New York State Department of Health

Office of Long Term Care
Division of Home and Community Based Services

Assisted Living Program Application
RFA # 1584

Release Date:	September 27, 2007
Questions Due:	October 12, 2007
Responses to Questions Posted:	October 19, 2007
Applications Due:	December 14, 2007
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OVERVIEW OF THE APPLICATION PROCESS FOR AN ASSISTED LIVING PROGRAM

Definition

The Assisted Living Program provides supportive housing and home care services to individuals who are medically eligible for placement in a nursing facility but, whose needs can be met in a less restrictive and lower cost residential setting. Home care services may be paid for through a capitated Medicaid rate or private pay rate set by the facility operator. Payment for the residential services may be through Supplement Security Income (SSI) level III or private pay.

Eligible Applicants

To be approved as an Assisted Living Program, an applicant must be an "eligible applicant", meaning either:

A. one entity; **OR**

B. two or more entities with identical ownership that, in combination, are approved to operate:

1. A certified Adult Home (AH) **OR** Enriched Housing Program (EHP)

   AND

2. A Licensed Home Care Services Agency (LHCSA), **OR**
   A Certified Home Health Agency (CHHA), **OR**
   A Long Term Home Health Care Program (LTHHCP).

Applicants who operate an Assisted Living Program must be either a not-for-profit corporation, a non-publicly traded business corporation or limited liability company, a public agency, or an individual or group of individuals acting as partners.

These entities must either already hold the required certificates, or have an appropriate application in process, or request such certification as part of the application for approval as an Assisted Living Program.

The legal entity applying for Assisted Living Program approval to provide the residential program services must be identical to the legal entity applying for Assisted Living Program approval to provide the home care services. For example, if a license to operate an adult home or enriched housing program is issued to a partnership that wants to operate an Assisted Living Program, only that identical partnership may be issued or hold the certificate to operate the licensed home care services agency, certified home health agency, or long term home health care program component of the Assisted Living Program.

Program Application

The Assisted Living Program application is divided into the following Schedules:

- Schedule 1 - Applicant Identification and Program Narrative
- Schedule 2 - Legal Requirements
- Schedule 3 - Financial Information
- Schedule 4 - Architectural
- Schedule 5 - Character and Competence
- *If applicable* – LHCSA Addendum

The Schedule Key, page 6 of this Assisted Living Program application, should be used to identify which schedules must be completed by the applicant and the **attachments which should also be included with the application.**

Review of the application will determine whether or not the basic program design is sound and feasible, the applicant is of acceptable character and competence, the applicant is fiscally sound, and the applicant has the ability to effectively develop and operate the proposed program.

If the application is given contingent approval, the applicant will be requested to submit a detailed program plan. Upon determination that the proposed Assisted Living Program is in compliance with all requirements, the facility will be approved to operate.

Application Steps

1. Each applicant seeking to develop an Assisted Living Program must submit an application to the New York State Department of Health for approval. Application forms may be accessed from the Department's Web site at www.nyhealth.gov.

If you cannot access the electronic application it can be obtained by calling (518) 408-1624 or request a copy in writing by sending an email to ALPapplication@health.state.ny.us.

2. As required by Article 7, § 461.1 of Social Services Law, an Assisted Living Program must possess either: a valid license as a LHCSA or a valid certificate of approval as a CHHA or valid authorization as a LTHHCP. Those applicants not currently licensed as one of these types of home care providers and want to obtain approval as a licensed home care services agency can do so by completing the LHCSA Addendum, pages 63-87 of the Assisted Living Program application.

   If the Assisted Living Program applicant is a LHCSA, a proposed agreement with an existing CHHA or LTHHCP to provide home health services and participate in the ALP residents' assessment/reassessment process is necessary.

3. All applicants must contract with the Local Department of Social Services (LDSS) for the provision of the Assisted Living Program. Applicants for Health Systems Agency Region 7 may contract with the Department as an alternative to contracting with the New York City Human Resource Administration. Indicate whether there is an existing (A), or new (B) contract. Include with the application either such contract signed by the LDSS or a letter of intent signed by the LDSS stating an intent to so contract with the applicant, if approved as an ALP operator.

4. A detailed description of the proposed Assisted Living Program as described on page 7, item A. Program Attachments, is also required.

5. The applicant must complete all components of the application and submit an **ORIGINAL AND FIVE COMPLETE COPIES** to:

   Joseph J. Meloveck, Jr.
   Health Program Administrator 2
   Bureau of Licensure and Certification
   Division of Home and Community Based Services
   Office of Long Term Care
   New York State Department of Health
   161 Delaware Avenue
   Delmar, New York 12054-1393

   Attention: 1584 Bed ALP

6. In order for your application to be considered, the application must be received no later than **December 14, 2007.**

7. Upon receipt of an application and required copies, the application will be screened to determine if it is complete and includes all required documentation. Applications which are complete and meet the technical requirements will be further reviewed. Any applications which are incomplete will be disqualified.

   Department staff will:

   a. Review the application for completeness and adequacy with regard to the legal component, the public need for the program, the character, competence and standing in the community of the applicant, the compliance history of existing operators, the financial feasibility of the proposal, the architectural component and with regard to the requirements of Part 485.6 (n);

   b. Approve the proposed provider of any LHCSA application submitted as part of this application.

8. Each applicant will be notified, in writing, of the approval or disapproval of the application. In the event of an unfavorable determination, the applicant will be advised of administrative and/or legal remedies available should the applicant wish to appeal the decision.

9. The granting of contingent approval of the Assisted Living Program application does not signify permission to begin operation of the Assisted Living Program. Upon notification by the Department of Health that the documentation requirements of the Assisted Living Program application have been approved, the applicant will have a period of time of 120 days for pre-construction activities and 18 months for construction, for a total of 22 months. If the applicant needs additional time to complete preparation for operation, the applicant must request an extension of time with the reasons why such extension is necessary. The Department reserves the right to approve or deny such requests.

10. Upon notice from the applicant of the date of anticipated opening, the Department of Health will schedule a pre-opening survey.

11. When the applicant has satisfied all application requirements and the pre-opening activities including a required survey are concluded satisfactorily, the applicant will be issued approval to operate the Assisted Living Program.

Assisted Living Program Application

Schedule Key

INSTRUCTIONS: The Schedule Key indicates which Schedules an applicant must complete. Choose the program configuration applicable to your application and read across the schedule. Any schedule number indicated with an x must be completed.

	PROGRAM					LEGAL		FINANCIAL				ARCH	CHARACTER/COMPETENCE		
	1-1	1-2	1-3	1-4	1-5	2-1	2-2	3-1	3-2	3-3	3-4	4-1	5-1	5-2	5-3
New NFP A.H	X	X	X	X	X	X	X	X			X	X	X	X	X
New NFP E.H.	X	X	X	X	X	X	X	X			X	X	X	X	X
New FP A.H.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
New FP E.H.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
New Public E.H.	X		X	X	X	X	X	X			X	X	X	X	X
Expansion NFP A.H.	X	X	X	X	X	X	X	X			X	X	X	X	X
Expansion NFP E.H.	X	X	X	X	X	X	X	X			X	X	X	X	X
Expansion FP A.H.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Expansion FP E.H.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Expansion Public E.H.	X		X	X	X	X	X	X			X	X	X	X	X
Conversion NFP A.H.	X	X	X	X	X	X	X	X			X	X	X	X	X
Conversion NFP E.H.	X	X	X	X	X	X	X	X			X	X	X	X	X
Conversion FP A.H.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Conversion FP E.H.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Conversion Public E.H.	X		X	X	X	X	X	X			X	X	X	X	X

NFP – Not for Profit
FP – For Profit - Sole Proprietor, Partnership, Corporation, LLC *
AH – Adult Home
EH – Enriched Housing

NOTE 1: Applicants who are or will be business corporations or LLC's must also provide the information required in the additional requirements appendices that apply to such applicants.
NOTE 2: Applicants who are applying as a Licensed Home Care Service Agency (LHCSA) are required to complete the ALP Application Addendum.

A. Program Attachments

The following information must be submitted as part of the application. Each attachment must be labeled in the right hand corner with the number corresponding to the following list of attachments (e.g. Program Attachment 1, Program Attachment 2, etc.)

1. A narrative description of the applicant indicating your primary purposes, organizational structure, past and current activities relating to your proposed Assisted Living Program (ALP), existing relationships with the local Department of Social Services, existing relationships with other providers or services in the community that will be serving residents and any other information that will enable the Department to assess your ability to implement and operate an ALP.

2. A narrative that describes the proposed ALP, including the following:

   - A general description of how the program will operate including any unique features of the program as it is envisioned.

   - Target Population: People who otherwise may be inappropriately placed in a nursing home and whose residential and healthcare needs can be met by the ALP, such as the frail elderly and physically disabled. If specific age, disability or diagnosis groups are to be targeted, indicate the specific population to be targeted, the special needs of the targeted population, specific numbers of the target population, from where the population will be drawn and how the ALP will be particularly suited to meeting the needs of the target population.

   - Relationships to other providers and services:

     - Indicate anticipated sources of referral to and discharge from the ALP and describe the proposed relationship with these sources.
     - If the ALP will be located in the same building with non-ALP adult home beds or enriched housing units, describe how the ALP will relate to these services programmatically.
     - Describe how the ALP will relate to other services in the community and which of these services are expected to be an integral part of the services provided to ALP residents.

   - Describe the proposed site for the ALP including physical relationship with and access to community services.

- Indicate the projected time frames for construction or renovation (if any) and start-up following approval of the ALP application.

3. At least five letters of community support and any other material which you consider important in support of the proposed program in your prescribed geographic area.

    - For not-for-profit applicants, the letters of support must include comment on your ability to successfully implement and operate the proposed ALP.

4. Any studies, marketing surveys or demographic data in support of the application.

5. For applications which include non-ALP adult home or non-ALP enriched housing program beds, in addition to the proposed ALP beds being solicited, attach the following:

    - A letter from the county Department of Social Services assessing the need for additional non-ALP adult home or enriched housing beds; and

    - A letter from the county Office for the Aging assessing the need for additional non-ALP adult home or enriched housing beds.

B. Schedule Instructions

1. SCHEDULE 1-1: APPLICANT IDENTIFICATION
This schedule must be completed by all applicants

- **SECTION 1-3** Fill in the name, address and phone number of the proposed ALP operator and contact person respectively.

- **SECTION 4** Indicate in the appropriate spaces, the sponsorship type of the proposed ALP.

- **SECTION 5** Indicate whether the applicant is seeking approval as a LHCSA as part of this application. If so, list the counties which will be served by the proposed LHCSA.

2. SCHEDULE 1-2: LIST OF APPLICANTS/BOARD MEMBERS (NFP Corporations)/MEMBERS (FOR Limited Liability Companies)/Shareholders (For Business Corporations)

This schedule is not required to be completed by public enriched housing program applicants.

- Fill in the name and title (or function), address, home phone number and business phone number of each individual applicant, partner, board member, LLC member or business corporation shareholder.

- Attach additional sheets as necessary. Each attached sheet should be labeled in the top right hand corner as Program: Schedule 1-2, Attachment.

3. SCHEDULE 1-3: BOARD RESOLUTION AND AUTHORIZING SIGNATURE

This schedule must be completed by all applicants.

- If the applicant is an existing corporation or local governmental sub-division, a certified copy of the resolution of the Board of Directors or Trustees, or the local legislature, Board of Supervisors or other governing body having jurisdiction over the proposed ALP required. This requirement is not applicable to sole proprietors or partnerships. Indicate in the boxes provided if a copy is attached or not applicable.

- If the applicant is an existing LLC, a certified copy of the resolution of members is required.

- If a certified copy is required, the attachment should be labeled in the top right hand corner as Program: Schedule 1-3, Attachment.

- Provide the name, title, signature and dates signed in the spaces provided for each applicant, partner or authorizing board member. Attach additional sheets as necessary, labeled in the right hand corner as Program: Schedule 1-3, Attachment.

4. SCHEDULE 1-4: PROGRAM CONFIGURATION

This schedule must be completed by all applicants.

- **SECTION 1** – Indicate the program configuration applicable to your application. Choose either Adult Home or Enriched Housing Program and indicate under column A, B, C, D whether it is an existing or adult home or enriched housing program (A), a new facility (B), addition to an existing facility (C) or conversion of all or part of an existing facility (D).

- **SECTION 2** – Choose the home care option that is applicable to the application and indicate whether it is an existing (A) or new (B) program.

- **SECTION 3** – If a Licensed Home Care Services Agency (LHCSA) was chosen in Section 2, the applicant must contract with either a Long Term Home Health Care Program (LTHHCP) or a Certified Home Health Agency (CHHA) for home health services. If applicable, indicate whether it is an existing contract (A) or new contract (B). Also indicate below the name and address of the contracted agency. Include with the application either a contract with the proposed ALP operator signed by the LTHHCP or CHHA, or a letter of intent from the LTHHCP or the CHHA stating intent to contract with the applicant if approved as an ALP operator. Personal care services must be provided directly by the ALP for residents who are in receipt of Medicaid.

- **SECTION 4** – All applicants must contract with the Local Department of Social Services (LDSS) for the provision of the Assisted Living Program. Applicants for Health Systems Agency Region 7 may contract with the Department as an alternative to contracting with the New York City Human Resource Administration. Indicate whether there is an existing (A), or new (B) contract. Include with the application either such contract signed by the LDSS or a letter of intent signed by the LDSS stating intent to so contract with the applicant, if approved as an ALP operator.

RESIDENTIAL SERVICES:

- Indicate the total ALP bed capacity on line 1, column A, as well as the combination of existing and/or proposed bed capacity in columns B and C. If the ALP facility will contain adult home or enriched housing beds/units in the ALP facility which will not be used for the ALP participants, indicate these beds on line 2. Any other types of beds/units in the ALP facility, which will not be used for the ALP participants, should be indicated on line 3. The totals of lines 1-3, should be reported on line 4.

PAYER SOURCE:

- Indicate the expected percentage of residents upon admission by payer source.

5. SCHEDULE 1-5: STAFFING SCHEDULE

This schedule must be completed by all applicants.

- This schedule lists the services that may be provided through the ALP. Indicate in Column A, whether the service is to be provided directly by the program (D) or by contract (C).

- The total annual projected number of cases applicable to the service should be entered in column B as well as the projected number of full-time equivalent employees (FTES) to provide that service. FTES must be calculated based on a forty hour work week.

- The figures reported in Column B, must be broken out for the individual programs within the total, i.e. the Assisted Living Program, Column (C), any adult care (adult home or enriched housing) service not provided to ALP residents, Column D and any home care services provided to other than ALP residents, Column E. The total of Columns C and D must equal the figures reported in Column B.

- The total annual salary or contract price associated with the caseload reported in Column B must be reported in column F.

- Line 1, Column F, total must also be reported on Schedule 3-4, Column A, Director/Administrator.

- Line 2, Column F, total must also be reported on Schedule 3-4, Column A, Supervisor/Case Management.

- The total of Lines 3-16, Column F, must also be reported on Schedule 3-4, Column A, Total Service Personnel.

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Applicant Identification

1.

NAME OF ASSISTED LIVING PROGRAM			
STREET ADDRESS			
CITY	STATE	COUNTY	ZIP
PHONE	( )		

2.

NAME OF APPLICANT			
STREET ADDRESS			
CITY	STATE	COUNTY	ZIP
PHONE	( )		
NAME OF APPLICANT			
STREET ADDRESS			
CITY	STATE	COUNTY	ZIP
PHONE	( )		
NAME OF APPLICANT			
STREET ADDRESS			
CITY	STATE	COUNTY	ZIP
PHONE	( )		

Additional sheets may be added if necessary.

3.

NAME OF PERSON TO CONTACT FOR ADDITIONAL INFORMATION			
STREET ADDRESS			
CITY	STATE	COUNTY	ZIP
PHONE	( )		

Assisted Living Program Application

4. How will this Assisted Living Program be sponsored?
[See Social Services Law § 461-b(1)(a) and 461-l(1)(a)]
Each applicant listed in number 2 above should individually complete this checklist. Additional sheets may be added if necessary.

A. _____ Sole Proprietor
B. _____ Partnership (general partnership comprised only of natural persons; limited partnerships are not permitted)
C. _____ Not-for-Profit Corporation (NFP)
D. _____ Public Corporation or Agency
E. _____ Business Corporation (not publicly traded, no shares owned by another corporation)
F. _____ Limited Liability Company (if members are corporations, partnerships or LLCs, the shareholders, partners or members of same must be natural persons)

Note: The applicant's Partnership Agreement must include a provision substantially similar to the following:

"By signing this agreement, each member of the partnership created by the terms of this agreement acknowledges that the partnership and each member thereof has a duty to report to the New York State Department of Health any proposed change in the partnership. The partners also acknowledge that the prior written approval of the Department is required before such change is made."

5. 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). If the ALP applicant(s) does not hold all requisite licenses, it may qualify to become approved if, in combination with another eligible entity <u>under identical ownership</u>, and they together hold all requisite licenses. [See SSL Article 7 §461-*l*.1(a)]

- Is the ALP applicant a separate business entity from the LHCSA?
  ☐ Yes ☐ No

- If yes, and already licensed as a LHCSA the licensee will need to submit copies of the following documents:

  - Operating License

  - Articles of Organization or Incorporation, or Partnership Agreements or other documents describing the legal status of the LHCSA which would demonstrate that both entities are under identical ownership.

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- Is the ALP applicant(s) seeking approval as a LHCSA as part of this application?

  ☐ Yes ☐ No

- If yes, please complete the LHCSA Addendum attached to this application.

Note: The LHCSA Addendum is only to be used when applying to establish a new LHCSA under an ALP Application. The LHCSA Addendum is NOT to be used when applying to establish a new LHCSA that is not part of an ALP.

Assisted Living Program Application

List of Applicants

Applicant 1		
	NAME AND TITLE	
	ADDRESS	
	HOME PHONE	BUSINESS PHONE

Applicant 2		
	NAME AND TITLE	
	ADDRESS	
	HOME PHONE	BUSINESS PHONE

Applicant 3		
	NAME AND TITLE	
	ADDRESS	
	HOME PHONE	BUSINESS PHONE

Applicant 4		
	NAME AND TITLE	
	ADDRESS	
	HOME PHONE	BUSINESS PHONE

Applicant 5		
	NAME AND TITLE	
	ADDRESS	
	HOME PHONE	BUSINESS PHONE

Attach additional sheets as necessary

Note: If your application involves co-applicants more than one legal entity with identical ownership that would, in combination, hold all requisite ACF/homecare/ALP approvals, each separate entity must be listed as a co-applicant and must submit all required documentation under this application.

Board Resolution and Authorizing Signature

Board Resolution

Attach a certified copy of the resolution of the Board of Directors, Members of the LLC Board of Trustees, or the local Legislature, Board of Supervisors or other governing body having jurisdiction over the program, as applicable.

☐ **Attached** ☐ **Not Required**

Note: If your application involves co-applicants or more than one legal entity with identical ownership that would, in combination, hold all requisite ACF/homecare/ALP approvals, each separate entity must be listed as a co-applicant and must submit a separate resolution and signature.

Authorizing Signature(s)

I/we, the undersigned hereby certify under penalty of perjury that I am/we are duly authorized to subscribe and submit this application and that the information contained herein and attached hereto, with the exception of those schedules pertaining to personal qualifying and disclosure information which must be individually certified, is accurate, true and complete in all material aspects.

I/we, if this application is approved, agree to operate the program in accordance with all applicable Department of Social Services and Department of Health regulations and the proposal contained herein.

Also, I/we agree to comply with the provision of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed pursuant thereto, to the end that no person shall, on the grounds of race, color, creed or national origin be excluded from participation in, be denied benefit of, or be subjected to discrimination in the provision of any assistance, care or services.

In addition, I/we authorize all corporations, companies, credit agencies, educational institutions, lending institutions and persons to release information that they may have about me/us to the New York State Department of Health; further I/we authorize the procurement of such an investigation and understand that such report may contain information as to my/our background, character and personal reputation.

SIGNATURE(S) OF PROPOSED OPERATOR(S)*	DATE SIGNED
_____ Signature	_____
_____ Print Name/Title	_____
_____ Signature	_____
_____ Print Name/Title	_____

*Signatures must be original. Stamped signatures and electronic signatures are not acceptable as original signatures. Attach additional sheets as necessary.

Assisted Living Program Application

Program Configuration

		Proposed		
	Existing (A)	New (B)	Addition (C)	Conversion (D)
1. Adult Care Facility (check one)				
Adult Home (A, B, C or D)				
Enriched Housing Program (A,B, C, or D)				
2. Home Care (check one)				
Licensed Home Care Services				
Long Term Home Health Care Program				
Certified Home Health Agency				
3. Contracted Services (check, if applicable)				
Long Term Home Health Care Program*				
Certified Home Health Agency*				
4. Contract with LDSS				

*If the ALP will contract with a CHHA or a LTHHCP for the provision of professional services to its residents provide the name and address of the agency to provide the services.

Name of contracted agency _____

Street Address_____

City_____State_____Zip_____

Phone ( ) _____ Fax ( ) _____

Residential Services

Indicate the total bed capacity for the ALP as well as the total capacity for any non-ALP programs in the chart below.

	Total (A)	Existing (B)	Proposed (C)
1. Assisted Living Program			
2. Adult Home or Enriched Housing/Non ALP			
3. Other (specify)			
4. Total			

Assisted Living Program Application

Payer Source

Indicate the expected percentage of residents upon admission by payer source.

Payer	Number of Residents Upon Admission
Private Pay	
Medical Assistance	
Supplemental Security	
Safety Net	

Assisted Living Program Application

Staffing Schedule

		Total		Assisted Living Program		Adult Care (Non-ALP)		Home Health Care Non-ALP		
	A	B		C		D		E		F
Services Provided	**Method of Provision (Direct or Contract)**	Number of FTEs	Annual Projected # of Cases	Number of FTEs	Annual Projected # of Cases	Number of FTEs	Annual Projected # of Cases	Number of FTEs	Annual Projected # of Cases	Total Annual Salary or Contract Price
Administration (1)										
Case Management (2)										
Personal Care (3)										
Nursing (4)										
Home Health Aide (5)										
Physical Therapy (6)										
Occupational Therapy (7)										
Respiratory Therapy (8)										
Speech Pathology (9)										
Audiology (10)										
Medical Social Services (11)										
Food Service (12)										
Homemaker (13)										
Housekeeper (14)										
Activities (15)										
Other (16)										

(1) Column F total to be reported on Schedule 3-4, Column A, Director/Administrator

(2) Column F total to be reported on Schedule 3-4, Column A, Supervisor/Case Management

(3-16) Combined Column F total for these services to be reported on schedule 3-4 Column A, Total Service Personnel

A. Attachments

The following information must be submitted, if applicable, as part of the application. Each attachment must be labeled in the top right hand corner with the number corresponding to the appropriate attachment as follows:
Legal: Attachment 1. Legal: Attachment 2, etc.

1. A narrative description and organizational chart of the legal structure of the existing or proposed organization, including any governing boards and advisory committees.

2. Proof of ownership of or right of access to real property (18 NYCRR 485.6(d)(11),(12) and (13) which may be one of the following:

   - Deed (proposed, if transaction has not been completed).
   - Lease (proposed, if transaction has not been completed).
   - Sales contract or agreement (proposed, if transaction has not been completed).
   - Agreement between enriched housing program operator and building manager, if applicant does not own or control the building in which the enriched housing program is to be located.

3. For an individual or partnership, a DBA-Certificate of Doing Business As, which will be filed with the county clerk in the county in which the ALP is located. For a corporation, a certificate of Assumed Name, which will be filed with the Secretary of State. If the facility is changing operators, submit the proposed document.

4. Partnership agreement (18 NYCRR 485.6(d)(5)). This is required if more than one person is to be certified. Only a general partnership comprised of natural persons is permitted; a limited partnership is not permitted.

Note: The applicant's Partnership Agreement must include a provision substantially similar to the following:

"By signing this agreement, each member of the partnership created by the terms of this agreement acknowledges that the partnership and each member thereof has a duty to report to the New York State Department of Health any proposed change in the partnership. The partners also acknowledge that the prior written approval of the Department is required before such change is made."

5. Certificate of Incorporation (18 NYCRR 485.6(d)(4)). This is required for corporate applicants. A proposed Certificate of Incorporation and the bylaws or proposed Certificate of Amendment of the Certificate of Incorporation must be submitted for review and approval as part of this application and subsequently filed with the Secretary of State prior to certification. This certificate must include among its purposes the establishment and operation of an adult home or enriched housing program; a home care services agency; and an
Assisted Living Program. A specific purpose clause related to home care is also required; acceptable language would be 'to operate a home care agency as authorized under Public Health Law Article 36.'

6. A. If Applicant is an LLC, also provide information required in Appendix entitled "ALP Limited Liability Companies; Additional Legal Requirements."

   B. If applicant is a business corporation, also provide information required in appendix entitled "ALP Business Corporations; Additional Legal Requirements."

7. Contracts

   - If the applicant proposes to contract with an independent entity to perform any of the ALP facility operations, a proposed contract must be submitted for review in accordance with 18 NYCRR 485.10(a)(4). **Personal care services must be provided by the applicant and cannot be contracted to an outside agency.**

   - If the applicant is not a Long Term Home Health Care Program (LTHHCP) or a Certified Home Health Agency (CHHA), then either a copy of a proposed contract with one of these programs signed by such program, or a letter of intent from the program stating an intent to contract with the applicant if approved as an ALP operator must be submitted in accordance with 18 NYCRR 485.4(h)(1) and 485.6(n)(5)(ii).

   - Submit either a proposed contract with the local Social Services district in which the ALP will operate, including any addenda in accordance with 18 NYCRR 494.4(h)(1) and 485.6(n)(5)(ii), or a letter of intent signed by the district stating an intent to so contract with the applicant if approved as an ALP operator.

8. If the applicant is a LTHHCP or a CHHA, a copy of the applicable certificate of approval.

9. If the applicant is already a Licensed Home Care Services Agency eligible to participate in the ALP, submit a copy of the current license demonstrating the agency's authority to provide personal care services. If the applicant has an application for licensure under review by the Department of Health, submit a copy of the acknowledgement letter received from the Bureau of Project Management which references the project number.

10. A zoning approval or letter from the appropriate municipal government office indicating that the proposed site is zoned to allow for the provision of adult residential care. If zoning or a variance has been applied for, submit proof of such application (18 NYCRR 485.6(d)(20)).

11. If the applicant is an existing adult care facility, submit a copy of the existing Certificate of Occupancy. Otherwise, a Certificate of Occupancy must be submitted to the Department of Health Regional office for inspection prior to certification. (18 NYCRR 485.6(h)(3) and (4). Also, submit a copy of the current operating certificate.

These schedules must be individually completed by each applicant, including co-applicants.

B. Schedule Instructions

1. SCHEDULE 2-1: RELATED ORGANIZATION INFORMATION

- **SECTION 1** – Indicate in the appropriate box if any parent corporation, controlling person or controlling organization either directly or indirectly, through one or more intermediaries, possesses the ability to direct or cause the direction of the actions, management or policies of the applicant (18 NYCRR 485.6(d)(11)(v)).

  If the answer in section one is yes, list in the box provided, the full legal name, address and phone numbers of the principal office and place of doing business of any such parent corporation, controlling person or organization. Attach additional sheets as necessary, and label in the top right hand corner as Legal: Schedule 2-1, Section 1, Attachment.

- **SECTIONS 2 and 3** are to be completed only if the response to section 1 is yes. Any attachments applicable to these sections should be labeled in the top right hand corner as Legal: Schedule 2-1, Section 2 Attachment or Legal: Schedule 2-1, Section 3, Attachment.

2. SCHEDULE 2-2: ASSISTED LIVING PROGRAM

Use this schedule to identify each private person, partnership, corporation, bank, savings and loan association or other group with a real property interest in the ALP. It is to be completed and signed in Section 6-Certification, by sole proprietor, an individual on behalf of partnership, a business or not-for-profit corporation, or Limited Liability Company.

- **SECTION 1** – List the name of the ALP which is the subject of this application.

- **SECTION 2** – Private Person With a Real Property Interest in the ALP.

  This section identifies any individual with a real property interest in the ALP. Use a separate form for each private person having such interest in the ALP.

  - Enter name of the private person (must be identical on all forms used for this person).

  - Enter his or her address.

- **SECTION 3** – Association/Organization With a Real Property Interest in the ALP.

  This section identifies any association/organization with a real property interest in the ALP. Use a separate form for each association/organization having such interest in the ALP.

  - Check the type of association/organization with a real property interest in the ALP named in Section 1.

  - Enter the name of association/organization (must be identical on all forms used for this association/organization).

  - Enter the address of the association/organization.

- **SECTION 4** – Nature of Real Property Interest in the ALP.

  This section shows the nature of any individual person's or any association's or organization's interest in the real property of the ALP.

  - Show the interests of any such individual, association or organization (either by lease or ownership) by checking the appropriate boxes under "Land" and "Building". Check all appropriate items and cross out the inapplicable word in parentheses (e.g. direct/indirect).

- **SECTION 5** – Persons With an Interest in the Association/Organization

  Use this section to identify persons with an interest in the association/organization named in Section 3 above.

  If more space is needed to list additional persons, place the entire list on an attachment page in the format required by this schedule. List both the ALP name and association/organization name in the attachment. Note the attachment number in the top right hand corner as Legal: Schedule 2-2 Attachment.

  Use the following chart to identify by number indicated, the nature of interest (position(s)) in the association/organization. List all numbers which apply to each individual.

General Partner	(1)
Limited Partner	(2)
Officer	(3)
Director	(4)
Principal Stockholder	(5)
Controlling Person	(6)
Member	(7)

- **SECTION 6** – Certification

  Use this section to certify that the information submitted on this schedule and on any attachment to this schedule is true, accurate and complete in all material respects, by signing on the signature line. The signature must be notarized.

Note: If your application involves co-applicants or more than one legal entity with identical ownership that would, in combination, hold all requisite ACF/homecare/ALP approvals, each separate entity must be listed as a co-applicant and must submit a separate certification with notarized signature.

Assisted Living Program Application

Related Organization Information

1. Will any parent corporation, controlling person or controlling organization either directly or indirectly, through one or more intermediaries possess the ability to direct or cause the direction of the actions, management or policies of the Assisted Living Program applicant?

   ☐ Yes ☐ No

   If yes, list in the box below the full legal name and address of the principal office and place of doing business of any such parent corporation, controlling person or organization. Attach additional sheets if necessary.

Name of related organization/entity: Address: Phone Numbers:
Name of related organization/entity: Address: Phone Numbers:

   IF THE ANSWER TO QUESTION #1 IS YES, PROVIDE THE FOLLOWING INFORMATION ON AN ATTACHMENT TO THIS SCHEDULE.

2. With respect to each parent corporation, controlling person or other controlling organization identified in response to question (1) above:

   a. List the full name of each of the members, directors, controlling persons, principal stockholders (stockholders owning ten percent or more of the stock), officers and sponsors of such parent corporation, limited liability company or controlling person or organization.

   b. List the full legal name and the address of the principal office and place of doing business of any hospital, nursing facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency, or other health care facility or program participating in the Medicare and/or

Medicaid programs, regardless of location, owned or operated by such parent corporation or controlling persons or organization, together with a photocopy of any operating license, permit or certificate issued for such facility or program, the full name of the issuing agency and dates of ownership.

c. Describe in detail the relationship between the applicant and any parent corporation, limited liability company, controlling person or organization and describe in detail the method or mechanism by which control over the applicant is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement, etc.)

3. With respect to the applicant and any parent corporation or controlling person or organization identified in response to question (1) above:

a. List the full legal name and the address of the principal office and place of doing business of any subsidiary corporation or organization that owns or operates any hospital, nursing facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency or other health care facility or program, together with a photocopy of any operating license, permit or certificate issued for such facility or program, the full name of the issuing agency and dates of ownership.

b. List the full name of each of the members, directors, controlling persons, principal stockholders (stockholders owning ten percent or more of the issued stock), officers and sponsors of each subsidiary corporation or organization identified in response to (3)(a) above.

c. Describe in detail the relationship between the applicant, parent corporation, controlling person or organization and each subsidiary corporation or organization identified in response to (3)(a) above and describe in detail the method or mechanism by which control over the subsidiary is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement, etc.)

Assisted Living Program Application

Real Property Interest in the Assisted Living Program

1. Assisted Living Program

2. Private Person With a Real Property Interest in the Assisted Living Program

Name and Address

3. Association/Organization With a Real Property Interest in the Assisted Living Program

Organization/Association	Name and Address:
Type: Check One ☐ Partnership ☐ Not-for-Profit ☐ Privately held Corporation ☐ Bank ☐ Publicly traded Corp. ☐ Savings & Loan ☐ LLC ☐ Other	

4.

LAND	BUILDING(S)
Interest	**Interest**
☐ (Directly/Indirectly) Lessee in a (Lease/Sublease) of the LAND on which the ALP is located.	☐ (Directly/Indirectly) Lessee in a (Lease/Sublease) of the BUILDING in which the ALP is located.
☐ (Directly/Indirectly) Lessor in a (Lease/Sublease) of the LAND on which the ALP is located.	☐ (Directly/Indirectly) Lessor in a (Lease/Sublease) of the BUILDING in which the ALP is located.
☐ (Directly/Indirectly) in the LAND on which the ALP is located.	☐ (Directly/Indirectly) in the BUILDING in which the ALP is located.
☐ (Directly/Indirectly) in a Mortgage, Note, Deed of Trust or other obligation secured in whole or in part by the LAND on which the ALP is located.	☐ (Directly/Indirectly) in a Mortgage, Note, Deed of Trust or other obligation secured in whole or in part by the BUILDING in which the ALP is located.

Assisted Living Program Application

5. Persons With an Interest in Association/Organization

Name: Last, First, MI Address:	Nature of Interest	
Name: Last, First, MI Address:	Nature of Interest	
Name: Last, First, MI Address:	Nature of Interest	

6. Certification

The undersigned hereby certifies, under penalty of perjury, that the information contained herein and attached is accurate, true and complete in all material respects.

Note: A stamped or electronic signature is not acceptable as an original signature.

Signature: _____ Date:_____

Printed Name: _____

Notarize:

Assisted Living Program Application

A. Attachments

The following information must be submitted, if applicable, as part of this application. Each attachment must be labeled in the top right hand corner with the number corresponding to the following list of attachments (e.g., Financial: Attachment 1. Financial: Attachment 2, etc.)

1. If the ALP is to be established through the purchase of an existing certified ACF/ALP, attach copies of the following:

   - Purchase agreement;

   - Letter of Interest from intended source(s) of permanent financing which indicates principal, interest, term and payback period;

   - Documentation to support any other financing arrangement not covered above.

2. If the ALP is to be established through new construction or rehabilitation of an existing structure, attach copies of the following:

   - Letter of Interest from the intended source(s) of construction and permanent financing which indicates principal, interest, term and payback period;

     Note: Letter of Interest in financing project to be followed by firm commitment for financing from lender when application is contingently approved for processing and financing has been secured. Firm commitment for financing is required for Part I approval.

   - Documentation to support any other financing arrangements not covered above.

3. Not-for-Profit applicants – attach a copy of the annual financial statements for the previous two fiscal years or copies of the two most recent tax returns.

4. Limited Liability Company (LLC) applicants – attach a copy of the LLC's annual financial statements for the previous two fiscal years. If the applicant is a new, or to be formed LLC without assets, or copies of the two most recent financial statements are not available, a copy of the current personal financial statement for each member of the LLC is required.

5. Business Corporation applicants – attach a copy of the business corporation's annual financial statements for the previous two fiscal years. If the applicant is a new, or to be formed business corporation without assets, or the two most recent financial statements are not available, a copy of the current personal financial statement for each shareholder of the business corporation is required.

B. Schedule Instructions

1. SCHEDULE 3-1: Estimate of Total Project Cost

   This schedule must be completed only by applicants who are proposing new construction or rehabilitation of an existing structure.

   Indicate in the spaces provided, the estimated project costs associated with this application. Indicate in the space provided the year on which the projections are based.

2. SCHEDULE 3-2: PERSONAL FINANCIAL STATEMENT

   This schedule is to be completed by each sole proprietor or member of a partnership applicant to reflect the individual's financial position as of the application filing date. In addition, if the applicant is a new, or to be formed LLC without assets, or a new, or to be formed business corporation without assets, a copy of the personal financial statements for each member of the LLC, or shareholder of the business corporation is required.

   Attach a completed copy of the schedule for each additional individual, labeled in the top right hand corner as follows: Financial: Schedule 3-2 Attachment.

   This schedule is not to be completed by not-for-profit or public applicants. Not-for-profit applicants must attach a copy of the annual financial statements in accordance with A (3) above.

   A summary report of the individual's financial position is to be reported on Schedule 3-2, A. A detailed breakout is to be reported on Schedule 3-2, B. The detail totals reported in each category on Schedule 3-2, B must equal the amount reported for the corresponding category on Schedule 3-2, A.

3. SCHEDULE 3-3: ANTICIPATED PERSONAL INCOME

   This schedule is to be completed by each sole proprietor or member of a partnership applicant. Attach a copy of the schedule for each individual

labeled in the top right hand corner as follows: Financial: Schedule 3-3 Attachment.

This schedule is not to be completed by not-for-profit or public applicants.

- Anticipated annual personal income for the current calendar year should be listed in the appropriate spaces. Anticipated income should be exclusive of that anticipated to be derived from the ALP.

4. SCHEDULE 3-4: PROJECTED TWELVE MONTH OPERATING BUDGET.

   This schedule must be completed by all applicants.

