Attachment 4

New York State Department of Health
Center for Health Care Quality and Surveillance
Division of Adult Care Facility/Assisted Living Surveillance

ASSISTED LIVING PROGRAM 4500 CONVERSION INITIATIVE FOR TRANSITIONAL ADULT HOMES

APPLICATION FORM

IMPORTANT: Please read the **ALP 4500 Conversion Initiative Application Form Instructions** prior to completing form.

1. ELIGIBLE APPLICANT

FACILITY INFORMATION

Facility Name	Operating Certificate Number	
Facility Address (Street and Number, Building and Floor)	City	Zip Code
	County	

APPLICANT INFORMATION*

Name	Title	
Address (Street and Number, Building and Floor)	City	Zip Code
	Telephone No.	E-Mail Address

*Must be an eligible applicant identified below.

_____ Sole Proprietor
_____ Partnership (general partnership comprised only of natural persons; limited partnerships are not permitted)
_____ Not for Profit Corporation (NFP)
_____ Business Corporation (not publicly traded, no shares owned by another corporation)
_____ Limited Liability Company (if members are corporations, partnerships or LLCs, the shareholders, partners or members of the same must be natural persons.)

NAME & ADDRESS TO WHOM CORRESPONDENCE SHOULD BE SENT (If different from Applicant)

Name	Title	
Address (Street and Number, Building and Floor)	City	Zip Code
	Telephone No.	E-Mail Address

2. ALP 4500 CONVERSION INITIATIVE PROPOSAL SUMMARY

A concise summary of your proposal must be attached. The application must address the following:

- Development of independent living skills (*i.e.*, no lines for medication, meals or activities);
- Resident choice in choosing from whom to receive services and supports;
- Individuals will share units only by choice;
- That privacy in the sleeping unit will be provided unless a roommate is chosen;
- Individual and shared (double occupancy) dwelling units must contain separate living, dining and sleeping areas which provide adequate space and comfortable, home-like surroundings;
- The unit must contain a full bathroom (including a toilet, washstand and shower or tub);
- That adequate closet space for storing personal effects must be provided;
- That units must have lockable doors with appropriate staff having keys;
- Individuals have the freedom and support to control their own schedules and activities and have access to food at any time;
- Kitchen (to include area for food storage, refrigeration and meal preparation);
- That individuals have the right to decorate and furnish their unit; and
- That individuals are able to have visitors of their choosing at any time.

3. PROGRAM INFORMATION

Provide information as stated in Section 3 of the Form Instructions and complete the chart below.

ACF RESIDENTIAL SERVICES - Bed Complement

TYPE	Adult Home (AH)	Assisted Living Program (ALP) Beds	Other Beds (specify)
Licensed Adult Care Facilities:			
1. Licensed AH Beds			
2. Licensed ALP Beds			
3. Proposed ALP Beds			
4. AH Beds being Decertified, if any			
5. Total Number of Beds			

4. LEGAL REQUIREMENTS

The applicant must provide a brief narrative description and organizational chart of the legal structure of the existing and/or proposed organization. Proof of ownership of or demonstration of site control to real property (*e.g.*, deed or lease) per 18 NYCRR 485.6(d)(11) and (12) and a copy of the current operating certificate must be provided.

5. FINANCIAL INFORMATION

Estimate of Total Project Cost: The projected amount and source of the funding for the proposed project must be provided. Examples of projected costs that should be included are cost of rehabilitation of existing building, architect cost and soft costs. Capital construction for approved ALP projects shall be subject to prior review and approval and reimbursement will be limited to necessary, certified costs not to exceed 25% of the applicable Residential Health Care Facility (RHCF) bed caps for the region.

6. ARCHITECTURAL COMPONENT(S)

For conversion/renovation of an existing adult home building:

- A narrative to describe proposed renovations as applicable to include:
  - Automatic sprinkler system
  - Smoke detectors/thermal detectors
  - Emergency battery- or generator-operated lighting
  - Fire alarm systems including audio visual alarms, pull stations, fire command stations and fire alarm panels
  - Resident room/bathroom emergency call system
  - Exit lighting/directional lighting
  - Exits
  - Estimated cost of renovation

7. LICENSED HOME CARE SERVICES AGENCY (LHCSA)

The applicant proposing to operate an ALP must obtain licensure as a LHCSA or a Certified Home Health Agency (CHHA) with approval to serve the county in which the ALP will operate.

Is the applicant shown above an existing LHCSA or a CHHA? □ Yes □ No

If Yes, provide the following:

LHCSA License # _____ CHHA Operating Certificate # _____

Agency Name _____

Operator _____

Counties currently served: _____

If No, does the applicant agree to submit an LHCSA Addendum? □ Yes □ No

Please be advised that a $2,000.00 application fee is required for submitting a LHCSA Addendum. After submission of your LHCSA Addendum, you will be contacted by the Department's Bureau of Project Management regarding payment of the application fee.

8. CERTIFICATION

I/We certify that the information submitted on this form and on any attachment to this form is true, accurate and complete in all material respects. (Attach additional sheets if necessary.)

APPLICANT SIGNATURE(S):

By: _____ Date: _____
(Signature)

Printed Name: _____

Title: _____

By: _____ Date: _____
(Signature)

Printed Name: _____

Title: _____

STATE OF NEW YORK)
)SS.:
County of _____)

On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Signature and office of the individual taking acknowledgement)