



RI Department of Health

Application and instructions for

CONTINUING CARE REGISTRATION

RI General Law Chapter 23-59

Registrant Name: _____

Registration Number: _____

Reason for application (Please check all that apply):

1. Initial Registration
2. Change of ownership
3. Change of address
4. Registration Name Change

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

Current registration name: _____ Registration #: _____

Current address: _____



State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/registration will not be issued. Please use a ballpoint pen.
- Sign the completed application 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.
- Continuing Care Registration 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.

Disclosure Statement: Section 23-59-3 of the Act requires the submission of a disclosure statement containing 15 areas of information (see "ATTACHMENT – Continuing Care Provider Registration Application"). If this information is contained in the Continuing Care Contract, then a copy of the contract may be attached to and made part of the initial disclosure statement.

Attachments: Please label and staple each separate attachment and securely affix any and all attachments to this application.

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:

<p>License Sub-Type: Please select one</p>	<p><input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit</p>
<p>Provider Name: Please provide the name of the Provider (as known to the public) .</p>	<p>Name: _____</p>
<p>Provider Contact Person: Please provide the name and telephone number of a person we can contact concerning this Provider.</p>	<p>Name: _____ Phone Number: _____</p>



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<p>Provider Mailing Information:</p> <p>Please provide the mailing information for all communication regarding this license.</p> <p>(Not published on HEALTH website).</p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>City, State, Zip Code _____</p> <p>Address Country _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p>Provider Location Information:</p> <p>Please provide the location information for this Provider.</p> <p>(Published on HEALTH website).</p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>City, State, Zip Code _____</p> <p>Address Country _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p>Ownership Type:</p> <p>Please check ONE</p>	<p><input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company</p> <p><input type="checkbox"/> Governmental Entity <input type="checkbox"/> Sole Proprietorship</p> <p><input type="checkbox"/> Partnership <input type="checkbox"/> Limited Partnership</p> <p><input type="checkbox"/> Partner</p>
<p>Ownership Information:</p> <p>Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p>Name: _____</p> <p>DBA: _____</p>
<p>Ownership Address Information:</p> <p>Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>Address City, State, Zip Code _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>



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<p>Parent Organization, Group Affiliation:</p> <p>Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Provider/agency control</p>	<p>Corporation Type _____</p> <p>Name of Organization _____</p> <p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>City, State, Zip Code _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p>Land/Building Info:</p> <p>If the owner of the land and building is other than the operator of this agency/Provider, please complete the following:</p>	<p>Name: _____</p> <p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>City, State, Zip Code _____</p> <p>Phone _____</p>
<p>Certified Public Accountant</p> <p>Please identify the Applicant's approved CPA</p>	<p>Name: _____</p> <p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>City, State, Zip Code _____</p> <p>Phone _____</p>



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Acknowledgements

I am aware of Chapter 23-59 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this Provider.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-59 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 registrant.

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 registrant:

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 Registration 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.

ATTACHMENT - Continuing Care Provider Registration Application

§ 23-59-3 Disclosure statement. – (a) The disclosure statement of each facility shall contain all of the following information unless the information is contained in the continuing care contract and a copy of that contract is attached to and made a part of the initial disclosure statement:

(1) The name and business address of the provider and a statement of whether the provider is a partnership, foundation, association, corporation, or other type of business or legal entity.

(2) Full information regarding ownership of the property on which the facility is or will be operated and of the buildings in which it is or will be operated.

(3) The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a ten percent (10%) or greater equity or beneficial interest in the provider, and a description of that person's interest in or occupation with the provider.

(4) For the provider, any person named in response to subsection (a)(3), or the proposed management, if the facility will be managed on a day-to-day basis by a person other than an individual directly employed by the provider:

(i) A description of any business experience in the operation or management of similar facilities.

(ii) The name and address of any professional service, firm, association, foundation, trust, partnership, or corporation or any other business or legal entity in which the person has, or which has in the person, a ten percent (10%) or greater interest and which it is presently intended will or may provide goods, leases, or services to the provider of a value of five hundred dollars (\$500) or more, within any year, including:

(A) A description of the goods, leases, or services and the probable or anticipated cost thereof to the provider;

(B) The process by which the contract was awarded;

(C) Any additional offers that were received; and

(D) Any additional information requested by the department detailing how and why a contract was awarded.

(iii) A description of any matter in which the person:

(A) Has been convicted of a felony or pleaded nolo contendere to a felony charge, or been held liable or enjoined in a civil action by final judgment if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property; or

(B) Is subject to an injunctive order of a court of record, or within the past five (5) years had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including without limitation actions affecting a license to operate a foster care facility, nursing home, retirement home, home for the aged, or facility registered under this chapter or similar laws in another state; or

(C) Is currently the subject of any state or federal prosecution or administrative investigation involving allegations of fraud, embezzlement, fraudulent conversion, or misappropriation of property.

(5) A statement as to:

(i) Whether the provider is or ever has been affiliated with a religious, charitable, or other nonprofit organization, the nature of any such affiliation, and

the extent to which the affiliate organization is or will be responsible for the financial and contractual obligations of the provider; and

(ii) Any provision of the federal Internal Revenue Code, 26 U.S.C. § 1 et seq., under which the provider is exempt from the payment of income tax.

(6) The location and description of the real property of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates of improvements, whether or not construction has begun and the contingencies under which construction may be deferred.

(7) The services provided or proposed to be provided under continuing care contracts, including the extent to which medical care is furnished or is available pursuant to any arrangement. The disclosure statement shall clearly state which services are included in basic continuing care contracts and which services are made available by the provider at extra charge.

(8) A description of all fees required of residents, including any entrance fees and periodic charges. The description shall include: (i) a description of all proposed uses of any funds or property required to be transferred to the provider or any other person prior to the resident's occupancy of the facility and of any entrance fee, (ii) whether provisions exist for the escrowing and return of any such funds, property, or entrance fee and the manner and any conditions of return, and (iii) the manner by which the provider may adjust periodic charges or other recurring fees and any limitations on such adjustments. If the facility is already in operation, or if the provider operates one or more similar facilities within this state, there shall be included tables showing the frequency and average dollar amount of each increase in periodic rates at each facility for the previous five (5) years or such shorter period that the facility has been operated by the provider.

(9) Any provisions that have been made or will be made to provide reserve funding or security to enable the provider to fully perform its obligations under continuing care contracts, including the establishment of escrow accounts, trusts, or reserve funds, together with the manner in which such funds will be invested and the names and experience of persons who will make the investment decisions.

(10) Certified financial statements of the provider, including: (i) a balance sheet as of the end of the two (2) most recent fiscal years and (ii) income statements of the provider for the two (2) most recent fiscal years or such shorter period that the provider has been in existence.

(11) A pro forma income statement for the current fiscal year.

(12) If the operation of the facility has not yet commenced, a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including:

(i) An estimate of the cost of purchasing or constructing and equipping the facility including such related costs as financing expense, legal expense, land costs, occupancy development costs, and all other similar costs that the provider expects to incur or become obligated for prior to the commencement of operations.

(ii) A description of any mortgage loan or other long-term financing intended to be used for any purpose in the financing of the facility and of the anticipated terms and costs of the financing, including without limitation all payments of the proceeds of the financing to the provider, management, or any related person.

(iii) An estimate of the percentage of entrance fees that will be used or pledged for the construction or purchase of the facility, as security for long-term financing

or for any other use in connection with the commencement of operation of the facility.

(iv) An estimate of the total entrance fees to be received from or on behalf of residents at or prior to commencement of operation of the facility.

(v) An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under continuing care contracts.

(vi) A projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged and including a description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of any government subsidies for health care services to be provided pursuant to the continuing care contracts.

(vii) A projection of estimated operating expenses of the facility, including (i) a description of the assumptions used in calculating any expenses and separate allowances for the replacement of equipment and furnishings and anticipated major structural repairs or additions and (ii) an estimate of the percentage of occupancy required for continued operation of the facility.

(viii) Identification of any assets pledged as collateral for any purpose.

(ix) An estimate of annual payments of principal and interest required by the mortgage loan or other long-term financing.

(13) A description of the provider's criteria for admission of new residents.

(14) A description of the provider's policies regarding access to the facility and its services for nonresidents.

(15) Any other material information concerning the facility or the provider that may be required by the department or included by the provider.

(b) The disclosure statement shall state on its cover that the filing of the disclosure statement with the department does not constitute approval, recommendation, or endorsement of the facility by the department.

(c) A copy of the standard form or forms for continuing care contracts used by the provider shall be attached as an exhibit to each disclosure statement.

(d) If the department determines that the disclosure statement does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 23-59-16.