STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND CERTIFICATION

Intermediate Care Facilities for Individuals with Intellectual Disabilities Application

SECTION 1: Provider Information			
Facility Name:		National Provider Identifier:	
Doing Business As:		MaineCare Provider Number:	
Physical Address:			
City:	State:	Zip:	County:
Mailing Address (If Different):			
City:	State:	Zip:	County:
Facility's Email Address:		Facility's Telephone Number: ( )	
Type: □ Nursing □ Group		Maximum Number of Clients: _____	

SECTION 2: Fees (all fees are non-refundable)	
APPLICATION FOR ICF/IID	
☐ New License ☐ Annual Renewal License ☐ Change ($10 per statute) (fee $10 x number of beds: _____) (fee -$10 – for change of administrator or any license change) Registration Renewal Period (dates): _____ to _____ **Total Fee Enclosed with application** ……	$ _____
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. Application fees are non-refundable. **Total Check/Money Order enclosed: =**	**$ ____**

SECTION 3: Administrator
Name of Administrator: _____
Administrator's License #: _____ Expiration Date: _____
Administrator's Home Address: _____
Administrator's Home Phone: ( ) _____ Administrator's Office Phone Number: ( ) _____

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Certification - MFU
11 State House Station
Augusta, ME 04333-0011
Tel: (207) 287-9300 Fax: (207) 287-9252 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: DLRS.medfacilities@maine.gov

Office Use Only:
Check# _____ *MO #* _____ *Amount $*_____ *Initials:* _____
License# _____

SECTION 4: Part A Ownership Information (Use additional sheets, if necessary)

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

Type of Entity:

☐ Sole Proprietorship ☐ Corporation (complete section C)

☐ Partnership (complete section B) ☐ Not-for-Profit (complete section D)

☐ Other: _____(Please attach any additional information)

B. Partnership

List the names and addresses of partners or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 10% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity. Attach additional names and addresses on a separate piece of paper if necessary.

Full Name: _____ Address: _____

Full Name: _____ Address: _____

Full Name: _____ Address: _____

C. Corporation

List the names, address and titles of the Officers and Directors. Attach additional names and addresses on a separate piece of paper if necessary.

Officers:

Full Name: _____ Address: _____

Full Name: _____ Address: _____

Directors:

Full Name: _____ Address: _____

Full Name: _____ Address: _____

D. Not-for-Profit

List the name and address of the Board of Directors President or the appropriate Municipal Government Representative. Attach additional names and addresses on a separate piece of paper if necessary.

Full Name: _____ Address: _____

Full Name: _____ Address: _____

SECTION 5:

Emergency Contact Information:

Contact Name: _____

Contact's Phone Number _____

Contact's Email Address: _____

Water Supply: Public ☐ Private ☐ If private, please enclose the last water test.

Sewage Disposal: Public ☐ Private ☐

Description of all structures and buildings forming any part of this institution:

Name of the Owner(s) of the premises: _____

Initial Applicants ONLY: This application must include the following (Please check box(s) to indicate included):

Certificate of Need Letter ☐ Copy of Building Lease (if applicable): ☐ Copy of Facility Floor Plans ☐

State Fire Marshall Office Certificate of Occupancy ☐ Written Statement from OADs ☐

Statement form CDC Water Drinking Program ☐

Forms for drinking water program can be found at:
http://www.maine.gov/dhhs/mecdc/environmental-health/dwp/index.shtml

Renewal Applicants ONLY: Please submit any request for waivers with each license renewal. See regulation 3.K. for details.

SECTION 6: Declaration

- I, the below signed, being duly authorized to assume responsibility for the conduct of the institution herein described, do hereby apply for a license to operate the facility and do agree to assume responsibility that the facility will comply with all current regulations of the Department of Health and Human Services.
- I have read and understand the notice of successor liability included with this application.

_____ _____ _____

Print Name of Administrator **Administrator's Signature** **Date**

If the application is on the behalf of a corporation, association, or government unit, this application must be signed by any two officers thereof or by its managing agency and by any general partner of a partnership.

_____ _____ _____

Print Name & Title **Signature** **Date**

_____ _____ _____

Print Name & Title **Signature** **Date**

Notice of Successor Liability

As required by 22 M.R.S.A. § 1714-A(4), the Division hereby provides written notice of successor liability regarding debts owed the Department.

Successor Liability

When a nursing home, boarding home, hospital or other provider of health care services is transferred, the transferee is liable for debts owed to the Department by the former provider unless by the time of sale:

> *(1) All debts owed by the former provider to the Department have been paid, except as stated in subparagraph (2);*
>
> *(2) If the indebtedness is the subject of an administrative appeal, an escrow account has been created and funded in an amount sufficient to cover the debt as claimed by the Department; or*
>
> *(3) An interim cost report has:*
>
> > *(a) Been filed and an escrow account has been created and funded in an amount sufficient to cover any overpayment identified in the report; or*
> >
> > *(b) Not been filed and an escrow account has been created and funded in an amount sufficient to cover 5% of Medicaid reimbursement or cost reimbursement for the last fiscal year or $50,000, whichever is less.*

Any transferee may request that the Department identify the amount of any debt owed by a nursing home, boarding home, hospital or other provider of health care services. When the Department receives such a request, it shall identify the debt within 30 days. Failure to identify the amount of a debt when a request is made in writing at least 30 days prior to the transfer precludes the Department from recovering that debt from the transferee.

If a transferee becomes liable for a debt, the transferee shall succeed to any defenses to the debt that could have been exercised by the former provider.

Liability of a transferee does not limit the liability of the former provider to the department for any debts whether or not they are identified at the time of sale. In addition, a transferee has a cause of action against a former provider to the extent that debts of the former provider are paid by the transferee, unless the transferee has waived the right to sue the former provider for those debts.

The Commissioner may waive all or part of a transferee's liability under this subsection if the Commissioner finds that a waiver of liability is in the public interest.

Questions about this notice or a request to identify the amount of any debt owed by a nursing home, boarding home, hospital or other provider of health care services should be directed to the following person:

Jonah Howard, Manager
MaineCare & Social Service Recovery
SHS#11
DHHS Financial Service Center
Augusta ME 04333-0011