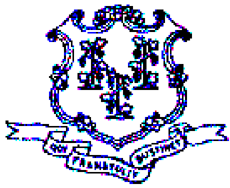


STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

[ ] INITIAL   [ ] RENEWAL

NOTE: A separate application must be completed for each licensed level of care which is located at a different address. One (1) application may be submitted for multiple levels of care provided each level of care has the same name and the same licensee and is located at the same address.

In accordance with Section 19a-491 and/or Section 19a-506 of the Connecticut General Statutes, application is hereby made for a license to operate the following (please check the appropriate box/boxes that apply):

[ ] Assisted Living Services Agency
[ ] Children's Hospital
[ ] Chronic and Convalescent Nursing Home
[ ] Chronic Disease Hospital
[ ] Family Planning Clinic
[ ] General Hospital
[ ] Home Health Care Agency
[ ] Homemaker-Home Health Aide Agency
[ ] Hospice
[ ] Hospital for Mentally Ill Persons
[ ] Mental Health Psychiatric OutPat.
[ ] Mental Health Intermediate Tmt.
[ ] Substance Abuse & Dependence
[ ] Infirmary Operated by an Educational Institution
[ ] Maternity Home
[ ] Maternity Hospital
[ ] Outpatient Clinic
[ ] Outpatient Dialysis Unit
[ ] Outpatient Surgical Facility
[ ] Residential Care Home
[ ] Rest Home with Nursing Supervision
[ ] Well Child Clinic
[ ] Mental Health Day Treatment
[ ] Mental Health Community Residence
[ ] Mental Health Residential Living

Please respond to all of the following questions:

1. ____
Facility "d/b/a" (doing business as) Name

____
Business Address   City   State   Zip Code   Telephone

____
Mailing Address (if applicable)   City   State   Zip Code

Phone: (860) 509-7444
Telephone Device for the Deaf (860) 509-719
410 Capitol Avenue - MS # 12HFL
P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

2. Bed Capacity Requested (if applicable). If submitting this application for multiple levels of care, please list the bed capacity for each level of care being requested.

Level of Care	Beds/ Hemodialysis Stations	Bassinets (if applicable)
_____________	________	________
_____________	________	________
_____________	________	_______

3. ________________________________
   Federal Employer Identification Number

4. Disclose the legal entity which owns/operates the facility. (Note: The license will be issued to this entity.)

   ____
   Licensee

   ____
   Business Address | City | State | Zip Code | Telephone

   ____
   Mailing Address (if applicable)

5. Is the above named legal entity a (please check the box which applies):

   [ ] Individual/Sole proprietor
   [ ] General Partnership
   [ ] Limited Partnership
   [ ] Limited Liability Company
   [ ] Other: ___________________________________
   [ ] Non-profit Corporation
   [ ] Municipality
   [ ] Trust
   [ ] Profit Corporation

6. Is the above named entity authorized by the Office of the Secretary of State to transact business in the State of Connecticut and considered in Good Standing? [ ] YES [ ] NO

7. Please disclose the name, business address and telephone number of the Agent for Service for the Licensee.

   ____
   Name | Address | Telephone

8. Attach an organizational chart which reflects the current ownership structure of the licensee <u>and</u> the licensee's relationship with the facility/agency.

FACILITY FAX #__________________________

9. Respond to the specific question that reflects the ownership structure of the licensee. **The Licensee is the legal entity which will be issued the license to operate.**

   A. If the Licensee is a **general partnership, limited partnership or limited liability company,** complete Form 1 (attached).

   B. If the Licensee is a **trust,** complete Form 2 (attached) for the Licensee.

      i. Attach a list including the name, address and telephone number of all trustees.

   C. If the Licensee is a **corporation (profit or non-profit)**, complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.

      i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
      ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.

10. Attach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)

11. Attach evidence of current compliance with the worker's compensation insurance coverage requirements in the form of one of the following:

   A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
   B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
   C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)

12. Ownership of Real Property

   ____
   Name

   ____
   Business Address City State Zip Code Telephone

13. Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Local Fire Marshal. **NOTE: Hospitals must have a separate Fire Marshal's Certificate of Inspection completed for each building on the hospital's campus and each satellite listed on the hospital's license. Additional forms may be copied if necessary. Each completed Fire Marshal's Certificate of Inspection that is submitted must have an original signature. (Not applicable for ALSA's, Homemaker Home Health and Home Health Agencies).**

****

FOR OFFICE USE ONLY

CHECK # _____________ AMOUNT $_______________

DATE RECEIVED ______________ INITIALS _________________

****

14. Affidavit of Owner:
I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

______________________________ ___________________________
Signature Date Signed

Check one as applicable:

[ ] Individual/Sole Proprietor
[ ] General/Managing Partner
[ ] President of Corporation
[ ] Secretary of Corporation
[ ] Municipal Officer
[ ] Trustee

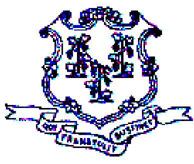
State of Connecticut)

County of _______________________) ss ___________________ 20_____

Personally appeared before me the above named _________________________________ and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

____
Notary Public [ ]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

My Commission Expires:
(If Notary Public)



STATE OF CONNECTICUT

Attachment 1

DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 1

FACILITY/AGENCY NAME: ____

Form 1 must be completed if the facility/agency is owned/operated by, or the Real Property Owner is, a partnership or a limited liability company. Please copy additional sheets if necessary.

For each partner or manager with a 10% or greater ownership interest in the Licensee/Real Property Owner, provide the information requested below. **Please complete a separate form for each legal entity listed below that is not an individual.**

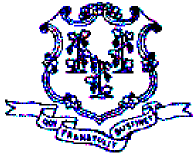
This information is for: ☐ Licensee ____________________________________
☐ Real Property Owner ___________________________

1. Name: ____
   Address: ____
   Telephone: ____
   Please indicate the category which best describes this entity:
   [ ] Manager [ ] General Partner [ ] Limited Partner
   Partner's/Manager's percentage of ownership: ____________________________

2. Name: ____
   Address: ____
   Telephone: ____
   Please indicate the category which best describes this entity:
   [ ] Manager [ ] General Partner [ ] Limited Partner
   Partner's/Manager's percentage of ownership: ____________________________

3. Name: ____
   Address: ____
   Telephone: ____
   Please indicate the category which best describes this entity:
   [ ] Manager [ ] General Partner [ ] Limited Partner
   Partner's/Manager's percentage of ownership: ____________________________

4. Name: ____
   Address: ____
   Telephone: ____
   Please indicate the category which best describes this entity:
   [ ] Manager [ ] General Partner [ ] Limited Partner
   Partner's/Manager's percentage of ownership: ____________________________
   [ ] Manager [ ] General Partner [ ] Limited Partner



STATE OF CONNECTICUT

Attachment 2

DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 2

FACILITY/AGENCY NAME: ____

Form 2 must be completed if the facility/agency or Real Property Owner is owned/operated by a trust. Please copy additional sheets if necessary.

For each beneficiary having an ownership interest of 10% or more in the trust, provide the information requested below:

This information is for: ☐ Licensee ___________________________________
☐ Real Property Owner ___________________________

1. Name: ____
   Address: ____
   Telephone: ____
   Beneficiary's percentage of ownership: _______________________________

2. Name: ____
   Address: ____
   Telephone: ____
   Beneficiary's percentage of ownership: _______________________________

3. Name: ____
   Address: ____
   Telephone: ____
   Beneficiary's percentage of ownership: _______________________________

4. Name: ____
   Address: ____
   Telephone: ____
   Beneficiary's percentage of ownership: _______________________________

5. Name: ____
   Address: ____
   Telephone: ____
   Beneficiary's percentage of ownership: _______________________________

6. Name: ____
   Address: ____
   Telephone: ____
   Beneficiary's percentage of ownership: _______________________________

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

Attachment 3

FORM 3

FACILITY/AGENCY NAME: ______________________________

Form 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or non-profit). Please copy additional sheets if necessary.

For each stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no owner owns 10% or more of the total shares, please indicate the two largest stockholders. **Please complete a separate form for each legal entity listed below that is not an individual.**

This information is for: ☐ Licensee ______________________
☐ Real Property Owner ______________________

1. Name: ______________________
   Address: ______________________
   Telephone: ______________________
   Stockholder's percentage of ownership: ______________________
   Stockholder's occupation with the owner: ______________________

2. Name: ______________________
   Address: ______________________
   Telephone: ______________________
   Stockholder's percentage of ownership: ______________________
   Stockholder's occupation with the owner: ______________________

3. Name: ______________________
   Address: ______________________
   Telephone: ______________________
   Stockholder's percentage of ownership: ______________________
   Stockholder's occupation with the owner: ______________________

4. Name: ______________________
   Address: ______________________
   Telephone: ______________________
   Stockholder's percentage of ownership: ______________________
   Stockholder's occupation with the owner: ______________________

Department of Public Safety
Division of Fire, Emergency & Building Services
Office of State Fire Marshall

STATE OF CONNECTICUT

On *(date)* __________, the *(Town/City)* ____________________ Office of the Fire Marshal conducted at inspection of *(name of facility)* ____ located at *(address)* ____ in the City/Town of ______________________to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as a *(new/existing)* __________ *(occupancy classification)* ____ as classified by the *CONNECTICUT FIRE SAFETY CODE*. As a result of this inspection, the following conditions were found:

I. At the time of inspection, no code violations were identified. **Certificate of approval recommended.**

II. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. *(See attached information)* **Certificate of approval recommended.**

III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. *(See attached information)* **Certificate of approval NOT recommended.**

IV. Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. *(See attached information)* **Certificate of approval NOT recommended.**

____ ______________________
Fire Marshal Date

City or Town: ____

FLIS LICAPP –001
Rev. 3-06

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

BEHAVIORAL HEALTH
and
SUBSTANCE ABUSE & DEPENDENT PERSONS

Please respond to all of the following questions:

1. ____
Facility “d/b/a” (doing business as) Name

____
Business Address City State Zip Code Telephone

2. ______________________ ______________________
Executive Director Director

3. Please attach a list of services provided:

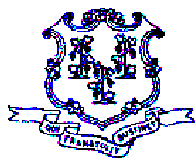
4. SUBSTANCE ABUSE FACILITIES ONLY, please check applicable services/beds:

[ ] Ambulatory Chemical Detoxification Treatment
[ ] Intensive Treatment Beds ____
[ ] Care and Rehabilitation Beds _________
[ ] Medical Triage Beds _____
[ ] Chemical Maintenance Treatment
[ ] Residential Detoxification & Evaluation Beds _____
[ ] Intermediate & Long Term Treatment & Rehab. Beds ______
[ ] Day or Evening Treatment
[ ] Outpatient Treatment

5. Attach a list of the names & titles of all professional staff.

6. Hours of Operation ______________________________________

7. **On initial and relocation applications only,** submit the following:
   A. Evidence of compliance with local zoning and building codes
   B. Evidence of financial viability
   C. OHCA approval for the establishment of the facility
   D. Certificate by Executive Director (attached)
   E. Certificate by Director (attached)
   F. Floor plans.



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

BEHAVIORAL HEALTH
and
SUBSTANCE ABUSE & DEPENDENT PERSONS

CERTIFICATE BY THE DIRECTOR

THIS IS TO CERTIFY THAT I HAVE ACCEPTED THE POSITION OF

DIRECTOR FOR____

LOCATED AT____

In accepting this position, I agree to assume responsibility for the above facility in accordance with the Public Health Code of the State of Connecticut and all applicable Connecticut General Statues.

Please attach a currently updated resume.

_____________________________ DIRECTOR'S NAME (PLEASE PRINT)

_______________________ DIRECTOR'S SIGNATURE

_____________________________ RESIDENCE ADDRESS

_______________________ HOME TELEPHONE NUMBER

__________________________________ CITY OR TOWN STATE ZIP CODE

AFFIDAVIT

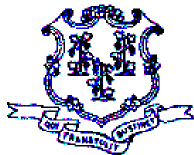
_______________________ personally appeared and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

Subscribed and sworn before me this __________ day of __________ , 20_____ .

____
Notary Public [ ]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of Superior Court [ ]

My commission expires: ____________________
(If Notary Public)

FLIS LICAPP –001
Rev. 3-06



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

BEHAVIORAL HEALTH
and
SUBSTANCE ABUSE & DEPENDENT PERSONS

CERTIFICATE BY THE EXECUTIVE DIRECTOR

THIS IS TO CERTIFY THAT I HAVE ACCEPTED THE POSITION OF

EXECUTIVE DIRECTOR FOR___________________________________

LOCATED AT____

In accepting this position, I agree to assume responsibility for the above facility in

accordance with the Public Health Code of the State of Connecticut and all applicable

Connecticut General Statues.

Please attach a currently updated resume.

____________________________________ ____________________________
EXECUTIVE DIRECTOR'S NAME (PLEASE PRINT) EXECUTIVE DIRECTOR'S SIGNATURE

________________________________ __________________________
RESIDENCE ADDRESS HOME TELEPHONE NUMBER

____
CITY OR TOWN STATE ZIP CODE

AFFIDAVIT

__________________________ personally appeared and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

Subscribed and sworn before me this ____________ day of ____________ , 20______ .

____
Notary Public [ ]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of Superior Court [ ]

My commission expires: _______________________
(If Notary Public)