CHILDREN & FAMILIES

Office of Refugee Resettlement Waiver Request

VERSION 2 (REVISED MM/DD/YYYY)

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to allow care providers, as well as home study and post-release service providers, to request a waiver of a regulatory, policy, procedure, or cooperative agreement requirement when appropriately justified and when the safety and well-being of children in Office of Refugee Resettlement custody will not be adversely affected. Public reporting burden for this collection of information is estimated to average 0.33 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (Homeland Security Act, 6 U.S.C. 279). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB control number is 0970-0547 and the expiration date is MM/DD/YYYY. If you have any comments on this collection of information please contact UACPolicy@acf.hhs.gov.

Next

CHILDREN & FAMILIES

Office of Refugee Resettlement (ORR) Waiver Request

* Required

Provider Information

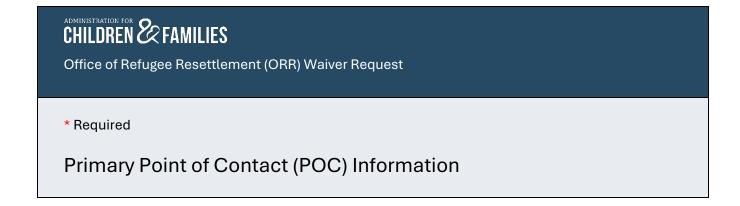
Provider Name *

Enter your answer

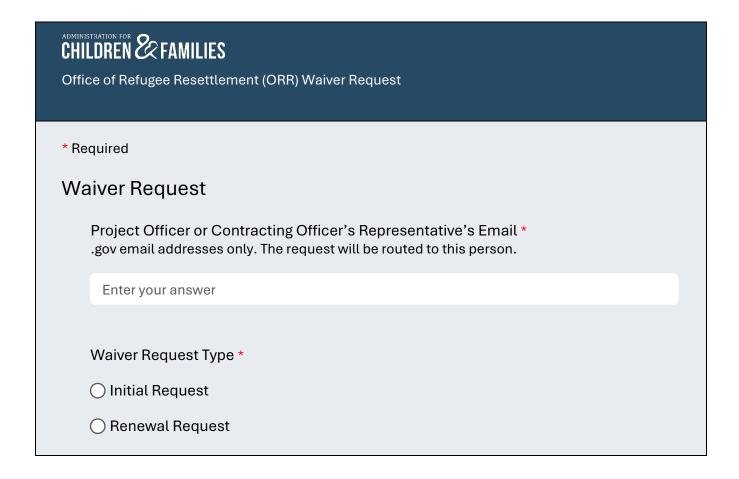
Provider Address *

Enter your answer

Provider Type		
Care Provider Facility		
O Home Study or Post-Release Service Pro	vider	
Out-of-Network Facility		
Out-of-Network Level of Care *	Only appears if user selects "Out-of- Network Facility" above	
Enter your answer		
Level of Care * Only appears if the control of the	user selects "Care Provider Facility" above	
Emergency or Influx Care Facility (EIF)		
Shelter		
Group Home		
Transitional Foster Care (TFC)		
☐ Long-Term Foster Care (LTFC)		
Heightened Supervision Facility		
Secure		
Residential Treatment Center (RTC)		
☐ Therapeutic Group Home		
Next		



DOO N		_
POC N	iame *	
Enter	your answer	
POC Pł	hone Number *	
Enter	r your answer	
POC Er	mail *	
Enter	r your answer	
POC Ti	itle *	
Enter	r your answer	
Next		



Date of Initial Request *	Only appears if user selects "Renewal Request" above
Enter your answer	
Requested Timeframe of Waiver *	
Enter your answer	
Specific Waiver Being Requested *	
Enter your answer	
Why is the waiver needed? * Include the specific provision you are made to rectify the issue prior to subr	unable to meet and why along with a description of effonitting this waiver.
Enter your answer	
	ns can be implemented to maintain quality or reducing requirements that will be adhered to? *
Enter your answer	
Was a supervision or training plan	developed as part of this waiver request? *
Yes	
○ No	
Upload the supervision or training	plan * Only appears if user selects "Yes" above
T Upload file	
	3 Allowed files types: Word, Excel, PPT, PDF, Image, Video, Auc

