

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <b>Health Resources and Services Administration</b>  <b>FORM 6B: REQUEST FOR WAIVER OF BOARD MEMBER REQUIREMENTS</b>	<b>FOR HRSA USE ONLY</b>	
	<b>Grant Number</b>	<b>Application Tracking Number</b>

Note: This form is applicable if you are proposing to serve only special populations (i.e., HCH,MHC, and/or PHPC)

**Request for Waiver**

Name of Organization Will pre-populate in EHB

**1. New Waiver Request**

Are you requesting a new waiver of the 51% patient majority governance requirement? ☐ Yes ☐ No

**2. For Applicants with Previous Waiver**

2a. Do you currently have a waiver of the 51% patient majority governance requirement? ☐ Yes ☐ No

2b. Are you requesting the patient majority waiver to be continued? ☐ Yes ☐ No (Governing board is in full compliance)  
(This question is required if you answered yes to question 2a.)

**3. Demonstration of Good Cause for Waiver**  
(Demonstrate good cause for the waiver request by addressing the following areas)

3a. Provide a description of the population to be served and the characteristics of the population/service area that would necessitate a waiver.  
This question is required if you answered 'Yes' to question 1 and/or question 2b.)  
(maximum 1,000 characters)

3b. Provide a description of the health center's attempts to meet the requirement to date and explain why these attempts have not been successful.  
This question is required if you answered 'Yes' to question 1 and/or question 2b.)  
(maximum 1,000 characters)

**4. Alternative Mechanism Plan for Addressing Patient Representation**

Present a plan for complying with the intent of the statute via an alternative mechanism that ensures patient input and participation in the organization, as well as direction and ongoing governance of the health center.  
(This question is required if you answered 'Yes' to question 1 and/or question 2b.)  
(maximum 1,000 characters)