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

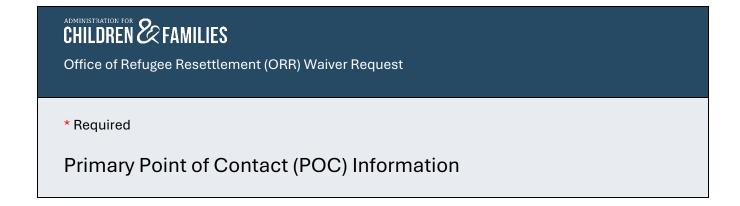
Provider Name *

Enter your answer

Provider Address *

Enter your answer

Provider Type			
Care Provider Facility	○ Care Provider Facility ○ Home Study or Post-Release Service Provider		
O Home Study or Post-Release Service Prov			
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 us	ser selects "Care Provider Facility" above		
☐ Emergency or Influx Care Facility (EIF)			
Shelter			
Group Home			
☐ Transitional Foster Care (TFC)			
☐ Long-Term Foster Care (LTFC)	☐ Long-Term Foster Care (LTFC)		
☐ Heightened Supervision Facility			
Secure			
Residential Treatment Center (RTC)			
☐ Therapeutic Group Home			
Next			



	POC Name *	
	Enter your answer	
	POC Phone Number *	
	Enter your answer	
	POC Email *	
	Enter your answer	
	POC Title *	
	Enter your answer	
	Next	



Date of Initial Request *	Only appears if user selects "Renewal Request" above
Enter your answer	
Requested Timeframe of Waiver	k
Enter your answer	
Specific Waiver Being Requested	*
Enter your answer	
Why is the waiver needed? * Include the specific provision you ar made to rectify the issue prior to sub	re unable to meet and why along with a description of effoomitting this waiver.
Enter your answer	
What other provisions or mitigations can be implemented to maintain quality or rerisk, including related state licensing requirements that will be adhered to? *	
Enter your answer	
Was a supervision or training plan	n developed as part of this waiver request? *
○Yes	
○No	
	g plan * Only appears if user selects "Yes" above
Upload the supervision or training	B ptan * Only appears it user selects fes above
T Upload file	
number limit: 1 Single file size limit: 100M	ив Allowed files types: Word, Excel, PPT, PDF, Image, Video, Aud

