Request for Federal 1135 Waiver

Date:

Name of facility:

Street address:

City:

ZIP code:

County:

Provider type:

□ Hospital

□ Critical Access Hospital

□ Psychiatric Hospital

□ Other:

CMS Certification Number (CCN) (Medicare Provider Number):

Describe the disaster or emergency:

Describe why the waiver is needed:

Describe the type of relief you are seeking or the regulatory requirements or references to be waived:

Name of hospital employee who can respond to follow-up questions:

Contact information:

Landline phone:

Cell phone:

Email:

This form should be emailed to RODALDSC@cms.hhs.gov.

NOTE: Use of this form is not required but is meant to be a helpful tool to request 1135 waivers.