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

Assisted Housing Program

Residential Care and Assisted Living Application

SECTION 1: Provider Information			
Facility Name (i.e. DBA):		Legal Name:	
Facility Physical Location:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Facility Telephone No.: ( )		Fax No.: ( )	
Facility Email Address:			NPI:
Please list all of your MaineCare NPI Plus 3 Numbers:			

SECTION 2: Fees (please check the box for type of application)

☐ Initial Application (1 Year) ☐ Renewal Application (2 years)

	Type of Program	**Beds/units**	**Fee**
☐	Residential Care Facility – Level I	____	(fee $10 x number of bed x year(s) : _____)
☐	Residential Care Facility – Level II	____	(fee $10 x number of beds x year(s): _____)
☐	Residential Care Facility – Level III	____	(fee $10 x number of beds x year(s): _____)
☐	Residential Care Facility – Level IV	____	(fee $10 x number of beds x year(s): _____)
☐	PNMI – Level I	____	(fee $10 x number of beds x year(s): _____)
☐	PNMI – Level II	____	(fee $10 x number of beds x year(s): _____)
☐	PNMI – Level III	____	(fee $10 x number of beds x year(s): _____)
☐	PNMI – Level IV	____	(fee $10 x number of beds x year(s): _____)
☐	Assisted Living – Type I	____	(fee $200 x year(s):_____)
☐	Assisted Living – Type II	____	(fee $200 x year(s):_____)

Total Fee Enclosed for licensed capacity …… $ _____

Background Check Fees (Select all that apply): (For all initial applications and renewal applications if there have been any changes since last licensure application.)

☐	Owner/Applicant	(fee $31)
☐	Administrator**	(fee $31)
☐	Household members 18 years or older**	(fee $31 x each member: _____)

****Note: background check fees apply to all initial applications and if there has been a change in administrator or household members over 18 since last licensure application, who reside in the facility and are not residents/consumers of assisted housing.**

Total Fee for Background checks…… $ _____

$ _____

Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Check/Money Order enclosed =** **$ _____**

Mail application to address below and for questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Certification
Assisted Housing Program
41 Anthony Ave, 11 State House Station, Augusta, ME 04333-0011
Email: dlrs.medfacilities@maine.gov
Tel: (207) 287-9300 Fax: (207) 287-5815 Toll Free: 1-800-791-4080 TTY users call Maine relay 711

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

SECTION 3: Program Ownership Information

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. Please attach a copy of your organizational chart.

Legal Name of Owner:			
Mailing Address:			
City:	State:	Zip:	County:
ID# (Owner SSN or EIN#):	Email Address:		
Telephone No.: ( )	Fax No.: ( )		
Legal Name of Co-Owner , if Partnership:			
Mailing Address:			
City:	State:	Zip:	County:
ID# (Owner SSN or EIN#):	Email Address:		
Telephone No.: ( )	Fax No.: ( )		

The next three questions apply to sole proprietors or partnership owners. Corporations please skip.

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: _____

_____

_____

If you own or operate any other assisted housing sites, adult day care site, or nursing home, please attach a list that includes the name, address, phone number and capacity to this application for each site.

Is the owner listed above also the owner of the building?

- ☐ Yes
- ☐ No

If no, you will need to submit a copy of the lease agreement for the building.

SECTION 4: Program Administrator/Person in Charge Information (to be completed by Administrator/Person in Charge)
Please complete this section. If this is a new application or a change in administrator, you must use Appendix A – References Form. If this is a level IV facility, you must include a copy of the Level IV Administrator License.

Name:		Title:	
Familiar Names (i.e. maiden name, aliases):			
Mailing Address:			
City:	State:	Zip:	County:
Date of Birth:			
Telephone No.: ( )		Fax No.: ( )	
Email Address:		Date Started:	

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: _____
  _____
  _____

If you are the administrator of any other assisted housing, adult day care site, or nursing home, please attach a list that includes the name, address, telephone number and capacity for each of those sites to this application for each site.

