

ADULT DAY HEALTH CARE PROGRAM FLEXIBILITY REQUEST

Licensee Name		
Center Name		Phone Number ()
Center Address		
Requested Effective Date:	Estimated Duration:	Date Submitted:
Program flexibility is requested for Title 22, California Code of Regulations,		
Section(s): _____		Staff Name: _____
Subject:		
Reason for requesting program flexibility:		
Description of proposed alternative to be used to meet the intent of the regulatory requirement:		
How you have determined that the proposed alternative will not adversely affect participants:		
<i>I hereby assure that the proposed alternative complies with the intent of the regulation and that the quality and level of service will not be compromised.</i>		
Print Administrator's Name	Administrator's Signature	Date Signed
STATE REVIEW: CDA ADHC Branch Approval: Yes ___ No ___ Date: _____ Standard flexibility: Yes ___ No ___ Signature: _____		COMMENT: