DHS
Oregon Department of Human Services

Department of Human Services
Addictions and Mental Health Division
REQUEST FOR VARIANCE

Please print clearly and complete all required sections

1. Facility Type:

❑ Adult Foster Home	[5 or fewer]	OAR 309-040-0350	Variance
❑ Residential Treatment Facility	[6 or more]	OAR 309-035-0110	Variance
❑ Residential Treatment Home	[5 or fewer]	OAR 309-035-0270	Variance

2. County: 3. Facility name:

4. Provider name: Contact person:

5. Site address:
City: State: Zip: Phone #:

6. OAR: _____ Section: _____

7. Reason for proposed variance: _____

8. Alternative practice proposed:

9. Time table for compliance:

10. Provider Signature: Date:

11. County Mental Health Representative recommendation, with comments:

12. _____ _____
Signature of County Mental Health Director Date

13. AMH Recommendations:

_____ _____
Name: Date:

14. _____ _____
AMH designated authority – Title/Signature Date

15. ❑ Denied/Comments: _____

❑ Approved
Variance effective date: Review/renewal date: