**SAMPLE TEMPLATE– FFY2019 MBQIP Reporting Waiver

Note: Submission of waiver does not guarantee hospital is eligible for FFY2019 Flex funds**
This is a request to waive the penalty for the MBQIP reporting requirement for the grant year from September 2019 – August 2020 due to extenuating circumstances and/or other reasons. By signing this, we understand that this is a waiver request and approval is on a case-by-case situation. In addition, we agree to participate in follow-up by FORHP and RQITA based on the action steps listed below. This waiver is only effective until August 31, 2020. The hospitals requesting this waiver and their reasons/situations for not submitting data for each MBQIP Quality Domain within the reporting periods are:

*CCN and Hospital Name*

1. Inpatient/Patient Safety (IMM-2 and OP-27; Includes NHSN Annual Facility Survey and ED-1 and ED-2)
	1. *Please state each of the reasons and situation for not being able to report*
	2. *Please state steps towards reporting in the next year*
2. Patient Engagement (HCAHPS)
	1. *Please state each of the reasons and situation for not being able to report*
	2. *Please state steps towards reporting in the next year*
3. Care Transitions (EDTC)
	1. *Please state each of the reasons and situation for not being able to report*
	2. *Please state steps towards reporting in the next year*
4. Outpatient (OP 1-5, 18b, 20-22)
	1. *Please state each of the reasons and situation for not being able to report*
	2. *Please state steps towards reporting in the next year*
5. Other
	1. *Please state each of the reasons and situation for not being able to report*
	2. *Please state steps towards reporting in the next year*
6. (If applicable) Progress made since FY18’s waiver/last year

Please see attached for documents that are relevant to our case.
Example documents to support a MBQIP reporting waiver:

1. Copy of the QualityNet “Case Status Summary Report” for each of the reporting periods
2. Steps planned for reporting next year (IE: action plan)

*(Signature) (Date)*

*Name, CAH Representative*

*(Signature) (Date)*

*Name, Flex Program Manager*