SECTION 5: House Manager/Person In Charge at the Location (if different from Administrator)

Name:
Phone Number:
Email Address:

SECTION 6: Members of Household

List all persons over the age of 18 who reside in the facility and are not residents/consumers of assisted housing. Always fill out this section if this is an initial application and for a renewal if there has been a change since last license.

Name	**Date of Birth**	**Relationship to Applicant**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For each Household member, indicate other names they have been known by (i.e. Maiden name, aliases):

_____
_____

SECTION 7: Resident Population Information (Demographics of the population you currently serve at your facility)

Age Range: _____

Sex:

- ☐ *Male*
- ☐ *Female*

Persons who are:

- ☐ *Wheelchair dependent*
- ☐ *Elderly*

Do you have residents with the following:

- ☐ *Dementia/Alzheimer's disease*
- ☐ *Hearing impairments*
- ☐ *Physical disabilities*
- ☐ *Neurological impairments*
- ☐ *Persons with mental illness*
- ☐ *Persons with intellectual disabilities or developmental disabilities*
- ☐ *Persons with acquired brain injury*
- ☐ *Vision impairments*
- ☐ *Alcohol or drug abuse issues*
- ☐ *Other (please specify) _____*

SECTION 8: **Assisted Living Questions:** (Complete only if you are an Assisted Living Provider)

Number of licensed units: _____

Describe the following for each type of unit.

Type of unit	**Number of units**	**Total number of people living in units**
Efficiency	_____	_____
1 Bedroom	_____	_____
2 Bedroom	_____	_____
Other Please specify	_____	_____

SECTION 9: Facility Information

1. Are you funded as an Adult Family Care Home:
   - ☐ Yes
   - ☐ No

2. Are you funded by MaineCare as a Waiver Home:
   - ☐ Yes
   - ☐ No

If yes, please indicate which MaineCare section below:

- ☐ Section 19 Traumatic Brain Injury
- ☐ Section 21 Intellectual Disabilities
- ☐ Section 20 CP, Epilepsy, etc
- ☐ Section 19/20 Adults & Elderly with Disabilities

3. Is this a Level IV (multi-level) facility that is on the same grounds as a nursing home?
   - ☐ No
   - ☐ Yes, name of nursing home below:

   _____

4. Are you handicapped accessible:
   - ☐ Yes
   - ☐ No

5. Is there an adult day program physically located at this facility:
   - ☐ No
   - ☐ Yes, list the name and address:

   Name of the Adult Day Program below:

   _____

6. Are you on municipal water:
   - ☐ Yes
   - ☐ No (submit a copy of your last water test)

7. If you are licensed for 6 beds or less, how many full and part-time employees do you have? (Do not include owners and those employees related to owner):

_____

8. Do you have a Mental Health license?
   - ☐ Yes
   - ☐ No

If yes, put the name of the agency on that license below.

_____

Specialized Units/Facilities Definition

There are two types of specialized providers: a provider with a specialized unit that serves one type of resident; or an entire facility that serves one type of resident.

For example, you may have a dementia/Alzheimer's **unit** in your facility or your **entire facility** may serve only dementia/Alzheimer's residents.

Other types of specialized services may include mental health, brain injury, or intellectual disabilities.

9. Do you meet the above definition of having either a specialized unit or specialized facility?
   - ☐ Yes – have a specialized unit or facility
   - ☐ No – have a mixed resident population (Skip to Section 9)

10. If yes above, please select one of the boxes below.
   - ☐ Dementia/Alzheimer's
   - ☐ Mental Illness
   - ☐ Intellectual Disability/Autism (MaineCare Section 21)
   - ☐ Brain Injury (MaineCare Waiver Section 19)
   - ☐ CP/Epilepsy/Other Closely Related to Intellectual Disability Disorders (MaineCare Waiver Section 20)
   - ☐ Adults and Elderly individuals with Disabilities (MaineCare Waiver Section 19 and 20)
   - ☐ Other (please specify on the line below)

