohio | |

Waiver/Flexibility Request Type

| | | |
|---|---|---|
| Medicaid Authorizations-Suspend fee-for-service prior authorizations | and Provider Signatures-191 S(c) | Evaluations, Assessments and Person-Centered Service Plans-Reevaluation of 191 S(i) Eligibility |
| Medicaid Authorizations-Extend pre-existing authorizations | Long Term Services and Supports (LTSS)-Person-Centered Plan Beneficiary and Provider Signatures-191 S(i) | Long Term Services and Supports (LTSSJ-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Independent Assessment of Need |
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| Long Term Services and Supports (L TSSJ -HCBS Settings Requirements-191 S(c) | Long Term Services and Supports (LTSSJ-Person-Centered Plan Beneficiary and Provider Signatures-HCBS services in approved 1115 Demonstration | Reassessments of Need Long Term Services and Supports |
| Long Term Services and Supports (LTSSJ-HCBS Settings Requirements-191 S(i) | Long Term Services and Supports (LTSS)-1915(c) Level of Care and Person-Centered Service Plan Timelines-Initial Evaluation of Need | (LTSS), 1915 (i) Evaluations, Assessments and Person-Centered Service Plans-Review and Revision of the Person-Centered Service Plan |
| Long Term Services and Supports (L TSSJ)-HCBS Settings Requirements-HCBS services in approved 11.15 Demonstration | Long Term Services and Supports (LT55)-1915(c) Level of Care and Person-Centered Service Plan Timelines-Reevaluation | Long Term Services and Supports (LTSSJ-1915(i) State Plan Benefit-Use of Representatives |
| Long Term Services and Supports (L TSSJ)-Conflict of Interest Requirements-191 S(c) | Long Term Services and Supports (LTSSJ-1915(c) Level of Care and Person-Centered Service Plan Timelines-Review and Revision of Person-Centered Service Plan | Long Term Services and Supports (LTSS)-1915(i) State Plan Benefit-Initial Assessments |
| Long Term Services and Supports (L TSSJ -Conflict of Interest Requirements-191 S(k) | Long Term Services and Supports (LTSS)-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Evaluation of 191 S(i) Eligibility | Long Term Services and Supports (LT55)-1915(i) State Plan Benefit-Annual Reviews |
| Long Term Services and Supports (LT55)-Conflict of Interest Requirements-HCBS services in approved 1115 Demonstration | Long Term Services and Supports (LT55)-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Evaluation of 191 S(i) Eligibility | Long Term Services and Supports (LTSSJ-1915(k) State Plan Benefit-Use of Representatives |
| Long Term Services and Supports (LTSSJ-Person-Centered Plan Beneficiary | Long Term Services and Supports (LT55)-1915(i) | Long Term Services and Supports (LTSS)-1915(k) State Plan Benefit-Initial Assessments |

Help tooltips

What would you like to do?

Choose the applicable option below.

I want to submit a waiver/flexibility request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

"Waiver" refers to a waiver or modification of a statutory requirement of the Social Security Act (Act) or its implementing regulations that may be waived or modified under the authority of §1135 of the Act or §1812(t). A "flexibility" is an agency policy or procedure that can be adjusted under current authority - and generally speaking can be adjusted without reprogramming CMS's systems. CMS will implement these waivers and flexibilities as necessary and appropriate to accommodate the needs of those impacted by an emergency or disaster.

I want to submit an inquiry request option

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I want to provide a status update on my patients and/or healthcare facility residents

You may use this option to report any impact on normal operations.

Select a Public Health Emergency

Select the applicable Public Health Emergency from the dropdown list.

Provide Your Contact Information - Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

Medicaid or CHIP State Contact Information

This is contact information for official CMS communications.

Organization Information

An organization is an organized body of people with a particular purpose (e.g., State, Corporation, Health System, etc.). Please provide the required information for your organization.

Organization Information - State/US Territory/Federal District dropdown

Choose all applicable States, US Territories and/or Federal Districts where your healthcare facilities are located.

Provide Your Contact Information - Organization Categories

This provides CMS additional information on the type of organization requesting a waiver. Please select all applicable organizations by reviewing the data on all three tabs (At least one category must be selected).

Provide Your Contact Information - Identification Number

Indicate all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

Describe Your 1135 Medicaid Waiver / Flexibility Request

CMS uses this information to route your request to the appropriate area for faster response.

Describe Your 1135 Waiver / Flexibility Request - Waiver / Flexibility Request Type dropdown

Start typing key words for your request. A list of waiver option(s) that match your key word(s) will appear to choose from.

