

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 6B: REQUEST FOR WAIVER OF BOARD MEMBER REQUIREMENTS	FOR HRSA USE ONLY	
	Grant Number	Application Tracking Number
Note: This form is applicable if you are proposing to serve only Homeless Populations, Migrant and Seasonal Agricultural Workers, or Residents of Public Housing.		
Request for Waiver		
Name of Organization		
1. New Waiver Request		
Are you requesting a new waiver of the 51% patient majority governance requirement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. For Applicants with Previous Waiver		
2a. Do you currently have a waiver of the 51% patient majority governance requirement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2b. Are you requesting the patient majority waiver to be continued? (This question is required if you answered yes to question 2a.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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 or question 2b.) (maximum 3,000 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 or question 2b.) (maximum 3,000 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 or question 2b.) (maximum 3,000 characters)		

Public Burden Statement: Health centers (section 330 grant funded and Federally Qualified Health Center look-alikes) are patient-directed organizations that deliver affordable, accessible, quality, and cost-effective primary health care services to patients and adjust fees based on income and family size. The Health Center Program application forms provide essential information to HRSA staff and objective review committee panels for application evaluation; funding recommendation and approval; designation; and monitoring. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0285 and it is valid until XX/XX/202X. This information collection is mandatory under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act ([42 U.S.C. 254b](#)). Public reporting

burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Information Collection Clearance Officer, 5600 Fishers Lane, Room 13N82, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please see <https://www.hrsa.gov/about/508-resources> for the HRSA digital accessibility statement.