

DHS – FAMILY SYSTEMS VARIANCE REQUEST FORM

Agency/County Name: _____ Licensor: _____ Date _____

Provider Name _____ Address, City, Zip _____

Type of Care License #	_____ Child Foster Care # _____	_____ Family Child Care # _____	_____ Adult Foster Care # _____	_____ Community Residential Setting # _____	
Type of variance requested:	_____ Dual MN Stat 245A.16, subd. 1 (a) (1)	_____ Minimum Age-AFC/CRS (under 18) MN Rules, 9555.5105, subp. 2 MN Stat 245A.11, subd. 2	_____ Minimum Age AFC/CRS (under 55) MN Stat 245A.11, subd. 2b.	_____ AFC/CRS Overnight supervision** MN Stat 245A.11, subd. 7.	Are crisis services being provided in this home? YES NO
_____ Maximum Age –CFC MN Rules, 2960.3010, subp. 21 MN Statutes, 245A.04 subd. 11	<p>If the request is for an individual 18 or older to be served in child foster care, PLEASE NOTE ** Per MN Rules, part 2960.3010, subp. 21. "Foster child means a <i>person under 18 years of age, a person in special education, or a juvenile under the jurisdiction of a juvenile court who is under 22 years of age</i> and placed in a foster home." Or per MN Statutes, 245A.04, subd. 11. " A child foster care program licensed by the commissioner under MN, Rules, chapter 2960 may serve persons who are over the age of 18 but under the age of 21 when the person is :</p> <ol style="list-style-type: none"> 1) Completing secondary education or a program leading to an equivalent credential 2) Enrolled in an institution which provides post-secondary or vocational education 3) Participating in a program or activity designed to promote, or remove barriers to employment 4) Employed for at least 80 hours per month, or 5) Is incapable of doing any of the activities described in clauses (1) to (4) due to a medical condition, which incapability is supported by regularly updated information in the case plan of the person. <p>** A variance is only required for individuals who do not meet any of the above criteria and placement in child foster care is requested.</p>				

1. How will you be out of compliance? _____
2. Why are you requesting a variance? _____
3. If approved, what specific alternative measures will you provide to ensure the health, safety, and protection of the persons in care in the program(s)?

4. If request is for a specific individual, include their **name or initials** and **date of birth** _____
5. Begin and end dates of variance request _____ to _____ 6. Is this a NEW request? **Yes No** 7. County recommendation: **Yes No**
8. Signature and title of person making recommendation _____ Phone _____
9. Signature of second licenser (if requesting dual license variance) _____ Phone _____

NOTE: If you have additional information which will assist in the processing of this request, please attach.
**** Please include the AFC – Alternate Overnight Supervision Variance Checklist**
Include checklist and/or all required documentation.

DHS – Family Systems
P.O. Box 64242
St. Paul, MN 55164-0242