

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES  
APPLICATION FORM  
ASSISTED HOUSING PROGRAMS

PLEASE COMPLETE AND **RETURN TO:**

Division of Licensing and Regulatory Services  
Medical Facility's Unit  
State House Station # 11  
Augusta, ME 04333

**For Agency Use Only**

**SBI** \_\_\_\_\_ **County** \_\_\_\_\_  
**H<sub>2</sub>O** \_\_\_\_\_ **Prog. Spec.** \_\_\_\_\_  
**SFMO** \_\_\_\_\_ **H.F.S.** \_\_\_\_\_  
**FEE \$** \_\_\_\_\_

- 1) THIS APPLICATION FORM MUST BE COMPLETE OR THE APPROVAL PROCESS COULD BE DELAYED.
- 2) **RETURN THIS APPLICATION AND RELATED DOCUMENTS, AND TWO (2) ADDITIONAL COPIES TO THE ADDRESS ABOVE.**
- 3) IF APPLYING FOR A LEVEL I, II, III, OR IV RESIDENTIAL CARE FACILITY THE APPLICATION MUST BE ACCOMPANIED WITH A **NON-REFUNDABLE FEE OF \$10.00 FOR EACH BED REQUESTED**. IF APPLYING FOR AN ASSISTED LIVING PROGRAM THE APPLICATION MUST BE ACCOMPANIED WITH A **NON-REFUNDABLE FEE OF \$200.00**.
- 4) THE APPLICATION MUST INCLUDE A SEPARATE CHECK (\$31.00 PER PERSON) FOR THE APPLICANT, ADMINISTRATOR AND/OR HOUSEHOLD MEMBERS 18 YEARS OR OLDER FOR CRIMINAL HISTORY BACKGROUND CHECK. **MAKE CHECKS PAYABLE TO: TREASURER, STATE OF MAINE.** *THE BACKGROUND CHECK IS WAIVED FOR LICENSED RESIDENTIAL CARE ADMINISTRATORS AND LICENSED MULTI-LEVEL ADMINISTRATORS.*

Projected Opening Date: \_\_\_\_\_

**FACILITY TYPE APPLYING FOR:**

**Level I** \_\_\_\_\_ **Level II** \_\_\_\_\_ **Level III** \_\_\_\_\_ **Level IV** \_\_\_\_\_ (See Section 2.49)

**Level I (PNMI)** \_\_\_\_\_ **Level II (PNMI)** \_\_\_\_\_ **Level III (PNMI)** \_\_\_\_\_ **Level IV (PNMI)** \_\_\_\_\_  
(See Section 2.40)

**Assisted Living:** Type I \_\_\_\_\_ Type II \_\_\_\_\_ (See Section 2.8)

Name of Facility \_\_\_\_\_ Legal Name (i.e., DBA, Inc.) \_\_\_\_\_

911 Address of Facility \_\_\_\_\_

Mailing Address of Facility \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Phone Number \_\_\_\_\_ 2nd Phone \_\_\_\_\_

FAX# \_\_\_\_\_ Number of Residential Care Facility Beds \_\_\_\_\_ Number of Assisted Living Units \_\_\_\_\_

Will you have designated respite beds? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes" how many? \_\_\_\_\_

Directions for Reaching Facility \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**APPLICANT INFORMATION:**

**CHECK WHAT APPLIES: INDIVIDUAL \_\_\_\_\_ CORPORATION \_\_\_\_\_.** **IF A CORPORATION CHECK EITHER PROPRIETARY \_\_\_\_\_ OR NON-PROFIT \_\_\_\_\_.**

**Company Name (if applicable):** \_\_\_\_\_

Ms.  
Mr. \_\_\_\_\_  
First Middle Last

(home/company address) Street Town State Zip Code

Phone Number Fax Number Date of Birth Social Security Number OR EIN

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES) \_\_\_\_\_

**Co-Applicant:**

Ms.  
Mr. \_\_\_\_\_  
First Middle Last

(home address) Street Town State Zip Code

Phone Number Fax Number Date of Birth Social Security Number

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES) \_\_\_\_\_

**ADMINISTRATOR / PERSON IN CHARGE:**

\_\_\_\_\_  
First Middle Last

(home address) Street Town State Zip Code

Phone Number Date of Birth Social Security Number

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES) \_\_\_\_\_

**BUILDING OWNERSHIP IDENTIFICATION (if applicable)**

Building Ownership, if different from Applicant: (Individual, Partners, Corporation Name, Company Name)