Describe Your 1135 Waiver / Flexibility Request - Description of Waiver Request

This description is auto-populated based on waiver type selected above. If this does not meet your needs, please select "Click here if you do not see your "Waiver Request Type" and enter your Waiver Request Type.


CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal Form


CMS 1135 Medicaid/CHIP Waiver Request
Other Waiver with Applicable Regulation


CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal 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 **0938-1384 (Expires 05/31/2024)**. 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.**

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

What would you like to do? 

I want to submit a waiver / flexibility request 

I want to submit an inquiry request 

I want to provide a status on my healthcare facility, patients and or residents 

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When a blanket waiver is issued, providers do not have to apply for an individual waiver. If there is no blanket waiver, providers can ask for an individual Section 1135 waiver.

Submit a waiver / flexibility request

1 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 | |
|-----------------------|-------------------------|
| 2023 Hurricane Idalia | 08/27/2023 - 11/28/2023 |
| 2023 Hawaii Wildfires | 08/08/2023 - 02/03/2024 |

2 Provide Your Contact Information

This will help keep you updated on your request's progress

Point of Contact 

Who should CMS contact in response to this waiver request?

Email address (required) *

Confirm 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 x California x Ne

- Nebraska
- Nevada
- New York

Organization Categories ?

Who is the organization making this request?

| General | Emergency Provider / Supplier Types | Other |
|---|--|---|
| <input type="checkbox"/> Advocacy Group | <input type="checkbox"/> Department of Health and Human Services | <input checked="" type="checkbox"/> State Medicaid or CHIP Agency |
| <input type="checkbox"/> Association | <input type="checkbox"/> Medicare Advantage Plan | <input type="checkbox"/> State Survey Agency |
| <input type="checkbox"/> Congressional Office | <input type="checkbox"/> Part D Prescription Plan | <input type="checkbox"/> Tribal Nation |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> State Government | |

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

| General | Emergency Provider / Supplier Types | Other |
|--|-------------------------------------|--|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Palliative | |
| <input type="checkbox"/> Durable Medical Equipment (DME) | <input type="checkbox"/> Physician | |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Other | |
| | | <input type="text" value="Other Organization Category"/> |

1 Background

Under section 1135 of the Social Security Act (the Act), the Secretary has the authority to temporarily waive or modify certain Medicare, Medicaid, and CHIP requirements to ensure that sufficient health care items and services are available to meet the needs of enrollees in an area affected by a federally-declared PHE. Section 1135 authority enables providers to furnish needed items and services in good faith during times of a PHE or disaster and be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

Please select all that apply

I want to submit a general waiver

I want to submit a Medicaid / CHIP waiver

1 Please click the above option to request a Medicaid / CHIP waiver. For all other waivers, use the 'general waiver' option.

Medicaid or CHIP State Contact Information ?

This is contact information for official CMS communications

State Official title (required) *

This is the Medicaid or CHIP designee for official CMS communications

State Agency name (required) *

State Official first name (required) *

State Official last name (required) *

State Official suffix

Examples, including, JD, MD, PhD, RN

State Agency address (required) *

Address 2

City (required) *

State/US Territory/Federal District (required) *

Zip code (required) *

XXXXX

State Agency email address (required) *

Confirm State Agency email address (required) *

3 Describe your 1135 Medicaid Waiver / Flexibility Request

Please note that unless otherwise indicated in the descriptions below, flexibilities operationalized under section 1135 authority terminate at the conclusion of the PHE.

Request #1

Waiver Request Type (required) * ?

Click here if you do not see your waiver type

Description of waiver Request (required) * ?

Please provide a description of the additional 1135 Medicaid 1135 waiver or modification requested by the state or territory.

Applicable Regulation (required)*

Please include the regulatory citation(s) associated with this request.

[+ Add another waiver request](#)

4 Submit your request

Submit

Thank You! Your request has been successfully submitted.

Your Medicaid / CHIP waiver case number is <Case#>

You will also receive an email confirmation summarizing your request and providing you with additional guidance.

To report technical issues please email qnetsupport@cms.hhs.gov and note "1135 Waiver/Flexibility" in the subject line.

If you are requesting an 1135 waiver or making an Inquiry about a public health emergency, please submit your request at the [CMS.PHE Emergency Web Portal](#). For all other questions, please contact Emergencies@cms.hhs.gov.

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 safeguarding protected healthcare information or data, please refer to the "HIPAA Security Rule" (<https://www.hhs.gov/hipaa/for-professionals/index.html>).

