

Certified Community Residential Services and Supports Initial Application

Application Instructions

When completing this application you must:

- Type or print clearly in BLUE or BLACK ink.
- Answer all questions or mark "N/A" if the question does not apply. You must complete the entire application (i.e., all of the sections must be filled out and/or marked) and you must include the required documents.
- If you have questions about completing the application, please call the Business Analysis and Applications Unit (BAAU) Manager at 360-725-2402.
- Submit all required supporting documentation.
- Use the application checklist to make sure you have submitted all required documentation.
- Sign the completed application.
- Make a copy of your application and all supporting documents for your files.
- Mail your completed application and required documents to:

AL TSA Business Analysis and Applications Unit
PO Box 45600
Olympia, WA 98504-5600

- You must notify BAAU in writing if any information in the application changes before the applicant is certified. Mail the corrected information to: Business Analysis and Applications Unit, PO Box 45600, Olympia, WA 98504-5600. Be sure to identify the individual or agency and contact information on all documents submitted.

Application Processing and Timelines

It is extremely important that the application is complete and that all documentation is provided with the application. Otherwise, there will be a delay in the application and certification process.

If the application is incomplete, you will receive a written notice of what is incomplete. You will have 60 days from the date of that written notice to complete the application and return it to our office. If you do not respond with a complete application within 60 days of the date of our request, your application will become void.

Applications are processed on a first-come, first-served basis.

The amount of time it takes to process an application will vary based on several factors (for example, whether the application is filled out completely, all of the required documents are attached, out-of-state background check results are needed, if the department has questions or concerns about the information associated with this application, and the number of applications in process). It could take 60 days or more to process an application from the time it is determined to be "complete".

The department will call the applicant if/when the applicant is certified for community residential services and support.

Certified Community Residential Services and Supports Initial Application Checklist

(This checklist must be included with the application.)

NAME OF PROPOSED CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORT PROVIDER	
NAME OF CONTACT PERSON	TELEPHONE NUMBER

Please check below to show that you have included the following with your application.

- Copy of your Washington state business license showing that your trade name has been registered with the Department of Licensing and showing the Unified Business Identifier (UBI) number for the proposed Services and Supports Provider.
 - A UBI is a 9-digit number issued to individuals and companies doing business in Washington State. To get a UBI number, fill out a Master License Service (MLS) Application. To obtain this form, contact Department of Licensing Master License Service, at (360) 664-1400. The form is available at: <http://www.dol.wa.gov/forms/700028.html>.

- Copy of a document issued by the Internal Revenue Service (IRS) showing the Employer Identification Number (EIN) for the proposed licensee for this application.
 - The applicant must have a federal EIN before applying for supported living certification.
 - An EIN is a 9-digit number assigned to businesses from the Internal Revenue Service for filing and reporting purposes.
 - To apply for an EIN, fill out Form SS-4, Application for Employer Identification Number which is available at local Social Security Administration offices, OR, contact the IRS, Business and Tax Specialty, at 1-800-829-4933. The SS-4 form is also available at <http://www.irs.gov>.
 - More information on EINs is found at <http://www.irs.gov/businesses>. Select Business Topics, then Employer ID Number.
 - When completing the EIN application, Question 10, please check (Y) "Other" and specify "Washington State Requirement" in the space provided. DO not check "Started new business."
 - Once you have filled out the form, send the completed Form SS-4 to: IRS Service Center, EIN Operations, Philadelphia, PA 19255.

- Completed background authorization forms for all persons listed in section 9. Note: Background results cannot be submitted in lieu of the background authorization forms.
- Provide three (3) professional letters of reference.
- Provide a professional resume for the Administrator.

Department Use Only

Certified Community Residential Services and Supports Initial Application

Check one:

This application is being submitted by a(n):

- Individual (to be certified under **my** name only as a sole proprietor)
- Married Couple or State Registered Domestic Partner couple (to be certified together as a sole proprietor)
- For Profit Corporation
- Nonprofit Corporation
- Partnership
- Limited Liability Company (LLC)
- Government Agency
- Group or Association

Type of Service to be provided:

- Supported Living Services
- Group Home (provide a copy of your Group Home license)
- Community Protection Services in Supported Living Program

Section 1. Information About the Proposed Services and Supports Provider

1. NAME OF PROPOSED INDIVIDUAL OR AGENCY

2. STREET ADDRESS CITY COUNTY STATE ZIP CODE

3. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) CITY STATE ZIP CODE

4. TELEPHONE NUMBER	5. CELL PHONE NUMBER	6. FAX NUMBER	7. E-MAIL ADDRESS
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Section 2. Geographic Area of Service

List the city / cities that you will be providing services and supports:

Section 3. Unified Business Identifier (UBI) and Federal Employer Identification Number (EIN)

The following numbers are required for the application. For information on getting these numbers, see the application instructions.

1. UBI NUMBER	2. EIN NUMBER
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Section 4. Entity

Fill out this section **ONLY** if an entity is applying for the certification. An entity is a corporation, partnership, or limited liability company (LLC). If you are applying as an individual, mark the N/A box and go to section 6.

N/A (I am applying as an individual)

1. LEGAL NAME OF ENTITY (NAME LISTED ON THE EIN AND UBI)	2. TELEPHONE NUMBER	3. FAX NUMBER
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4. MAILING ADDRESS CITY STATE ZIP CODE

Section 5. Individual Applicant

The individual applicant **must** complete this section.

1. NAME OF INDIVIDUAL APPLICANT (LAST, FIRST, MIDDLE)

2. NAME OF INDIVIDUAL APPLICANT AS IT APPEARS ON BIRTH CERTIFICATE(LAST, FIRST, MIDDLE)

3. DATE OF BIRTH

4. SOCIAL SECURITY NUMBER

5. E-MAIL ADDRESS

6. TELEPHONE NUMBER

Section 6. Individuals Affiliated with Applicant (for Entities Only)

Fill out this section **ONLY** if an entity (a corporation, partnership, or limited liability company (LLC)) is applying for the certification. If you are applying as an individual, skip this section and go to section 6.

N/A (I am applying as an individual)

Complete the following table for all Owners, Officers, Directors, and Managerial Employees (including the Administrator) of the entity. List percentage of ownership for all stockholders with 5% or greater ownership. If you need more space, provide it on a separate page and attach it to this application.

NAME OF PERSON	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	PERCENT OWNERSHIP
				%
				%
				%
				%
				%

Section 7. Administrator

1. NAME OF ADMINISTRATOR (LAST, FIRST, MIDDLE)

2. NAME OF ADMINISTRATOR AS IT APPEARS ON BIRTH CERTIFICATE (LAST,FIRST, MIDDLE)

3. DATE OF BIRTH

4. SOCIAL SECURITY NUMBER

5. E-MAIL ADDRESS

6. TELEPHONE NUMBER

7. ADDRESS

CITY

STATE

ZIP CODE

Section 8. Previous Licensing or Contracting Experience

1. Has any person or entity named in this application ever owned, held an interest in, managed, or held a license or certification for an adult family home, boarding home, nursing home, community residential services and support agency or other business providing services to children, vulnerable adults, or persons with mental illness or developmental disabilities? Yes No

If "yes", provide the information below for each person or entity in this application: (Attach additional pages if needed)

2. NAME AND TITLE OF PERSON

FACILITY NAME, CERTIFICATION OR LICENSE TYPE

NAME AND ADDRESS OF ISSUING AGENCY

CONTACT NUMBER OF ISSUING AGENCY

POSITION HELD

DATES HELD

3. NAME AND TITLE OF PERSON

FACILITY NAME, CERTIFICATION OR LICENSE TYPE		
NAME AND ADDRESS OF ISSUING AGENCY		
CONTACT NUMBER OF ISSUING AGENCY	POSITION HELD	DATES HELD