\_\_\_\_\_  
Name Street State Zip Code Main Office Telephone #

Identification Number: \_\_\_\_\_  
(Owner's Social Security Number or EIN)

If ownership is a corporation, indicate: Proprietary \_\_\_\_\_ or Non-Profit \_\_\_\_\_

If owner is a corporation, list on a separate sheet the names, addresses, and titles of each officer, director, and each person owning 10% or more of the total stock, specifying the percentage of ownership if Proprietary.  
**If applicant doesn't own the building submit copy of lease agreement with owner.**

**MEMBERS OF THE HOUSEHOLD (If applicable)**

List all persons who are not residents/consumers of assisted housing and who reside in the facility.

Name	Date of Birth	Social Security # (For ages 18 +)	Occupation	Relationship to Applicant
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FOR EACH HOUSEHOLD MEMBER INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES)

\_\_\_\_\_

\_\_\_\_\_

Comment on the health of each person in the household listed above, giving special emphasis to any physical or mental limitations.

\_\_\_\_\_

Facility Physician and Address: \_\_\_\_\_

Type of insurance, liability, home owner's etc. (please list) \_\_\_\_\_

**FACILITY DESCRIPTION**

Dually Licensed? Yes \_\_\_\_\_ No \_\_\_\_\_

Funded as an Adult Family Care Home? Yes \_\_\_\_\_ No \_\_\_\_\_

Funded as a Waiver home? Yes \_\_\_\_\_ No \_\_\_\_\_

Receiving other MaineCare Funds? Yes \_\_\_\_\_ No \_\_\_\_\_

Level IV (Multi-level)? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "Yes" what nursing home is associated with the multi-level?  
 \_\_\_\_\_

Handicapped Accessible? Yes \_\_\_\_\_ No \_\_\_\_\_

Municipal Water? Yes \_\_\_\_\_ No \_\_\_\_\_

Alzheimer's Unit? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "Yes", how many Alzheimer beds? \_\_\_\_\_

Will there be an adult day program physically located at this facility? Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes" list the name/address.

1. \_\_\_\_\_ # of Consumers \_\_\_\_\_

\_\_\_\_\_

Is this a scattered site? Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes" list the names/addresses of the facilities associated with this site and number of beds at each location.

1. \_\_\_\_\_ Beds \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_ Beds \_\_\_\_\_

\_\_\_\_\_

**TYPE OF POPULATION TO BE ADMITTED:** (Check all that apply)

Male\_\_\_\_ Female\_\_\_\_ Age Range\_\_\_\_\_

**Persons with:**

dementia/Alzheimer's disease\_\_\_\_  
hearing impairments\_\_\_\_  
physical disabilities\_\_\_\_  
neurological impairments\_\_\_\_  
mental health issues \_\_\_\_  
mental retardation or developmental disabilities\_\_\_\_  
sight impairments\_\_\_\_  
alcohol or drug abuse issues \_\_\_\_  
head trauma \_\_\_\_

**Persons who are:**

wheelchair dependent\_\_\_\_  
elderly\_\_\_\_

**LIST ALL HOME HEALTH AGENCIES, REGISTERED PERSONAL CARE AGENCIES, DAY CARE and LONG TERM CARE FACILITIES (including assisted housing programs and nursing homes) owned and/or operated by applicant or spouse:**

Address:\_\_\_\_\_ Phone # \_\_\_\_\_

Address:\_\_\_\_\_ Phone # \_\_\_\_\_

Address:\_\_\_\_\_ Phone # \_\_\_\_\_

**EDUCATION OF APPLICANT OR CHIEF EXECUTIVE OFFICER OF APPLICANT:**

School Name	City/State	Last Grade Completed	Degree	Year
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----

**SPECIAL QUALIFICATIONS OF APPLICANT (Enclose Copy of all Pertinent Credentials)**

\_\_\_\_ Multi-Level Administrator's License    \_\_\_\_ Residential Care Administrator's License    \_\_\_\_ Registered Professional Nurse  
\_\_\_\_ Licensed Practical Nurse    \_\_\_\_ Certified Nurses Aide    \_\_\_\_ Certified Residential Medication Aide  
\_\_\_\_ Sign Language    \_\_\_\_ Other Language Spoken \_\_\_\_\_    \_\_\_\_ CPR  
\_\_\_\_ Resident Care Specialist I    \_\_\_\_ Personal Support Specialist    \_\_\_\_ Direct Support Specialist

**OTHER RELEVANT EXPERIENCE:** Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (Use reverse side, if necessary)

The following questions are used to help evaluate the safety and security of residents/consumers who will be living in the facility. Issues in the following areas do not automatically mean a license will be denied. (To be answered by applicant or chief executive officer of the applicant)

Have you ever been convicted of a criminal offense? \_\_\_\_\_

If so, explain. \_\_\_\_\_

Have you (or the agency, if applicable) ever had a license for any long term care facility denied, suspended or revoked in this state or any other state? \_\_\_\_\_

If so, by whom. Please explain. \_\_\_\_\_

Have you or anyone previously listed as a household member been *investigated* for child abuse or adult abuse? \_\_\_\_\_

If so, explain. \_\_\_\_\_

Have you ever been treated for drug/alcohol abuse? \_\_\_\_\_

If so, explain. \_\_\_\_\_

Have you ever been an inpatient in a mental health facility? \_\_\_\_\_

If so, explain. \_\_\_\_\_

**The applicant certifies that all information contained in this application is true and correct to the best of my knowledge.**

**The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.**

I/We, \_\_\_\_\_, certify to be in compliance with all local laws and ordinances as they relate  
(Print Name of Applicant)  
to zoning, plumbing, water supply, and sewage disposal. I/We further appoint \_\_\_\_\_ to assume  
(Print Name of Administrator)  
responsibility for the day to day conduct of the Assisted Housing Program herein described, and do hereby apply for a license to operate the facility and do agree to assume responsibility that the facility will comply with all the current regulations of the Department of Health and Human Services, as authorized by Title 22, M.R.S.A. s7802. I/We understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain any criminal history and Bureau of Motor Vehicle record which may be on file in any county or state office.

**If Applicant is an individual or partnership please sign and date below.**

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Co-Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Applicant is a corporation, please sign and date below that you have the legal authority to make this application.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The following questions are used to help evaluate the safety and security of residents/consumers who will be living in the facility (To be answered by administrator as soon as selected). Issues in the following areas do not automatically mean a license will be denied. Answers may be submitted separate from the application.**

Have you ever been convicted of a criminal offense? \_\_\_\_\_

If so, explain. \_\_\_\_\_

Have you (or an employer, if applicable) ever had a license for any long term care facility denied, suspended or revoked in this state or any other state? \_\_\_\_\_

If so, by whom. Please explain. \_\_\_\_\_

Have you ever been *investigated* for child abuse or adult abuse? \_\_\_\_\_

If so, explain. \_\_\_\_\_

Have you ever been treated for drug/alcohol abuse? \_\_\_\_\_

If so, explain. \_\_\_\_\_

Have you ever been an inpatient in a mental health facility? \_\_\_\_\_

If so, explain. \_\_\_\_\_

**TO BE COMPLETED BY ADMINISTRATOR**

**EMPLOYMENT HISTORY OF ADMINISTRATOR OR PERSON IN CHARGE**

Give last five years employment history: (Attach separate sheet if necessary)

<u>Name and Address of Employer</u>	<u>Job Responsibilities</u>	<u>Dates</u> <u>From</u>	<u>To</u>	<u>Reasons For Leaving</u>
-------------------------------------	-----------------------------	-----------------------------	-----------	----------------------------

