Schedule 1 – General Information

Contents:

Directions and Information for all Adult Care Facility Applicants

The Department's Licensing and Supervisory Authority

New York State, through the State Department of Health licenses and supervises Adult Care Facilities which provide temporary or long term nonmedical residential care services to adults who are substantially unable to live independently. Adult Care Facilities provide or arrange long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults. Under state law no person or organization may operate an adult care facility without an operating certificate from the Department. Establishment of or changes to the license of an adult care facility must be preauthorized by the Department of Health.

The Adult Care Facility Common Application

The Adult Care Facility Common Application ("Common Application") replaces the adult care facility certificate of need application, the assisted living residence application and the assisted living program application. The Common Application should be submitted for any licensure change or establishment for adult homes, enriched housing programs, assisted living residences and assisted living programs for which an abbreviated application has not been developed.

The Common Application is divided into six schedules. Schedules 1 through 5 are reviewed by the "Central Office" located in Albany and each application is assigned a project manager who will communicate with the applicant. The Department of Health will only communicate with the person designated as the contact person on the Common Application. Schedule 6 is reviewed by the regional office that serves the county of the facility or proposed facility. The regional office will assign a regional project manager to communicate with the contact person during the course of the review.

Successful completion of Schedules 1-5 will result in a Part I approval. Successful completion of Schedule 6 will result in a Part II approval. Final approval to commence or assume operations requires the approval of both Part I and Part II, which may not occur simultaneously. A proposed opening date should be discussed with your project manager and arrangements should be made to apply for a Class 3A license to assist residents with controlled substances when final approval is near.

Approvals are issued by e-mail, and will contain the operating certificate number for the facility. The actual operating certificate is delivered to the facility thereafter by mail.

Abbreviated Applications Used in Lieu of the Common Application

Abbreviated applications have been developed for the following requests:

1. Increase in licensed capacity of an adult home, enriched housing program or assisted living residence by up to nine beds;
2. Increase in the certified enhanced assisted living residence or special needs assisted living residence beds by up to nine beds;
3. Limited Change in Ownership of an existing adult home, enriched housing program, assisted living residence or assisted living program of either:
   a. a transfer of less than 10% ownership interest to a new person; or
   b. a transfer in any amount to a person who currently has an ownership interest in the approved operator, provided that such person underwent a character and competence review when he or she obtained the ownership.
4. Business Conversions of an existing operator;
5. Application for proposed and existing operators to operate a program for temporary services to nonresidents (i.e. a respite program);
6. Application for proposed and existing operator to operate a day program for non~residents;
7. Decertification of a portion of licensed beds, without construction or renovations that exceed routine maintenance and repair.

Table of Required Schedules

The following table lists the schedules required for each type of Adult Care Facility Common Application type:

Application Type	Schedules Required
Establishing, with or without construction, a new ACF or ALR	1,2,3,4,5, and 6
Establishing an ALP **after** receipt of Department approval	1,2. 3, 4, 5, and 6*
Construction or Renovation of an Existing Licensed Facility that exceeds routine maintenance and repair	1,4,5, and 6
Change of Operator of an existing licensed ACF, ALR or ALP	1, 2, 3, 4, 5, and 6
Increase in Capacity of an ACF or ALR by more than 9 beds or Increase in certification of an EALR or SNALR by more than 9 beds	1,4,5, and 6
Establishment of a new Manager	1, 2a, 3, and 4c.
Transfer of 10% or more ownership interest in the Operator to a new person or increase in the ownership interest of an existing owner to 10% or more if such person never underwent a character and competence review.	1,2 and 3

***Establishment of an ALP may also require establishment of a home care agency. See http://www.health.ny.gov/forms/doh-1056.pdf for more details.**

Each schedule contains instructions that should be carefully reviewed prior to submission. The Department reserves the right to return any incomplete application to the applicant.

Submission Information

An original and two copies of the applicable Common Application Schedules 1-5 and any abbreviated applications should be submitted to the Department of Health at: New York State Department of Health, Bureau of Licensure and Certification, 875 Central Ave., Albany, New York 12206.

