STATE OF RHODE ISLAND

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
OFFICE OF LICENSURE AND STANDARDS
14 Harrington Road, Cranston, Rhode Island 02920
Phone # 462-2317 Fax # 462-0393

APPLICATION FOR LICENSE
TO PROVIDE SERVICES TO ADULTS WITH DEVELOPMENTAL DISABILITIES

Date: _____

License Number: _____ (for Licensing Office use only)

Application to apply for: Initial Licensure ☐ Renew License☐ Add a Service☐ Add a Location☐
Change of address for Administrative Offices only (submit Page 1) : ☐

PART I: Applicant Information

- Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide services:

Name of Organization: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ **Fax:** _____ **FEIN:** _____

Chief Executive Officer or Director: Identify the person responsible for the overall management and oversight of the service(s) to be operated by the applicant:

Name: _____ **Title:**_____

E-mail Address: _____ **Telephone:**_____

Fax: _____ **Cell phone:** _____

Website (if applicable):_____

PART II: Organizational Structure

- Identify the organizational structure of the applicant's governing body:

Type of Ownership: Individual☐ Partnership☐ Corporation☐ Other☐:_____

Check One: For Profit☐ Non-Profit☐

Is the Organization Incorporated: Yes☐ No☐ If yes, Date of Incorporation**:** _____

Do you have a Board of Directors/Advisory Board? Yes☐ No☐

- Attach a current list of the Board of Directors or Advisory Board with the address, title, and term of office for each member.

Is the organization licensed, certified, or accredited by any other authority? Yes☐ No☐

- If yes, list authority and type of license, accreditation, or certification:_____

Has any application for a license, certification or accreditation ever been denied? Yes☐ No☐

- If yes, explain: _____

PART III: Service Location Information

- The Agency shall identify the following information for each service site location that the organization is requesting to have licensed. Each site needs its own application.

- **Service Site Location:**

Location Name:_____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Telephone: _____ **Fax:** _____

Site contact person: _____
Title:_____ **Cell phone:** _____

Type of Building: Commercial☐ Residential☐ Office☐ Other☐: _____

- Does the building comply with all applicable federal, state, and local laws, codes, rules, and regulations relative to health, accessibility, fire safety, building, minimal housing and zoning? Yes☐ No☐
  - **Date of last State Fire Marshal Inspection**: _____
    - Attach a copy of current State Fire Marshal Inspection Report

Name and Address of Building Owner:_____

- If rented or leased, is owner willing to allow any necessary repairs or renovations to be made to the building to meet necessary life-safety requirements? Yes☐ No☐
  - If No, what is the alternative plan? _____

- **Service and Certification(s):** The applicant shall check-off the services/certifications that the organization is requesting to provide on-site at the location specified above.
  - ☐ **Employment Services**
    - ☐ Supported Employment Services (Certification Standard)
  - ☐ **Day and Community Supports Services**
    - ☐ Community Based Day Program Service (Certification Standard)
    - ☐ Community Based Supports Services (Certification Standard)
    - ☐ Center Based Day Program Service (Certification Standard)
  - ☐ **Residential Supports Services** **Bed Capacity**: _____
    - ☐ Community Residence Support Service
    - ☐ Non-Congregate Residential Support Service
    - ☐ Shared Living Arrangement Service (See Section 1.10.2)
  - ☐ **Fiscal Intermediary Services** (See Section 1.10.3)

- For Sites that provide Residential Supports Services but are not a community residence, such as a Non-Congregate Setting or Shared Living Arrangement, please attach a list that includes the following for each site:

- The address of the site, the type of Residential Supports Services provided at the site (i.e. Non-Congregate Residential Support Service or Shared Living Arrangement Service), and the name(s) of the supported participant(s) at the site.

- Attach all written residential agreements to support Section 1.11 Residential Settings Subject to Licensing

PART IV: Initial License Applications; Required Information

- If the applicant is not licensed and submitting an Initial license application the following required information must be attached to the application. Applicants shall check-off all items submitted with application.

1.) Admission Requirements

☐ Describe your program's admission criteria, including any exclusion criteria, if appropriate.

2.) Program

☐ Describe basic program: mission statement, philosophy, goals, treatment modalities, program components, etc.

☐ Describe staffing, including number and types of each position, and consultants hired or utilized.

☐ If your program utilizes volunteer services, describe how these volunteers are utilized.

☐ Attach written job descriptions for each position.

☐ Describe your program's staff training program, including orientation and schedule of in-service training.

☐ Describe daily program schedule, including hours of operation and provision for emergency services.

☐ Describe your program's criteria for participant transition or dismissal from the program (discharge criteria).

☐ Describe your program's process for follow-up of discharged participants.

☐ Attach a copy of a sample participant record.

3.) Financial

☐ Describe the proposed financial plan which demonstrates the financial viability of the applicant.

☐ Describe funding sources and amounts for facility and facility sponsored programs. Include any fees charged to participants.

☐ Attach proposed budget.

