

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/MR beds to waiver beds, please attach a statement of your interest to this application. For more information you may contact Debbie Jenkins at (614)387-0578.**
- If you are relocating licensed beds and the existing facility is currently certified as an ICF/MR, 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 (877) 289-3636, 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.

NOTE: SEND THE ORIGINAL APPLICATION AND COUNTY BOARD LETTER OF SUPPORT TO:

Ohio Department of Developmental Disabilities
Division of Legal and Oversight
Attn: Office of Provider Standards and Review
1810 Sullivant Avenue
Columbus, Ohio 43222-1055

Phone: (614) 466-6670
Fax: (877) 644-6671

CHECKLIST FOR RESIDENTIAL CARE FACILITIES

Instructions: The following items must be submitted to complete the Development Application (double-click on checkboxes here and throughout the form to apply a check that box):

	YES	NO	N/A
1) The development application form (as attached).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Directions to the facility (form attached).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Photograph of the facility to be licensed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) A set of floor plans for all floors, including the basement, of group homes and specialized care facilities.	<input 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) A copy of the written and drawn fire control and evacuation plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) A written statement with the effective date of the new license. Note: this will be the same date the old facility will close, decrease in capacity, or relocate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) A letter of support from the County Board in which the new facility will be located.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) A statement closing or decreasing the capacity of the existing facility.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) A copy of the following policies: MUI Policy Medication Administration Policy Behavior Support Policy Training Policy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
11) A copy of the agency or individual I.O. Waiver certification.	<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:

For a facility being licensed for one to five beds:

- Approved fire inspection by a local or state fire inspector
- Approved heating inspection by a certified heating inspector
- Approved wiring inspection by a certified wiring inspector
- Approved septic inspection by a county health department (if not on city septic)
- Approved water inspection by a county health department (if not on city water)

For a facility being licensed for six or more beds:

- Approved fire inspection by local or state fire inspector
- Approved formal building inspection by the local city building department or State Factory and Buildings
- Approved septic inspection by a county health department (if not on city septic)
- Approved water inspection by a county health department (if not on city water)

A feasibility inspection will be completed after the receipt of the license application. 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.)

- | | |
|---|--|
| <input type="checkbox"/> Relocation (<i>Complete Sections I, II & IV</i>) | <input type="checkbox"/> Change of Ownership (<i>Complete Sections I, II, III & IV</i>) |
| <input type="checkbox"/> Increase in Capacity
<i>(Complete Sections I, II & IV)</i> | <input type="checkbox"/> Change of License from ODH to DODD
<i>(Complete Sections I & IV)</i> |
| <input type="checkbox"/> Decrease in Capacity
<i>(Complete Sections I, II & IV)</i> | <input type="checkbox"/> Other (attach explanation) |
| <input type="checkbox"/> Replacement of Existing Facility Beds (<i>Complete Sections I & IV</i>)
<i>(attach DODD award letter)</i> | |

PLEASE PROVIDE THE DATE THAT YOU WISH THIS DEVELOPMENT TO BE COMPLETE:

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

SECTION I – Proposed Licensee

Proposed Licensee		Telephone Number	
Mailing Address of Proposed Licensee		City	State Zip
County	Fax Number	E-mail Address	
Name of Chief Executive Officer/Administrator		Telephone Number	
Mailing Address if different from above		City	State Zip
Name of Person completing this form			
Tax ID/Social Security Number of Proposed Licensee			
<input type="checkbox"/> For Profit Corporation	<input type="checkbox"/> Non-Profit Corporation	<input type="checkbox"/> County Board Operated	
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> Other	

Name of Proposed Management Contractor (if applicable)

Address

Township (if not located within city limits)

City

State

Zip

County

Phone Number

Fax Number

Tax ID/Social Security Number of Proposed Management Contractor

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

Address

City

State

Zip

County

Facility Identification (License) Number
(IF CURRENTLY LICENSED)

Facility Phone Number

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

Has a license for this facility ever been revoked?
(If yes, explain on a separate sheet)

Yes

No

PROPOSED FACILITY:

Current Licensed Capacity:

Current Number of Individuals:

Proposed Licensed Capacity:

Ambulation (check one) Ambulatory Non-Ambulatory

Funding Source:

Waiver (any type)

ICF/MR

Other (explain)

This facility will be used:

Currently as is Structure with renovations New Construction

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).

SECTION II – Current Licensee

Name of Current Licensee (if different from Proposed Licensee) Telephone Number

Mailing Address of Current Licensee City State Zip

County Fax Number E-mail Address

Name of Current Chief Executive Officer/Administrator Telephone Number

Mailing Address (if different from above) City State Zip

Name of Person completing this form

Tax ID/Social Security Number of Current Licensee

For Profit Corporation Non-Profit Corporation County Board Operated
 Sole Proprietorship Partnership Other

Name of **Existing Facility**

Address of Existing Facility Telephone Number

City State Zip County

Facility Identification (License) Number Fax Number

CENSUS INFORMATION (PER FACILITY) - USE SEPARATE SHEET IF NECESSARY:

EXISTING FACILITY:

Current Licensed Capacity:

Current Number of Individuals:

Ambulation (check one) Ambulatory Non-Ambulatory

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.

Note: In accordance with Ohio Administrative Code 5123:2-16-01, approval by the Department of a relocation of a facility currently licensed under 5123.19 of the Ohio Revised Code, requires a letter of recommendation from the county board of developmental disabilities. The movement of some or all of the licensed capacity of a home from one county to another shall be recommended by all county boards affected by the modification.

Department of Developmental Disabilities Use Only

Authorization Number:

Date Received:

Received by:

SECTION III

IF THIS IS A CHANGE OF OWNERSHIP, PLEASE COMPLETE THE FOLLOWING:

Please give a brief narrative as to why this change is occurring and how it will affect the services currently being provided to the individuals living in the facility?

(Use separate sheet if necessary)

Have the individuals and guardians been notified?

Yes

No (*if no, please explain*)

Explain how the ownership will change, i.e., type of corporation status, number of shares of stock, identification of owners, percentage of shares of ownership, and change in family-owned business (Use separate sheet if necessary)

Please be advised that the license cannot be issued until the following conditions have been met (the following questions must be responded to in writing and a copy of the purchase agreement must be submitted):

- 1) Specify either the buyer or the seller as the party responsible for the start-up obligations of the facility.
- 2) Specify the seller to indemnify buyer 100% of funded client accounts as of the date of the change of ownership.
- 3) Specify either the buyer or the seller as the party responsible for payment of audit findings and entitled to receipt of audit settlements resulting from Department audits.

SECTION IV – Proposed and Current Licensee

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 Licensee or Representative Date

Type or Print Name Title

Signature of Existing 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.

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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 PARTICIPATION 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 it's 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?

I certify that the information contained in this application and other materials submitted are correct and complete.

Signature of Current Licensee or Representative

Date

Type or Print Name

Title