Center for Health Facilities and Regulations
ALR Variance/Extension Request for Hospice and Skilled Nursing Services

Required when requesting additional days beyond the first 45 days of services for established residents only
Email to: DOH.OFR@Health.ri.gov

Residence: ____ License #: _________EMAIL # ____________

Resident's Name: ____ Date of Adm. _____________

- Residence has current Limited Health Services License: □ Yes □ No Additional information:
- Resident suitable for ALR admission/continued residence: □ Yes □ No
- Resident resides on a Dementia Unit: □ Yes □ No
- Resident requires a two person assist: □ Yes □ No
- Resident is bed bound: □ Yes □ No

☐ **Hospice** (Brief explanation and name of Hospice provider. OFR will fax a written acknowledgement or denial).

Expected duration of Hospice services: __________ days (no more than 6 months for this request)

☐ **Skilled Nursing Services Required:** (Specify type of service required, brief summary of improvement during the first 45 days and explanation of the need for additional services. OFR will fax a written acknowledgement or denial)

□ **Pressure Ulcer** □ **Diabetic Ulcer** □ **Assessment** □ **Urinary Catheter** □ **Ostomy**
□ **Vascular Ulcer** □ **Cellulitis** □ **Surgical Wound** □ **Skin Tear/Laceration** □ **Other**

- Wound Measurement as provided by Home Care Agency ___________________ Stage _______
  Improved since last measured: □ Yes □ No
- Expected duration of additional skilled nursing services: __________ days
- Name of RI licensed agency providing Services: ____
- Residence providing care under Limited Health Services License: □ Yes □ No □ Not Applicable

ALR Registered Nurse"'P co g: ________________________________ Date: ____________________

ALR Administrator'P co g: ________________________________ Date: ____________________

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