DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street
Concord, New Hampshire 03301
(603) 271-9040 Fax (603) 271-4968 TDD Access 1-(800)-735-2964

REQUEST FOR CERTIFICATION OF COMMUNITY RESIDENCE AND/OR INDIVIDUAL COMMUNITY PARTICIPATION SERVICES PROVIDER

Check the type(s) of certification for which you are applying (you may check more than one):

☐ Community Residence (3 or less beds) ☐ Community Residence (4 or more beds) ☐ Community Participation Services

GENERAL INFORMATION

☐ Initial Certification Requested Start Date: ________ ☐ Other ________

☐ Renewal Certification Expiration Date if Currently Certified: ________

Residence or program name: ________ Cert #: ________

Location: ________
(Street) (Town) (State) (Zip)

Mailing: ________
(Street) (Town) (State) (Zip)

Contact for Site Visit (Name): ________ Contact Phone: ________

E-Mail Address: ________

RESIDENTIAL

Number of beds currently certified: ________ Number of beds requested: ________

Home provider's name (if applicable) and Home Phone#: ________

Is this residence currently under Emergency Certification? ☐ Yes ☐ No **If yes, certification #:** ________

Is this residence currently licensed? ☐ Yes ☐ No **If yes, Type and #:** ________

Check type of residence ☐ Family Residence ☐ Staffed 24 hrs ☐ Staffed less than 24 hrs

COMMUNITY PARTICIPATION SERVICES (CPS)

Number of CPS _slots currently certified: ________ Number of CPS slots requested: ________

Is any individual at the CPS site for more than one hour per day? ☐ Yes ☐ No

Is the CPS program located at a currently certified Community Residence? ☐ Yes Cert #: ☐ No

PLEASE SEND DIRECTIONS TO ALL PROGRAMS

INDIVIDUAL INFORMATION

In the middle column indicate if the individual is served by Developmental Services (DS), Behavioral Health (BH), ABD Waiver (ABD) or Other. If there are more than 4 individuals, please attach a list.

Individual Name(s)	Date of Birth	Male/ Female	Served by	Hrs Day or Wk Supervised Per SA at CR	CPS Provider and Hours Per Week at Day Services Per SA

VENDOR AGENCY

Vendor Agency: ______________________________

Mailing Address: ______________________________

Vendor Rep.: ______________________________ Day Phone: ______________

AREA AGENCY

Area Agency: ______________________________ Region: ______________

Mailing Address: ______________________________

Area Agency Rep.: ______________________________ Day Phone: ______________

List all non-family members currently receiving services in the home or CPS program not listed under individual information. Specify Date of Birth and funding source, if any:

NAME: DOB: FUNDING SOURCE:

NAME: DOB: FUNDING SOURCE:

PLEASE CHECK INFORMATION ATTACHED TO APPLICATION

☐ **Include directions to all Residential Programs or CPS Programs with initial applications**.

☐ Current Life Safety Code Report: If this is a new Residential Program, a bed increase or a facility based CPS program the LSC report cannot precede the date of this application by more than 90 days.

☐ Policies, staff names and qualifications per He-M 507 if this is a new CPS program.

☐ Copies of any request for waiver for the new certificate period or for renewals attach a copy of the waiver.

Has any provider or adult household member, excluding the Individual(s), been convicted of a felony or misdemeanor, or had a substantiated report of abuse, neglect, or exploitation? Reference RSA 161-F:49, He-M 507.10(f)-(i), He-M 1001.15(a)(1)-(3) and He-M 1002.14(a)(1)-(3). ☐ Yes ☐ No

I swear or affirm that the information provided on this application is accurate to the best of my knowledge and belief. I believe that this residence/community participation service program is in full compliance with the statutes and regulations governing these services. I understand that providing false information shall be grounds for denial, suspension or revocation of the certification.

Authorized Signature

______________________________ ______________

Residential/CPS Coordinator or Director *Date*

____

Print name and title

Please send a copy of this application to the Area Agency or Community Behavioral Health QA department