

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
 ASSISTED HOUSING PROGRAMS
Application for Relicensure

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**. **MAKE CHECKS PAYABLE TO: TREASURER, STATE OF MAINE.**

Application for: Level I _____ Level II _____ Level III _____ Level IV _____ Assisted Living: Type I _____

Level I (PNMI) _____ Level II (PNMI) _____ Level III (PNMI) _____ Level IV (PNMI) _____ Type II _____

Name of Facility _____ Legal Name (DBA, Inc.) _____

Location of Facility (911 Address): _____

Mailing Address of Facility: _____

Mailing Address of Agency: _____

E-Mail Address: _____

Name of Administrator: _____ **Facility Telephone Number:** _____ FAX# _____

Agency Telephone Number: _____ FAX# _____

POPULATION 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 _____

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? _____
- Is there 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 _____

PLEASE INDICATE WHICH ADDRESS ALL FUTURE CORESPONDENCE SHOULD BE SENT TO:

Agency/Owner Mailing Address

Facility Mailing Address

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

Current resident census: _____

Do you have designated respite beds? Yes _____ No _____ If "Yes" how many? _____

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

Additions / renovations to facility: _____

Other changes: _____

Does facility have a waiver? Yes _____ No _____ If so, please indicate Item # and reason for waiver

Does waiver still apply? Yes _____ No _____

Have you (Applicant, Administrator and/or member of household) ever:

	YES	NO
Been convicted of a crime?	___	___
Been an inpatient in a mental health facility?	___	___
Been treated for drug/alcohol abuse?	___	___
Been investigated for child/adult abuse, neglect, or exploitation?	___	___
Had a license / application to operate a residential care facility revoked / denied / placed on conditional status?	___	___

If you (Applicant, Administrator and/or member of household) answered "YES" to any of the above questions then please explain and state persons involved.

The applicant certifies that information contained in this reapplication is true and correct to the best of their knowledge. The Department of Health and Human Services reserves the right to determine the suitability of the applicant for relicensure.

I, _____, being duly authorized to assume responsibilities for the conduct of the facility herein described, do hereby apply for relicensure / re-approval 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. §7802.

Date Signature of Applicant

Date Signature of Co-Applicant

Date Signature of Owner, if different from above; Corporate officer, if operated by a Corporation

Please return to: Department of Health and Human Services
Division of Licensing and Regulatory Services
Medical Facility's Unit
11 State House Station
Augusta, ME 04333

FOR OFFICE USE ONLY
FEE RECEIVED _____
CHECK # _____