INFORMATION NOT TO BE RELEASED TO PUBLIC UNLESS AUTHORIZED BY LAW: This information is for internal Government use only and has not been publicly disclosed. It may contain information that is privileged, confidential, or otherwise protected from disclosure under public law. Do not share Personally Identifiable Information (PII) and/or Protected Health Information (PHI). Unauthorized disclosure may result in prosecution to the full extent of the law.



Drop down options

PHE

2023 Hurricane Idalia 08/27/2023 - 11/28/2023
2023 Hawaii Wildfires 08/08/2023 - 02/03/2024

State/US Territory/Federal District

| | | |
|----------------|--------------------------|-----------------|
| Alabama | Maine | Oklahoma |
| Alaska | Marshall Islands | Oregon |
| American Samoa | Maryland | Palau |
| Arizona | Massachusetts | Pennsylvania |
| Arkansas | Michigan | Rhode Island |
| California | Micronesia | South Carolina |
| Colorado | Minnesota | South Dakota |
| Connecticut | Mississippi | Tennessee |
| Delaware | Missouri | Texas |
| Florida | Montana | Utah |
| Georgia | Nebraska | Vermont |
| Guam | Nevada | Virginia |
| Hawaii | New Hampshire | Washington |
| Idaho | New Jersey | Washington D.C. |
| Illinois | New Mexico | West Virginia |
| Indiana | New York | Wisconsin |
| Iowa | North Carolina | Wyoming |
| Kansas | North Dakota | |
| Kentucky | Northern Mariana Islands | |
| Louisiana | Ohio | |

Waiver/Flexibility Request Type

| | | |
|---|--|--|
| Medicaid Authorizations-Suspend fee-for-service prior authorizations | and Provider Signatures-191 S(c) | Evaluations, Assessments and Person-Centered Service Plans-Reevaluation of 191 S(i) Eligibility |
| Medicaid Authorizations-Extend pre-existing authorizations | Long Term Services and Supports (LTSS)-Person-Centered Plan Beneficiary and Provider Signatures-191 S(i) | Long Term Services and Supports (LTSSJ-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Independent Assessment of Need |
| Long Term Services and Supports (LTSS)-PASRR | Long Term Services and Supports (LTSSJ)-Person-Centered Plan Beneficiary and Provider Signatures-191 S(k) | Long Term Services and Supports (LTSS)-1915(i) Evaluations, Assessments and Person-Centered Service Plans |
| Long Term Services and Supports (L ISSJ)-HCBS Settings Requirements-191 S(c) | Long Term Services and Supports (LTSSJ)-Person-Centered Plan Beneficiary and Provider Signatures-HCBS services in approved 1115 Demonstration | Reassessments of Need Long Term Services and Supports (LTSS) 1915 (i) Evaluations, Assessments and Person-Centered Service Plans-Review and Revision of the Person-Centered Service Plan |
| Long Term Services and Supports (LTSS)-HCBS Settings Requirements-191 S(i) | Long Term Services and Supports (LTSS)-1915(c) Level of Care and Person-Centered Service Plan Timelines-Initial Evaluation of Need | Long Term Services and Supports (LTSSJ-1915(i) State Plan Benefit-Use of Representatives |
| Long Term Services and Supports (LTSS)-HCBS Settings Requirements-191 S(k) | Long Term Services and Supports (LTSSJ)-1915(c) Level of Care and Person-Centered Service Plan Timelines-Reevaluation | Long Term Services and Supports (LTSS)-1915(i) State Plan Benefit-Initial Assessments |
| Long Term Services and Supports (L ISSJ)-HCBS Settings Requirements-HCBS services in approved 11.15 Demonstration | Long Term Services and Supports (LTSSJ)-1915(c) Level of Care and Person-Centered Service Plan Timelines-Review and Revision of Person-Centered Service Plan | Long Term Services and Supports (LT55)-1915(i) State Plan Benefit-Annual Reviews |
| Long Term Services and Supports (L TSSJ)-Conflict of Interest Requirements-191 S(c) | Long Term Services and Supports (LTSSJ)-1915(c) Level of Care and Person-Centered Service Plan Timelines-Review and Revision of Person-Centered Service Plan | Long Term Services and Supports (LTSSJ-1915(k) State Plan Benefit-Use of Representatives |
| Long Term Services and Supports (L TSS)-Conflict of Interest Requirements-191 S(i) | Long Term Services and Supports (LTSSJ)-1915(c) Level of Care and Person-Centered Service Plan Timelines-Review and Revision of Person-Centered Service Plan | Long Term Services and Supports (LTSS)-1915(k) State Plan Benefit-Initial Assessments |
| Long Term Services and Supports (L ISSJ)-Conflict of Interest Requirements-191 S(k) | Long Term Services and Supports (LTSS)-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Evaluation of 191 S(i) Eligibility | |
| Long Term Services and Supports (LT55)-Conflict of Interest Requirements-HCBS services in approved 1115 Demonstration | Long Term Services and Supports (LT55)-1915(i) Evaluations, Assessments and Person-Centered Service Plans-Initial Evaluation of 191 S(i) Eligibility | |
| Long Term Services and Supports (LTSSJ)-Person-Centered Plan Beneficiary | Long Term Services and Supports (LT55)-1915(i) | |

Help tooltips

What would you like to do?

Choose the applicable option below.

I want to submit a waiver/flexibility request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

"Waiver" refers to a waiver or modification of a statutory requirement of the Social Security Act (Act) or its implementing regulations that may be waived or modified under the authority of §1135 of the Act or §1812(t). A "flexibility" is an agency policy or procedure that can be adjusted under current authority - and generally speaking can be adjusted without reprogramming CMS's systems. CMS will implement these waivers and flexibilities as necessary and appropriate to accommodate the needs of those impacted by an emergency or disaster.

I want to submit an inquiry request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

I want to provide a status update on my patients and/or healthcare facility residents

You may use this option to report any impact on normal operations.

Select a Public Health Emergency

Select the applicable Public Health Emergency from the dropdown list.

Provide Your Contact Information - Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

Medicaid or CHIP State Contact Information

This is contact information for official CMS communications.

Organization Information

An organization is an organized body of people with a particular purpose (e.g., State, Corporation, Health System, etc.). Please provide the required information for your organization.

Organization Information - State/US Territory/Federal District dropdown

Choose all applicable States, US Territories and/or Federal Districts where your healthcare facilities are located.

Provide Your Contact Information - Organization Categories

This provides CMS additional information on the type of organization requesting a waiver. Please select all applicable organizations by reviewing the data on all three tabs (At least one category must be selected).

Provide Your Contact Information - Identification Number

Indicate all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

Describe Your 1135 Medicaid Waiver / Flexibility Request

CMS uses this information to route your request to the appropriate area for faster response.

Describe Your 1135 Waiver / Flexibility Request - Waiver / Flexibility Request Type dropdown

Start typing key words for your request. A list of waiver option(s) that match your key word(s) will appear to choose from.

Describe Your 1135 Waiver / Flexibility Request - Description of Waiver Request

This description is auto-populated based on waiver type selected above. If this does not meet your needs, please select "Click here if you do not see your "Waiver Request Type" and enter your Waiver Request Type.

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal Form




Health Care Facility Status

CMS 1135 Waiver / Flexibility Request and Inquiry Web Portal 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 **0938-1384 (Expires 05/31/2024)**. 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.**

Sometimes the normal operations of a healthcare provider are disrupted by emergencies or disasters. Please document the current status of your organization including impact to beneficiaries.

What would you like to do?

- I want to submit a waiver / flexibility request 
- I want to submit an inquiry request 
- I want to provide a status on my health care facility, patients and or residents 

Provide a status update

1 Emergency Information

Type of emergency

Select the applicable emergency event below.

Emergency event (required) * 

2 Facility Information

Organization Information

Please provide the required information for your organization below.

CMS Certification Number (CCN) 

Organization name (required) *

Organization category (required) * 

Click here if you do not see your organization category

ZIP code (required) *

City (required) *

State/US Territory/Federal District (required) *

Operational status (required) *

Evacuation status**Do you have sufficient staffing?** (required) *

Please let us know if your staffing numbers are sufficient to care for your patients.

 No - we do not have sufficient staffing to care for our residents Yes - we have sufficient staffing to care for our residents**Patient/Resident Information**

Please provide the following information about your patients or residents in your facility.

Number of beds or stations (if applicable)**Number of patients/residents with injuries****Number of patient/resident fatalities****Facility census information**

Please provide us with the details below regarding total number of patients or residents in your facility and their disposition when applicable.