   _____

11. How many beds are in this specialty unit or facility?

_____

SECTION 10: **Renewal Information:** (Complete only if renewing your license)

Current capacity: _____ Capacity being applied for if different: _____

Note: you will need to attach blueprints and a budget if this is an increase

Do you have designated respite beds? ☐ No ☐ Yes If yes, how many: _____

Additions/renovations to facility since last licensure:

_____

_____

Was change application sent to DLRS? ☐ No ☐ Yes If yes, date sent? _____

Other changes since last licensure:

_____

Does this facility have a licensing regulation waiver (for example a heat waiver)? ☐ No ☐ Yes

If yes, please indicate regulation #, reason for waiver and expiration date:

_____

SECTION 11: Submission Documents for all applicants

Submit your completed application and the following additional information: Check or money order made payable to "Treasurer, State of Maine" – (for all applications)

- Three (3) written references on the form in Appendix A – (for all new applications and for renewal applications if there is a **change in administrator)**
- A copy of the administrators license if this is a level IV facility (for initial applications or if a change in administrator)
- Admissions Policy (Appendix B) – (for all initial applications)
- Financial Information (Appendix C) – (for all initial applications)
- Floor plans or blueprints of facility (Appendix D) – (for all initial applications and renewals if there is a change in floor plan or number of beds)
- If this is for a corporation or nonprofit organization, attach a list of you Board of Directors with their addresses – (for all initial applications and renewals if there is a change in Board of Directors)
- If this is for a corporation or nonprofit organization, attach a copy of your organizational chart (for all initial applications and renewals if there is a change in Board of Directors)
- A copy of the lease agreement, if building owner is different than program owner – (for all initial applications and renewals if there is a change in the agreement)
- If facility is on a private water supply, submit a copy of an acceptable water test. To be acceptable, the water test must have been done and had passing results within the last year. See Section 14 for additional information – (for all initial applications and all renewals with private water supplies)
- Copy of legal name documentation – for all initial applications or and all renewals (Legal documentation an IRS "EIN – employer identification number or [2] documentation from the Maine Secretary of State)

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

SECTION 13: 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/our 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 (Print name of administrator here) _____ to assume responsibility for the Assisted Housing Program 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 have read and understand the Notice of Successor Liability contained as Appendix E (page 14).
- 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**

SECTION 14: Explanations

Change to Licenses

– Once a license is printed and sent to a provider, any requested change to a facility regarding number of beds, services, provided, change in administrator, etc. requires the payment of a $10.00 processing fee for a new license in addition to any other charges incident to the request. See statute M.R.S. Title 22 §1723.

Requirement for a water test if facility is on private water supply (M.R.S. Title 22)

16.22 Water supply. The water supply shall be adequate, of a safe and sanitary quality and from a source, which meets applicable State and local laws and regulations. The following standards shall apply: *[Class III]*

16.22.1 Water not piped directly from its source shall be transported, handled, sorted and dispensed in a sanitary manner.

16.22.2 Adequate supplies of hot and cold water shall be provided at all hand washing facilities and where equipment and utensils are washed, unless otherwise approved in writing by the Department.

16.22.3 Water supply systems shall be reviewed and approved according to Chapter 231, Drinking Water Rules, adopted by the Department.

16.22.4 The source of all water supplies must be protected from pollution and treated in a manner approved by the Department.

16.22.5 A private water supply shall be tested annually and a satisfactory result must be obtained.

Reference Form for Assisted Housing Program Providers
(Must be completed by persons who are not related by blood or marriage.)

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, etc.)

