

**Maine Department of Health and Human Services
Application Form
Adult Day Services Program**

PLEASE COMPLETE AND RETURN TO:

Division of Licensing and Regulatory Services
Community Services Programs
11 State House Station
442 Civic Center Drive
Augusta, ME 04333

For Agency Use Only		Fee: \$ _____
SBI _____	County _____	
H ₂ O _____	Prog. Spec. _____	
HFS _____	SFMO _____	
Ins. _____	Multi-Level _____	

- 1) This application form must be complete or the approval process could be delayed.
- 2) Return this application and related documents, and two (2) additional copies to the address above.
- 3) This application must be accompanied with a **non-refundable fee of \$10 for every ten (10) adults** and a **separate check** (\$31.00 per person) for the applicant and administrator for a criminal history background check.
Make Checks Payable To: Treasurer, State of Maine.

In accordance with 22 MRSA Section 8601 et. seq. and the Department's licensing regulations, I/We apply for a license to operate an Adult Day Services Program for _____ adults.

PROGRAM IDENTIFICATION

Name of Program: _____

Mailing Address: _____
Street Address City State Zip

Physical Address: _____

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Directions to Facility from Augusta: _____

PROGRAM ADMINISTRATOR INFORMATION

Ms. _____
 Mr. _____
First Middle Last

(home address) Street Town State Zip Code

Phone Number Date of Birth Social Security Number

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES): _____

1) Have you ever been convicted of a criminal offense? If so, explain:

2) Have you ever had a license for any long term care facility, assisted housing program (includes residential care

facilities and assisted living programs) denied, suspended or revoked in this state or any other state?

If so, by whom? Please explain.

EDUCATION OF ADMINISTRATOR

School Name	City/State	Last Grade Completed	Degree	Year
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EMPLOYMENT HISTORY OF PROGRAM ADMINISTRATOR

Give last 5 years employment history: (Attach separate sheet if necessary)

<u>Name and Address of Employer</u>	<u>Job Responsibilities</u>	Dates		<u>Reasons For Leaving</u>
		<u>From</u>	<u>To</u>	

PROGRAM ADMINISTRATOR PROFESSIONAL REFERENCES

(Submit attached completed references with application.)

<i>Name</i>	<i>Address</i>	<i>Daytime Telephone</i>
1.		
2.		
3.		

I certify that all information provided herein is true and correct to the best of my knowledge. I also understand that signing this application effectively serves as a release of information and gives permission to the Department to obtain any criminal history and Bureau of Motor Vehicle record which may be on file in any county or state office.

Signature of Administrator: _____ **Date:** _____

APPLICANT INFORMATION (If different from Administrator)

Name: _____

Street _____ Town _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____ ID# (Owner SSN or EIN#) _____

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES): _____

If owner is a corporation, list on a separate sheet the names, addresses, and titles of each officer, director, and each person owning 10% or more of the total stock, specifying the percentage of ownership.

If ownership is a corporation, indicate: Corporation **And if:** For Profit

- Individual
- Partnership

- Non Profit

1) Have you ever been convicted of a criminal offense? If so, explain:

2) Have you ever had a license for any long term care facility, assisted housing program (includes residential care facilities and assisted living programs) denied, suspended or revoked in this state or any other state?

If so, by whom? Please explain.

LIST all HOME HEALTH AGENCIES, REGISTERED PERSONAL CARE AGENCIES, ADULT DAY SERVICES and LONG TERM CARE FACILITIES (including assisted housing and nursing facilities) owned and/or operated by applicant or spouse:

Name: _____ Phone # _____

Address: _____

Name: _____ Phone # _____

Address: _____

Name: _____ Phone # _____

Address: _____

DESCRIPTION OF FACILITY

1. Type of Dwelling:
 House Duplex Apartment
 Mobile Home Commercial Building
2. Approximate age of home: _____
3. Landlord's Name (if renting): _____

4. Number of exits from building, including fire escapes: _____

5. Are rooms currently furnished with required furniture?
 Yes No
 If not, the expected date of completion: _____
6. Will a listed telephone be available for use by clients?
 Yes No
7. Sewage system (check one): Municipal Other
8. Water supply (check one): Municipal Other

9. Number of rooms and bathrooms available for consumer use:

	Rooms	/	Square Feet	Bathrooms
First Floor	_____	/	_____	_____
Second Floor	_____	/	_____	_____
Basement	_____	/	_____	_____

