RI Department of Health

Licensing Application

and instructions for

Assisted Living Residences

RI General Law Chapter 23-17.4

Licensee Name: _____

Licensee Number: _____

Reason for application (Please check all that apply):

1. ☐ Initial Licensure
2. ☐ Change of ownership
3. ☐ Change of address
4. ☐ Licensee/Residence Name Change

(Complete the following for either 1, 2, or 3)

Current residence name:_____ License #:_____

Current address:_____

5. ☐ Increase, or
6. ☐ Decrease in occupancy/bed capacity:

From:_____ To:_____[1]

[1] Requires a fee payment equal to $70.00 per bed added.

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INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ballpoint pen.
- The fee for initial (new), change of ownership applications, or change of address is $330.00, plus $70.00 per licensed bed, $70 per bed for increases in existing capacity, and no charges for name change.
- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.

Sign the completed application, return it with the required fee and mail to:

Rhode Island Department of Health
3 Capitol Hill, Room 306
Providence, RI 02908-5097

- If you have any questions concerning this application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.
- **You must attach a printed current list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.**

Attachments: Please label and staple each separate attachment and securely affix any and all additional documents and/or approvals to this application. Required documents include, but are not limited to:

- State Fire Marshall's occupancy approval;
- Department of Health, Office of Food Protection (401-222-2750) license for operation of a kitchen;

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following:

ALR Bed Capacity: Includes all locations/wings Related to this license.	**Total** Bed Capacity = _____ If Separate areas, # of beds by designation = F1-SCU =_____ F1 =_____ F2 _____ Number of Single Bedrooms: _____ Number of Double Bedrooms: _____
Levels of Care: **1: Special Care Units** (SCU)**:** Please write "0" if you do not have any special-care beds.	Of total bed capacity, how many beds are located in a special care unit/program (i.e. Alzheimer's/Dementia)? SCU capacity = _____ **NOTE**: For a special care unit designation, you must attach a copy of your disclosure statement per sections "22.3, a) through h)" of the State Regulations, noting the additional care that is provided in the Special Care Unit.
2. Occupancy-Life Safety[2]: Please select appropriate levels of care.	Occupancy and Fire Safety designation: ☐ **F1** - For SPECIAL CARE and residents who are **not capable of self-preservation in an emergency**: ☐ **F2** - For residents who are capable of self-preservation in an emergency. Other Fire Safety: ☐ F1 Location _____ ☐ F2 Location_____ **# F2 beds =**_____
3. Medication Services: Please select appropriate levels of medication assistance	Medication: ☐ **M1** - For residents who require someone to **administer their medication to them**. ☐ **M2** - For residents who can self-administer medications or may only require reminding to take medications.

[2] Requires documentation from State Fire Marshall's office regarding occupancy approval.

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Residence Name: Name of the Residence as known to the public	_____

Assistant Living Residence Administrator: Please provide the name of the Assistant Living Residence Administrator of Record for this Residence. **NOTE: This section must be completed as a requirement of your license.**	Name:_____ E-mail:_____ RI Assisted Living Administrator's License #:_____ RI Nursing Facility Administrator's License #:_____

Residence Contact Information: Please provide the name and telephone number of a person we can contact concerning this Residence.	Phone:__(____)____-_____ Fax:____(____)____-_____ Wed site/address: _____ Residence e-mail address:_____

Residence Physical Location: Please provide the location information for this Residence. (**Published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code_____ Address Country_____ Phone:_____ Fax: _____ Email Address: _____

Residence Mailing Information: Please provide the mailing & contact information for other communication regarding this license. (**Not published on HEALTH website**).	Contact name:_____ Address Line 1_____ Address Line 2_____ Address Line 3_____ Address City, State, Zip Code_____ Address Country_____ Phone:_____ Fax: _____ Email Address: _____

Services Provided: Please check which services are provided by your employees or through written agreement with others.	☐ Housing ☐ Activities ☐ Medication (administer) ☐ Medication (assist) ☐ Referrals ☐ Transportation ☐ Housekeeping ☐ Laundry ☐ Assistance w/personal care needs ☐ Food services/kitchen[3] ☐ Fiduciary Agent ☐ Other: List Additional Services _____

[3] Requires license approval from the Office of Food Protection

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Ownership Type: Please check ONE **License sub-type:** Please select one	☐ Corporation ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Governmental Entity ☐ Profit ☐ Non-Profit
Ownership Information: Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ DBA: _____ Contact information (if different from above): _____
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip code _____ Phone: _____ Fax: _____ Email Address: _____
Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Residence/agency control	Corporation Type _____ Name of Organization _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip code _____ Phone: _____ Fax: _____ Email Address: _____
Land/Building Info: If the owner of the land and building is other than the operator of this agency/Residence, please complete the following:	Name: _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip code _____ Phone _____

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Acknowledgements

I am aware of Chapter 23-17.4 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed there under, which regulate the operation of this Residence.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17.4 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any Residence/residence.

FEIN Number:

(Federal Employer Identification Number)

Note: If you are a sole proprietor this number may be your Social Security Number.

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide below SSN/FEIN for this license:

SSN/F.E.I.N. Number: _____

Affidavit of Applicant

Read, sign, and date this affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

_____ _____

Signature of Authorized Person **Date of Signature** (MM/DD/YY)

_____

Printed Name of Authorized Person

_____

Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.