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| http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/sites/default/files/graphics/DCYF-Logo-BW.jpg | **FFN**  **Waiver Request** | |
| **FFN Program Information** | | |
| Provider Name: | | Provider ID #: |
| Mailing Address:       City:       State:       Zip Code: | | |
| Telephone: | Email: | |
| Provider Type: Location of care:  Grandparent or great grandparent  Cousin  Provider’s home  Adult sibling  Non-Relative  Child’s home  Aunt/uncle or great aunt/uncle  Other: | | |
| **Waiver Request Details (one WAC per form)** | | |
| This request is for a waiver from license-exempt care rule, WAC #:  WAC Description: | | |

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| Explain, in detail, why you are requesting this waiver. It must be for a specific need to provide care for the child or children. (Attach additional page, if needed.) |

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| Explain, in detail, how you will ensure the health, welfare and safety of all children is not jeopardized if this waiver request is approved. (Attach additional page, if needed.) |

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| Requested waiver dates for this WAC:       through        No end date  **IMPORTANT! A waiver goes into effect only when the FFN provider**  **receives notification from DCYF that the request is approved.**  **DCYF may rescind the waiver at any time.** | | |
| **Signature of person submitting this request** | **Print name** | **Date** |

Submit to: Your local DCYF license exempt specialist.

DCYF will return this request to you with the department’s decision indicated in the space below.

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| **DCYF Use Only** |
| This waiver (exception) request is:  Approved  Disapproved because: |

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| **DCYF Signature Position Title Date** |