**EDUCATION OF ADMINISTRATOR:**

<u>School Name</u>	<u>City/State</u>	<u>Last Grade</u> <u>Completed</u>	<u>Degree</u>	<u>Year</u>
--------------------	-------------------	---------------------------------------	---------------	-------------

**SPECIAL QUALIFICATIONS ( Enclose Copy of all Pertinent Credentials)**

- |  |   |
|--|---|
| <input type="checkbox"/> Multi-Level Administrator's License | <input type="checkbox"/> Residential Care Administrator's License |
| <input type="checkbox"/> Registered Professional Nurse       | <input type="checkbox"/> Licensed Practical Nurse                 |
| <input type="checkbox"/> Certified Nurses Aide               | <input type="checkbox"/> Certified Residential Medication Aide    |
| <input type="checkbox"/> Sign Language                       | <input type="checkbox"/> Other Language Spoken                    |
| <input type="checkbox"/> CPR                                 | <input type="checkbox"/> Resident Care Specialist 1 certified     |
| <input type="checkbox"/> Personal Support Specialist         | <input type="checkbox"/> Direct Support Specialist                |

**OTHER RELEVANT EXPERIENCE:** Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (Use reverse side, if necessary)

**I certify that all information provided herein is true and correct to the best of my knowledge. I also understand that signing this application effectively serves as a release of information and gives permission to the Department to obtain any criminal history and Bureau of Motor Vehicle record which may be on file in any county or state office.**

**Signature of Administrator:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## ADDITIONAL INFORMATION/APPENDICES

**THE FOLLOWING ADDITIONAL INFORMATION IS NEEDED. PLEASE SUBMIT THE ITEMS MARKED WITH AN "X" WITH THE APPLICATION. THE ITEMS MARKED WITH AN ASTERISK CAN BE SUBMITTED WITH THE APPLICATION OR AT THE TIME OF THE SCHEDULED ONSITE VISIT. FAILURE TO SUBMIT THE REQUIRED INFORMATION WILL DELAY THE PROCESSING OF YOUR APPLICATION.**

	Level I	Level II	Level III	Level IV	Assist. Living
<b>Appendix A (References)</b>	X	X	X	X	X
<b>Appendix B (Admission Policy)</b>	X	X	X	X	X
<b>Appendix C (Financial Info.)</b>	X	X	X	X	X
<b>Floor plans or Blueprints of facility</b>	X	X	X	X	X
<b>Policies required by Regulations, Section 10.9.4</b>				*	
<b>Complaint Resolution Procedure, Section 5.8</b>	*	*	*	*	*
<b>Disaster Plan, Section 3.31.6</b>	*		*	*	*
<b>If the facility is being leased, provide copy of lease agreement</b>	X	X	X	X	X
<b>Names/Addresses of Board of Directors, if applicable.</b>	X	X	X	X	X

**REFERENCES - INCLUDE THREE (3) WRITTEN LETTERS OF REFERENCE FOR THE APPLICANT AND ADMINISTRATOR FROM PERSONS WHO ARE NOT RELATED BY BLOOD OR MARRIAGE. THE QUESTIONNAIRE BELOW NEEDS TO BE COPIED AND GIVEN TO REFERENCES TO COMPLETE.**

### Reference for Assisted Housing Providers

Referent's Name: \_\_\_\_\_ Applicant/Administrator's Name: \_\_\_\_\_  
Facility Name: \_\_\_\_\_

**Please respond to the questions below. Use the back of this sheet if necessary.**

1. How long have you known the applicant/administrator?
2. In what capacity do you know this person?
3. Are you familiar with this person's experiences in serving persons who are elderly or disabled? If yes, please describe.
4. Describe this person's ability to give care and services to persons who are elderly or disabled.
5. Describe this person's strengths and weaknesses in the following areas:
  - A. Coping with problems and stress.
  - B. Working with other people
  - C. Decision making
  - D. Communication and Listening
  - E. Ability to work with people who are elderly or disabled
  - F. Ability to work with outside resources such as social workers, medical professionals, state agencies, friends and families of residents, etc.
6. Do you have any concerns about this person's ability to work in an Assisted Housing Program?
7. Do you recommend that this person be given the opportunity to work in or operate an Assisted Housing Program?