Additionally, one copy of Schedule 6, if applicable, should be mailed together with one copy of Schedule 1A to the appropriate regional office serving the county in which the facility is located. A copy of the cover letter to the regional office must be submitted to the attention of your main project manager at the Department's 875 Central Avenue address. The regional offices and counties served are:

Capital District Regional Office New York State Department of Health 875 Central Ave. Albany, NY 12206	Albany Clinton Columbia Delaware	Essex Franklin Fulton Greene	Hamilton Montgomery Otsego Rensselaer	Saratoga Schenectady Schoharie Warren	Washington
Central Regional Office 214 South Salina Street Syracuse, NY 13202	Broome Cayuga Chenango Cortland	Herkimer Jefferson Lewis Madison	Oneida Oswego St. Lawrence Tioga	Tompkins	
Metropolitan Area Regional Office 90 Church Street New York, NY 10007-2919	Bronx Dutchess Kings New York	Orange Putnam Queens Richmond	Rockland Sullivan Ulster Westchester		
MARO – Long Island 320 Carleton Avenue, Suite 5000 Central Islip, NY 11722	Nassau Suffolk				
Western Regional Office 335 East Main Street, First Floor Rochester, NY 14604-2127	Allegany Cattaraugus Chatauqua Chemung	Erie Genesee Livingston Monroe	Niagara Ontario Orleans Schuyler	Seneca Steuben Wayne Wyoming	Yates

More Information on Adult Care Facilities, Assisted Living Residences and Assisted Living Programs , including law, regulations and operations can be found at: http://www.health.ny.gov/facilities

Project Site

PROJECT SITE | TYPE OF FACILITY | PROJECT SITE NAME

STREET AND NUMBER

CITY | COUNTY | ZIP

Operator Information

OPERATING CERTIFICATE NUMBER | TYPE OF FACILITY | LEGAL ENTITY THAT WILL OPERATE THE FACILITY (PROPOSED OPERATOR)

STREET AND NUMBER

CITY | COUNTY | ZIP

Program Configuration

Type	☐ AH	☐ EHP	☐ ALP	☐ ALR	☐ EALR	☐ SNALR
Current Number of Beds						
Proposed Number of Beds						

Type of Application (check all that apply): ☐ Establishment ☐ New Construction ☐ Renovation ☐ Administrative/Other ☐ Change of Operator

Is the proposed building currently in use as independent senior housing or for another residential purpose? ☐ Yes ☐ No

Do you have a dementia unit that has been approved by the Department but is not certified as a Special Needs Assisted Living Residence (SNALR)? ☐ Yes ☐ No

Total Project Cost:

Amount of Applicatlon Fee (for ALR and EALR and/or SNALR only - see Schedule 1 D):

Acknowledgement and Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant:

I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of Article 46 of the Public Health Law and/or Article 7 of the Social Service Law, and Finance Law and implementing regulations, as applicable. **Note: Original signature required.**

SIGNATURE | DATE

PRINT OR TYPE NAME AND TITLE

Applicant should identify the operator's Chief Executive Officer, or equivalent official, to whom all official correspondence from DOH about this application should be addressed.

Chief Executive

NAME AND TITLE

STREET AND NUMBER

CITY | STATE | ZIP

E-MAIL ADDRESS | TELEPHONE | FAX

Applicant must designate **one person** to whom all official correspondence from DOH about this application should be addressed. (This could be the Lead Contact's attorney, consultant, facility administrator or any other party the operator chooses.)

Lead Contact

NAME AND TITLE

STREET AND NUMBER

CITY | STATE | ZIP

E-MAIL ADDRESS | TELEPHONE | FAX

Lead Attorney

NAME AND TITLE

STREET AND NUMBER

CITY | STATE | ZIP

E-MAIL ADDRESS | TELEPHONE | FAX

If a consultant prepared the application, please identify.

Consultant

NAME AND TITLE

STREET AND NUMBER

CITY | STATE | ZIP

E-MAIL ADDRESS | TELEPHONE | FAX

Provide a project description not to exceed five pages in length, that includes the following information:

1) A project description.

2) The specific licensure and/or certification sought (i.e. AH or EHP and/or ALR/EALR/SNALR and/or ALP).

3) The number of beds proposed to be licensed or transferred.

4) Facility information, including:

   a. The name of the facility;

   b. The current use of the facility, if any (e.g. vacant, independent senior housing, apartment building);

   c. Whether the facility is located on the same campus as other service or housing providers (e.g.: Nursing Home, Hospital or Independent Senior Living). List other facilities/providers on campus (if applicable);

   d. The address and county of the facility.

5) Building Information, including:

   a. Is the building new construction or renovation, and if so, include:

      i. The name of the developer/contractor, and escribe their experience (if applicable);

      ii. Whether they have previous experience constructing Adult Care Facilities;

      iii. Project cost; and

      iv. Projected completion date.

   b. Whether the building is owned by the operator or leased.

