Executive Office of Aging & Independence

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary, Executive Office of Health & Human Services

ROBIN LIPSON
Secretary, Executive Office of Aging & Independence

Application Form for Assisted Living Certification

Initial ☐ Proposed opening date: _____ Date of Submission: _____

Renewal* ☐ Recertification year: _____

Other: Select _____

***651 CMR 12.03(2)(g)** Applications for renewal Certification must also include a statement that the data required by 651 CMR 12.04(13), information documenting all substantial changes to the operating plan prior to the effective date, and all other information required by **the Executive Office of Aging & Independence (AGE),** have been submitted.

A. GENERAL INFORMATION

The Applicant hereby submits this notarized Application for Certification to advertise, operate and maintain an Assisted Living Residence in accordance with Chapter 354 of the Acts of 1994 (M.G.L. c. 19D, s. 4 et seq.). An Applicant as defined in 651 CMR 12.02 is any person or a legal entity applying to AGE for original Certification or for renewal of Certification as a Sponsor of an Assisted Living Residence. A person applying on behalf of an entity shall answer on behalf of the entity.

1. Assisted Living Residence for Which Renewal of Certification is sought

_____
Name of Assisted Living Residence

_____
Address of Assisted Living Residence

_____
Executive Director/Manager's Name

_____ _____
Phone Number of Assisted Living Residence Fax Number

_____
Name of the Management Company & Address, (if applicable)

Name of the Management Company & Address, (if applicable)

Assisted Living Residence Website

Beginning and ending dates of the Sponsor's fiscal year: _____ to _____

TRADITIONAL AL UNITS PROPOSED

Unit Type	# Units by Type
Single Occupancy:	
Double Occupancy:	
TOTAL (A):	

SPECIAL CARE RESIDENCE(SCR) UNITS PROPOSED

Unit Breakdown	# Units per SCR			
	1st SCR	2nd SCR	3rd SCR	4th SCR
Single Occupancy:				
Double Occupancy:				
Total Each SCR:				

TOTAL All SCRs (B):

TOTAL number of Units proposed:

*Note: this number should equal the total of A and B above; confirm this number is correct

2. **Certification Registration** (Choose one: Individual or Co-Owners, Corporation, Partnership or Other Entity, or Trust)

Individual or Co-Owners ☐

_____

Owner's Name: First, Initial (if used), Last

_____

Owner's Address

_____

Name of the Leasee or Mortgagee, if applicable

_____

Leasee's or Mortgagee's Address

_____ _____

Owner's Telephone # Owner's Social Security #

_____

Co-Owner's Name: First, Initial (if used), Last

_____

Co-Owner's Address

_____ _____

Co-Owner's Telephone # Co-Owner's Social Security #

Corporation, Partnership or Other Entity

Corporation ☐ Non- Profit ☐ Profit ☐

Un-incorporated Assoc. ☐ Partnership ☐ Other ☐
(please Identify)

_____

Name of Corporation or other Entity

_____

Address of Corporation or Entity

_____

Corporation or Entity Telephone #

_____

Date and Place of Incorporation or Formation of Entity

_____ _____

Name of Corporate Contact Person Email Address

_____

Federal Taxpayer Identification #

_____ _____

Name of person making application on behalf of Entity Email Address

_____

Address of person making Application on behalf of Entity

_____

Telephone # of person making Application

Trust ☐

_____

Name of Trust Agreement

_____

Trustee's Name

_____

Trustee's Address

_____

Federal Taxpayer Identification #

B. SUITABILITY STANDARDS

Any Applicant for initial Certification or for renewal of Certification as a Sponsor who knowingly or willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable state laws. If you need additional space, please attach additional sheets to the Application and reference the Application section and sub-section.

1. List the names and addresses of each officer, director or trustee of the Applicant.

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. List the names and addresses of limited partners or shareholders of the Applicant or Sponsor with more than twenty five percent interest in the Assisted Living Residence being certified.

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. For each individual listed in section 1 or 2 above, list all multifamily housing or health care facilities or providers in the Commonwealth or in other states in which he or she has been or is an officer, director, trustee, or general partner.

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. For each individual listed in section 1 or 2 above, list the names and addresses of those who have, within the five years before the date of this application, directly or indirectly had an ownership interest in one or more of the following entities:

a. Hospital, clinic, long term care facility, mammography facility, institutions for unwed mothers, out of hospital dialysis unit, hospice program, bacteriological laboratory, blood bank, or other entity licensed by the Massachusetts Department of Public Health under M.G.L. c. 111;
b. Medical provider licensed under other applicable state statutes; including facility, halfway house or treatment program unit for alcoholism licensed under M.G.L. c. 111B, ambulance service licensed under M.G.L. c. 111C, clinical laboratory licensed under M.G.L. c. 111D, and drug rehabilitation facility licensed under M.G.L. c. 111E; or,
c. Home health agency in Massachusetts certified under Title XVIII of the Social Security Act, as amended.

Name	Address
_____	_____
_____	_____
_____	_____

_____ _____

_____ _____

5. For each individual listed in section 4 above, list the name and address of the applicable entities in which there was an ownership interest during the applicable period.

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. With respect to each licensed or certified entity named in section 5 above and within such five year period, the Applicant shall furnish a written statement from the Massachusetts Department of Public Health that such licensed or certified entity has:

a. a. Substantially met applicable criteria for licensure or certification; and,
b. b. If applicable, has corrected all cited deficiencies without delicensure or decertification being imposed.

(attach separately)

C. STATEMENT

Each Applicant shall respond to the following questions. If the answer to any of the following questions is yes, please explain in the space provided below or attach a statement explaining the issue and the current status with any state, local or federal agency or court of law. If additional information concerning the matter is necessary, you will be so notified in writing.

1. Has the Applicant ever directly or indirectly had an ownership interest in an entity licensed by the Massachusetts Department of Public Health under M.G.L. c. 111, or a medical provider licensed under M.G.L. c. 111B, 111C, 111D or 111E or a home health agency certified under Title XVIII of the Social Security Act, as amended, that:

a. Has been the subject of a patient care receivership action?

Yes ☐ No ☐

b. Has ceased to operate such an entity as a result of a settlement agreement arising from a decertification action?

Yes ☐ No ☐

c. Has ceased to operate such an entity as a result of a settlement agreement in lieu of a patient care receivership?

Yes ☐ No ☐

d. Has ceased to operate such an entity as a result of a delicensure action or involuntary termination of participation in either the Medical Assistance program under Title XIX of the Social Security Act, as amended, or the Medicare Program under Title XVIII of the Social Security Act?

Yes ☐ No ☐

e. Has been the subject of a substantiated case of patient abuse or neglect involving material failure to provide adequate protection or services for the Resident in order to prevent such abuse or neglect?

Yes ☐ No ☐

f. Has over the course of its operation been cited for repeated, serious and willful violations of rules and regulations governing the operation of said health care facility that indicate a disregard for Resident safety and an inability to responsibly operate an Assisted Living Residence?

Yes ☐ No ☐

2. Has the Applicant ever been found in violation of any local, state or federal statute, regulation, ordinance or other law by reason of that individual's relationship to an Assisted Living Residence?

Yes ☐ No ☐

If response is yes, please explain:

3. I (We), the Applicant have sufficient personal knowledge and information to affirm that the ownership entity governing the Assisted Living Residence for which I (we) seek certification is in sound fiscal condition and is maintaining sufficient cash flows and reserves to operate and maintain the Assisted Living Residence and all Resident service expenses at this time and upon commencement of operations.

Yes ☐ No ☐

If response is yes, please explain:

4. I (We), the Applicant affirm that the Assisted Living Residence for which certification is sought meets all applicable local, state, and federal statutes, regulations, ordinances or other laws including, but not limited to, the federal Americans with Disabilities Act and the Fair Housing Amendments Act, the Massachusetts Architectural Access Board regulations, State Sanitary Code, State Building Code, fire safety regulations, and other regulations affecting the health, safety or welfare of Residents and staff.

Yes No

D. CHECK LIST

1. Application Form ☐

2. $200 Application Fee, made payable to "The Commonwealth of Massachusetts" ☐

3. Operating Plan*

**NOTE: Applicants for re-certification are only required to submit documents listed below if they have been revised since obtaining certification approval from AGE. If changes have been made, please submit an updated version of the document which highlights the revisions.*

a. The location of Units and Special Care Units, common spaces, and egresses by floor (may attach a floor plan) ☐

b. The fee structure for lodging, meals and services ☐

c. The type and extent of services to be offered, arrangements for providing such services, including third party contracts, and linkages with hospital and nursing facilities ☐

d. A Medication Policy for each of the following:

   a. Self-Administered Medication Management (SAMM) ☐

   b. Limited Medication Administration (LMA) ☐

   c. As needed medication (PRN) ☐

   d. Controlled Substance Management, required under 651 CMR 12.04(14) ☐

e. A means for Residents to communicate urgent or emergency needs, and a plan to provide timely assistance to them ☐

f. The number of staff to be employed in the operation of the Assisted Living Residence and their minimum qualifications and responsibilities ☐

g. A copy of the Residency Agreement ☐

h. A copy of all required current building, fire safety, and locally approved state sanitary code certificates and permits ☐

i. Procedures for notification of a Resident and his or her representative when, due to changes in the Resident's service needs, the Assisted Living Residence is no longer an appropriate environment ☐

j. A copy of the quality improvement and assurance program required under 651 CMR 12.04(10) ☐

k. A copy of the disaster and emergency preparedness plan required under 651 CMR 12.04(11) ☐

l. A copy of the communicable disease control plan required under 651 CMR 12.04(12) ☐

m. Policies and procedures designed to ensure a safe environment for all Residents ☐