   - Report projected revenues and expenses for the first twelve full months of operation of the ALP. In projecting revenues and expenses, a 90 percent occupancy rate for the entire facility should be assumed.
   - Total aggregate revenues and expenditures are to be reported under Column A, Total. This is to include ALP, non-ALP adult care and non-ALP home care if operating in the same facility.
   - ALP specific revenues and expenditures are to be reported under Column B.
   - Revenues and expenditures associated with any adult care facility beds located in the same facility but not part of the ALP are to be reported in Column C.
   - Revenues and expenditures associated with any home care program located in the same facility but not allocated to the ALP, are to be reported in Column D.
   - The total of Columns B, C and D must be equal to the amounts reported in Column A.
   - The amount reported for Director/Administrator under Salaries and Wages, Column A, must equal the amount reported on Schedule 1-5, Column F, line 1.
   - The amount reported under Supervisors/Case Management, Column A must equal the amount reported on Schedule 1-5, Column F, line 2.
   - The amount reported under Total Services Personnel, Column A, must equal the total of the amounts reported on Schedule 1-5, Column F, lines 3-15.

Assited Living Program Application

Estimate of Total Project Cost

Item	Estimated Cost
1. Land Acquisition	
2. Building	
a. Purchase Price of Existing Facility	
b. Cost of New Construction	
c. Cost of Rehabilitation of Existing Building	
3. Site Development	
4. Architect	
5. Consultant	
6. Construction Interest	
7. Site Security	
8. Bank Counsel	
9. Broker's Commission	
10. Legal and Organization Expense	
11. Title and Recording Fees	
12. Taxes	
13. Insurance	
14. Marketing	
15. Feasibility and Appraisal	
16. Pre-Opening Expenses	
17. Furniture, Fixtures and Equipment	
18. Other (specify _____)	
19. Other (specify _____)	
TOTAL PROJECT COST ESTIMATE	$0.00

* Cost projected for calendar year 20____
If calendar year is not applicable, enter appropriate fiscal year:_____

Personal Financial Statement

Name: _____ **Date:** _____

ASSETS

I. Current Assets

Cash	_____	
Stocks and Bonds	_____	
Accounts Receivable	_____	
Notes Receivable (current)	_____	
Cash Surrender Value of Life Insurance	_____	
Other Current Assets (Itemize)	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
Total Current Assets		_____

II. Non-Current Assets

Real Estate	_____	
Health Facility Realty Interests	_____	
Health Facility Operational Interests	_____	
Adult Care Facility Realty Interests	_____	
Other Business Interests (Itemize)	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
Motor Vehicle (Less Accumulated Depreciation)	_____	
Equipment (Less Accumulated Depreciation)	_____	
Other Non-Current Assets	_____	
Total Non-Current Assets		_____

III. Investments and Other Assets

Mortgages Receivable	_____	
Notes Receivable	_____	
Investments (Itemize)	_____	
_____	_____	
_____	_____	
Organization Expense (Less Accumulated Abort.)	_____	
Good will - Purchase Only	_____	
Other Assets (Itemize)	_____	
_____	_____	
_____		
Total Investments and Other Assets		_____
Total Assets		_____
Assets Pledged		_____

Personal Financial Statement

Name: _____ **Date:** _____

LIABILITIES

IV. Current Liabilities

Accounts Payable	_____	
Notes Payable (current)	_____	
Fed. & State Withholding Taxes Payable	_____	
Mortgages Payable (current)	_____	
Interest Payable	_____	
Installment Contracts Payable (current)	_____	
Other Current Liabilities (Itemize)	_____	
_____	_____	
_____	_____	
_____	_____	
Total Current Liabilities		_____

V. Non-Current Liabilities

Mortgages Payable - Health Care Facilities	_____	
Mortgages Payable - Adult Care Facilities	_____	
Other Mortgages Payable	_____	
Other Non-Current Liabilities (Itemize)	_____	
_____	_____	
_____	_____	
_____	_____	
Total Non-Current Liabilities		_____
Total Liabilities		_____

VI. Net Worth _____

Total Liabilities & Net Worth _____

Amount of Liabilities Secured _____

Personal Financial Statement

Name: _____ **Date:** _____

Section I - Current Assets

CASH

Name of Bank	Account Number	Account Balance	Amount Pledged As Collateral
Cash on Hand			
Total as per statement			

STOCKS & BONDS

Shares or Bonds	Name of Security	In Name of	Present Market Value	If Pledged, State to Whom

ACCOUNTS & NOTES RECEIVABLE

Name and Address of Debtor	Amount	Are Assets Pledged as Collateral?	Amount Pledged

Personal Financial Statement

Name: _____ **Date:** _____

Section I - Current Assets (cont'd)

LIFE INSURANCE

Face Amount	Name of Company	Beneficiary	Type of Policy	Cash Value	Method of Payment

OTHER CURRENT ASSETS

Type of Asset	Cost	Fair Market Value	Amount Pledged as Collateral

Personal Financial Statement

Name: _____ **Date:** _____

Section I I - Non-Current Assets

REAL ESTATE OWNED

Location, Type of Property	Date Acquired	Title in Name of	Cost	Fair Market Value	Mortgages		Method of Payment
					Original Amt	Current Amount	

HEALTH CARE REALTY INTERESTS

Location, Type of Health Care Property	Date Acquired	Title in Name of	Cost	Fair Market Value	Mortgages		Method of Payment
					Original Amt	Current Amount	

HEALTH CARE OPERATIONAL INTERESTS

Location, Type of Health Care Facility/Entity	Percent Interest	Cost	Fair Market Value	Amount Pledged As Collateral

Personal Financial Statement

Name: _____ **Date:** _____

Section I I - Non-Current Assets

ADULT CARE FACILITY REALTY INTERESTS

Location, Type of Health Care Property	Date Acquired	Title in Name of	Cost	Fair Market Value	Mortgages		Method of Payment
					Original Amt	Current Amount	

ADULT CARE FACILITY OPERATIONAL INTERESTS

Location, Type of **Health Care** Facility/Entity	Percent Interest	Cost	Fair Market Value	Amount Pledged As Collateral

OTHER NON-CURRENT ASSETS (excluding real property)

Type of Asset	Cost	Fair Market Value	Amount Pledged as Collateral
Motor Vehicles (net of depr)			
Equipment (net of depr) Other			
Non-Current Assets			

Personal Financial Statement

Name: _____ **Date:** _____

Section III - Investments and Other Assets

INVESTMENTS AND OTHER ASSETS

Type of Asset	Cost	Fair Market Value	Amount Pleged as Collateral

Section IV- Current Liabilities

CURRENT LIABILITIES

Name & Address of Creditor	Amount	Due Date	Specify Amount & Assets Offered as Security

Section V - Non-Current Liabilities

NON-CURRENT LIABILITIES

Name & Address of Creditor	Amount	Due Date	Specify Amount & Assets Offered as Security

Anticipated Personal Income

Name: _____ **Date:** _____

Social Security #: _____

Salaries & Wages	_____
Interest & Dividends	_____
Investments	_____
Rents	_____
Other Partnerships/Proprietorships	_____
Other Business Interests	_____
Other Sources (specify)	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
TOTAL	_____

Anticipated Personal Income

Name: _____ **Date:** _____

Social Security #: _____

Salaries & Wages	_____
Interest & Dividends	_____
Investments	_____
Rents	_____
Other Partnerships/Proprietorships	_____
Other Business Interests	_____
Other Sources (specify)	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
TOTAL	_____

Projected Twelve Month Operating Budget

Projected operating budget for twelve months ending: _____

	Total A	ALP B	Adult Care (Non-ALP) C	Home Care (Non-ALP) D
Anticipated Revenue				
Room, Board and Routine Care				
Home Care				
Other Resident Revenue (attach schedule)				
Other Revenue (attach schedule)				
Total Anticipated Revenue				
Anticipated Expense				
Salaries and Wages				
Director/Administrator (1)				
Supervisor/Case Management (2)				
Total Service Personnel (3)				
Clerical Staff				
Other				
Payroll Taxes				
Other Fringe Benefits				
Purchase of Service Contracts (attach schedule)				
Dietary Consultant				
Raw Food Costs - Resident meals				
Raw Food Costs - Employee meals				
Food Supplies				
Medical and Nursing Supplies (including non-				
depreciable equipment)				
Rental of Facility				
Real Estate Taxes				
Water and Sewer				
Heat, Light and Power				
Repairs and Maintenance				
Housekeeping Supplies				
Laundry and Linen				
Social and Recreation				
Transportation				
Security				
Insurance				
Interest expense (attach schedule)				
Telephone				
Legal and Accounting				
Advertising				
Other Administrative and general (attach schedule)				
Depreciation and Amortization				
Total Anticipated Expenses				
Net Operating Surplus (deficit)				
Anticipated Resident Care Days				

(1) From Schedule 1-5, Column F, Line 1

(2) From Schedule 1-5, Column F, Line 2

(3) From Schedule 1-5, Column F, Lines 3 thru 16

Assisted Living Program Application

A. Attachments

1. For existing Adult Homes or Enriched Housing program submit two sets of floor plans certified by a registered architect or professional engineer indicating the following:

   - Complete layout of existing building; and

   - Detailed plan of specific ALP location showing:

     a. Sprinkler location
     b. Smoke detectors/thermal detectors
     c. Emergency battery operated lighting
     d. Pull alarm stations
     e. Audio-visual alarms
     f. Resident room/bathroom emergency call system
     g. Exit lighting/directional lighting
     h. Exits

2. For a new building, building addition to an existing adult home or existing building conversion/renovation:

   - A narrative or description of the following:
     1. Site and Location
     2. Type of Construction
     3. Height and Floor Area
     4. Mechanical/Electrical Systems
     5. Cost of Construction or Renovation

   - Preliminary plans describing complete proposal and construction shall be submitted in duplicate.

     PROCEDURE

     Proposals will be reviewed and comments returned to applicant. Applicants will be directed to make corrections as appropriate, and to submit final plans, sealed and signed by a NYS licensed registered architect (RA) or professional engineer (PE) for review and/or record purposes. Applicants will be advised that construction may not commence until Part 1 of the application has been approved.

     When project is approximately 85 to 90% complete, the applicant shall request for a final (construction only) inspection.

     New project may not be occupied or approved until the pre-opening inspection has been completed by the New York State Department of Health (NYSDOH) Regional Office (RO) and the following certificates have been received by the NYSDOH RO:

     1. From Local Building/Fire Department:

        Certificate of Occupancy

2. Certificates from:

   a. Electrical Underwriters
   b. Sprinkler Installer
   c. Interior Finishes
   d. Fire/Smoke Detection work

NOTE: It is recommended that the applicant consult with a registered architect or professional engineer to determine the financial feasibility of the proposed project. The professional chosen shall be informed that the building, building addition or building renovation shall meet the following criteria:

ADULT HOME

1. Building Code of New York State applicable to I-1 or R-4 occupancy classification effective January 1, 2003.

ENRICHED HOUSING

2. Building Code of New York State applicable to I-1 or R-4 occupancy classification effective January 1, 2003.

1. Schedule Instructions

   a. SCHEDULE 4-1: Project Type/Building Checklist.

      This schedule is to be completed by all applicants.

      - SECTION 1: Project Type – Indicate in the space provided the type of project applicable to this application.

      - SECTION 2: Building Features Checklist – Indicate in the spaces provided (1) whether the listed features are present and, if present, whether they are operable, and (2) if not present, whether they are planned. If the features are not present, the operable columns should not be completed. If the features are present, the planned column should not be completed.

*Applicable building codes for New York City:

H-2 Adult Home
J-2 Enriched Housing

Architectural Component

Provide the following information about your proposed physical plant:

1. Project type (check those appropriate):

a. _____ New Construction
b. _____ Building Addition
c. _____ Renovation of existing ACF - No change in certified capacity
d. _____ Renovation of existing ACF - Change in certified capacity
e. _____ Existing building which is not currently utilized as an ACF to be renovated
f. _____ Existing ACF/other building - no construction, addition and/or renovation

2. Building Features Checklist

For each of the building features listed below, indicate if the feature is present or planned, and if present, whether the feature is operable. If the feature is not present, the operable column should not be completed. Also indicate whether each feature is considered mandatory in your type building.

Building Feature	Present		Operable		Planned		Mandatory	
	Yes	No	Yes	No	Yes	No	Yes	No
Sprinkler System-Complete Building								
Sprinkler System-Partial Installation								
Alarm System - 24 hour Supervised								
Alarm System - Internal Only								
Smoke Detection System - Hard Wired								
Smoke Detectors - Battery Operated								
Heat Detection System - Hard Wired								
Fire Extinguishers - Type A								
Fire Extinguishers-Type A, B, C								
Standpipe System								
Public Hydrants								
Emergency Lighting - Battery Operated								
Generator								
Elevators								
Escalators								
Dumb Waiter								
Smoke Stop Doors - Stair Wells								
Smoke Stop Doors - Hallways								
Heating System								

Architectural Component (cont'd)

Building Feature	Present		Operable		Planned		Mandatory	
	Yes	No	Yes	No	Yes	No	Yes	No
Air Conditioning System								
Ventilation System								
Panic Hardware on Exit Doors								
Evacuation Floor Plans								
Fire Escapes								
Interior Enclosed Stairwells								
Incinerator								
Window Guards or Security Screen								
Space Heaters or Hanging Heaters								
Fire Rated Doors Entering into Hallways								
Fixed Pipe Extinguisher System								
Lighted Exit Signs								
Lighted Directional Signs								
Hazard Warning Signs								
Exit Possible Type Door Locks								
Storage Areas Over 100 Sq. Ft.								
Hand Rails on All Stairways								
Window Screens on all Operable Windows								
Sky Lights								
Security Alarms								
TV Security Monitor System								
Other (specify)								

Assisted Living Program Application

A. Attachments

The following information must be submitted, if applicable, as part of this application. Each attachment must be labeled in the top right hand corner with the number corresponding to the following list of attachments (e.g. Character/Competence: Attachment 1).

1. Each individual proprietor and each member of a partnership must submit three letters of personal reference which must include as a minimum, the following:

   - Name of the individual for whom the reference is being provided;
   - Name, address, phone number and occupation of the respondent;
   - Nature and length of respondent's association with the applicant;
   - Respondent's knowledge of applicant's background, experience and interest in the care of dependent adults;
   - Respondent's knowledge of applicant's character and ability; and
   - Date and signature of respondent.

B. Schedule Instructions

Note: Schedules 5-1, 5-2 and 5-3 must be completed by the following individuals:

- individual proprietors;
- each member of a partnership;
- each member and officer of the Board of Directors and shareholders of a corporation;
- each member of a Limited Liability Company;
- each member, director, controlling person, principal stockholder (stockholder owning ten percent or more of the stock), officer and sponsor of any parent corporation, controlling person or organization.

Character/Competence: Schedule 5-1 Attachment, etc.

1. SCHEDULE 5-1: PERSONAL QUALIFYING INFORMATION

   - SECTION A – Indicate in the space provided the name of the individual, address, phone number, date of birth, other names the individual has gone by and position with the ALP.
   - SECTION B – Indicate in the space provided any licenses held by the individual including the type of license, license number, name and address of the licensing agency, date received and expiration date of licenses and an indication of any license denials or any action taken against the individual's license. If any license was denied or any action taken against a license, indicate the details in the space provided.
   - SECTION C – Indicate the individual's educational history, starting with high school in the spaces provided.

- SECTION D – Indicate the individual's employment history for the past ten years in the spaces provided.

- SECTION E – Sign and date the certification in the space provided. Each individual's certification must be individually notarized.

2. SCHEDULE 5-2: AFFILIATION WITH OTHER ADULT CARE AND/OR HEALTH CARE OPERATIONS

   - Indicate in the space provided the individual's name and relationship to the proposed ALP (e.g. proprietor, partner, board member, member, etc.).

   - Indicate in the spaces provided whether the individual has ever owned or operated any adult care facility or other health care residences or had affiliation with any health care or health related operations in New York, in the USA or other countries. If applicable, indicate the detail in the spaces provided.

   - Sign and date the certification statement. Each individual's certification must be individually notarized.

3. SCHEDULE 5-3

   - In the spaces provided, enter the individual's name and relationship to the proposed ALP (e.g. proprietor, partner, board member, etc.)

   - Answer yes or no to each of the questions 1-14.

   - If any of the questions 1-14 is answered "Yes", provide the requested detail in the space provided.

   - Sign and date the certification statement. Each individual's certification must be individually notarized.

Assisted Living Program Application

Personal Qualifying Information

A. Personal Identifying Information

Name (Last, First, MI)

Address/Street and Number

City | State | Zip Code

Telephone Number (Area Code)
( )

Date of Birth (mm/dd/yyyy) | Place of Birth (Country/State) | Social Security Number

Any other Name/Alias by which you have been known in the past 10 years
Name (Last, First, MI)

Current or proposed position with proposed assisted living program:

B. Licenses Held

Type of License/Specialty | License Number

Licensing Agency/Address

Date Received – Date of Expiration

Have you ever been denied a professional license, or had one suspended or revoked?

If the answer to this question is "Yes", complete below:

Date of Action (mm/dd/yyyy)	Type of Action	Location
Persons and/or Facilities Involved		
Give any further details		

Assisted Living Program Application

C. Educational History (High School is to be included)

Institution	Address/Street & No. City, State, Zip	Years Attended	Degree	Date Received

D. Employment History for the Past Ten Years:

Name of Employer:

Address/Street & Number:

City State Zip Code

Dates of Employment Type of Business
From: To:

Name of Supervisor or Reference Telephone Number

Position Held/Responsibilities

Reason for Departure

Assisted Living Program Application

Employment History (cont'd)

Name of Employer:

Address/Street & Number:

City State Zip Code

Dates of Employment Type of Business
From: To:

Name of Supervisor or Reference Telephone Number

Position Held/Responsibilities

Reason for Departure

Name of Employer:

Address/Street & Number:

City State Zip Code

Dates of Employment Type of Business
From: To:

Name of Supervisor or Reference Telephone Number

Position Held/Responsibilities

Reason for Departure

E. Certification

The undersigned hereby certifies, under penalty of perjury, that the information contained herein and attached hereto is accurate, true and complete in all material respects. A stamped or electronic signature is not acceptable as an original signature.

Signature Date

Notary Public:

Assisted Living Program Application

Affiliation with Other Adult Care and/or Health Care Operations

Name of Individual	Relationship to Proposed ALP

Have you ever owned or operated any adult care facilities or other health care residences or institutions or had any affiliations with health care or health related operations New York, in the USA or in other countries?

☐ Yes ☐ No

If "yes" complete the following:

Name and Address of Facility	Facility Type	Certificate No. (if any)
☐ Open ☐ Closed ☐ Proposed	Dates of Affiliation From: To:	
Nature of Affiliation (see instructions)		

Name and Address of Facility	Facility Type	Certificate No. (if any)
☐ Open ☐ Closed ☐ Proposed	Dates of Affiliation From: To:	
Nature of Affiliation (see instructions)		

Certification

The undersigned hereby certifies, under penalty of perjury, that the information contained herein and attached hereto is accurate, true and complete in all material respects. A stamped or electronic signature is not acceptable as an original signature.

Signature Date

Notary Public:

Assisted Living Program Application

History of Legal Actions

Name of Individual	Relationship to Proposed ALP

1. Except for minor traffic violations, have you ever been convicted of any violation of the Law?

☐ Yes ☐ No

2. Are there any criminal actions now pending against you?

☐ Yes ☐ No

3. Have you ever pleaded *nolo contendre* to a felony charge?

☐ Yes ☐ No

4. Have you ever been held liable or enjoined by final judgment as a result of a criminal or civil action involving fraud, embezzlement, fraudulent conversion, or misappropriation of property?

☐ Yes ☐ No

5. Are you/have you ever been subject to an injunctive restrictive/restraining order, or federal or state restrictive/restraining order, relating to business or health care related activity as a result of an action brought by a public agency or department?

☐ Yes ☐ No

6. Have you ever had a discharge in bankruptcy, or have you been found insolvent in any court action?

☐ Yes ☐ No

7. Have you ever been involved in a hearing before an official body with respect to any health related operation or institution caring for people?

☐ Yes ☐ No

8. Have you ever been dismissed or discharged from any employment for reasons other than lack of work or funds?

☐ Yes ☐ No

9. Have you ever resigned from any employment rather than face dismissal?

☐ Yes ☐ No

Assisted Living Program Application

10. Have you ever received a discharge from the Armed Forces of the United States which was other than "honorable" or which was issued under other than honorable circumstances?

☐ Yes ☐ No

11. Have you ever forfeited bail or bond posted to guarantee your appearance in court to answer to any criminal charge?

☐ Yes ☐ No

12. Have you ever been involved as a defendant in a hearing before an official body in relation to the operation of a home, facility or institution caring for people (including a nursing home, health related facility, or community residence)?

☐ Yes ☐ No

13. Have you ever been denied approval to care for unrelated dependent children or adults, or had any such approval withdrawn?

☐ Yes ☐ No

14. Have you ever been denied a professional license, or had any such license suspended or revoked?

☐ Yes ☐ No

If the answer to any of the previous questions is "Yes", complete the following;

Date of Action:	Type of Action:	Location:
Person/Facility Involved:		
Date of Conviction/Judgment		Issuer of Order
Penalty Imposed/Damages Assessed		
Further Details		

Certification

The undersigned hereby certifies, under penalty of perjury, that the information contained herein and attached hereto is accurate, true and complete in all material respects. A stamped or electronic signature is not acceptable as an original signature.

Signature Date

Notary Public:

ALP: Limited Liability Companies
Additional Legal Requirements

An applicant to establish and operate an Assisted Living Program (ALP) as a limited liability company (LLC) must comply with the following requirements, in addition to the other applicable legal requirements and components of the ALP application.

Chapter 591 of the Laws of 1999 amended Social Services Law (SSL) § 461-b (1)(a) to authorize certain limited liability companies (LLCs) to operate adult homes, residences for adults and enriched housing programs. The Department may issue an operating certificate to an LLC provided that if the LLC has a member that is a corporation, an LLC or a partnership, the shareholders of the member corporation, the members of the member limited liability company or the partners of the member partnership must be natural persons. An applicant must obtain the prior written approval of the Department before filing its Articles of Organization with the Department of State.

The following information will assist applicants in submitting application information and documents in support of an application for an LLC to be approved to establish and operate an adult assisted living program (ALP). The information is organized as follows:

I. General Requirements …… p.2
II. Articles of Organization …… p.4
III. Operating Agreement …… p.5
IV. Management Agreement for Outside Managers … p.6
V. LLC Resolution and Authorizing Signature ……. p.7

I. GENERAL REQUIREMENTS

The ALP application must contain the following documentation:

a. A photocopy of the applicant's fully executed Articles of Organization;

b. A photocopy of the applicant's fully executed Operating Agreement;

c. Identification of all members of the applicant and the membership interest of each;

d. A statement that the LLC is an eligible LLC under the provisions of (SSL) § 461-b (1)(a) as follows:

A statement as to whether any of the members identified in "c" above is a corporation, an LLC or a partnership. If the LLC has any member that is a corporation, identification of all shareholders of each member corporation and a statement that all members of each member corporation are natural persons. If the LLC has any member that is an LLC, identification of each member of the member LLC and a statement that all members of the member LLC are natural persons. If the LLC has any members that are partnerships, identification of each member of the member partnership and a statement that all members of the member partnership are natural persons;

e. If the applicant has any business corporation members, (i) fully executed copies of their Certificates of Incorporation and Bylaws which must include sufficient powers and purposes to own membership interests in the applicant proposed ALP operator LLC, and (ii) identification of all officers, directors and stockholders;

f. If the applicant has any not-for-profit corporation members, (i) fully execute copies of their Certificates of Incorporation and Bylaws which must include sufficient powers and purposes to own membership interests in the applicant proposed ALP operator LLC;

g. If the applicant has any LLC members, (i) fully executed copies of their Articles of Organization (ii) fully executed copies of their Operating Agreements, and (iii) identification of all members and managers. Please note that the Articles of Organization and the Operating Agreement of such member LLC must provide that:

all of the "second tier" LLC members shall be natural persons; and that any transfer, assignment or other disposition of membership interests or voting rights must have prior approval of the Department;

h. If the applicant has any general partnership members, (i) fully executed copies of their Partnership Agreements, and (ii) identification of all partners;

i. Identification of all managers of the applicant;

j. If the applicant will be managed by managers who are not members, a photocopy of the proposed Management Agreement between the applicant and the manager;

k. If the LLC will be managed by managers who are not members, that the following powers are reserved to the members:

Direct independent authority over the appointment of the administrator, approval of all other persons working in the facility and dismissal of all persons working in the facility; (ii) approval of facility operating and capital budgets and independent control of the books and records including that all facility accounts and billing must be in the name of, on behalf of and for the benefit of the operator; (iii) adoption or approval of facility operating policies and procedures and independent adoption of policies affecting the delivery of facility services; (iv) authority over the disposition of assets and authority to incur liabilities not normally associated with day-to-day operations; (v) approval of facility debt necessary to finance the cost of compliance with operational or physical plant standards required by law; (vi) approval of contracts; and (vii) approval of settlements of administrative proceedings or litigation to which the facility is a party.

II. ARTICLES OF ORGANIZATION

The applicant's Articles of Organization must include provisions to the following effect:

a. The name of the LLC which must contain either the words "Limited Liability Company" or the abbreviations "LLC" or "L.L.C.";

b. A statement that the LLC is an eligible LLC under the provisions of SSL § 461-b (1)(a) as amended by Chapter 591 of the Laws of 1999, and providing the basis for such statement. (For example, that all members are natural persons; or if a member is a corporation, an LLC or a general partnership, that the members of such member corporation, member LLC or member partnership are natural persons.)

c. Designation of the Secretary of State as agent of the LLC for service of process and an address to which the Secretary of State may mail a copy of any such process;

d. A specific statement of the purposes of the limited liability company for which certification is being sought must be included. The following language would be acceptable.

Note: Choose either the adult home or the enriched housing purpose and the home care and the assisted living program purposes.

"The purposes for which the limited liability company is formed are:

(Adult home) to establish, maintain and operate an adult home as defined in Section 2(25) of the Social Services Law; provided, however, that the limited liability company shall not establish or operate such adult home without the prior written approval of the New York State Department of Health.

or

(Enriched housing program) to establish, maintain and operate an enriched housing program as defined in Section 2(28) of the Social Services Law; provided, however, that the limited liability company shall not establish or operate such adult home without the prior written approval of the New York State Department of Health.

and

(Home care) to establish and operate a home care agency as authorized under Article 36 of the Public Health Law, provided, however, that the limited liability company shall not establish or operate such home care agency without the prior written approval of the Public Health Council and the New York State Department of Health.

and

(Assisted living program) to establish, maintain and operate an assisted living program as defined in Section 461-1 of the Social Services Law; provided, however, that the limited liability company shall not establish or operate such assisted living program without the prior written approval of the New York State Department of Health.

e. How the LLC will be managed and that neither the management structure, nor any provision setting forth such structure may be deleted, modified or amended without the prior approval of the Department;

f. If the LLC will be managed by managers who are not members, that the manager may not be changed without the prior approval of the Department;

g. That no person may own any membership interest or voting rights unless approved by the Department;

h. That transfers, assignments or other dispositions of membership interests or voting rights must be approved by the Department.

III. OPERATING AGREEMENT

The Operating Agreement must include provisions to the following effect:

a. How the LLC will be managed and that neither the management structure nor the provision setting forth such structure may be deleted, modified or amended without the prior approval of the Department; and

b. If the LLC will be managed by managers who are not members, that the following powers are reserved to the members:

direct independent authority over the appointment of the administrator, approval of all other persons working in the facility and dismissal of all persons working in the facility; (ii) approval of facility operating and capital budgets and independent control of the books and records including that all facility accounts and billing must be in the name of, on behalf of and for the benefit of the operator; (iii) adoption or approval of facility operating policies and procedures and independent adoption of policies affecting the delivery of facility services; (iv) authority over the disposition of assets and authority to incur liabilities not normally associated with day-to-day operations; (v) approval of facility debt necessary to finance the cost of compliance with operational or physical plant standards required by law; (vi) approval of contracts; and (vii) approval of settlements of administrative proceedings or litigation to which the facility is a party.

c. That no person may own any membership interest or voting rights unless approved by the Department;

d. That transfers, assignments or other dispositions of membership interests or voting rights must be approved by Department.

IV. MANAGEMENT AGREEMENT FOR OUTSIDE MANAGERS

If the LLC will be managed by managers who are not members, the following additional requirements must be met:

a. A Management Agreement must be submitted which contains provisions to the following effect:

1. That the manager may not be changed without prior approval of the Department, and

2. That the following powers are reserved to the members:

direct independent authority over the appointment of the administrator, approval of all other persons working in the facility and dismissal of all persons working in the facility; (ii) approval of facility operating and capital budgets and independent control of the books and records including that all facility accounts and billing must be in the name of, on behalf of and for the benefit of the operator; (iii) adoption or approval of facility operating policies and procedures and independent adoption of policies affecting the delivery of facility services; (iv) authority over the disposition of assets and authority to incur liabilities not normally associated with day-to-day operations; (v) approval of facility debt necessary to finance the cost of compliance with operational or physical plant standards required by law; (vi) approval of contracts; and (vii) approval of settlements of administrative proceedings or litigation to which the facility is a party.

b. The Management Agreement must comply with the requirements of 18 NYCRR § 485.10 and the provisions in “a” above and must be approved by the Department before it is effective.

V. LLC RESOLUTION AND AUTHORIZING SIGNATURE

As stated in Program Instruction B.3., provide a certified copy of the resolution of the Members of the LLC, as required at Program Schedule 1-3.

ALP: BUSINESS CORPORATIONS
ADDITIONAL LEGAL REQUIREMENTS

An applicant to establish and operate an Assisted Living Program (ALP) as a business corporation must comply with the following requirements, in addition to the other applicable legal requirements and components of the ALP application.

Section 461-b (1)(a) of the Social Services Law, as amended by Chapter 543 and 462 of the Laws of 1996, provides that a business corporation other than a corporation whose shares are traded on a national securities exchange or are regularly quoted on a national over-the-counter market or subsidiary of such corporation or a corporation any of the stock of which is owned by another corporation may be issued an operating certificate by the Department for the purpose of operating an adult home or enriched housing program.

A. Certificates of Incorporation: A Certificate of Incorporation must be approved by the Department before it is filed with the Department of State (Section 460-a of the Social Services Law). The applicant must submit the filing receipt to the Department before an operating certificate is issued. If a corporation is already formed with a general purpose, the purposes must be amended to include a specific statement of authority to establish and operate an assisted living program, as discussed in greater detail on page three of this document. In that situation, the Certificate of Amendment of the Certificate of Incorporation requires the Department's approval before it is filed with the Department of State.

B. Corporate Ownership: The applicant must include a statement about ownership of shares. The statement must show that the shares are not traded on a national securities exchange and are not regularly quoted on a national over-the-counter market; that the corporation is not a subsidiary of a corporation whose shares are traded on a national securities exchange or over-the-counter market; and that no stock of the corporation is owned by another corporation.

C. List names of each shareholder and percentage of shares held by each shareholder.

D. Submit corporate by-laws.

E. Liability: Section 461-b (3-a) of the Social Services Law provides that person who is a "controlling person" of an adult home, residence for adults or enriched housing program which is liable under any provision of the Social Services Law to any person or class of persons for damages or to the State for any civil fine, penalty, assessment or damages, shall also be liable, jointly and severally, with and to the same extent as such adult home, residence for adults or enriched housing program, to such person or class of persons for damages or to the State for any such civil fine, penalty, assessment or damages. If applicant's certificate of incorporation contains a provision that limits a director's liability, the limitation must be consistent with Section 461-b (3) (a) of the Social Services Law. Language such as "to the extent such limitation is consistent with Section 461-b (3-a) of the Social Services Law" should be included in a prevision that limits a director's liability.

F. Transfers of Stock or Voting Rights: Any transfer of stock or voting rights in a business corporation requires the prior approval of the Department.

G. Assumed Name: If the corporation will be conducting business under an assumed name a Certificate of Assumed Name must be submitted pursuant to General Business Law Section 130.

H. Corporation Resolution and Authorizing Signature: As stated in Program Instructions B.3, provide a certified copy of the resolution of the Board of Directors as required at Program Schedule 1-3.

Corporate Purposes: The Department requires a specific statement of purposes in the certificate of incorporation. The purposes as stated in the certificate of incorporation must authorize the corporation to establish and operate: the specific type of adult care facility (adult home or enriched housing program) the corporation will be certified to operate; home care; and an assisted living program. The following language would be acceptable.

Note: Choose either the adult home or the enriched housing program purpose and the home care and the assisted living program purposes.

"The purposes for which the corporation is formed are:

(Adult home) to establish, maintain and operate an adult home as defined in Section 2(25) of the Social Services Law; provided, however, that the corporation shall not establish or operate such adult home without the prior written approval of the New York State Department of Health.

or

(Enriched housing program) to establish, maintain and operate an enriched housing program as defined in Section 2(28) of the Social Services Law; provided, however, that the corporation shall not establish or operate such adult home without the prior written approval of the New York State Department of Health.

and

(Home care) to establish and operate a home care agency as authorized under Article 36 of the Public Health Law, provided, however, that the corporation shall not establish or operate such home care agency without the prior written approval of the Public Health Council and the New York State Department of Health.

and

(Assisted living program) to establish, maintain and operate an assisted living program as defined in Section 461-1 of the Social Services Law; provided, however, that the corporation shall not establish or operate such assisted living program without the prior written approval of the New York State Department of Health.

Addendum for requesting a New Licensed Home Care Services Agency as part of the Assisted Living Program Application

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Addendum for requesting a New Licensed Home Care Services Agency as part of the Assisted Living Program Application

GENERAL INSTRUCTIONS

This Addendum can only be used by a proposed home care services organization seeking initial approval as a licensed home care services agency (LHCSA) as part of the application for the Assisted Living Program (ALP). Addendum cannot be used to establish a new LHCSA that is not part of an ALP. A separate complete LHCSA application is required. The complete LHCSA application can be obtained by calling (518) 408-1629.

Reference Material

The reference materials listed below may be of assistance when completing this application. These materials may be accessed through links contained in the New York State Department of Health's internet page: www.nyhealth.gov

1. Article 36 of the Public Health Law.
2. Approval and Licensure of Home Care Services Agencies – Part 765 of 10 NYCRR.

The review process for applications requires presentation of an Office of Long Term Care staff review with recommendations concerning the application to both the State Hospital Review and Planning Council and the Public Health Council.

Instructions to Schedules and Attachments

In addition to these general instructions, instructions for the completion of specific portions of the application also are included within the application itself. Responses to questions that require an attachment should be identified by number. Any non-duplicating numbering system may be used, but all instructions and questions which require attachments must have such attachment number noted in the appropriate section. Additional attachments may also be submitted.

Acknowledgement/Completeness Review

The entire ALP application including the LHCSA addendum must be mailed to the address referenced in the ALP RFA. LHCSA applicants will receive an acknowledgment letter from the Bureau of Project Management which will include the project number which must be used in all correspondence referring to the LHCSA application. Please be advised that separate LHCSA and ALP application numbers will be assigned.

As part of the review process, applicants should be aware that additional information may be requested.

AFFIDAVIT

This statement must be signed by a duly authorized representative of the applicant to affirm that no services requiring home care licensure are presently provided and will not be provided until such time as a license is received.

Name of Agency: _____

As defined in Article 36 of the New York State Public Health Law, a home care services agency subject to licensure is an organization engaged in arranging and/or providing, either directly or through contractual arrangement, nursing, home health aide or personal care services.

Please confirm the following by signing this statement in the space provided below:

- Neither the applicant nor any related agency is providing home health aide or personal care either directly, by referral, or by contract at the present time without an Article 36 license.
- Neither the applicant nor any related agency is providing registered nurse or licensed practical nurse services in the home of any person at this time beyond that permitted as an individual practitioner within the scope of his/her license.
- Regardless of the title of the workers, neither the applicant nor any related agency is either directly, by contract or through referrals, placing in the home of any person any individuals that deliver “hands on” personal care to patients.
- Neither the applicant nor any related agency will commence operation of a home care services agency until the application has obtained Public Health Council approval AND the agency has obtained a license from the Department of Health.

Authorizing Signature:

Name ☐Ms. ☐Mrs. ☐Mr. ☐Dr.		Date:
Signature **X**	Title	

Notary:

Sworn to before me this _____ day of _____, 20___.

Name:	Date:
Signature: **X**	

SCHEDULE 1
IDENTIFYING DATA

NAME UNDER WHICH THE AGENCY WILL CONDUCT BUSINESS			
AGENCY STREET ADDRESS	CITY	STATE	ZIP CODE
LEGAL OPERATOR NAME (IF DIFFERENT FROM ABOVE)			
STREET ADDRESS	CITY	STATE	ZIP CODE
TYPE OF OWNERSHIP			
☐ SOLE PROPRIETOR	☐ PARTNERSHIP	☐ LIMITED LIABILITY COMPANY	
☐ BUSINESS CORPORATON	☐ NOT-FOR-PROFIT CORPORATION		
☐ OTHER (SPECIFY)			
NAME OF CONTACT PERSON (MUST BE AFFILIATED WITH THE LHCSA APPLICANT)			
☐Ms. ☐Mrs. ☐Mr. ☐Dr.			
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NO.	FAX NO.	APPLICANT E-MAIL ADDRESS	
CONSULTANT NAME (IF APPLICABLE)			
☐Ms. ☐Mrs. ☐Mr. ☐Dr.			
STREET ADDRESS	CITY	STATE	ZIP CODE
CONSULTANT TELEPHONE NO.	CONSULTANT FAX NO.	CONSULTANT E-MAIL ADDRESS	

Resolution

Existing corporations or limited liability companies must submit a resolution of the Board of Directors, members of the LLC, or other governing body having jurisdiction over the program authorizing submission of the application. This requirement is not applicable to sole proprietors or partnerships. Attachment #☐

Authorizing Signature

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto, with the exception of those schedules pertaining to personal qualifying and disclosure information (which must be individually certified), is accurate, true and complete in all material aspects.

Name: ☐Ms. ☐Mrs. ☐Mr. ☐Dr.	Date:
Signature: **X**	Title:

Notary - Sworn to before me this _____ day of _____, 20___.

Name:	Date:
Signature: **X**	

SCHEDULE 2
PROJECT NARRATIVE

In the space below, provide a concise overview of your proposal. The summary should provide the key elements of the proposed project. Details will be requested in subsequent schedules of the application.

SCHEDULE 3
PROGRAM ANALYSIS

1. Enter the counties to be served by the proposed agency.

Note: A LHCSA may serve *one contiguous* county outside the jurisdiction of the DOH Area in which the agency is located without need to establish a second office site. Appendix A to this addendum contains a list of counties included in each DOH Area.

For example, an agency located in the Central New York Area may also serve Fulton County from the same site because Fulton County is contiguous to the Central New York Area. However, it may not serve Schenectady County because that county is not contiguous to the Central New York Area. If a LHCSA proposes to serve more than one county outside the designated DOH Area in which it is located, a second office site in the second DOH Area must be established.

2. Indicate which services will be provided by the agency, the method of service provision in full- time equivalents, the availability of the service, and the projected number of cases and visits for each service for the first year of operation. Attach a job description for each service listed. Attachment #

Table 1 – Service Availability

	Method of Provision	Availability (FTE)	Projected # of:	
Services Provided:	(Direct/Contract)	Hours & Days/Week	Cases	Visits
Nursing*				
Home Health Aide				
Personal Care				
Physical Therapy				
Occupational Therapy				
Respiratory Therapy				
Speech-Language Pathology				
Audiology				
Medical Social Services				
Nutrition				
Homemaker				
Housekeeper				

***NOTE: THE AGENCY MUST DIRECTLY EMPLOY AT LEAST ONE REGISTERED NURSE FOR OVERSIGHT OF SERVICES.**

3. Specify, by name, the *anticipated* sources of referral. Do not use general terms such as hospitals, home health agencies, county agencies, etc.

4. Describe proposed or existing relationships with local departments of social services, third party payers, and health, mental health, developmental disabilities, social services and Office for the Aging providers in your community as it relates to the referral, case management and discharge of home care patients.

5. Are you planning to provide personal care services under contract with the local social services district? If yes, confirm in the space below that the district has been contacted and a contract is attainable.

   ☐ Yes ☐ No

6. Describe the agency's Quality Improvement (QI) plan. Include the composition of the QI Committee, frequency of QI meetings, method and frequency of data collection, responsible persons, scope of services to be reviewed, and what initiatives the agency will take to ensure a high standard of care.

7. All applicants must include a summary of operating costs in Table 2.

Table 2 – Summary of Operating Costs of the proposed LHCSA

	Present Annual Costs (If applicable)	Estimated Operational Costs First 12 month period
1. Salaries		
a. Director/Administrator		
b. Supervisors		
c. Registered Professional Nurses		
d. Home Health Aides		
e. Personal Care Workers		
f. Clerical Staff		
g. Other		
2. Transportation Costs		
3. Services Purchased from other agencies (Contract Services)		
4. Medical and Nursing Supplies (Including non-depreciable equipment)		
5. Space Occupancy Costs		
6. Office Costs		
7. Other General Costs (specify)		
TOTAL		

Note: The agency must directly employ at least one registered nurse for oversight of services.

SCHEDULE 4
LEGAL INFORMATION

GENERAL INSTRUCTIONS

1. Unless otherwise specifically indicated, legal documentation submitted should be photocopies of fully executed original documents and **not** the originals themselves. Please ensure that all information is legible.

2. Whenever a requested legal document has been amended, modified or restated, all amendments, modifications and/or restatements should also be included.

3. Attachments must be numbered and arranged sequentially. The list of attachments at the end of the schedule must also be completed. Enter either the attachment name or NA in the column labeled, Attachment Title. Enter the attachment number in the third column.

Note: An entity cannot be approved to operate both a certified home health agency (CHHA) or long term home health care program (LTHHCP) and a licensed home care services agency (LHCSA). If an entity is currently approved to operate a CHHA and/or LTHHCP, and it wishes to operate a LHCSA, a separate legal entity (partnership, corporation or limited liability company) must be *proposed*.

Part 1 – All applicants must complete this section in its entirety.

Part 2 – Contains the definition of Controlling Person. Answer the questions accordingly.

Part 3 – The appropriate section of Part 3, “Additional Documentation Depending on Type of Legal Entity” must be completed.

SCHEDULE 4 - PART 1
All Applicants

1. Is the name of the agency different from the name of the applicant's legal entity?
   ☐ Yes ☐ No

   If yes, submit the Certificate of Assumed Name. Attachment #☐

2. Is the applicant a natural person? ☐ Yes ☐ No

   Type of legal entity:
   ☐ Sole Proprietor
   ☐ General Partnership
   ☐ Registered Limited Liability Partnership
   ☐ Not-for-Profit Corporation
   ☐ Business Corporation
   ☐ Limited Liability Company
   ☐ Other, specify:

3. Does the applicant have any partners, members or stockholders that are not natural persons?
   ☐ Yes ☐ No

   If yes, the applicant must comply with the requirements of Section 3611 of Article 36 of the New York State Public Health Law.

4. Are any of the directors or owners (partners, stockholders or members) of the applicant physicians who are in a position to make referrals to the facility? ☐ Yes ☐ No

   If yes, submit a signed statement that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate. Attachment #☐

5. Are any of the directors or principal stockholders (affiliated with either the applicant or its member/parent corporations) attorneys?
   ☐ Yes ☐ No

   If yes, each attorney must submit a Certificate of Good Standing from every jurisdiction in which he or she is licensed. Attachment #☐

6. Submit an organizational chart depicting the applicant's legal structure and its relationship to all sister, parent and subsidiary organizations. Attachment #☐

7. Submit a list of all health care entities operated under the structure depicted in the organizational chart requested above. Include entities operating both in and outside New York State. Please include the full name and address of the health care entities, the license or certificate number, if applicable and indicate the type of services provided. Attachment #☐

Note: For each facility located outside of New York State, documentation must be submitted reflecting its current and past compliance with the applicable regulations in the state in which it operates. This information is required for the most recent ten-year period, or for the period it was owned, operated or managed by the proposed management entity, whichever is less. HOWEVER, DO NOT SEND ANY CORRESPONDENCE UNTIL INSTRUCTED TO DO SO BY THE DOH REVIEWER.

8. Does the applicant intend to enter into a management agreement for the LHCSA?
   ☐ Yes ☐ No

   If yes, submit the proposed agreement and continue with question 9. A management agreement must include all provisions under 10 NYCRR §766.9(m).
   Attachment #

   If no, skip to Schedule 4 - Part 2.

9. Has the proposed management entity previously received approval by the DOH?
   ☐ Yes ☐ No

   List below the principal stockholders/members (those owning ten percent or more of the manager's issued stock/membership interest) and/or the directors of the management entity.

Note: If these individuals did not submit Character/Competency Schedules (Schedules 5-1, 5-2 and 5-3) as part of the Assisted Living Application, these schedules must be completed by each individual and submitted as part of this addendum.

10. Enter on the following chart, the addresses of the health care facilities/agencies owned, operated or managed by the proposed management entity and the time period that each was owned, operated or managed by the proposed management entity. Include out-of-state entities.

Facility Name	Type of Facility	Facility Address	Time Period Owned or Managed

Note: For each facility located outside of New York State, documentation must be submitted reflecting its current and past compliance with the applicable regulations in the state in which it operates. This information is required for the most recent ten-year period, or for the period it was owned, operated or managed by the proposed management entity, whichever is less. HOWEVER, DO NOT SEND ANY CORRESPONDENCE UNTIL INSTRUCTED TO DO SO BY THE DOH REVIEWER.

11. Have any fines or other sanctions related to a disciplinary or enforcement action been imposed by a state regulatory agency against the proposed management entity related to the ownership, operation or management of any health care facility or agency?

☐ Yes ☐ No

If yes, provide further details regarding the action taken in the space below.

12. Are there any criminal actions pending against the proposed management entity or any of the principal stockholders/members?

☐ Yes ☐ No

If yes, provide further details regarding the criminal action.

13. Has the Centers for Medicare and Medicaid Services, or other regulatory agency, ever imposed a civil monetary penalty, denial of payment for new admissions or taken an enforcement action against the proposed management entity for issues related to quality of care? ☐ Yes ☐ No

If yes, provide further details regarding the action taken.

SCHEDULE 4 - PART 2
Controlling Person

For purposes of this application, a "controlling person" is an individual, a parent or member corporation that exercises control over the LHCSA by directing or causing the direction of the actions, management or policies of the agency, whether through the ownership of voting securities or voting rights, electing or appointing directors, the direct or indirect determination of policies, or otherwise. Full disclosure of the LHCSA operator, as well as the governing bodies of each immediate, intermediate and ultimate parent or member entity of the LHCSA is required since these entities/persons possess direct or indirect operational authority over the LHCSA. This includes directors of a corporation, managers and principal members of a LLC, and principal stockholders of a business corporation, as well as both active and passive parent/member corporations. For the purposes of this application, a principal stockholder and a principal member are defined as an individual or corporation that owns ten percent or more of the issued stock of a corporation or membership interest of a limited liability company

1. Does the LHCSA have a controlling person or an immediate, intermediate or ultimate parent or member entity? ☐ Yes ☐ No

   If no, skip to Schedule 4 - Part 3.

   If yes, list the controlling person(s), or immediate, intermediate or ultimate parent or member corporation(s) below.

Legal Name of Controlling Person	Type of Legal Entity Specify For-Profit or Not-for-Profit, if a Corporation

2. Submit copies of any agreements between the LHCSA and the controlling person or parent entity relating to the manner and mechanisms by which the controlling person or parent entity controls or will control the LHCSA. Attachment #

SCHEDULE 4 - PART 3
ADDITIONAL DOCUMENTATION DEPENDING ON TYPE OF LEGAL ENTITY

Submit the following legal documentation as applicable for the applicant's type of legal entity.

A. Sole Proprietors

1. Name of Individual Proprietor.

2. Certificate of Doing Business. Attachment #

B. General Partnerships

1. On the following chart, list the partners and percentage of ownership for each partner.

Partner Name	Percentage Ownership

2. Partnership Agreement: Attachment #

3. Certificate of Doing Business as a Partnership: Attachment #

C. Limited Liability Partnerships

1. List the partners and the percentage of ownership for each partner.

Partner Name	Percentage Ownership

2. Partnership Agreement: Attachment #

3. Certificate of Doing Business as a Partnership: Attachment #

4. Certificate of Registration: Attachment #

D. Not-for-Profit Corporations

1. Is the corporation a membership corporation? ☐ Yes ☐ No
(Refer to the corporate bylaws to determine if the corporation has either a corporate member or members that are natural persons.)

If yes, list the names of the members below.

2. List the names of the officers (President, CEO, COO, CFO) and directors of the applicant corporation (proposed operator of the LHCSA) and indicate the position held by each. Specify the officers (Chairperson, Vice Chairperson, Secretary, Treasurer) of the governing body.

Officer/Director Name	Position Held

3. Submit a chart similar to that requested in D.2 for each member corporation of the LHCSA listed in response to D.1. (Not required if the members are natural persons.) Attachment #

4. Submit the Certificate of Incorporation for the corporation to be established as the legal operator of the LHCSA. Attachment #

The Certificate of Incorporation of the legal operator must include purposes that are adequate to encompass the authority to operate a LHCSA. Language similar to the following would be acceptable to the Department:

> "The purpose for which the corporation is formed is to establish and operate a licensed home care services agency approved under Article 36 of the Public Health Law, provided that no such licensed home care services agency shall be established and operated without the prior written approval of the New York State Department of Health."

