

**INFORMATION NEEDED TO REQUEST
1135 CMS WAIVER**

- The following information to be completed for each waiver item requested
- E-Mail request to both of the following addresses
 - ROSFOSO@cms.hhs.gov
San Francisco Regional Office
 - HEOC_OPS@siren.gov
Arizona State Agency

Facility Name:		CMS Provider #:			
Address:		City:		State:	ZIP:
Provider Type:		County:		Requester Date:	
Waiver Requested: (Regulation)					
Requester Name:		Requester E-Mail:		Requester Phone:	
Justification:					
Time Needed for Waiver: Date(s)/Hours					
Action Taken Prior to Waiver Request:					
CMS Approval Yes No					
_____ CMS Signature			Date:		Time: