VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2306
http://www.dlp.vermont.gov
Voice/TTY: (802) 241-0480
Fax: (802) 241-0343

For DLP office use only

_____

Initial & date for approval

LICENSE APPLICATION/REAPPLICATION

I. IDENTIFYING INFORMATION

► **FEDERAL EMPLOYER IDENTIFICATION NUMBER**: _____

► **FEDERAL TAX IDENTIFICATION NUMBER**: _____

Type of license applied for:

☐ Assisted Living Residence: # of Units:_____ Maximum Occupancy: _____

☐ Home for the Terminally Ill: # of Beds: _____

☐ Residential Care Home: **Level III or IV** (circle one) # of Beds: _____

☐ Therapeutic Community Residence: # of Beds: _____

► Does the facility have a **DESIGNATED SPECIAL CARE UNIT**? YES NO
If YES, what type is it?_____How many beds/units? _____

Name of Facility: _____

Mailing Address: _____

_____

Physical Address: _____

_____

Licensee: _____

Facility Telephone #: _____ Facility Fax #: _____

Facility E-mail: _____

Name of Manager (**phone and E-mail if it differs from above**):

_____

Are you listed as the Manager on any **OTHER** license? YES NO (circle one)

If YES, name the OTHER facility _____

II. **PERSONNEL** (For all facilities as applicable)

Name of Director of Nursing or Registered Nurse/Agency providing medication delegation:

Name of Registered Nurse:_____License #: _____

Name of Agency (if applicable): _____

Address: _____

Telephone #: _____ E-mail: _____

III. CRIMINAL RECORD AND ABUSE REGISTRY CHECKS

Answer the following questions by circling YES or NO. If YES, list the names and addresses of the individuals under each question.

A. Has any individual or organization owning or having more than 5% or more controlling interest in the facility been convicted of a criminal offense or had a substantiation of abuse, neglect or exploitation? YES NO

Name: _____

Address: _____

B. Are there any directors, officers or employees of the home who have had a substantiated complaint of abuse, neglect or exploitation? YES NO

Name: _____

Address: _____

C. Have Criminal Record Checks plus Adult and Child Abuse Registry Checks been completed on all staff, including the Manager? YES NO

IV. OWNERSHIP

A. List names and addresses for individuals or organizations having direct ownership or controlling interest in the business. Attach a separate page if needed.

Name: Contact information (address, phone and e-mail):

_____

_____

_____

_____

B. Is the facility a non-profit? YES NO

C. Type of business (check one):

___Partnership ___Corporation ___Sole Owner ___Other (describe)

If corporation is checked, then list names and addresses of the Directors. Attach a separate page if needed.

Name: Contact information (address, phone and e-mail):

_____

_____

_____

V. FOR ALL APPLICANTS – Please answer the following questions.

A. Does the facility currently carry Workers' Compensation Insurance? YES NO
If yes, please attach proof of current coverage. (Please check the expiration date.) (This is generally a one-page document with *"Certificate of Liability Insurance"* written at the top of the page.)

If no, please provide an explanation on a separate sheet.

B. Is the facility registered with the Vermont Secretary of State's office? YES NO
If yes, under what name: _____

VI. FOR REAPPLICATION ONLY - Answer the following questions by circling YES or NO. Fill in the additional information if applicable.

A. **For RCH only**, what is the total number of residents currently residing in the home with Level of Care Variances? _____

B. **For RCH and ALR only**, are you currently enrolled in the Enhanced Residential Care (ERC) Program? YES NO
If yes, how many residents are currently receiving the ERC benefit? _____

C. Has there been a change of ownership or control in the past year? YES NO
If yes, give date of change _____

D. Do you anticipate any change of ownership or control within the next year? YES NO
If yes, give date of change _____

E. Do you anticipate filing for bankruptcy within the next year? YES NO
If yes, give date of change _____

F. Is the facility operated by a management company, or leased in whole or part by another organization? YES NO
If yes, name of company/organization _____

G. Has there been a change in Manager within the past year? YES NO
If yes, give date of change _____

Name of new Manager: _____

H. Have you increased your bed capacity within the past year? YES NO
If yes, give date of change _____
Number of current beds:_____# of prior beds:_____Current census: _____

I. Has the nature of services been expanded or any changes anticipated (such as adult day care, senior meals site, etc.)? YES NO
If yes, please describe:

_____

VII. REFERENCES *(For initial application only)*

Please provide three (3) letters of reference from unrelated persons. Acceptable references will address the applicant's ability to run the facility and the applicant's character.

