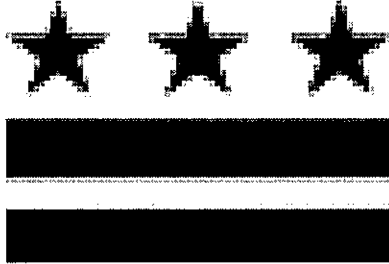

DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

APPLICATION TO OPEN AND OPERATE A MENTAL HEALTH COMMUNITY RESIDENCE FACILITY

Department of Behavioral Health
Office of Accountability
Division of Licensure
November 19, 2014

ITEMIZED MHCRF APPLICATION INSTRUCTIONS

APPLICABILITY

The Licensure / Renewal Application is valid only for entities seeking to obtain a license to operate a Mental Health Community Residence Facility in the District of Columbia.

GENERAL INSTRUCTIONS

1. All applicants must complete Parts 1 through 4 of this Licensure Application.
2. Applicants planning to operate a MHCRF at more than one location must complete the licensure application (one for each location).
3. Applicants must submit materials described in Part 4 with the completed licensure application. The supporting materials must be labeled and submitted in the order listed in Part 4.
4. If questions on this application do not apply to you, please write "N/A" in the appropriate section. Do not leave any blank spaces.
5. The Instruction Sections may be detached from the licensure application; however, keep the completed license application intact.
6. The completed licensure application should be typed or completed electronically.
7. Please submit the completed licensure application and supporting materials to:

District of Columbia
Department of Behavioral Health
64 New York Avenue, Northeast, 3rd Floor
Washington, DC 20002
Attn: Office of Accountability
Division of Licensure

Do not submit this Licensure Application to the Department of Behavioral Health (DBH) if you are not ready to be inspected. After the on-site inspection is completed, a decision will be made concerning the appropriateness for licensure in accordance with the Licensure regulations for Community Residence Facilities for Mentally Ill Persons (Title 22, DCMR, Chapter 38).

<u>Receipt of a MHCRF License does not guarantee the receipt of a DBH Contract</u>.

Part 1 MHCRF Applicant Information

1. **Date of Application:** ____________________

2. **Type of Application:** ☐ **New** ☐ **Renewal**

3. **Full Name of Applicant:**

4 **Business Office Location** (Check all that apply):
☐Headquarters ☐Service Site ☐Other Specify: ______________

4.a **Does MHCRF Owner operate any other business (or group homes) within any other DC, Md. or Va. agencies?** ☐ Yes ☐ No
Indicate Locations:
____

6 **Doing Business As:**

Type of Organization: ☐ Profit ☐ Non-Profit Specify: __________

7 **Business Address:**

8 **City**	9 **State:**	10 **Zip Code:**

11. **Telephone #:**	12 **FAX #:**
13 **E-mail:**	14 **Web Site:**

15 **Name and Title of CEO, MHCRF Owner- Director, Residence Director:**

16 **Has the CEO, MHCRF Program Director, Residence Director been convicted of any crime(s) besides minor traffic offenses?**
☐ Yes ☐ No

If yes, state who/title, charge(s), and jurisdiction(s) where conviction occurred. Add additional sheets if needed for explanation.______________________________________

17 **Federal Employee Identification Number (FEIN):**

18 **D.C. Tax obligations satisfied:** ☐ Yes ☐ No

19. **Request to provide services for:**
☐ _____ persons **Annual Fee** (1 – 5 beds) $**50.00** **$25.00 Late Fee**
☐ _____ persons **Annual Fee** (6 – 10 beds) **$75.00** **$37.50 Late Fee**
☐ _____ persons **Annual Fee** (11–20 beds) **$100.00** **$50.00 Late Fee**

20. **Facility Type:**

a. **Supported Residence (SR)**
☐ Yes ☐ No **(Staff to resident ratio 1:8 whenever a resident is present)**

b. **Supported Rehabilitative Residence (SRR)**
☐ Yes ☐ No **(Staff to resident ratio is 1:8 twenty four hours (24 hrs.) per day whenever a resident is present and 2:8 during periods of peak activity, such as meals and when most residents are home and awake.)**

c. **Intensive Residence (IR)**
☐ Yes ☐ No **(Staff to resident ratio is 2:8 for sixteen hours (16 hrs.) a day whenever a resident is present and 2:8 during periods of peak activity, such as meals and when most residents are home and awake.)**

d. **Is this Current MHCRF Facility in operation ?**
☐ Yes ☐ No **License #:** ____________________

License Date: ____________________

e. **Suspended or Revoked** ☐ Yes ☐ No **Reinstated?** ☐ Yes ☐ No
If yes, specify:____________________________________

Date of Reinstatement: ______________________________

g. **Professional Licensure Information:**
Have any professional staff had their license(s) suspended, restricted, or revoked. ☐ **Yes** ☐ **No**

If yes, identify the employee and disposition. (Attach additional pages if necessary.)