4. NAME AND TITLE OF PERSON

FACILITY NAME, CERTIFICATION OR LICENSE TYPE		
NAME AND ADDRESS OF ISSUING AGENCY		
CONTACT NUMBER OF ISSUING AGENCY	POSITION HELD	DATES HELD

5. Has any person or entity named in this application ever held a contract to provide services to children, vulnerable adults, or persons with mental illnesses or developmental disabilities? Yes No

If "yes", provide the information below for each person or entity in this application: (Attach additional pages if needed)

NAME OF PERSON	TYPE OF CONTRACT	STATE	DATES HELD

6. Has any person or entity named in this application now or previously been under investigation by a professional licensing agency, Division of Licensing Resources, a state licensing or contracting agency, Division of Children and Family Services, Child Protective Services, Adult Protective Services or the police for any disciplinary action or for abuse, neglect, exploitation or misappropriation of property of any person? Yes No

7. Has any person or entity named in this application now or previously been denied a contract, license, license renewal or certification to operate a facility or to be a certified community residential services and support provider providing care to adults or children? Yes No

8. Has any person or entity named in this application been certified, licensed or contracted with to provide care or services to adults or children, and:

- had such certification or license revoked, suspended, suspended with stay, enjoined, or imposed with conditions, civil fine or stop placement? Yes No
- had a Medicaid or Medicare provider agreement revoked, cancelled, suspended or not renewed?
 Yes No
- relinquished or returned such certification or license; or did not seek the renewal of certification or license when notified by the state agency of initiation of denial, suspension, cancellations, or revocation of certificate, license, or contract? Yes No

If the answer is "yes", to questions 6 through 8 above, you must provide the following on a separate sheet of paper and attach it to this application:

- Name of the individual;
- Effective date of license, contract or certification;
- Date of action taken;
- Type of action taken;
- Name and address of facility;
- Name, address and contact information of agency that took the action; and
- Circumstances.

Section 9. Background Information

List below and attach a completed Background Authorization form for the following:

- Individual Applicant
- Entity Owners, Partners, Officers, Directors, and Managerial Employees (Includes all members of a corporation)
- Administrator
- Persons age 11 or older who currently or who will, work, volunteer, or otherwise have unsupervised access to clients.

You can print out the Background Authorization form from: www.dshs.wa.gov/msa/bccu/bccu-forms.htm.

Do not complete Background Authorizations for other children age 10 or under.

Do not include clients.

Section 2 of the Background Authorization forms must have ALL blanks filled in.

Previous results from a Background Inquiry are not accepted.

1. NAME OF PERSONS AGE 11 OR OLDER (ATTACH ADDITIONAL SHEETS OF PAPER IF NEEDED)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT

2. Are you or your household member currently employed by the Department of Social and Health Services?
 Yes No

If "yes" to the above question, list below the name and job title of the person(s) in this application that is: employed by the Department of Social and Health Services.

NAME OF PERSON / JOB TITLE	ADMINISTRATION / DIVISION

- Are you or your household member currently employed by the Aging and Long-Term Support Administration?
 Yes No

3. List below any person named in this application who is over the age of 18 and has lived in another state in the past three years. Also, contact the application unit at 360-725-2420 regarding the out-of-state background check process before you submit this application.

NAME OF PERSON	OUT OF STATE ADDRESS	DATES LIVED IN OTHER STATE(S) (MONTH/YEAR)

If none, check here N/A

4. List any person named in this application who is over the age of 18 and has lived in another country in the past three years.

NAME OF PERSON	COUNTRY	DATES LIVED IN OTHER COUNTRY (MONTH/YEAR)

If none, check here N/A

Section 10. Financial Assessment Information

Answer this section for the individual applicant, administrator, partners, officers, directors or managerial employees of the entity, and owner of 5% or more of the entity. Place an "x" in the appropriate "yes" or "no" boxes below. Attach additional sheets of paper if needed.