5. Submit corporate bylaws for the corporation to be established as the legal operator of the LHCSA. Attachment #

6. If the applicant is not a New York corporation, submit an Application for Authority to Do Business in New York State: Attachment #

7. Submit the Certificate of Incorporation for each member corporation named in response to Question D.1. Attachment #

8. Submit Corporate Bylaws for each member corporation named in response to Question D.1. Attachment #

E. Business Corporations

In regard to the corporation to be licensed as the Article 36 operator of the LHCSA:

1. What is the total number of shares authorized?

2. How many of these shares have been issued?
   Note: A business corporation must issue at least 1 share of stock.

3. List the principal stockholders (those owning ten percent or more of the corporation's ISSUED stock), the number of shares owned and percentage of ownership for each stockholder of the applicant corporation.

   NOTE: The total of the number of shares owned must equal the number of issued shares entered in response to Question E.2.

Stockholder Name	No. of Shares Owned	Percentage Ownership

4. List the names of the officers (President, CEO, COO, CFO) and directors of the applicant corporation (proposed operator of the LHCSA) and indicate the position held by each. Specify the officers (Chairperson, Vice Chairperson, Secretary, Treasurer) of the governing body.

Officer/Director Name	Position Held

5. Submit the Certificate of Incorporation. Attachment #

The Certificate of Incorporation of the legal operator must include purposes that are adequate to encompass the authority to operate a LHCSA. Language similar to the following would be acceptable to the Department:

"The purpose for which the corporation is formed is to establish and operate a licensed home care services agency approved under Article 36 of the Public Health Law, provided that no such licensed home care services agency shall be established and operated without the prior written approval of the New York State Department of Health.

As an alternative, the Certificate of Incorporation may include general purposes. The purpose clause should state, either alone or with other purposes, that the purpose of the corporation is to engage in any lawful act or activity for which corporations may be formed under the New York State Business Corporation Law. It must also state that it is not to engage in any act or activity requiring the approval of any state official, department, board, agency or other body without such consent or approval first being obtained.

Note: Stockholders of a LHCSA applicant that is a business corporation not incorporated in New York State must be natural persons. Otherwise, a New York subsidiary must be incorporated.

6. Submit Corporate Bylaws. Attachment #

7. If the applicant is not a New York corporation, submit an Application for Authority to Do Business in New York: Attachment #

8. List all immediate, intermediate and ultimate parent corporations and indicate the number of shares authorized and issued for each.

Parent Corporation Name	Number of Authorized Shares	Number of Issued Shares

9. Submit charts similar to those requested under E.3 and E.4 above for each parent corporation of the LHCSA named in response to E.9. Attachment #

11. Submit the Certification of Incorporation for each parent corporation named in response to Question E.9. Attachment #

12. Submit Corporate Bylaws for each parent corporation named in response to Question E.9. Attachment #

F. Limited Liability Companies

1. On the following chart, list the members and percentage of ownership interest for each member.

Member Name	Percentage Ownership Interest

2. List the managers and their titles, if any, below.

3. Submit charts similar to those requested under F.1 and F.2 above for each controlling person of the limited liability company. List members and managers for limited liability companies. List the board of directors for not-for-profit corporations. List principal stockholders (those owning ten percent of more of the company's issued stock) and the board of directors for business corporations. Attachment #

4. Articles of Organization: Attachment#

The Articles of Organization must include provisions to the following effect:

a. The name of the LLC, which must contain either the words, “Limited Liability Company’, or the abbreviations, “LLC”, or “L.L.C.”;

b. Designation of the Secretary of State as agent of the LLC for service or process and an address to which the Secretary of State may mail a copy of any such process;

c. If the LLC is to be managed by managers, a statement to that effect;

d. Sufficient powers and purposes to operate a LHCSA; and

e. That notwithstanding anything to the contrary in the Articles of Organization or the Operating Agreement, transfers, assignments, or other dispositions of membership interests or voting rights must be effectuated in accordance with Section 3611-a(1) of the Public Health Law and implementing regulations.

5. Operating Agreement: Attachment #
The Operating Agreement must include provisions to the following effect:

a. That notwithstanding anything to the contrary in the Articles of Organization or the Operating Agreement, transfers, assignments, or other dispositions of membership interests or voting rights must be effectuated in accordance with Section 3611-a(1) of the Public Health Law and implementing regulations;

b. How the LLC will be managed and that neither the management structure nor the provision setting forth such structure may be deleted, modified or amended without the prior approval of the Department of Health;

c. If the LLC is managed by managers who are not members, that the manager may not be changed without the prior approval of the Department of Health; and

d. If the LLC will be managed by managers who are not members, that the following powers are reserved to the members: (i) direct authority to hire or fire the LHCSA administrator; (ii) independent control of the books and records; (iii) authority over the disposition of assets and the authority to incur on behalf of the agency liabilities not normally associated with the day-to-day operation of an agency; and (iv) independent adoption of policies affecting the delivery of health care services.

6. Will the LLC be managed by managers who are not members?
☐ Yes ☐ No

If yes, submit the proposed Management Agreement (see Questions I.9 through I.15 of this schedule) between the LLC and the manager, which must include the following provisions. Attachment #

a. That the manager may not be changed without the prior approval of the DOH; and

b. That the following powers are reserved to the members: (i) direct authority to hire or fire the LHCSA administrator; (ii) independent control of the books and records; (iii) authority over the disposition of assets and the authority to incur on behalf of the agency liabilities not normally associated with the day-to-day operation of an agency; and (iv) independent adoption of policies affecting the delivery of health care services.

7. If the applicant is not a New York limited liability company, Application for Authority to Do Business in New York: Attachment #

SCHEDULE 5
RELATED ORGANIZATION INFORMATION

1. List the full legal name and the address of the principal office and place of doing business of any existing or proposed parent corporation, controlling person or controlling organization which directly or indirectly, through one or more intermediaries, possesses or will possess the ability to direct or cause the direction of the actions, management or policies of the person, corporation, organization or other entity that is applying for approval as a licensed home care agency.

2. With respect to each parent corporation, controlling person or other controlling organization identified in response to question (1) above:

(a) List the full name of each member of the Board of Directors, board officer, controlling person, principal stockholder, sponsor of such parent corporation or controlling person or organization. Be advised that each principal stockholder, board officer and member of the Board of Directors must submit Character/Competency Schedules (Schedules 5-1, 5-2 and 5-3), if these schedules were not submitted as part of the ALP application.

(b) List the full legal name and the address of the principal office and place of doing business of any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency, or other health care facility or program, regardless of location, owned or operated by such parent corporation or controlling person or organization, together with a photocopy of any operating license, permit or certificate issued for such facility or program, the full name of the issuing agency and dates of ownership. Attachment #

(c) Describe in detail the relationship between the applicant and any parent corporation, controlling person or organization and describe in detail the method or mechanism by which control over the licensed home care services agency is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement).

3. With respect to any existing or proposed parent corporation or controlling person or organization identified in response to question (1) above:

(a) List the full legal name and the address of the principal office and place of doing business of any subsidiary corporation or organization that owns or operates any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency or other health care facility or program, regardless of location, and the full legal name and the address of the

principal office and place of doing business of any such health care facility or program, together with a photocopy of any operating license, permit or certificate issued for such facility or program, and the full name of the issuing agency and dates of ownership.
Attachment #

(b) List the full name of each of the members, directors, controlling persons, principal stockholders, officers and sponsors of each subsidiary corporation or organization identified in response to (3) (a) above.

(c) Describe in detail the relationship between the applicant, parent corporation, controlling person or organization and each subsidiary corporation or organization identified in response to (3) (a) above and describe in detail the method or mechanism by which control over the subsidiary is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement).

SCHEDULE 6 ATTACHMENTS

Complete the section labeled "All Applicants." Then, check the box(es) that apply to your organizational structure and enter the corresponding information for each attachment included in this Addendum. If the document is not applicable, enter "N/A" in the column labeled "Attachment Title."

DOCUMENT	ATTACHMENT TITLE	ATTACHMENT NUMBER
ALL APPLICANTS		
Resolution authorizing submission of application		
Job Descriptions for each service		
Certificate of Assumed Name		
Anti-Kickback Statement		
Attorney(s) Certificate of Good Standing		
Organizational Chart		
List of Related Health Care Entities		
Management Agreement		
List of Additional Health Care Entities Affiliated with Management Entity		
CONTROLLING PERSON		
Control Agreement(s)		
SOLE PROPRIETOR		
Certificate of Doing Business		
GENERAL PARTNERSHIP		
Partnership Agreement		
Certificate of Doing Business as a Partnership		
REGISTERED LIMITED LIABILITY PARTNERSHIP		
Partnership Agreement		
Certificate of Doing Business as a Partnership		
Certificate of Registration		
NOT-FOR-PROFIT CORPORATION		
Lists of Officers & Directors of Member Corporations		
Certificate of Incorporation for LHCSA operator		

DOCUMENT	ATTACHMENT TITLE	ATTACHMENT NUMBER
Corporate Bylaws for LHCSA Operator		
Application for Authority to do Business in NYS		
Certificates of Incorporation for each Member Corporation		
Corporate Bylaws for each Member Corporation		
BUSINESS CORPORATION		
Certificate of Incorporation for LHCSA Operator		
Corporate Bylaws for LHCSA Operator		
Application for Authority to do Business in NYS for LHCSA Operator		
List of Additional Parent Corporations		
Lists of Stockholders, Officers & Directors of Parent Corporations		
Certificates of Incorporation for each Parent Corporation		
Corporate Bylaws for each Parent Corporation		
LIMITED LIABILITY COMPANY		
List of Members, Stockholders, Directors of Parent Companies		
Articles of Organization		
Operating Agreement		
Management Agreement		
Application for Authority to do Business in NYS		
OTHER ATTACHMENTS (SPECIFY)		

APPENDIX A – COUNTY LISTING

Capital District Area – Frear Building, One Fulton St., Troy, NY 12180

Albany	Fulton	Saratoga
Clinton	Greene	Schenectady
Columbia	Hamilton	Schoharie
Delaware	Montgomery	Warren
Essex	Otsego	Washington
Franklin	Rensselaer	

Central New York Area – 217 South Salina St., Syracuse, NY 13202

Broome	Jefferson	Oswego
Cayuga	Lewis	St. Lawrence
Chenango	Madison	Tioga
Cortland	Oneida	Tompkins
Herkimer	Onondaga	

Metropolitan Area – 90 Church St., 13th Floor, New York, NY 10007

Bronx
Kings
New York
Queens
Richmond

Long Island/ Hudson Valley Area - 320 Carleton Ave., Suite 5000, Central Islip, NY 11722
45 Huguenot St., 6th Floor, New Rochelle, NY 10801

Dutchess	Rockland	Westchester
Orange	Sullivan	Nassau
Putnam	Ulster	Suffolk

Western Region (Buffalo Area) – 584 Delaware Ave., Buffalo, NY 14202

Allegany	Genesee
Cattaraugus	Niagara
Chautauqua	Orleans
Erie	Wyoming

Western Region (Rochester Area) – 335 East Main St., Rochester, NY 14604

Chemung	Ontario	Steuben
Livingston	Seneca	Wayne
Monroe	Schuyler	Yates

APPENDIX B – DEFINITIONS

10 NYCRR - Title 10 (Health) of the Official Compilation of the Codes, Rules and Regulations of the State of New York

Active Member Corporation - A member is considered active if it possesses **any** of the following powers:

- Appointment or dismissal of management-level employees and medical staff, except the election or removal of corporate officers;
- Approval of operating and capital budgets;
- Adoption or approval of operating policies and procedures;
- Approval of certificate of need applications filed by or on behalf of the facility;
- Approval of debt necessary to finance the cost of compliance with operational or physical plant standards required by law;
- Approval of contracts for management or clinical services; or
- Approval of settlements of administrative proceedings or litigation to which the hospice is a party, except approval of settlements of litigation that exceed insurance coverage or any applicable self-insurance fund.

Article 36 - Article 36 of the Public Health Law, which governs licensed home care services agencies

Commissioner - Commissioner of the Department of Health

CMS – Centers for Medicare and Medicaid Services

Controlling Person – an individual, or a parent or member corporation, that exercises control over the LHCSA by directing or causing the direction of the actions, management or policies of the agency, whether through the ownership of voting securities or voting rights, electing or appointing directors, the direct or indirect determination of policies, or otherwise. Full disclosure of the LHCSA operator, as well as the governing bodies of each immediate, intermediate and ultimate parent or member entity of the LHCSA is required since these entities/persons possess direct or indirect operational authority over the LHCSA. This includes directors (if a corporation), managers (if an LLC), and principal stockholders (if a business corporation), as well as both active and passive parent/member corporations.

Department/DOH - New York State Department of Health

Passive Member Corporation – Operational control rests with the governing body of the organization. A passive member typically holds only the power to elect the governing body of its subsidiary corporation.

PHL - New York State Public Health Law

Principal Stockholder (Member) – an individual or corporation that owns ten percent or more of the issued stock of a corporation or membership interest of a limited liability company.