RI Department of Health

Licensing Application
and instructions for

ADULT DAY CARE PROGRAMS
RI General Law Chapter 23-1-52

Licensee Name: _____

Licensee Number: _____

Reason for application (Please check all that apply):

1. ☐ Initial Licensure
2. ☐ Change of ownership
3. ☐ Change of address
4. ☐ Licensee/Program Name Change

(Complete the following for either 1, 2, or 3)

Current Program name:_____ License #:_____

Current address:_____

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ballpoint pen.
- There is no fee for this application.
- Sign the completed application, return it with the required attachments and mail to:

  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097

- If you have any questions concerning this application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.
- Please attach a description of the target population that will be served in this program.

You must attach a printed current list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following:

Additional Documentation: Please include the following documentation with this application	1. Programs Mission and Philosophy Statement 2. Description of the Programs Target Population 3. Anticipated Number of Participants 4. Admission and Discharge Criteria 5. Basic Services Offered 6. Acknowledgement to Adhere to Participant Rights 7. Plan of Operation 8. Acknowledgement of contract and agreements with other agencies and individuals 9. Staffing Pattern and Staff Profiles 10. Days and Hours of Program Operation 11. Any non-financial obligations of the participant and his/her family, such as a commitment of the participant to attend the program a specified number of days per week 12. Schedule of Days the Program Will Be Closed 13. Procedure for Unexpected Closures 14. Certificate of Occupancy (from the local town department) 15. Current State Fire Marshal Inspection (Call the FMO at 462-4215 to schedule a LSC/Fire Safety Inspection). 16. Current Food Service license from the RIDOH Office of Food Protection (Call 222-2750 for food license application)
Participant Capacity What is the program's maximum daily enrollment capacity?	☐

License Sub-Type: Please select one	☐ Profit ☐ Non-Profit
Program Director: Please provide the name of the program director of record for this program.	Name _____ Title _____
Program Name: Please provide the name of the program (as known to the public) .	Name _____
Program Contact Person: Please provide the name and telephone number of a person we can contact concerning this Program.	Name _____ Phone Number ( ) _____
Program Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone _____ Fax _____ Email Address _____
Program Location Information: Please provide the location information for this facility. (**Published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone _____ Fax _____ Email Address _____

Ownership Information: Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name _____ DBA _____
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1_____ Address Line 2_____ Address Line 3_____ Address City, State, Zip Code _____ Phone _____ Fax _____ Email Address _____
Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control	Corporation Type _____ Name of Organization_____ Address Line 1_____ Address Line 2_____ Address Line 3_____ Address City, State, Zip Code_____ Phone_____ Fax _____ Email Address _____
Land/Building Info: If the owner of the land and building is other than the operator of this agency/facility, please complete the following:	Name_____ Address Line 1_____ Address Line 2_____ Address Line 3_____ Address City, State, Zip Code_____ Phone _____
Compliance with Conditons of Approval Please check yes or no.	This facility/agency is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Control, Initial Licensure and/or Licensure renewal). ☐ Yes ☐ No

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Acknowledgements

I am aware of Chapter 23-1-52 of the General Laws of Rhode Island, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-1-52 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number:

(Federal Employer Identification Number)

Note: If you are a sole proprietor this number may be your Social Security Number.

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide below SSN/FEIN for this license:

SSN/F.E.I.N. Number: _____

Affidavit of Applicant

Read, sign, and date this affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

_____ _____

Signature of Authorized Person **Date of Signature (MM/DD/YY)**

_____

Printed Name of Authorized Person

_____

Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.