6) Residents and Services

   a. For applications establishing a new facility or increasing the licensed capacity of an existing program by more than nine beds, describe how the proposed facility/program will meet a public need in the geographic area to be served. Include an accurate description of services/programs currently available, any service gap analysis studies and/or pertinent market studies for the area.

   b. For all applicants, provide a resident profile: Describe the specific population to be served, including the expected source of resident referrals. Include a demographic profile of the target population and a description of any special populations you intend to serve.

   c. Will the program accept residents who are receiving Supplemental Security Income? If yes, estimate the percentage of total beds that will be available at the SSI rate.

   d. Describe the services to be provided above and beyond that which is required by the regulations, if any (e.g. transportation) and the proposed methods of service delivery.

7) Any other information that will help the Department understand the project.

Schedule #	Schedule Name	Required	Included
1A	General Information – All Applicants	☐	☐
1B	Project Description	☐	☐
1C	Checklist of Schedules Included in the Application – All Applicants	☐	☐
1D	General Information – ALR/EALR and/or SNALR Applicants Only	☐	☐
1E	General Information – ALP Applicants Only	☐	☐
2A	Personal Qualifying Information	☐	☐
2B	Personal Financial Statement	☐	☐
2C	Directors' Statement for Not-for-Profit Applicants	☐	☐
2D	Review of Out-of-State Facilities	☐	☐
3A	General Legal Information	☐	☐
3B	Adult Care Facility Legal Certification	*	☐
4A	Financial Information Required for All Applicants	☐	☐
4B	Start-up Operating Budget Projections	☐	☐
4C	Projected 12-month Operating Budget at 90% Occupancy	☐	☐
4D	Substantial Bed Increase Application Attestation Regarding Operating Budget	*	☐
4E	Change of Operator Application Attestation Regarding Operating Budget	*	☐
5A	General Architectural Information	☐	☐
5B	Adult Care Facility Architectural Certification	☐	☐
5C	Final Architectural Certification	☐	☐
5D	Adult Care Facility Architectural Matrix	n/a	n/a
5E	Adult Care Facility Early Commencement of Construction Acknowledgement	☐	☐
6A	Program Information – All Applicants (Part II)	☐	☐

*Schedules marked with an asterisk are optional and available for some applicants onLy.
They are not required for all applications.

1. To be completed by all applicants for ALR. Status of AH or EHP Operating Certificate (check all that apply).
NOTE: Day one of the timeframes specified in criteria c – g is the date of the Schedule 1A Acknowledgement and Attestation.

a. ☐ Applicant does not have an Adult Home or Enriched Housing Program operating certificate.

b. ☐ Applicant's operating certificate is current and operator is in good standing. Operators in good standing are those to whom the criteria listed in c – g below do not apply.

c. ☐ Applicant has received any official written notice from the Department of a proposed revocation, suspension, denial or limitation on its operating certificate in the past three (3) years.

d. ☐ Applicant has been assessed a civil penalty after hearing conducted pursuant to SSL 460-d 7(b)(1) for a violation that was not timely rectified, in the past three (3) years.

e. ☐ Applicant has received any official written notice from the Department of a proposed assessment of a civil penalty for a violation described in SSL 460-d 7(b) (2), in the past year.

f. ☐ Applicant has been issued an order pursuant to SSL 460-d 2(Department of Health order approved by court), SSL 460-d 5 (equitable relief ordered by a court) or SSL 460-d 8 (Commissioner's Order), in the past three (3) years.

g. ☐ Applicant has been placed on, and if placed on, removed from the Department of Health's "Do Not Refer List" pursuant to SSL 460-d 15, in the past three (3) years.

If boxes a, c, d, e, f and /or g are checked, applicant must complete and submit with this application Schedule 2A (Personal Qualifying Information.)

2. To be completed by all applicants for EALR Certification

a. Do you intend to employ nurses to provide nursing services to residents? ☐ Yes ☐ No

b. Do you have a contract with a CHHA or LHCSA to provide EALR services to residents? ☐ Yes ☐ No

If yes, attach a copy of the contract.

Attachment # _____

Biennial Fee Calculation

ALR Licensure Fee Calculation:

a. # of ALR residents on projected date of licensure whose income will exceed 400% of FPL _____

b. Base ALR fee: $500.00

c. Total ALR licensure fee = [(a * $50) + b]

(___ * $50) + $500 = $ _____

EALR and/or SNALR Certification Fee:

a. EALR only fee = $2,000

b. SNALR only fee = $2000

c. EALR and SNALR fee = $3,000

d. Total certification fee = $ _____

Total fee (add ALR licensure fee and EALR/SNALR certification fee): $_____.
The fee for ALR ONLY not to exceed $5000. ALR/EALR/SNALR total application fee not to exceed $8000.