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:

SERVICE EXPENSES	Annual	CAPITAL EXPENSES	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 EXPENSES	_____
TOTAL SERVICE BUDGET	_____		

RESOURCES:

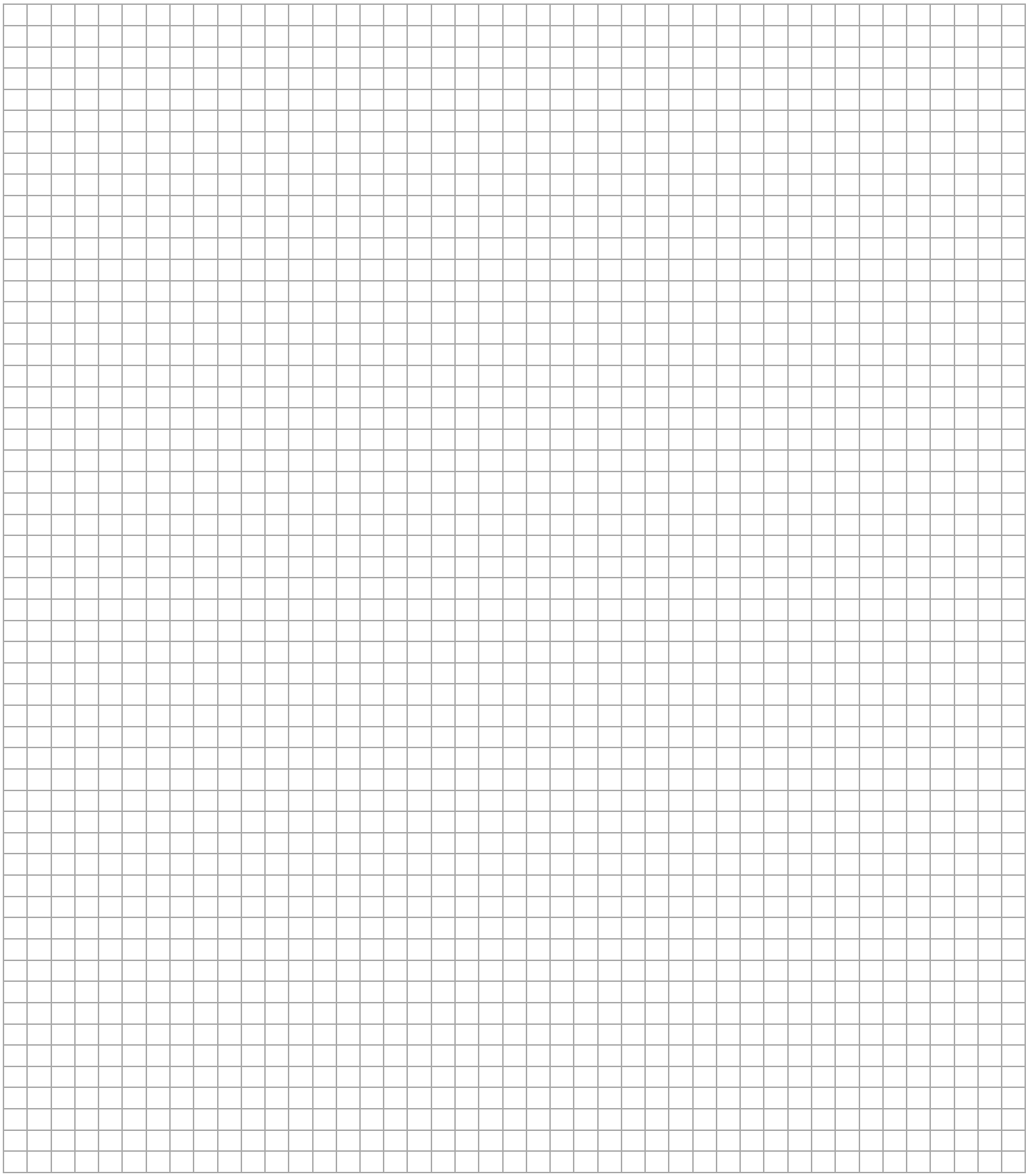
RESOURCE	ACCOUNT #	WHERE HELD	AMOUNT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.



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