4. Individual Service Plan Form ☐

5. Assessment Form ☐

6. Resident Satisfaction Survey Form ☐

7. Printed Marketing Materials*(inclusive of current rental and service fees) ☐
**NOTE: Prior to receiving certification, all advertisements must disclose "Pending AGE certification" in a minimum 14 point font size.*

8. Disclosure of Rights and Services (see 651 CMR 12.08(3)) ☐

9. Resident Handbook (if applicable) ☐

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SPECIAL CARE RESIDENCE ONLY

Applicants proposing a Special Care Residence (SCR) must submit the following additional information.*

NOTE: Applicants for re-certification are only required to submit documents listed below if they have been revised since obtaining certification approval from **AGE. If changes have been made, please submit an updated version of the document which highlights the revisions.*

The SCR Operating Plan must include the following:

1. A brief description of type of Special Care Residence or the population characteristics to be served by the SCR ☐

2. A floor plan of the building indicating which area(s) comprise the SCR (if the entire building will be a SCR, indicate "N/A" here) ☐

3. A description of how the SCR will meet the specialized needs of its Resident population, including those who may need assistance in directing care due to cognitive or other impairments. The description must include the following elements: ☐

a. Physical design of the structure and the units ☐

b. Physical environment ☐

c. Specialized safety features, including the Residence's policy on ensuring Resident safety during power outages or other situations when the locking or unlocking mechanisms of the doors may not work ☐

d. Enrichment activities ☐

e. Staff training ☐

f. 24-hour emergency preparedness plan based upon the anticipated needs of the occupants of the Special Care Residence ☐

4. A copy of all policies and procedures related to the design and operation of a SCR required under 651 CMR 12.04(5) including, at a minimum, the following:

a. Policies and procedures to assess and reduce the risk of potential hazards in the physical environment related to the special characteristics of the population ☐

b. Policies and procedures for the Special Care Residence that address unsafe Resident behaviors such as wandering, and verbally or physically aggressive behavior including coercive or inappropriate sexual behavior ☐

c. Policies and procedures governing the transition of Residents moving in or out of the Special Care Residence ☐

d. A 24-hour preparedness plan based on the assessed needs of each occupant of the Special Care Residence for emergency assistance. This plan must also include appropriate method(s) to provide the necessary assistance. ☐

E. SIGNATURE AND SEAL

1. I,_____, being first duly sworn on oath depose and say that the statements contained in this Application are true, complete and correct to the best of my knowledge.

2. Pursuant to M.G.L. c. 62C, s. 49A, I hereby certify under the penalties of perjury that I, and the entity on behalf of which I am signing, have complied with all laws of the commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting child support.

   _____
   Type or Print Name of Applicant (Individual, Corporation, or Trust)

   _____
   Signature of Person Authorized to sign for Applicant (Officer, Trustee or Individual)

   Subscribed and sworn to before me on this _____day of _____, 20___.

   My Commission expires: _____, 20___.

   _____
   Notary Public (Seal)

This Application for Renewal of Certification will not be issued unless this certification clause is signed and notarized by the Applicant, and the Application includes all required information, attachments and statements, and fee payments.

Your Social Security number/Federal Taxpayer identification number will be furnished to the

Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Applicants who fail to correct any non-filing or delinquency will be subject to suspension or revocation of Certification. This request is made under the authority of M.G.L. c. 62C s. 49A.

APPLICATION SUBMISSION:

In accordance with the regulations (651 CMR 12.03(2), every Application shall be notarized and signed under the pains and penalties of perjury by the Applicant. A scanned version of the completed application must be submitted to ALRHelp@mass.gov accompanied by a $200.00 fee payment. The payment options are listed below.

By check made payable to: The Commonwealth of Massachusetts.	Send to: Executive Office of Aging & Independence Assisted Living Certification and Compliance Unit One Ashburton Place – 10th floor Boston, MA 02108
Pay online:	https://www.ncourt.com/x-press/X-onlinepayments.aspx?Juris=547e29f9-c775-472b- a792-faf78d3643b8