

**Schedule 6 – Program Information (Regional Office)**

Applicants may submit Schedule 6 at any time, however, no later than 90 days after the Department has notified the applicant of approval of its Part I Application. The completed Schedule 6 must be submitted together with a cover letter to the appropriate regional office. A copy of that cover letter must also be submitted to the assigned project manager in the central office in Albany.

**Contents:****Schedule 6 Program Information – All Applicants (Part II)**

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**Instructions:****Schedule 6 submissions are required for:**

- the establishment of all new Adult Care Facilities (ACF);
- all Change of Operator applications;
- establishment of new ALR, EALR or SNALR – limit your response to any changed or new materials pertinent to the items listed below and check “no change” where applicable; and
- establishment of new ALP – limit your response to any changed or new materials pertinent to the items listed below and check “no change” where applicable.

Your application should include information for each license or certification sought.

The Department of Health website contains all mandated forms required by Adult Care Facility, Assisted Living Program and Assisted Living Residence regulations. The forms can be found at [http://www.health.ny.gov/facilities/adult\\_care/forms.htm](http://www.health.ny.gov/facilities/adult_care/forms.htm).

## 1. Check the type of application (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Applicant is an existing licensed ACF         | <input type="checkbox"/> Establishment of New ALR   |
| <input type="checkbox"/> Establishment of New Adult Home               | <input type="checkbox"/> Establishment of New EALR  |
| <input type="checkbox"/> Establishment of New Enriched Housing Program | <input type="checkbox"/> Establishment of New SNALR |
| <input type="checkbox"/> Change of Operator                            | <input type="checkbox"/> Establishment of New ALP   |

## 2. Administrator or Enriched Housing Program Coordinator, Assisted Living Program Coordinator, Case Manager, and Activity Director Qualifications:

- Attachment # \_\_\_\_     To be submitted at a later date     No Change

As soon as they are available, submit qualifications of the administrator or enriched housing program coordinator on form DSS-3233 and qualifications of the case manager and activities director in a letter format. Attach copies of diplomas or stamped transcripts for all candidates. Please note that the Department may request three letters of reference as it deems necessary.

## 3. Staff Orientation and Aide Training:

a. Submit a copy of your proposed general staff orientation to be used for all employees.

- Attachment # \_\_\_\_     No Change

b. Submit a copy of the initial training required for each job title that provides personal care, home health care and/or medication services.

- Attachment # \_\_\_\_     No Change

## 4. Planned Staffing Schedule:

- Attachment # \_\_\_\_     No Change

Submit planned staffing schedule to be implemented upon approval of this application. Include:

- Adequate staffing for each shift on each day of the week;
- Persons trained in first aid (one of which must be scheduled for each shift); and
- The employee in charge for each shift when the administrator or program coordinator is absent; and
- All employees in all departments.

## 5. Resident Services:

Describe philosophy, goals, and scope of your resident service program. (List cultural, spiritual, diversional, physical, political, social and intellectual activities to be provided by facility and community.)

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6. Optional Resident Services: Check all that apply below or check if  No Change

NOTE: For change of operator application, the applications contained in Schedule 7D for the social day care program must be submitted to continue the operation of the previous operator's respite or social day care programs.

- Applicant wishes to offer or continue a respite program
- Applicant wishes to offer or continue a social day care program (see Schedule 7D)
- Applicant plans to use a portion of the requested **adult home** for purposes other than the operation of an adult care facility such as to house medical office for outside providers (submit a waiver request for section 487.11(l)(1)) Attachment # \_\_\_\_\_ .

**Schedule 6 Part II - Program Information**

7. Admission Policies: All applicants should submit the following or indicate No Change:

- a. admission and retention standards  Attachment # \_\_\_\_\_  No Change
- b. resident profile that includes a description of any target populations  Attachment # \_\_\_\_\_  No Change
- c. pre-admission evaluation policy  Attachment # \_\_\_\_\_  No Change

If you are applying for an Assisted Living Residence, also submit the following:

- d. ISP form, policy and process  Attachment # \_\_\_\_\_  No Change
- e. Palliative Care Policy (EALR and SNALR);  Attachment # \_\_\_\_\_  No Change

8. Resident Fund Accounts:  Attachment # \_\_\_\_\_  No Change

NOTE: You must offer resident fund accounts for residents who are SSI and/or SNA recipients, even if you do not accept SSI/SNA as payment in full.

9. Mental Health Agreement, if required by 18 NYCRR 487.7(b):  Attachment # \_\_\_\_\_  No Change  Not Applicable

10. Disaster and Emergency Plan:  Attachment # \_\_\_\_\_  No Change

Submit a copy of your disaster and emergency plan, including evacuation procedures.

11. Medication Management Policies and Procedures:  Attachment # \_\_\_\_\_  No Change

NOTE: Applicant must apply for a Class 3A limited controlled substance license. This is typically done just prior to the regional office’s on-site inspection.

12. Supporting Documents:

List any proposed substitutes to DOH mandated forms as well as all other non-mandated forms that applicant will use. Attach a copy of each form. Examples of non-mandated forms include Enriched Housing Program functional assessment, pre-admission evaluation form, employee medical statement, ISP (if ALR), etc. Please note, any substitutes will require the submission of an equivalency. See Section 16.

| TITLE OF SUPPORTING DOCUMENT | ATTACHMENT # |
|------------------------------|--------------|
| 1 _____                      | _____        |
| 2 _____                      | _____        |
| 3 _____                      | _____        |
| 4 _____                      | _____        |
| 5 _____                      | _____        |

13. EALR Policies and Procedures:

For EALR **only**, submit copies of all policies and procedures for skilled nursing services and those HHA services above and beyond what resident care aides may deliver, to be delivered directly by Operator’s staff. This list of policies **must** match the list of services in your EALR addendum. Any addition or deletion of EALR services must be prior approved by the regional office.

List policies below or Check if  Not Applicable.

| TITLE OF POLICY | ATTACHMENT # |
|-----------------|--------------|
| 1 _____         | _____        |
| 2 _____         | _____        |
| 3 _____         | _____        |
| 4 _____         | _____        |
| 5 _____         | _____        |

14. SNALR Policies and Procedures: For SNALRs **only**, submit a copy of your:

a. dementia unit/SNALR plan:

Attachment # \_\_\_\_\_

b. dementia unit/SNALR activities schedule:

Attachment # \_\_\_\_\_

15. ALP Program Information:

For newly established ALPs, complete 15a-15f. For a change in operator, complete 15e-15f.

a. Describe the anticipated sources of referral to, and discharge from, the ALP and describe the proposed relationship with these sources.

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b. Will the ALP be located in the same building with non-ALP adult home or enriched housing beds?  Yes  No  
If yes, describe how the ALP will relate to these services programmatically.

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

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d. Submit five letters of community support for your proposed ALP.

| SUPPORTER'S NAME, TITLE, EMPLOYER | ATTACHMENT # |
|-----------------------------------|--------------|
| 1 _____                           | _____        |
| 2 _____                           | _____        |
| 3 _____                           | _____        |
| 4 _____                           | _____        |
| 5 _____                           | _____        |

e. Submit the ALP's written agreement with one or more nursing facilities for transfers of residents who require a higher level of care.  Attachment # \_\_\_\_\_

f. Submit a copy of the ALP's contract with the local Department of Social Services.  Attachment # \_\_\_\_\_

16. For all change of operator and establishment of a new adult care facility applications, list all waivers and equivalencies and indicate whether they will be continued, discontinued or new. Attach copies of approvals for all existing waivers and copies of all proposed waivers and equivalencies:

**Note:** If they are to be continued, you must resubmit waivers under the new operator.

| TITLE OF WAIVER OR EQUIVALENCY | CONTINUE                 | DISCONTINUE              | NEW                      | ATTACHMENT # |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------|
| 1 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 2 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 3 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 4 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 5 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 6 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 7 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 8 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 9 _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 10 _____                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 11 _____                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| 12 _____                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

## Schedule 6 Part II - Program Information

17. Personnel Policies and Procedures: Include the following: rules of conduct, facility policy regarding grievance procedures, hiring and termination policies.  Attachment # \_\_\_\_\_  No Change
18. Workers' Compensation:  Attachment # \_\_\_\_\_  No Change
- Pursuant to Section 57 of the Workers' Compensation Law and Section 220(8) of the Disability Benefits Law, please submit a copy of your certification of coverage for worker's compensation and disability benefits. The certification can be obtained from your insurance carrier. Employers who are not required by law to carry workers' compensation and/or disability benefits coverage must submit an approved WC/DB-100 or WC/DB-101 exemption form. The WC/DB-100 or WC/DB-101 form may be obtained from any office of the Workers' Compensation Board.
19. Job Descriptions for all staff positions: For EALRs and ALPS that employ Home Health Aides (HHAs), include the tasks that HHAs are authorized to perform, which must be within the HHA scope of tasks.  Attachment # \_\_\_\_\_  No Change
20. In-Service Training, 12 month in-service schedule:  Attachment # \_\_\_\_\_  No Change
21. Activity Schedule for One Month:  Attachment # \_\_\_\_\_  No Change
22. Social Contact: A description of how the facility will encourage contact between residents, relatives and friends.  Attachment # \_\_\_\_\_  No Change
23. House Rules, if any:  Attachment # \_\_\_\_\_  No Change
24. Resident Organizations and, if SNALR, Family Organization Policies:  Attachment # \_\_\_\_\_  No Change
25. A Description of Special Services, if any:  Attachment # \_\_\_\_\_  No Change
26. Food Services, including:
- (a) three weeks of menus for meals and snacks, including the special modified diets offered including diets such as finger foods and consistency modifications, and a definition of each diet offered. Include the times of each meal and snack service:  Attachment # \_\_\_\_\_  No Change
  - (b) a copy of the written agreement between the proposed operator and the proposed dietary consultant:  Attachment # \_\_\_\_\_  No Change
  - (c) resume for dietary consultant:  Attachment # \_\_\_\_\_  No Change
  - (d) copy of documentation of license(s) or certification(s) held by the dietary consultant:  Attachment # \_\_\_\_\_  No Change
  - (e) policy and procedure for kitchen staff to have current and accurate information regarding each resident's prescribed diet, allergies, food preferences and any changes.  Attachment # \_\_\_\_\_  No Change
  - (f) include a description or diagram of your kitchen and dining room layout, including equipment and the number of tables and chairs in the dining room(s).  Attachment # \_\_\_\_\_  No Change
  - (g) policy and procedure for food purchase and storage.  Attachment # \_\_\_\_\_  No Change
  - (h) policy and procedure to ensure meals and snacks are handled properly to ensure proper temperatures and other food protections.  Attachment # \_\_\_\_\_  No Change
  - (i) policy on food service staff training.  Attachment # \_\_\_\_\_  No Change
27. Volunteer Policy and Orientation, if volunteers are to be used in the facility:  Attachment # \_\_\_\_\_  No Change
28. Record Keeping policy for maintaining records and reports:  Attachment # \_\_\_\_\_  No Change
29. Housekeeping Plan:  Attachment # \_\_\_\_\_  No Change
30. Maintenance Plan:  Attachment # \_\_\_\_\_  No Change
31. Resident Fund Account Statement:  Attachment # \_\_\_\_\_  No Change
32. Where applicable a copy of the your non-discrimination statement, and reasonable accommodation policies. Copies of "model " documents can be found on the DOH website at [www.health.ny.gov/facilities/adult\\_care/application/](http://www.health.ny.gov/facilities/adult_care/application/)  Attachment # \_\_\_\_\_  No Change

NOTE: If you are assuming operation of an adult care facility in which resident fund accounts are maintained, you must obtain prior to the on-site inspection, a written statement of all resident fund accounts in compliance with Section 487.6(d) and/or Section 488.6.