12. Physical features of the home (check all that apply):
- Wheelchair Ramp _____ Handicap Accessible _____
- Smoke detectors & Extinguishers _____
- Intercom System _____ Elevator _____

10. Type of heating: _____

11. Are all windows screened? _____

PROGRAM INFORMATION

Type: Social Adult Day Services Program Day Services Only
 Adult Day Health Services Program Night and Day Services
 Night Program Only

Days/Hours of Operation:

Monday **Tuesday** **Wednesday** **Thursday** **Friday** **Saturday** **Sunday**

Staff (minimum ratio one staff/six consumers):

Administrator: Name: _____ Age 21 or over? Yes No
Other Staff: Name: _____ Age 18 or over? Yes No
 Name: _____ Age 18 or over? Yes No
 Name: _____ Age 18 or over? Yes No
 Name: _____ Age 18 or over? Yes No

TYPE OF POPULATION TO BE SERVED:

Male _____ Female _____ Age Range _____

Persons with: *(Check all that apply)*

- _____ dementia/Alzheimer's disease
- _____ persons with mental illness
- _____ persons with mental retardation or developmental disabilities
- _____ persons with acquired brain injury

THE FOLLOWING ADDITIONAL INFORMATION IS NEEDED. PLEASE SUBMIT THE ITEMS MARKED WITH AN "X" WITH THE APPLICATION. THE ITEMS MARKED WITH AN ASTERISK CAN BE SUBMITTED WITH THE

APPLICATION OR AT THE TIME OF THE SCHEDULED ONSITE VISIT. FAILURE TO SUBMIT THE REQUIRED INFORMATION WILL DELAY THE PROCESSING OF YOUR APPLICATION.

- Admissions Policy on participants who are appropriate.
- * Certificate of Insurance for property, liability and vehicle (if transportation is provided by the program). Proof of insurance not needed if a licensed nursing facility.
- Names/Addresses of Board of Director, if applicable.
- Floor plan of facility identifying program area(s), and exits, including dimensions of rooms.
- * Evidence of compliance with Federal, State and municipal laws, codes, and ordinances which regulate health, fire safety, building, land use, and sanitation if not located in a licensed nursing facility (If stand alone program).
- * Written Emergency Plan.
- * Medication Administration Policy.
- * Written Refund Policy.
- * Written Complaint Resolution Policy.
- * Confidentiality Policy
- * Samples of the consumer record forms for the proposed program as outlined in the regulations.
- If the facility is being leased, provide copy of lease agreement.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, certify that I am in compliance with all local laws and ordinances as they relate to zoning, plumbing, water supply, and sewage disposal.

I, _____, being duly authorized to assume responsibility for the Adult Day Services Program herein described, do hereby apply for a license to operate the program and do agree to assume responsibility that the program will comply with all the current regulations of the Department of Health and Human Services, as authorized by Title 22, M.R.S.A. §7801. I/We understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain criminal history and Bureau of Motor Vehicle record which may be on file in any county or state office.

Signature of Applicant: _____ Date: _____

REFERENCES – INCLUDE THREE (3) WRITTEN LETTERS OF REFERENCE FOR THE APPLICANT AND ADMINISTRATOR FROM PERSONS WHO ARE NOT RELATED BY BLOOD OR MARRIAGE. THE ATTACHED QUESTIONNAIRE NEEDS TO BE COPIED AND GIVEN TO REFERENCES TO COMPLETE.

REFERENCE FORM FOR ADULT DAY SERVICES PROGRAM PROVIDERS

Name of Proposed Administrator/Applicant: _____

Name of Facility: _____

Please respond to the following questions (use the back of this sheet, if necessary):

1. How long have you known the applicant/administrator?
2. In what capacity do you know this person?
3. Are you familiar with this person’s experiences in serving people who are elderly or disabled? If yes, please describe.
4. Describe this person’s ability to give care and services to people who are elderly or disabled.
5. Describe this person’s strengths and weaknesses in the following areas:
 - A. Coping with problems and stress:
 - B. Working with other people:
 - C. Decision-making:
 - D. Communication and listening skills:
 - E. Ability to work with outside resources such as social workers, medical professionals, state agencies, friends and families of residents, etc.:
6. Do you have any concerns about this person’s ability to work in an Adult Day Services Program?
 Yes No
7. Do you recommend that this person be given the opportunity to work in or operate an Adult Day Services Program?
 Yes No
8. Additional comments:

Reference Information

Name of person completing form: _____ Occupation: _____

Home address: _____ Telephone: _____

Signature: _____