Department *of*
DISABILITY & AGING

POLICY EXEMPTION REQUEST FORM

INSTRUCTIONS:

Use this form to request an exemption from DDA policy, procedure, written document, or instrument. All questions must be answered, or the request will be returned unprocessed. This form must be submitted to the Regional Office Director of the region in which services are provided at DDA.ETRO.Policy@tn.gov, DDA.MTRO.Policy@tn.gov, and DDA.WTRO.Policy@tn.gov.

To: _____ **Date:** _____

From:

*Include name **AND** email address of person completing form, agency/provider name, and agency address*

_____

For what is the exemption being requested?
Include a specific reference to the policy or provider manual section applicable to this request

NON-BACKGROUND CHECK EXEMPTIONS

Is this request for a person supported? ☐ Yes ☐ No If yes, who: _____

If applicable, is the Circle of Support in agreement with this request? ☐ Yes ☐ No ☐ N/A

What other solutions were sought before the exemption was requested?

_____

Is an alternative solution being developed to eliminate the need for the exemption? ☐ Yes ☐ No

BACKGROUND CHECK EXEMPTION REQUESTS

Name of prospective employee _____

Last 4 of SSN# _____ Date of Birth: _____

Has the prospective employee been a resident of TN for MORE than one (1) year? ☐ Yes ☐ No

Is a nationwide background check, which may be limited to those states where the person has lived during the past seven (7) years or since the age of 18, whichever is fewer, included? ☐ Yes ☐ No ☐ N/A

Is current background check included (within last 30 days) ☐ Yes ☐ No

Is disposition of conviction(s) included (either on background check or other supporting documentation)? ☐ Yes ☐ No

Is a written statement from the prospective employee regarding the circumstances surrounding conviction(s) included? ☐ Yes ☐ No

If the prospective employee is listed on the Felony Offender Information Lookup (FOIL) registry, is a comprehensive Tennessee Bureau of Investigation background check dating back to age 18 included? ☐ Yes ☐ No ☐ N/A

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ADDITIONAL INFO **REQUESTED** DATE: _____

ADDITIONAL INFO **RECEIVED** DATE: _____

COMMENTS & RECOMMENDATIONS

Regional Office Director Recommendation: ☐ Approved ☐ Approved with Conditions ☐ Denied ☐ Not Necessary

Regional Office Director (required): _____

SIGNATURE DECISION DATE

PERC Recommendation: ☐ Approved ☐ Approved with Conditions ☐ Denied ☐ Not Necessary

Three of the following (or designees) are required for approval/denial. ***Please sign, recommend, and date.***

Deputy Commissioner of Program Operations (*or designee*): _____

Assistant Commissioner & General Counsel (*or designee*): _____

Deputy Commissioner of Clinical Services (*or designee*): _____

Assistant Commissioner of Quality Management (*or designee*): _____

Assistant Commissioner or Human Resources and Organizational Development (*or designee*): _____

Commissioner (if applicable per DDA Policy 60.6.1): _____

SIGNATURE DECISION DATE

Disposition: ☐ Approved ☐ Approved with Conditions ☐ Denied ☐ Not Necessary **Date:** _____