



RI Department of Health

Licensing Application and instructions for

Assisted Living Residences Limited Health Services

RI General Law Chapter 23-17.4

Licensee Name: _____

Current Assisted Living Residence Licensee Number: _____

Reason for application (Please check all that apply):

1. Initial Licensure – Limited Health Services - \$600.00 Application Fee
2. Increase in Services Offered – (May only increase services offered one time per annual licensing period) – No Fee



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.
- The fee for initial (new) Limited Health Services license is \$600.00. Increases and/or decreases of services offered require no fee. Note: Increases in services provided may only be made one time per annual licensing period and decreases require notice of thirty (30) days or more prior to ceasing to offer a licensed service
- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.

Sign the completed application, return it with the required fee 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.

Attachments: Please label and staple each separate attachment and securely affix any and all additional documents and/or approvals to this application. Required documents include, but are not limited to:

- 1) Copy of document that meets the requirement for right to access a home care provider as stated in 46.4 of the regulations.
- 2) Copy of the ALR's disclosure form specific to Limited Health Services as required in 47.6 of the regulations.
- 3) Name of Rhode Island licensed physician identified to provide direction in the development of policies and procedures.
- 4) Copy of Quality Assurance Plan that meets the requirements of 2.7.
- 5) Name of physician, nurse practitioner, and/or physician assistant that will serve as a member of the QA committee.
- 6) Name of Registered Nurse that will be on staff full-time thirty-five (35) hours per week.
- 7) Copy of policy that demonstrates the residence meets the requirements for emergency power as required in Section 47.0
- 8) Evidence of a residence-specific infection prevention program as required in Section 16.3.1
- 9) Admission and discharge criteria for residents requiring limited health services
- 10) Copies of all applicable policies and procedures that detail the services to be offered:
 - Stage I and stage II pressure ulcer treatment and prevention;
 - Simple wound care including postoperative suture care/removal and stasis ulcer care;
 - Ostomy care including appliance changes for residents with established stomas;
 - Urinary catheter care;
 - If applicable, coordination of hospice services for residents who are bed-bound or in need of assistance from more than one staff person for ambulation.



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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:

<p>Residence Name: Name of the Residence as known to the public</p>	<hr/>
<p>Please check all services that are to be provided:</p>	<p><input type="checkbox"/> Stage I and stage II pressure ulcer treatment and prevention</p> <p><input type="checkbox"/> Simple wound care including postoperative suture care/removal & stasis ulcer care</p> <p><input type="checkbox"/> Ostomy care including appliance changes for residents with established stomas</p> <p><input type="checkbox"/> Urinary catheter care</p> <p><input type="checkbox"/> Coordination of hospice services for residents who are bed-bound or in need of assistance from more than one staff person for ambulation. (Note: if you plan to provide this service then the residence must also be licensed to provide Stage I and stage II pressure ulcer treatment and prevention)</p>



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Acknowledgements

I am aware of Chapter 23-17.4 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed there under, which regulate the operation of this Residence.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17.4 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 Residence/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.