



Please complete all applicable sections of this application and checklist. Please note the following:

- **If you are interested in participating in the voluntary conversion of ICF/IID beds to waiver beds, please attach a statement of your interest to this application. For more information you may contact Ann Weisent at 614-949-8792.**
- If you are relocating licensed beds and the existing facility is currently certified as an ICF/IID, you will need to contact Biljana Manev at the Ohio Department of Job and Family Services at 614-752-3573 at least 90 days prior to the proposed relocation date.
- An operator of a licensed facility, which will deliver services to waiver consumers, shall apply for and must be certified as a HCBS waiver provider in order to receive reimbursement for waiver services. Contact the Provider Certification office at 800-617-6733, if you need an application.
- If relocating licensed beds, you must notify the local county Department of Job and Family Services of the change of address for involved individuals. This may be done on or before the actual move date. Failure to do so may jeopardize the individuals' Medicaid eligibility, and consequently, also their eligibility for waiver services.
- A new license must be in place prior to relocating individuals.
- All facilities serving individuals with disabilities shall be appropriate to the needs of the individuals. As a measure of compliance with Section 504 of the Rehabilitation Act of 1973, facilities serving persons with a qualified handicapped must be accessible to and usable by the handicapped. New construction and renovated facilities shall be designed and constructed so as to be accessible, to the maximum extent feasible. If the facility is an existing structure and it is not accessible, evidence must be provided that a search has been conducted to determine that no other more appropriate facility in the area could be attained. American National Standards Institute accessibility standards (A117.1), or other equivalent measures shall be used to judge architectural accessibility.
- **If development includes the construction of a new building to be licensed, approval should occur at least 60 days PRIOR to the start of construction to ensure that the project will meet licensure requirements. DODD cannot guarantee that a newly constructed building will meet the requirements for licensing and DODD will not issue rule waivers for projects started prior to receiving approval from DODD.**

CHECKLIST FOR DEVELOPMENT OF RESIDENTIAL CARE FACILITIES

Instructions: Items with an asterisk (*) must be submitted with the Development Application. All other items must be submitted during your development process, but must be submitted before a license can be issued (*double-click on checkboxes here and throughout the form to apply a check that box*):

	YES	NO	N/A
1) The development application form. *	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Directions to the facility.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Photograph of the facility to be licensed.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) A set of floor plans for all floors, including the basement. *	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) The name and address of the Clerk of the City Council (if the facility is located in the city limits) or the name and address of the Clerk of the Board of County Commissioners AND the Clerk of the Board of Township Trustees (if the facility is located in a township or village). *	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) A copy of the written and drawn fire control and evacuation plan.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) A written statement with the anticipated effective date of the new license. * (This date may be modified as needed during the development process)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) A statement closing or decreasing the capacity of the existing facility.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Fire Inspection – required for ALL facilities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) Water Inspection – required for facilities NOT on a city system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11) Sewer Inspection – required for facilities NOT on a city system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) Building Inspection – See below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13) Heating Inspection – See below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) Wiring Inspection – See below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All necessary forms and inspections for the facility being licensed must be received at least 30 days before a license can be issued or the facility can be occupied:

- Approved fire inspection by a local or state fire inspector (For **ALL** facilities)
- Approved septic inspection by a county health department (For **ALL** facilities if not on city septic)
- Approved water inspection by a county health department (For **ALL** facilities if not on city septic)
- Approved heating inspection by a certified heating inspector (For facilities **5 beds or LESS**)
- Approved wiring inspection by a certified wiring inspector (For facilities **5 beds or LESS**)
- Approved formal building inspection by the local city building department or State Factory and Buildings (For facilities **6 beds or MORE**)

A feasibility (walkthrough) inspection will be completed within 30 days of notification that the facility is ready for occupancy. The license cannot be issued until the all required documents and inspections have been submitted, the feasibility inspection has been completed, and the appropriate licensing fee has been paid.

**APPLICATION FOR A LICENSE TO OPERATE A RESIDENTIAL CARE FACILITY
FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**

NOTE: For a change of ownership, this application must be completed by the proposed new licensee and signed by both the existing and the proposed licensee.

CHECK ALL THAT APPLY:

(NOTE: This application must be received 60 days prior to the proposed effective date of the new license.)

- Relocation
- Increase in Capacity/New Facility
- Decrease in Capacity/Downsizing/Conversion
- Replacement of Existing Facility Beds
- DODD 6 – bed ICF Project
- Other (attach explanation)

PLEASE PROVIDE THE ANTICIPATED DATE OF OCCUPANCY:

PLEASE COMPLETE APPLICABLE SECTIONS. IF “NOT APPLICABLE,” PLEASE INDICATE BY INSERTING “N/A”. PLEASE DO NOT LEAVE ANY ITEMS BLANK.

SECTION I – New Facility

Property Information

Name of **Proposed Site** as it will appear on the License (a separate application is needed for each site)

Address _____ Phone Number _____
City _____ State _____ Zip _____ County _____
Township (if not located within city limit)

Is the proposed site currently, or has it ever been, licensed by another state agency? If so, identify the agency and license numbers.

Name of Proposed Licensee

Address _____ Phone Number _____
City _____ State _____ Zip _____ County _____

Tax ID/Social Security Number of Proposed Licensee

Capacity

Current Licensed Capacity:

Address of Existing Facility

Telephone Number

City

State

Zip

County

Facility Identification (License) Number

Capacity

Current Licensed Capacity:

Current Number of Individuals:

Proposed Licensed Capacity:

Did the Ohio Department of Developmental Disabilities award Capital Construction Assistance Funds for the construction, site, or equipment for the proposed or existing facilities noted above?
(See attachment A)

Yes Proposed (If yes, Project Number:)
 Existing

No

If yes, please complete the attached Application for Transfer or Sale of Property Purchased/Constructed/Renovated with DODD Capital Bond Dollars and with an Existing Participation Agreement.

Accessibility requirements pursuant to Section 504:

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits the Ohio Department of Developmental Disabilities from paying for any services in new construction (defined as after 1977) that is not accessible to handicapped individuals. Therefore, any newly constructed facility of any category or for any level of care will be physically accessible whether built by the Ohio Department of Developmental Disabilities, by a sub-grantee, or by any other organization or arrangement (even if leased).

The Ohio Department of Developmental Disabilities reserves the right to ask for additional information to assist in the review of this application.

Name of Person completing this form

Telephone Number

Email Address

SECTION III – Proposed and Current Owners/Licensees

I certify that the information contained in this **Residential Licensure Application** and other materials submitted, are correct and complete. I understand that failure to provide all requested information may result in disapproval.

Signature of Proposed Owner/Licensee or Representative

Date

Type or Print Name

Title

Signature of Existing Owner/Licensee or Representative

Date

Type or Print Name

Title

Any false statement in this application is sufficient grounds for denial or revocation of a license.

A license is not transferable to another licensee and does not apply to occupancy of any building(s) other than that specified on the license.

Department of Developmental Disabilities Use Only

Authorization Number:

Date Received:

Received by:

NOTE: SEND THE ORIGINAL APPLICATION TO:

Ohio Department of Developmental Disabilities
Division of Legal & Oversight
Attn: Office of Provider Standards & Review
1810 Sullivant Avenue
Columbus, Ohio 43222
Phone: (614) 466-6670 Fax: (877) 644-6671

ATTACHMENT A

**APPLICATION FOR TRANSFER OR SALE OF PROPERTY
PURCHASED/CONSTRUCTED/RENOVATED WITH
OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES
CAPITAL BOND DOLLARS AND WITH AN EXISTING PARTICPATION AGREEMENT**

A. CHECK ALL THAT APPLY:

RELOCATION/REPLACEMENT OF RESIDENTIAL FACILITY

- SALE OF RESIDENTIAL FACILITY TO:
(Name of Organization/Person)
- TRANSFER OF OBLIGATION TO ANOTHER NON-PROFIT/GOVERNMENT AGENCY
- SALE OF COUNTY BOARD OF MR/DD ADULT SERVICES FACILITY TO:

- SALE OF COUNTY BOARD OF MR/DD SCHOOL BUILDING TO:

B. Name of Agency requesting sale/transfer Telephone Number

Address

City State Zip County

Tax ID Number or Social Security Number: Fax #:

C. Name of Buyer Telephone Number

Address

City State Zip County

Tax ID Number or Social Security Number: Fax #:

E. Proposed Selling Price:

Fair Market Value:

(Attach Descriptive Narrative Appraisal)

Amount of Outstanding Financial Obligation:

F. What are the reasons for this modification, replacement, transfer or sale and how are services to the individuals affected?

G. Brief description of replacement/substitution project including its proposed use and estimated value/cost of replacement/substitution project.

H. Describe the projected timelines for the development of the new site, i.e., when will it be purchased or leased, licensed, zoned, contracted and ready for occupancy?