VIII. PERMITS (*For initial application or request for increased licensed capacity, submit the following):*

A. Written evidence of compliance with local zoning codes or a statement signed by official representatives of the city, town or village clerk that zoning codes have not been adopted in the community.

B. Written evidence of compliance from Environmental Conservation in regard to water and sewage systems.

IX. BUILDING PLANS *(For initial application, new construction and/or request for increased licensed capacity)*

Building plans/blueprints must be submitted to the Department of Public Safety, Division of Fire Safety in your district. Address and phone numbers are included with initial application packet. Floor plans must be submitted to Division of Licensing and Protection (**not** blueprints).

X. ONE (1) ORIGINAL TAX FORM *(For initial application and reapplication)*
The applicant and licensee shall be in good standing with the Vermont Department of Taxes, pursuant to V.S.A. Section 3113. Failure to do so shall result in denial or revocation of license. Submit enclosed tax certification form with application or reapplication, signed and dated.

XI. ASSISTIVE COMMUNITY CARE SERVICES (ACCS)**

Please answer the following questions by circling YES or NO, and fill in additional information if applicable.

A. Are you currently enrolled for participation? YES* NO

***If YES, how many current residents are receiving the ACCS benefit? _____**

B. If no, do you wish to enroll? YES NO

C. If YES,

1. What is the proposed date to begin participation? _____
2. Are there any residents eligible for the program residing in the residence? YES NO

**Reapplication also indicates reapplication for ACCS Program if you already participate.

XII. LIFE SAFETY

A. Date of most recent Labor and Industry Inspection:_____, **OR**
B. Date of most recent local Fire Marshall Inspection (authorized by Labor and Industry): _____.

The undersigned agrees to comply with the applicable State of Vermont and Federal Regulations. In making this application for licensure, the undersigned agrees to submit a written notice to the Vermont Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, at least 90 days in advance of sale or change in ownership of the facility, in the event residents will be required to move.

I hereby certify that the above statements are made for the purpose of obtaining a license to operate a facility of the type I have indicated above. Failure to provide complete, truthful and accurate information as required shall be grounds for automatic denial or revocation of a License to Operate.

_____ _____
SIGNATURE OF LICENSEE or MANAGER DATE

RENEWAL APPLICATIONS DUE 45 DAYS PRIOR TO EXPIRATION DATE OF LICENSE

Rev. 4/22/13

TAX CERTIFICATION FORM

VERMONT DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

By law (32 V.S.A. Section 3113) no agency of the state may renew a license or other authority to conduct a trade or business (including a license to practice a profession) unless the licensee first certifies, under the pains and penalties of perjury, that he/she is in good standing with the Department of Taxes. A person is in good standing if no taxes are due and payable and all returns have been filed, if the liability for any tax that may be due is on appeal, if the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or if the licensing authority determines that immediate payment of taxes due and payable would pose an unreasonable hardship.

The maximum penalty for perjury is fifteen (15) years in prison, a $10,000 fine or both.

CERTIFICATION OF COMPLIANCE WITH 32 V.S.A. SECTION 3113

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to, or in full compliance with a plan approved by the Commissioner of Taxes to pay any and all taxes due to the State of Vermont as of the date of this application.

_____ _____

DATE SIGNATURE

NAME OF FACILITY: _____

IF YOU ARE NOT IN GOOD STANDING AT THIS TIME, YOU MAY DO ONE OF THE FOLLOWING THREE THINGS:

1. Discontinue this license or license renewal application;
2. Arrange with the Vermont Department of Taxes to bring yourself into good standing through a payment plan approved by the Commissioner or otherwise;
3. Seek a determination from the Licensing Agency that immediate payment of taxes due and payable would impose an unreasonable hardship.

If you desire to continue this application you should complete the statement below:

ALTERNATE CERTIFICATION

I am not in good standing with the Department of Taxes at this time and,

a) I will arrange with the Department of Taxes to bring myself into good standing, or
b) Seek a determination that immediate payment would impose an unreasonable hardship.

_____ _____

DATE SIGNATURE

Arrangement to achieve good standing should be made by contacting the Department of Taxes at (802) 828-2518.