Please attach a check for the amount of the total fee, made out to: **New York State Department of Health**

Instructions: An ALP applicant(s) must become approved to operate as an Adult Home or Enriched Housing Program and a Licensed Home Care Services Agency (LHCSA), Long Term Home Health Care Program (LTHHCP) or Certified Home Health Agency (CHHA). All required licenses must be held by the applicant or another eligible entity under identical ownership. [See SSL Article 7 §461-l.1(a)]

1. The home care component of the ALP is or will be:

Licensed Home Care Services Agency	☐ Current	☐ Proposed
Long Term Home Health Care Program	☐ Current	☐ Proposed
Certified Home Health Agency	☐ Current	☐ Proposed

2. Is the ALP applicant(s) seeking approval as a LHCSA or CHHA as part of this application? ☐ Yes ☐ No

   If yes, you must file a separate application as described in these links:

   LHCSA – http://www.health.ny.gov/forms/doh-1056.pdf

   CHHA – http://www.health.ny.gov/facilities/cons/more_information/schedules.htm

3. Is the ACF component of the ALP owned by a separate entity from the home care entity? ☐ Yes ☐ No

   If yes, provide the Operating Agreement, Partnership Agreement, and the ALP Affidavit of Shareholders form contained in Schedule 1E or other documents that would demonstrate that both entities are under identical ownership. Attachment # _____

4. Will the ALP contract with one or more CHHAs or LTHHCPs for the provision of professional services to its residents? ☐ Yes ☐ No

   If yes, provide the name and address of the agency or agencies to provide the services below.
   Attach additional pages as necessary. Attach the letter of intent or contract for each. Attachment # _____

NAME OF CONTRACTED AGENCY

STREET ADDRESS

CITY | STATE | ZIP

TELEPHONE | FAX

5. Attach letters addressing the need for additional ALP beds from:

   a. County Department of Social Services (in NYC, HRA)

   b. County Office for Aging (in NYC, NYC Office for the Aging)

6. Payer Source: Indicate the expected percentage of residents by payer source.

	EXPECTED % OF RESIDENTS
Private Pay	_____
Public Pay (Medicaid/SSI)	_____

Instructions: Complete one affidavit for each shareholder of the ALP's ACF and Home Health Agency if operated by a business corporation. If both the ACF and the Home Health Agency are operated by corporations, each person will submit two affidavits, one for each entity.

STATE OF_____)

SS:

COUNTY OF_____)

SHAREHOLDER AFFIDAVIT

The undersigned hereby certifies that:

1. This Shareholder Affidavit is made in connection with an application for licensure as an Assisted Living Program (ALP) submitted by

   _____, a business corporation that is the proposed operator of the ALP.
   APPLICANT

2. I am the sole beneficial owner of the voting shares of which I am the holder of record in _____,
   THE "CORPORATION"

   which is the operator of the adult care facility/home care (choose one) component of the ALP.

3. I am the holder of record of _____ voting shares of the total _____ issued shares in the Corporation.

4. The Certificate of Incorporation of the Corporation authorizes the issuance of _____ total shares.

5. All shares of the Corporation authorized by the Certificate of Incorporation will be issued and outstanding.

6. The shares of the Corporation are not traded on a national securities exchange and are not regularly quoted on a national over-the-counter market. No share of the Corporation is owned by another corporation.

SIGNATURE _____ DATE _____

PRINT OR TYPE NAME _____

TITLE _____

NOTARY _____ DATE _____

Instructions: This affidavit must be completed for applicants who are applying for the change of operator of an assisted living program. Enter the signatory's name after "Affidavit of" and before "being duly sworn." Enter the county in which the affidavit is signed and notarized, NOT the county of the signatory's residence or the location of the applicant facility.

AFFIDAVIT OF _____

STATE OF_____)

SS:

COUNTY OF_____)

_____, being duly sworn, hereby deposes and says:

Re: ALP Application for _____

1. I am the _____(Title) of the

   _____(Applicant) and am duly authorized to make and deliver this affidavit on behalf of the (Applicant). I submit this affidavit in connection with the change of operator application for the above referenced assisted living program.
2. Notwithstanding any agreement, arrangement or understanding between the (Applicant) and the

   _____(Seller) to the contrary, the (Applicant) hereby agrees that it will be liable and responsible for any Medicaid overpayments made to the facility and/or any surcharges, assessments, or fees due from the (Seller) pursuant to the Public Health Law with respect to the period of time prior to the (Applicant) acquiring its interest, without releasing the (Seller) of its liability and responsibility.
3. I declare under penalty of perjury that the foregoing is true and correct.

_____ _____
SIGNATURE DATE

_____
PRINT OR TYPE NAME

_____
TITLE

AFFIX STAMP HERE

_____ _____
NOTARY DATE