☐ Please attach copies of all of your financial policies and procedures.

☐ List name, address, and telephone number of accountants.

4.) Program Evaluation

☐ Describe proposed system for conducting:

- A program self-evaluation, and
- Staff evaluations.

5.) Additional Required Information

☐ Attach evidence of ability to provide supports to Participants with complex behavioral issues and/or medical needs

☐ Attach a notarized listing of the names and addresses of all owners, officers, and directors, whether individual, partnership, or corporation, with percentages of ownership designated.

- If the Organization is organized as a for-profit corporation, the list shall also include all officers, directors, and other persons or any subsidiary corporation owning stock, and all partners if the Organization is organized as a partnership.

☐ Describe the Organization's current infrastructure and its ability to develop, support, and maintain a billing system that can track services provided and bill accordingly.

☐ Attach evidence of compliance with the requirements for licensure stated in Section 1.5, *Rules and Regulations Licensing Procedure and Process for Facilities and Programs Licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.*

PART V: License Renewal Applications; Required Information

- If the applicant is fully licensed and submitting a license renewal application the following required information must be attached to the application. Applicants shall check-off all items submitted with application.

☐ Describe any changes in your program since your last application.

☐ Describe any changes of the organization's owners and/or officers, and any changes in the organizational structure since your last application.

☐ Describe the proposed financial plan.

☐ Describe funding sources and amount funded by each source.
- Include any fees charged to participants.

☐ Attach current budget.
- List accountant and date of last audit.

PART VI: Applicant Agreement and Signature

- The applicant shall check-off that they have read the following items prior to signature:

☐ I am aware that the Department may require additional financial indicators that are necessary to establish that the applicant is in good financial standing.

☐ I am aware that authorized representatives of the Licensing Agency have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility for which an application has been received or for which a license has been issued. This application shall constitute permission for and willingness to comply with such inspections.

☐ I am aware of the statutory authority of the Department as contained in chapter 40.1 of the Rhode Island General Laws, and of the standards, rules and regulations prescribed therein, which regulate the operation of facilities and programs that provide services to adults with developmental disabilities.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

Signature of Applicant: _____ Date: _____

Name of Applicant (print): _____ Title: _____

- This application shall be returned before the end of the current licensure period to:
  OFFICE OF LICENSURE AND STANDARDS
  DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
  14 HARRINGTON ROAD, BARRY HALL
  CRANSTON, RHODE ISLAND 02920
- If there are any questions concerning the application, please contact this office at (401) 462-6043.

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

_____ (hereinafter called the "applicant")
(Name of Applicant)

HEREBY AGREES THAT it will comply with title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health, Education, and Welfare (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with title VI of that Act and the Regulation, no person in the United Stated shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THAT ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts, or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

Signature of Applicant: _____ Date: _____

Name of Applicant (print): _____ Title: _____

Applicant's mailing address:

_____

_____

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS RULES AND REGULATIONS

_____ ("Applicant")
(Name of Developmental Disability Organization or Cognitive Disability Organization)

HEREBY ATTESTS THAT it has reviewed and is familiar with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals ("Department") Rules and Regulations, to wit: "Rules and Regulations Licensing Procedure and Process for Facilities and Programs Licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals" and "Rules and Regulations for the Licensing of Developmental Disability Organizations" and HEREBY GIVES ASSURANCE THAT the Applicant, to the best of its knowledge and belief, is in compliance with said Rules and Regulations and that the Applicant agrees to maintain compliance and take any measures necessary to remain in compliance therewith.

SAID ASSURANCE is given in consideration of and for the purposes of maintaining all current licensure and obtaining any and all Department licenses (initial or renewal) granted on and after the date hereof to the Applicant by the Department. The Applicant recognizes and agrees that any such licenses will be granted in reliance on the representations and statements made in this assurance, and that the Department has and retains the right to initiate licensing action in enforcement of this assurance.

This assurance is binding on the Applicant.

Under the penalties of perjury, the undersigned certifies that the statements set forth in this assurance are true and correct and that the person and/or persons whose signature(s) appear below are authorized to sign this assurance on behalf of the Applicant.

Signature of Applicant: _____ Date: _____

Name of Applicant (print): _____ Title: _____

State of Rhode Island
County of _____
In _____ in said County on the _____ day of_____, 20_____, before me personally appeared _____
each and all to me known and known by me to be the party(ies) executing the foregoing instrument and acknowledged said instrument to be executed as their free act and deed.

_____
(Signature of Notary, title)

DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS OFFICE OF LICENSURE AND STANDARDS

ADDENDUM TO LICENSE APPLICATION

License Number: _____

Verification of Federal Employer Identification Number and affidavit concerning taxpayer status.

Federal Employer Identification Number (FEIN): _____

- Furnishing the FEIN is mandatory. The FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due to the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Signature of Applicant: _____ Date: _____

Name of Applicant (print): _____

- This form **MUST** be completed, signed, and attached to the license application in order to process the application**.**