NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facilities
Medical Equipment Waiver Checklist

The Department of Health provides this Medical Equipment Waiver Checklist to assist adult care facilities in the submission of resident-specific medical equipment waivers. Please note that all documentation and information requested below must be provided and the checklist must be completed and attached to the waiver request for Department review and consideration. Waivers without a completed checklist will be returned unreviewed.

Adult Care Facility Use		For Department of Health Use ONLY
Check if Included	Requirements for All Waivers	
☐	**Resident:** • First and Last Name: • Level of Care (check all that apply): ☐ AH ☐ EHP ☐ ALP ☐ ALR ☐ EALR ☐ SNALR	Comments: Reviewer Initials:
☐	**Proof of Justification/Need:** • A copy of the **order from the resident's primary care physician** indicating medical need for the specific medical equipment for which the waiver is sought. *Please note, such order must be renewed not less than annually, upon change in condition and with each new medical evaluation. The order must be present in the resident's medical record and available upon request by the Department.* • **Statement of Need/Medical Justification** ☐ DOH-4235B ACF Medical Equipment Waiver Addendum. **OR** ☐ If ordered by the resident's primary care physician, a copy of the physical therapist or occupational therapist assessment for the specific medical equipment for which the waiver is sought.	Comments: Reviewer Initials:
☐	**Evaluation of Safe and Independent Use:** • A note in the resident's record confirming the resident was initially evaluated by a registered nurse, physical therapist or occupational therapist, indicating performance of an evaluation and the resident's ability to safely and independently** self-manage and use the specific medical equipment for which the waiver is sought. The statement must be present in the resident's medical record and available upon request by the Department.	Comments: Reviewer Initials:
☐	**Policies and Procedures:** • The facility's policy and procedure including, but not limited to, the following: 1) How the specific equipment ordered will be installed and maintained properly with routine preventative maintenance checks for safety per manufacturer's instructions. 2) Individual(s) responsible for the installation of the specifically ordered equipment. 3) Individual(s) responsible for the maintenance of the specifically ordered equipment. 4) The frequency of routine preventative maintenance checks. 5) Routine assessment/evaluation, including upon any significant change of condition, of the resident's ability to safely and independently** self-manage and use the specific medical equipment for which the waiver is sought and referral to resident's primary care physician when any change is identified. 6) Annual renewal of DOH-4235B ACF Medical Equipment Waiver Addendum (if applicable and still in use).	Comments: Reviewer Initials:

**There may be situations where the resident is dependent upon staff of the facility, for example if the resident has had a stroke and needs staff to support their left side while the resident uses an enabler bar located on their right side.

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☐	**Disaster Plan Roster:** A copy of the facility's current disaster plan roster of residents with transfer assistance levels clearly identified for all residents and specifying residents in need of assistance with evacuation. Please note, facilities must have specific and current procedures for evacuation of residents needing individual procedures documented and available upon request by the Department.	Comments: Reviewer Initials:

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Check if Included	Additional Requirements for Hospital Bed Waivers	
☐	**Check all those that apply:** ☐ No wheels. ☐ Wheels are locked. ☐ Bed height is no more than 36 inches as measured from the floor to the top of the mattress, not the footboard and not the headboard. Bed Measurement: _____	Comments: Reviewer Initials:

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Check if Included	Additional Requirements for Hospital Beds with ½ side rail Waivers	
☐	**Check to confirm:** ☐ Only one side rail will be in use ☐ ½ side rail will not be placed in the middle of the bed. ☐ ½ side rail cannot be used as restraints.	Comments: Reviewer Initials:

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Check if Included	Additional Requirements for Enabling Device Waivers	
☐	**Type of enabling device:** _____ **Check to confirm:** ☐ Only one type of enabling device per bed is permitted. ☐ Enabling devices may not be used as a restraint.	Comments: Reviewer Initials:

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Check if Included	Additional Requirements for Trapeze Waivers	
☐	**Emergency Evacuation:** **Check to confirm:** ☐ Bed can be rolled through the door with the attached apparatus if/when required for emergency evacuation. Resident's bedroom door measurement Bed w/ apparatus width measurement	Comments: Reviewer Initials:
☐	**Daily Safety Checks:** • Provide documentation that confirms, at minimum, daily safety checks of the trapeze device.	Comments: Reviewer Initials:

The New York State Department of Health reserves the right to request any information as deemed necessary to make a determination on the waiver request.

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☐ Incomplete ☐ Missing Checklist	Notified On: _____	By: _____
☐ Denied	Notified On: _____	By: _____
☐ Conditionally Approved	Notified On: _____	By: _____