



# RI Department of Health

## Licensing Application and instructions for

- ✓ Assisted Living Residences (ALR)
- ✓ ALR Special Care Units
- ✓ ALR Limited Health Services

### RI General Law Chapter 23-17.4

Licensee Name: \_\_\_\_\_

Current License number: \_\_\_\_\_  
(assigned by RIDOH)

Reason for application (Please check all that apply):

1.  Initial Licensure
  - Assisted Living Residence License  
(Complete Section I, II & III)
  - Special Care Unit License  
(Complete Section I & IV)
  - Limited Health Services License  
(Complete Section I & V)
2.  Change of address  
(Complete Section I, II & III)
3.  Change of ownership  
(Complete Section I, II, III, IV, (as applicable V))
4.  Licensee Name Change  
(Complete Section I & II)
5.  Increase in Bed Capacity (From: \_\_\_\_\_ To: \_\_\_\_\_)  
(Complete Section I, III & IV)
6.  Decrease in Bed Capacity (From: \_\_\_\_\_ To: \_\_\_\_\_)  
(Complete Section I, III & IV)
7.  Limited Health Services Change in services or Change of ownership  
(Complete Section I & V)



**State of Rhode Island**  
Department of Health

## INSTRUCTIONS

- Please answer all questions. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ballpoint pen.
- The fee for the ALR license, initial (new), change of ownership applications, or change of address is \$330.00, plus \$70.00 per licensed bed, \$70 per bed for increases in existing capacity. There is no fee for a name change.
- The fee for the Special Care Unit license is an additional \$600.00.
- The fee for the Limited Health Services license is an additional \$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 **Center for Health Facilities Regulations** at (401) 222-2566.
- 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 use the appropriate postage necessary to mail your completed application.
- 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) 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.  
(Required for: initial ALR licensure, change of ownership and/ or change of name)
- 2) Office of State Fire Marshall's (401-889-5555) Life Safety Code (LSC) inspection report  
(Required for: initial ALR license, change in location and/ or bed increase)
- 3) Department of Health, Office of Food Protection (401-222-2750) license for operation of the kitchen  
(Required for: initial ALR licensure and change of location)
- 4) Certificate of Occupancy  
(Required for: initial ALR license and change in location)



**State of Rhode Island**  
Department of Health

**Attachments for Alzheimer's Dementia Special Care Unit/Program: Required if applying for Dementia Special Care Unit/ Program, Bed Increase/ Decrease or Change of ownership**

- 1) Copy of the ALR's disclosure form specific to Alzheimer's Dementia Special Care Unit/ Program as required in § 2.5.2(B-E) of the regulations.
- 2) Copy of Quality Assurance Plan that meets the requirements of § 2.4.3 of the regulations.
- 3) Name of Registered Nurse that will be on staff full-time thirty-five (35) hours per week, and available for consultation at all times, as required under § 2.5.2(I) of the regulations.
- 4) Name of dietitian licensed by RIDOH who will direct development of the menu as required under § 2.5.2(K) of the regulations.
- 5) Copy of policy that demonstrates the residence meets the requirements for emergency power as required in § 2.5.3 of the regulations.
- 6) Admission and discharge criteria for residents requiring limited health services.
- 7) Copies of all policies and procedures that detail the services to be offered, including admission and discharge criteria.

**Attachments for Limited Health Services license: Only required if applying for Limited Health Services (LHS) license, requesting a change in LHS offered or change of ownership.**

- 1) Copy of document that meets the requirement for right to access a home care provider as stated in § 2.6.2(D) of the regulations.
- 2) Copy of the ALR's disclosure form specific to Limited Health Services as required in § 2.6.2 (E-G) of the regulations.
- 3) Name of Rhode Island licensed physician identified to provide direction in the development of policies and procedures as required under § 2.6.2(L) of the regulations.
- 4) Copy of Quality Assurance Plan that meets the requirements of § 2.4.3 (A-B) of the regulations.
- 5) Name of physician, nurse practitioner, and/or physician assistant that will serve as a member of the QA committee as required under § 2.6.2 (M) of the regulations.
- 6) Name of Registered Nurse that will be on staff full-time thirty-five (35) hours per week as required under § 2.6.2(Q) of the regulations.
- 7) Copy of policy that demonstrates the residence meets the requirements for emergency power as required in § 2.6.3 of the regulations.
- 8) Evidence of a residence-specific infection prevention program as required in § 2.4.2 (C)(5) of the regulations.
- 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.