Census (required) ***Number of patients/residents evacuated to Health Care Facilities (HCFs)**Percentage of patients/residents evacuated to **Health Care Facilities (HCFs):****50%****Number of patients/residents evacuated to Non-Health Care Facilities (HCFs)**Percentage of patients/residents evacuated to **Non-Health Care Facilities (HCFs):****25%****Number of patients/residents evacuated with family members/caregiver**Percentage of patients/residents evacuated **with families:****24%****Number of patients/residents evacuated**Percentage of patients/residents **evacuated:****99%****Number of patients/residents repatriated**Percentage of patients/residents **repatriated:****1%****Point of Contact** 

Please provide reliable contact information to minimize delay or disruption of direct communication and updates on the facility's operational status.

Email address (required) ***Confirm email address** (required) ***First name** (required) ***Last name** (required) ***Phone number**

3 Impact to Facility ?

Please complete the following fields to notify us of your current status to facilitate the provision of aid from Federal resources.

Structural damage?

Select for yes

Select the type of damage (required) *

There is an area below where you can describe the damage.

- Minor damage
- Major damage
- Destroyed

Power loss?

Select for yes

Current source of power (required) *

- Commercial
- Generator

Generator type (required) * ?

Select the type of generator

Remaining fuel (required) * ?

Select the number of hours of remaining fuel

Health Care Microgrid System (HCMS)

- Mixed
- Unknown
- No Power

HVAC loss?

Select for yes

Is the HVAC on a generator backup? (required) *

- No
- Yes

Select the HVAC loss type (required) *

- Partial HVAC loss
- Full loss of HVAC

Other impacts to facility

- No Access (Road closure) Sewer Outage Supply / Equipment concerns
- Telephone Outage Water Outage Other

Details of the Health Care Facility Status (including anticipated needs during emergency)

- Cyber security status Equipment needs Fuel needs
- Patient/Resident needs Repair status Staffing needs
- Supply needs Water needs Other

Submit

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CMS Healthcare Facility Status Form



A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore MD 21244

Drop down options

Emergency event

Hurricanes
Flooding
Wildfires
Mudslides
Tornadoes
Earthquakes

Volcanoes
Cyber Security
Pandemic Event (e.g., H1 N1,
COVID-19, etc.)
Fire
Power Outage

Chemical Spill
Nuclear or Biological Terrorist
Attack
Shootings
Other

Organization Category

Ambulatory Surgical Center (ASC)
Community Mental Health Center (CMHC)
Comprehensive Outpatient Rehabilitation Facility (CORF)
Critical Access Hospital (CAH)
Community Mental Health Center (CMHC)
End Stage Renal Disease (ESRD)
Home Health Agencies (HHA)
Hospice
Hospital
Intermediate Care Facility for Individuals with Intellectual
Disabilities (ICF/11D)

Nursing Homes (SNF/NF)
Organ Procurement Organization (OPO)
Outpatient Physical Therapy/Speech Therapy (OPT/ST)
Programs of All-Inclusive Care for Elderly (PACE)
Psychiatric Residential Treatment Facility (PRTF)
Religious Non-Medical Health Care Institution (RNCHI)
Rural Health Clinic/Federally Qualified Health Center
(RHC/FQHC)
Transplant Center
Other

State/US Territory/Federal District

Alabama
Alaska
American Samoa
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Florida
Georgia
Guam
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana

Maine
Marshall Islands
Maryland
Massachusetts
Michigan
Micronesia
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Northern Mariana Islands
Ohio

Oklahoma
Oregon
Palau
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
Washington D.C.
West Virginia
Wisconsin
Wyoming

Operational status

Fully Operational Partially Operational Closed Unknown

Evacuation status

Fully Evacuated Shelter in Place (SIP)
Partially Evacuated Re-Patriation Relocated
Unknown

Generator Type

Diesel Propane Combination
Gasoline Natural Unknown

Remaining Fuel

Less than 24 hours 48 to 72 hours More than 96 hours
24 to 48 hours 72 to 96 hours Unknown

Help tooltips

What would you like to do?

Choose the applicable option below.

I want to submit a waiver/flexibility request [option](#)

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Emergency Event

This option should be used if your facility has been impacted by an emergency event that has not been declared a PHE.

Facility Information - Organization Information

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Facility Information - CMS Certification Number (CCN)

Indicate the applicable identification number for the healthcare facility/provider affiliated with your organization impacted by the emergency event.

Facility Information - Organization Category

This provides CMS additional information on the type of organization providing this healthcare facility status information.

Provide Your Contact Information - Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

Impact to Facility

Physical, electrical, power, environmental, etc. impacts to facility.

Generator Type

Identification of the fuel used to support the backup power supply via the generator.

Remaining Fuel

Selection of what remaining hour ranges apply to the amount of fuel available for the generator.