

SECTION 3: Program Administrator/Person in Charge Information (to be completed by Administrator/Person in Charge)
A Résumé may be submitted in lieu of completing the sections on education, experience and employment.

Legal Name: _____ Title: _____

Familiar Names (i.e. maiden name, aliases): _____

Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Date of Birth: _____ Social Security Number: _____

Telephone No.: () _____ Fax No.: () _____

Email Address: _____

Education:

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

Special Qualifications: Enclose a copy of all pertinent credentials.

- Please check all that apply:
- | | |
|---|--|
| <input type="checkbox"/> Multi-Level Administrator's License | <input type="checkbox"/> Licensed Practical Nurse |
| <input type="checkbox"/> Registered Professional Nurse | <input type="checkbox"/> Certified Residential Medication Aide |
| <input type="checkbox"/> Certified Nurse's Aide | <input type="checkbox"/> Residential Care Specialist I certified |
| <input type="checkbox"/> Sign Language | <input type="checkbox"/> Direct Support Specialist |
| <input type="checkbox"/> Other Spoken Language: _____ | <input type="checkbox"/> Personal Support Specialist |
| <input type="checkbox"/> CPR | <input type="checkbox"/> Other, explain: _____ |
| <input type="checkbox"/> Residential Care Administrator's License | |

Employment History: Provide the last five (5) years of employment history (attach separate sheet if necessary).

Name and Address of Employer	Job Responsibilities	Dates		Reason(s) for Leaving
		From	To	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other Relevant Experience:

Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (Use back of page, if necessary). _____

Safety and Security:

The following questions are used to help evaluate the safety and security of consumers who will be served in the program. Issues in the following areas do not automatically mean a license will be denied.

Have you ever been convicted of a criminal offense?

- No
- Yes, please explain: _____

Have you ever had a license for any long term care facility, assisted housing program (including residential care facilities and assisted living programs) denied, suspended, or revoked in this state or any other state?

- No
- Yes, please explain: _____

Have you been investigated for child or adult abuse, neglect and/or exploitation?

- No
- Yes, please explain: _____

Have you ever been treated for drug/alcohol abuse?

- No
- Yes, please explain: _____

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

- No
- Yes, please explain: _____

Professional References: Submit attached completed references with application.

Name	Address	Daytime Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 4: Applicant Information (if different from Administrator)

Company Name (if applicable):

Applicant Legal Name:

Familiar Names (i.e. maiden name, aliases):

Home Address:

City:	State:	Zip:	County:
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Date of Birth:	ID# (Owner SSN or EIN#):
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Telephone No.: ()	Fax No.: ()
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Email Address:

Have you ever been convicted of a criminal offense?

- No
- Yes, please explain: _____

Have you ever had a license for any long term care facility, assisted housing program (including residential care facilities and assisted living programs) denied, suspended, or revoked in this state or any other state?

- No
- Yes, please explain: _____

Company Name (if applicable):

Co-Applicant Legal Name:

Familiar Names (i.e. maiden name, aliases):

Home Address:

City:	State:	Zip:	County:
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Date of Birth:	ID# (Owner SSN or EIN#):
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Telephone No.: ()	Fax No.: ()
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Email Address:

Have you ever been convicted of a criminal offense?

- No
- Yes, please explain: _____

Have you ever had a license for any long term care facility, assisted housing program (including residential care facilities and assisted living programs) denied, suspended, or revoked in this state or any other state?

- No
- Yes, please explain: _____

Owned and/or operated by applicant(s) or spouse:

List ALL Home Health Agencies, Registered Personal Care Agencies, Adult Day Services and Long Term Care Facilities (including assisted housing and nursing facilities) owned and/or operated by applicant or spouse.

Name	Address	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 5: Ownership Information

Building Ownership (if different from applicant)

Please select all that apply:

- Corporation
- Individual
- Partnership
- For Profit
- 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.

Legal Name:

Mailing Address:

City:	State:	Zip:	County:
ID# (Owner SSN or EIN#):		Email Address:	
Telephone No.: ()		Fax No.: ()	

SECTION 6: Members of Household

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: _____

SECTION 7: Facility/Program Information

Facility Description: (Check all that apply)

1. Is this facility dually licensed:

- Yes
- No

2. Funded as an Adult Family Care Home:

- Yes
- No

3. Funded as a Waiver Home:

- Yes
- No

4. Receiving other MaineCare funds:

- Yes
- No

5. Is this a Level IV (multi-level) facility?

- No
- Yes, what nursing home is associated with the multi-level: _____

6. Handicapped accessible:

- Yes
- No

7. Municipal water:

- Yes
- No

8. Is there an Alzheimer's Unit:

- No
- Yes, how many Alzheimer beds: _____

9. Will there be an adult day program physically located at this facility:

- No
- Yes, list the name and address:

Number of consumers: _____

Program Information:

Type of population to be served: (Check all that apply)

Age Range: _____
 Male
 Female

Persons who are:
 Wheelchair dependent
 Elderly

- Dementia/Alzheimer's disease
- Hearing impairments
- Physical disabilities
- Neurological impairments
- Persons with mental illness
- Persons with mental retardation or developmental disabilities
- Persons with acquired brain injury
- Vision impairments
- Alcohol or drug abuse issues

Please indicate which address all future correspondence should be mailed to: (Select one)

- Program Address (Section 1)
- Administrator/Person in Charge Address (Section 3)
- Applicant Address (Section 4)
- Owner Address (Section 5)

Facilities licensed for 6 beds or less, how many full and part-time employees are there? (Do not include owners and those employees related to owner): _____

Name of the facility Physician: _____
Address: _____

Type of insurance, liability, home owner's, etc. (Please list): _____

Is this a scattered site?

No

Yes, please list the names/addresses/beds of the facilities associated with this site:

Facility Name

Address

Number of Beds

Facility Name	Address	Number of Beds
_____	_____	_____
_____	_____	_____

Renewal Information: (Complete only if renewing your license)

Current number of licensed beds: _____ Increase/Decrease in number: _____

Current resident census: _____ Do you have designated respite beds? No Yes, how many: _____

Additions/renovations to facility since last licensure: _____

Other changes since last licensure: _____

Does facility have a waiver? No Yes, please indicate item # and reason for waiver: _____

Does the waiver still apply? No Yes

SECTION 8: Submission

Submit your completed application and the following additional information:

- Two (2) checks or money orders made payable to "Treasurer, State of Maine"
- Three (3) written references for the applicant and administrator from persons who are not related by blood or marriage (Appendix A)
- Admissions Policy (Appendix B)
- Financial Information (Appendix C)
- Floor plans or blueprints of facility (Appendix D)
- Names/Addresses of Board of Director, if applicable
- A copy of the lease agreement, if applicable
- A copy of all pertinent credentials for the Administrator

The following information must also be submitted. These may be submitted with the completed application or at the time of the scheduled onsite visit:

- Policies required by Regulations, Section 10.9.4 (**LEVEL IV facilities ONLY**)
- Complaint Resolution Procedures, Section 5.8
- Disaster Plan, Section 3.31.6 (**Not required for Level II facilities**)

Failure to submit the required information will delay the processing of your application.

SECTION 9: Declaration

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 that all information provided herein is true and correct to the best of my knowledge.
- I/We certify that I am in compliance with all local laws and ordinances as they relate to zoning, plumbing, water supply, and sewage disposal.
- I/We, further appoint _____ to assume responsibility for the Assisted Housing Program
(Print name of Administrator)
herein described, and do hereby apply for a license to operate the program and do agree to assume responsibility that the program will comply with all the current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA §7802.
- I/We understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain criminal history and Bureau of Motor Vehicle records, which may be on file in any county or state office.

Print name of Applicant

Signature of Applicant

Date

Print name of Co-Applicant

Signature of Co-Applicant

Date

Print name of Administrator

Signature of Administrator

Date

Reference Form for Assisted Housing Program Providers

Name of Proposed Administrator/Applicant: _____

Name of Facility: _____

Please respond to the following questions (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 applicant/administrator: _____

3. Are you familiar with this person's experiences in serving people who are elderly or disabled?
 - No
 - Yes, Please describe: _____

4. Describe this person's ability to give care and services to people who are elderly or disabled: _____

5. Describe this applicant's/administrator'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 skills: _____

 - e) Ability to work with outside resources, such as social workers, medical professionals, state agencies, friends and families of resident, etc. : _____

6. Do you have any concerns about this person's ability to work in or operate an Adult Day Services Program?
 - No
 - Yes, please explain: _____
7. Do you recommend that this person be given the opportunity to work in or operate an Adult Day Services Program?
 - Yes
 - No, please explain: _____
8. Additional Comments: _____

Reference Information

Name of person completing this form: _____ Telephone: _____

Home Address: _____

Occupation: _____

Signature of Reference_____
Date

Admissions Policy

Directions: You may complete this form or you may submit a narrative which addresses each of these areas. The admissions policy for **Assisted Housing Programs** shall describe who may be admitted and scope of services provided, including scope of Nursing Services, consistent with applicable state and federal law.

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, number 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, bookkeeping, 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, number 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, and 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.)

Financial Information

Directions: To be completed by all Assisted Housing Programs. A copy of the Pro-Forma (estimated financial budget) may be submitted in lieu of this form for programs that have budgets approved by DHHS for reimbursement purposes.

OPERATING PROJECTIONS:

<u>SERVICE EXPENSES</u>		<u>CAPITAL EXPENSES</u>	
	Annual		Annual
Payroll, Taxes & Insurance	_____	Heat	_____
Consultants	_____	Hot Water	_____
Respite Care	_____	Electric	_____
Respite Care/Vacation	_____	Cooking	_____
Insurance – W/C	_____	Water/Sewer	_____
On-going Training	_____	Insurance	_____
Food	_____	Real Estate Taxes	_____
Telephone	_____	Rubbish Removal	_____
Entertainment/Activities	_____	Snow Removal	_____
Travel	_____	Repairs	_____
Supplies – Household	_____	Replacement Escrow	_____
Supplies – Hygiene	_____	Mortgage Payments	_____
Supplies – Office	_____	Other Loans	_____
Legal/Accounting	_____	Other	_____
Professional Insurance	_____		
Miscellaneous	_____	TOTAL CAPITAL BUDGET	_____
Other	_____	plus TOTAL SERVICE BUDGET	+ _____
Other	_____		
TOTAL SERVICE BUDGET	_____	TOTAL EXPENSES	_____

RESOURCES:

RESOURCE	ACCOUNT #	WHERE HELD	AMOUNT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TOTAL RESOURCES	_____
minus TOTAL EXPENSES	- _____
BALANCE	_____

Floor Plans

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.