**State of Rhode Island**  
Department of Health

**Please complete the following:**

<b>Section I</b> Complete for all applications	
<b>Residence Name</b> Name of the Residence as known to the public	Name: _____
<b>Assistant Living Residence Administrator</b> Please provide the name of the Assistant Living Residence Administrator of Record for this Residence.  <b>NOTE: This section must be completed as a requirement of your license.</b>	Name: _____  E-mail: _____  RI Assisted Living Administrator's License #: _____ RI Nursing Facility Administrator's License #: _____
<b>Residence Contact Information</b>  Documents and notifications may be sent to the Residence e-mail address.	Phone: (    )    -    _____    Fax: (    )    -    _____  Web site/address: _____  Residence e-mail address: _____
<b>Residence Physical Location</b>  Please provide the location information for this Residence.  <b>(Published on RIDOH website)</b>	Address Line 1: _____  Address Line 2: _____  Address Line 3: _____  Address City, State, Zip Code: _____  Address Country: _____  Phone: _____  Fax: _____  Email Address: _____
<b>Residence Mailing Information</b>  Please provide the mailing & contact information for other communication regarding this license.  <b>(Not published on RIDOH website)</b>	Address Line 1 _____  Address Line 2 _____  Address Line 3 _____  Address City, State, Zip Code _____  Address Country _____  Phone: _____  Fax: _____  Email Address: _____



**State of Rhode Island**  
Department of Health

<b>Section II</b> Complete for Initial ALR licensure, Change of Ownership, Change of Address	
<b>Ownership Type:</b> Please check ONE   <b>License sub-type:</b> Please select one	<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Governmental Entity  <input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit
<b>Ownership Information</b>	Name: _____  DBA: _____
<b>Ownership Address Information:</b>  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: _____
<b>Parent Organization, Group Affiliation:</b>  Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Residence/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: _____



**State of Rhode Island**  
Department of Health

<p><b>Land/Building Info</b></p> <p>If the owner of the land and building is other than the operator of this agency/Residence, please complete the following</p>	<p>Name: _____</p> <p>Address Line 1: _____</p> <p>Address Line 2: _____</p> <p>Address Line 3: _____</p> <p>Address City, State, Zip Code: _____</p> <p>Phone: _____</p>
--	---



**State of Rhode Island**  
Department of Health

<p><b>Section III</b></p> <p>Complete for Initial ALR application, Change of Ownership, Change of Address, Increase/ Decrease Bed Capacity</p>			
<p><b>ALR Bed Capacity:</b></p> <p>Includes all locations/wings Related to this license.</p>	<p><b>Total</b> Bed Capacity = _____</p> <p>Number of Single Bedrooms: _____      Number of Double Bedrooms: _____</p>		
<p><b>Occupancy-Life Safety<sup>1</sup></b></p> <p>Please select appropriate levels of care.</p>	<p>Occupancy and Fire Safety designation:</p> <p><input type="checkbox"/> <b>F1</b> - For SPECIAL CARE and residents who are <b>not capable of self-preservation in an emergency:</b></p> <p style="padding-left: 40px;"># F1 beds _____      F1 Location _____</p> <p><input type="checkbox"/> <b>F2</b> - For residents who are capable of self-preservation in an emergency.</p> <p style="padding-left: 40px;"># F2 beds _____      F2 Location _____</p>		
<p><b>Medication Services</b></p> <p>Please select appropriate levels of medication assistance</p>	<p>Medication:</p> <p><input type="checkbox"/> <b>M1</b> - For residents who require someone to <b>administer their medication to them.</b></p> <p><input type="checkbox"/> <b>M2</b> - For residents who can self-administer medications or may only require reminding to take medications.</p>		
<p><b>Services Provided</b></p> <p>Please check which services are provided by your employees or through written agreement with others.</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Housing  <input type="checkbox"/> Activities  <input type="checkbox"/> Medication (administer)  <input type="checkbox"/> Medication (assist)  <input type="checkbox"/> Referrals  <input type="checkbox"/> Transportation         </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Housekeeping  <input type="checkbox"/> Laundry  <input type="checkbox"/> Assistance w/personal care needs  <input type="checkbox"/> Food services/kitchen<sup>2</sup>  <input type="checkbox"/> Fiduciary Agent  <input type="checkbox"/> Other: List Additional Services         </td> </tr> </table> <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>	<input type="checkbox"/> Housing <input type="checkbox"/> Activities <input type="checkbox"/> Medication (administer) <input type="checkbox"/> Medication (assist) <input type="checkbox"/> Referrals <input type="checkbox"/> Transportation	<input type="checkbox"/> Housekeeping <input type="checkbox"/> Laundry <input type="checkbox"/> Assistance w/personal care needs <input type="checkbox"/> Food services/kitchen <sup>2</sup> <input type="checkbox"/> Fiduciary Agent <input type="checkbox"/> Other: List Additional Services
<input type="checkbox"/> Housing <input type="checkbox"/> Activities <input type="checkbox"/> Medication (administer) <input type="checkbox"/> Medication (assist) <input type="checkbox"/> Referrals <input type="checkbox"/> Transportation	<input type="checkbox"/> Housekeeping <input type="checkbox"/> Laundry <input type="checkbox"/> Assistance w/personal care needs <input type="checkbox"/> Food services/kitchen <sup>2</sup> <input type="checkbox"/> Fiduciary Agent <input type="checkbox"/> Other: List Additional Services		

<sup>1</sup> Requires documentation from State Fire Marshall's office regarding occupancy approval.

<sup>2</sup> Requires license approval from the Office of Food Protection



**State of Rhode Island**  
Department of Health

**Section IV**  
**Special Care Unit License**  
Only complete this section for a Special Care Unit License  
Initial SCU license, Change of Ownership or Increase/ Decrease of beds.

<p><b>Levels of Care:</b></p> <p><b>Special Care Units (SCU):</b></p> <p>Please write "0" if you do not have any special-care beds.</p> <p>Must be a F1-M1 facility.</p>	<p>Of total bed capacity, how many beds are located in a special care unit/program (i.e. Alzheimer's/Dementia)?</p> <p>SCU capacity = _____</p> <p><b>NOTE:</b> For a special care unit designation, you must attach a copy of your disclosure statement per § 2.5.2(D)(1) through (8) of the State Regulations, noting the additional care that is provided in the Special Care Unit.</p>
--	--

**Section V**  
**Limited Health Services License**  
Only complete this section for Limited Health Services  
Initial LHS license, change of services, change of ownership (as applicable)

<p><b>Services Provided:</b></p> <p>Please check which services are provided by your employees or through written agreement with others.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Stage I and stage II pressure ulcer treatment and prevention</li> <li><input type="checkbox"/> Simple wound Care including postoperative suture care/ removal and stasis ulcer care</li> <li><input type="checkbox"/> Ostomy Care including appliance changes for residents with established stomas</li> <li><input type="checkbox"/> Urinary catheter care</li> <li><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.<sup>1</sup></li> </ul> <p><sup>1</sup> <b>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. Must also be an F1</b></p>
--	--



**State of Rhode Island**  
Department of Health

**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.

<p><b>FEIN Number:</b> <b>(Federal Employer Identification Number)</b></p> <p><b>Note: If you are a sole proprietor this number may be your Social Security Number.</b></p>	<p>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.</p>
	<p>Please provide below SSN/FEIN for this license:</p> <p>SSN/F.E.I.N. Number: _____</p>

<p><b>Affidavit of Applicant</b></p> <p>Read, sign, and date this affidavit.</p>	<p><b>AFFIDAVIT AND SIGNATURE</b></p> <p><b>This Application Must be Signed</b></p> <p><b>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.</b></p> <p><b>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.</b></p> <p><b>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.</b></p>						
	<table style="width: 100%;"> <tr> <td style="width: 60%; border-top: 1px solid black;"> <p><b>Signature of Authorized Person</b></p> </td> <td style="width: 40%; border-top: 1px solid black;"> <p><b>Date of Signature (MM/DD/YY)</b></p> </td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black;"> <p><b>Printed Name of Authorized Person</b></p> </td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black;"> <p><b>Title of Authorized Person</b></p> </td> </tr> </table> <p><b>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.</b></p>	<p><b>Signature of Authorized Person</b></p>	<p><b>Date of Signature (MM/DD/YY)</b></p>	<p><b>Printed Name of Authorized Person</b></p>		<p><b>Title of Authorized Person</b></p>	
<p><b>Signature of Authorized Person</b></p>	<p><b>Date of Signature (MM/DD/YY)</b></p>						
<p><b>Printed Name of Authorized Person</b></p>							
<p><b>Title of Authorized Person</b></p>							