Appendix B DIRECTIONS: ALL ASSISTED HOUSING PROGRAMS - You may complete this form or you may submit a narrative which addresses each of these areas.

The admissions policy for Assisted Living Programs shall describe who may be admitted and scope of services provided, including scope of Nursing Services, consistent with applicable state and federal law.

## Admission Policy

**NAME OF HOME:**

**DATE:**

**PROVIDER NAME:**

**This is a general statement describing this home and the services it provides:** (Description of facility should include accessibility, # of rooms, singles or doubles, first or second floor, smoking/non-smoking, pets, outdoor setup, agency or private owned, setting, description of home, cable TV, telephones, storage of personal belongings, etc. Services available may include transportation, ADLs, supervision, recreational/motivational activities, spiritual, social, educational opportunities.)

**This home intends to provide services for persons who have the following care needs** (note: Do not list the conditions or persons you will not serve. as this is discriminatory and in violation of federal law.)

**List and describe community services available to residents of your home.** (social, recreational spiritual, health, educational, volunteer services, shopping)

**List and description of the types of staff the home intends to hire.** (Resident Manager, cook, book keeping, direct care staff, RN Consultant, volunteers)

**Description of training that will be regularly provided to all care providers, including resources to provide training.**

**Description of accommodations the home has for persons with impairments.** (ramps, special bathing equipment, lighting, furniture, # of accessible bathrooms)

**Description of steps the home is willing to take to increase accommodations for persons with impairments.**

**Description of how coordination with medical and other programs/professionals will be accomplished.**

**Description of specific expertise, training/education, experience of the care providers that qualifies each to deal successfully with the residents/consumers to be served and to create positive living conditions for these residents.** (You may attach relevant copies of degrees, certificates, licenses, and other documentation related to the information below.)

Appendix C - DIRECTIONS: TO BE COMPLETED BY LEVEL II, III AND IV RESIDENTIAL CARE FACILITIES AND ASSISTED LIVING PROGRAMS. PROGRAMS WHICH HAVE BUDGETS APPROVED BY DHHS FOR REIMBURSEMENT DO NOT HAVE TO COMPLETE THIS FORM *IF* A COPY OF THE PRO-FORMA (ESTIMATED FINANCIAL BUDGET) IS SUBMITTED.

### FINANCIAL INFORMATION

**OPERATING PROJECTIONS:**

SERVICE EXPENSES

	Annual
Payroll, Taxes & Insurance	
Consultants	
Respite Care	
Respite Care/Vacation	
Insurance - W/C	
On-going Training	
Food	
Telephone	
Entertainment/Activities	
Travel	
Supplies: Household	
Supplies: Hygiene	
Supplies: Office	
Legal/Acctg	
Prof. Insurance	
Misc.	
Other	
Other	
TOTAL	
SERVICE BUDGET	

CAPITAL EXPENSES

Heat	
Hot Water	
Electric	
Cooking	
Water/Sewer	
Insurance	
Real Estate Taxes	
Rubbish Removal	
Snow Removal	
Repairs	
Replacement Escrow	
Mortgage Payments	
Other Loans	
Other	
TOTAL	
CAPITAL BUDGET	
plus	
TOTAL	
SERVICE BUDGET	
TOTAL EXPENSES	

**RESOURCES:**

RESOURCE	ACCOUNT #	WHERE HELD	AMOUNT
			\$
			\$
			\$
			\$
			\$
TOTAL RESOURCES			\$
minus			
TOTAL EXPENSES			\$
BALANCE			\$

## FLOORPLANS

**Directions:** Sketch the floor plan of the facility, noting location, size and number of resident/consumer bedrooms. Also note other areas designated for resident/consumer use, rooms to be occupied by family members or others who are not residents/consumers, bathrooms, living and dining areas, and exits. You may send printed floor plans or blueprints in lieu of this sketch.

A large grid of graph paper, consisting of 20 columns and 30 rows of small squares, intended for sketching a floor plan.