# Waiver of Administrative Rules Petition

## What is a waiver?

A waiver is a request to the Iowa Department of Health and Human Services (HHS) asking to temporarily suspend an administrative rule for a specific person or organization because of special circumstances.

## When can HHS approve a waiver?

HHS may approve a waiver if all of the following are true:

* The rule causes a hardship for the person or group asking for the waiver;
* Granting the waiver won’t affect someone else’s rights;
* The rule isn’t required by state or federal law; and
* The requestor’s health, safety, and welfare will still be protected even if the rule is waived.

## Important Notes

* Waivers only apply to HHS rules. They cannot be used to change rules based on federal laws or program eligibility (like income limits).
* The HHS Director makes the final decision. There is no appeals process if the request is denied, but you can ask for reconsideration if you disagree with the decision.
* There is no fee to request a waiver.
* Only ask for a waiver after all other options have been tried.

## How to Request a Waiver

Option 1: Fill out the online form: <https://hhs.iowa.gov/programs/appeals>

Option 2: Write a letter and send by:

* Mail: HHS Appeals Bureau  
   321 E 12th Street, 4th Floor  
   Des Moines, IA 50319
* Email: [exceptions@hhs.iowa.gov](mailto:exceptions@hhs.iowa.gov)
* Fax: (515) 564-4118

Questions? Call the Appeals Bureau at (888) 723-9637.

## What to Include in Your Waiver Request

* Your name and address.
* The name, ID number (State ID, Tax ID or NPI), and birthdate (if needed) of the person or group needing the waiver.
* What the person or group needs.
* Why it’s needed (include medical reasons, if any).
* Costs and possible savings.
* What’s been tried already.

## Extra Information Needed for Certain Requests

For Home Health Agency Requests:

* Needed services, hours, and level of care.
* List of other programs the person uses.
* Breakdown of costs (salary, benefits, mileage, etc.).
* Plan of care or treatment.
* Notes from the past 30 days of care.

If requesting to reduce an overpayment or monthly payment:

* Who lives in your home.
* Your household’s monthly income and expenses.
* Why you can’t pay the full amount.
* What amount you can afford to pay each month.

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Use this form to ask Iowa HHS to waive (change or suspend) an administrative rule due to special circumstances.

**Section 1: Your Information (Person Filling Out the Form)**

Date of Request:

Your Full Name:

Phone Number:

Company/Agency (if applicable):

Mailing Address:

City:       State:       Zip Code:

Email Address:

**Section 2: Person Who Needs the Waiver**

Name of Person or Entity the Waiver is for:

State ID / Tax ID / NPI (if available):

Birth Date:

Have you already filed an appeal for this issue?  Yes  No  
If yes, provide the appeal number:

**Section 3: Program Area (Check one or more)**

Adoption/Guardianship Subsidy  Adult Abuse

Behavioral Health  Child Care Assistance/Eligibility

Child Care Regulation  Child Support

Cost Reports  Disability Services

Employee Requirements  Family Investment Program (FIP)

Foster Care Licensing/Staffing  Home and Vehicle Modifications

Medicaid Claims  Medicaid Eligibility

Medicaid Waivers  Overpayment

Pharmacy  SNAP Eligibility

Substance Use Requirements  Other, please explain:

**Section 4: About Your Waiver Request**

Describe your waiver request (include the specific rule if known). Attach a separate page if more space is needed:

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Why are you asking for this waiver?

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How long do you want the waiver to last (e.g., 3 months, 1 year):

When do you want the waiver to start?

**Section 5: Additional Information (Optional but Helpful)**

Is there someone else who can provide helpful information about this request?   
 Yes  No If yes, give their name, address and phone number:

What information can they provide?

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Has HHS handled a similar situation before?   
 Yes  No If yes, describe what happened:

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Have you tried other solutions or talked to HHS before about this request?  
 Yes  No If yes, describe what was tried or who you spoke with:

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Do you know anyone who might be affected by this waiver?  
 Yes  No If yes, list names, addresses and phone numbers:

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Would anyone be harmed if this waiver is granted?   
 Yes  No If yes, please explain:

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**Section 6: Signature**

**By signing below, you give permission to release information to HHS and confirm everything you’ve provided is true to the best of your knowledge.**

Signature:

Date: