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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**              |