1. Have you ever filed for bankruptcy? Yes No
If "yes", provide the following:

NAME OF THE INDIVIDUAL	WHAT TYPE OF BANKRUPTCY WAS FILED?	DATE FILED	DATE CONCLUDED

2. Have any judgments ever been filed against you or the entity? Yes No
If "yes", provide the following:

NAME OF THE INDIVIDUAL	DATE OF JUDGMENT	COUNTY AND STATE
DESCRIBE THE CIRCUMSTANCES		

Section 11. Consent to Release and / or Use Confidential Information

Each person listed in the application must sign this section.

I consent to the release and use of confidential information about me within the Department of Social and Health Services (DSHS) for purposes of certification. I grant permission to DSHS and any agency, division, office, or the police to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, mail, or hand delivery.

I am aware that the department is required to respond to requests for disclosure of information from the public. The department may only withhold information if a specific disclosure exemption exists. (RCW 42.56, Chapter 388-01 WAC).

Completion of this form allows the use and sharing of confidential information within DSHS and with the individual applicant / agency for application processing purposes. DSHS may disclose and receive confidential information from outside agencies, divisions, offices and/or the police.

This consent is valid for as long as I am the person named in this application. A copy of this form is valid for my permission to release and use this information.

NAME OF INDIVIDUAL APPLICANT	SIGNATURE	DATE
NAME OF ADMINISTRATOR	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT	SIGNATURE	DATE

NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE AGENCY APPLICANT	SIGNATURE	DATE
NAME OF DIRECT SERVICES STAFF PERSON	SIGNATURE	DATE
NAME OF DIRECT SERVICES STAFF PERSON	SIGNATURE	DATE
NAME OF DIRECT SERVICES STAFF PERSON	SIGNATURE	DATE

Section 12. Certification

I certify, under the penalty of perjury under the laws of the State of Washington and by my signature, that the information provided in this application and all additional documents and forms required for Certified Community Residential Services and Support Agency are true, complete, and accurate. I understand that the department may obtain additional information, verification and/or documentation related to my answers or information.

I certify that the administrator is at least 21 years of age or older, has a high school diploma or GED equivalent, and meets the qualification standards per WAC 388-101-3200.

Copies of all documents needed to verify the items in this application are attached, and original documents will be readily available to the department.

I understand that failure to accurately answer or fully complete the questions on this application may result in denial of the certification and / or contract, or other sanctions as allowed by law.

I understand that the department may check the credit of the corporation, individual or business and its principals; obtain a credit report; and verify any responses provided. The department will use such information and may disclose this information to other parts of the department as appropriate. The department may define some or all of such information as public information and also disclose this information to third parties when requested according to law to the extent that such information is not exempt from such disclosure by state or federal law.

I understand and agree that the information I give to the department will be used to verify the information in this application. Any information I give to the department may be used by the department for this purpose.

I understand that if my application for a Certified Community Residential Services and Support Agency is denied, I may request an administrative review within 28 days of receiving the denial letter from DSHS.

I have read Chapters 71A.12, 74.34 RCW, and 388-101 WAC, and any other applicable laws and rules.

If/when I am certified:

- I understand that each staff I employ must meet the requirements of WAC 388-101-3200.
- No clients receiving care and services by the certified community residential services and support provider will be subject to discrimination on the basis of race, color, national origin, gender, age, religion, creed, marital status, disabled or Vietnam veteran's status, or the presence of any physical, mental, or sensory disability.

I certify and declare under penalty of perjury under the laws of the State of Washington that the information in this application and all of the supporting documents are true and correct to the best of my knowledge.

SIGNATURE OF INDIVIDUAL OR AGENCY REPRESENTATIVE AUTHORIZED TO COMPLETE THIS APPLICATION		DATE
PRINT NAME	DAYTIME TELEPHONE NUMBER	
SIGNATURE OF ADMINISTRATOR		DATE
PRINT NAME	DAYTIME TELEPHONE NUMBER	