

Assisted Living Program (ALP) 6000 – SOLICITATION OF INTEREST

IMPORTANT: Please read the instructions before completing this form. If the proposal includes more than one applicant/facility, a copy of this form must be completed for each. One applicant/facility must be designated as the Lead Applicant.

1. ELIGIBLE APPLICANT

FACILITY INFORMATION

Facility Name	Operating Certificate Number	
Facility Address (Street and Number, Building and Floor)	City	Zip Code
	County	

APPLICANT INFORMATION* (Please check one: Lead Applicant Co-applicant)

Name	Title	
Address (Street and Number, Building and Floor)	City	Zip Code
	Telephone No.	E-Mail Address

*Must be an eligible applicant (see Instructions, Section 3)

NAME & ADDRESS TO WHOM CORRESPONDENCE SHOULD BE SENT (If different from Applicant)

Name	Title	
Address (Street and Number, Building and Floor)	City	Zip Code
	Telephone No.	E-Mail Address

2. ABBREVIATED EXECUTIVE SUMMARY

A concise summary of your proposal must be attached. The proposal must state the type of Adult Care Facility (ACF) proposed (Adult Home or Enriched Housing Program), the number of Assisted Living Program beds requested, and if appropriate, the number of Residential Health Care Facility beds you plan to decertify. The projected timeline until the ALP becomes operational must be included. This Summary should be no longer than five pages.

3. PROGRAM INFORMATION

Provide information as stated in Instructions, Section 3, and complete the chart below.

RESIDENTIAL SERVICES - Bed Complement

TYPE	Adult Home or Enriched Housing / Non-ALP Beds	Assisted Living Program (ALP) Beds	Skilled Nursing Facility Beds	Other Beds (specify)	Total
1. Licensed Non-ALP Beds: <input type="checkbox"/> AH <input type="checkbox"/> EHP					
2. Licensed ALP Beds					
3. Licensed RHCF Beds					
4. Change in Non-ALP Beds (additional only)					
5. Change in ALP Beds (additional only)					
6. RHCF Beds being Decertified					
Total					

4. LEGAL REQUIREMENTS

The entity must have ownership of or right of access to real property (18 NYCRR 485.6(d)(11),(12) and (13)) for example, a deed, lease, sales contract or agreement.

For the facility shown above, is the real property owned, or has right to the property been granted?

Yes No

5. FINANCIAL INFORMATION

Estimate of Total Project Cost: The total cost must be provided by applicants who are proposing new construction or rehabilitation of an existing structure or are planning to purchase an existing ACF. Examples of costs that should be included are land acquisition (if applicable), cost of building (purchase price of existing facility, cost of new construction or cost of rehabilitation of existing building), site development, architect cost, soft costs, RHCF decertification costs.

6. ARCHITECTURAL COMPONENT(S)

For each proposal, scaled, schematic drawings must be attached. The schematics should be at minimum 1/16" = 1'-0" showing all floors of the entire building, with rooms labeled. The number of beds per bedroom must be indicated. (Attach schematic(s), demonstrating compliance with Section 6 of the Instructions.)

1. Project Type (check those appropriate)

a. Existing Licensed ACF

- 1) _____ No proposed construction, addition and/or renovation
- 2) _____ Building Addition
- 3) _____ Renovation – no change in certified capacity
- 4) _____ Renovation – change in capacity
- 5) _____ Separated Mixed Use Occupancy Building*
- 6) _____ Non-separated Mixed Use Occupancy*

b. Skilled Nursing Facility or other existing building converted to an ACF

- 1) _____ No proposed construction, addition and/or renovation
- 2) _____ Building Addition
- 3) _____ Renovation
- 4) _____ Change of Occupancy
- 5) _____ Separated Mixed Use Occupancy Building*
- 6) _____ Non-separated Mixed Use Occupancy*

c. Construction of New Building

- 1) _____ New Construction
- 2) _____ Separated Mixed Use Occupancy*
- 3) _____ Non-separated Mixed Use Occupancy*

*As defined by NYS (2007) / NYC (2008) Building Codes

7. LICENSED HOME CARE SERVICES AGENCY (LHCSA)

The applicant operating an Assisted Living Program must be approved to operate a Licensed Home Care Services Agency (LHCSA) or a Certified Home Health Agency (CHHA) in the county in which the ALP will operate.

Is the applicant shown above approved to operate a LHCSA, or a CHHA? Yes No

If yes, provide the following:

LHCSA License # _____

Agency Name _____

Operator _____

8. CERTIFICATION

I certify that the information submitted on this form and on any attachment to this schedule is true, accurate and complete in all material respects.

APPLICANT SIGNATURE:

By: _____ Date: _____
(signature)

Printed Name: _____

Title: _____