Part 2 MHCRF Property Information

21. **Name of Applicant:**

22. **Address of MHCRF:**

22a. **Ward:**

23 **Address:**

24 **City**	25. **State:**	26. **Zip Code:**

27. **Telephone #:**	28. **FAX #:**
29. **E-mail:**	30. **Web Site:**

31. **Additional Mailing Address:**

32. **City:**	33. **State:**	34. **Zip Code:**

35. **Name of Program or Residence Director:**

36. **Type of home:** ☐ Attached ☐ Detached
☐ Semi-detached ☐ Row ☐ Apartment

a.. **Residential levels in the home (include basement)** ______

b. **Number of toilet facilities available per level:**______________
1st floor: _____ **2nd floor:** _____ **3rd floor:** _____
basement: ____________

d. **Number of hand washing facilities available:** ______________

e. **Bedrooms available per level:**
1st floor: _____ **2nd floor:** _____ **3rd floor:** _____
basement: ____________

f. **Handicap accessible:**
Does the home have a ramp: ☐ Yes ☐ No
Home (are steps required to enter home) ☐ Yes ☐ No
Are doors wide enough to allow wheel chair entry into the following rooms:
Bedroom(s) ☐ Yes ☐ No
Bathroom(s) ☐ Yes ☐ No
kitchen ☐ Yes ☐ No
dining room ☐ Yes ☐ No

Revised: November 19, 2014

Part 3 MHCRF Program Information

37. **Briefly describe any consultant services planned for this site:**	40. **Does the applicant plan to administer medications to consumers?** ☐ Yes ☐ No **If yes, include who will administer medications:** ________________ **Type of License(s):** ________________________ **License Number(s):** ________________________
38. **What is the staff to client ratio at this address:** ☐ 1:1 ☐ 1:8 ☐ 2:8 ☐ Other (describe in detail)	41. **Name the designated back up staff for this location:** _______________ **Name the staff designated to notify DBH that you are out of town or unavailable to provide services at this location:** ___________________ **List both their telephone number which is available 24 hours daily for emergency contact:**____________________
39. **Describe how the MHCRF will assist the Core Services Agency (CSA) in coordinating services to ensure that each resident's health, safety and welfare are protected ?**	42. **Describe how you are able to determine that the mental health professional designated to provide back- up service will be able to reach the residential facility within thirty (30) minutes in case of an emergency:**

Part 3 Program Information

43. Briefly describe MHCRF services planned for this site. You may attach a separate piece of paper for a detailed explanation:	50. Describe how your program will integrate residents into the Community? How will you train staff and residents to react to unfriendly or hostile neighbors?
44. Describe how the MHCRF will provide assistance with activities of daily living ?	51. What is your schedule for MHCRF house meetings for the Residents ?
45. Describe what type of training in working with mental health consumers will your staff receive from the MHCRF prior to being placed on duty.	52. Will the MHCRF owners be in attendance at each staff meeting and at each resident house meeting ?
46. Who within your operation will be responsible for submitting treatment planning information to CSA's for updates ?	53. List and identify on the resume' the required additional two (2) years of experience that the Residence Director has in working with persons with a principal diagnosis of mental illness:
47 What arrangements will you make for you and your staff to participate in treatment planning conferences ?	
48. Describe how you will provide for meals and special diets. 48 a. Where is the home is the emergency food stored ? 48 b. Is the amount appropriate for the number of persons residing in the MHCRF ?	
49. Describe how you will make provisions for family, friends and significant others to visit at the MHCRF ?	

54. MHCRF or Consultant Services planned for this Site

Part 3
Program Information

	Service Provided	Indicate if service is provided by MHCRF (CRF), Consultant (C) or Both (B)			For DMH Verification Only Initials Date
1.	Housekeeping	☐CRF	☐C	☐B	
2.	Laundry Services	☐CRF	☐C	☐B	
4.	Dietary Services	☐CRF	☐C	☐B	
5.	Recreation Activities	☐CRF	☐C	☐B	
6.	Treatment Plan updates to CSA	☐CRF	☐C	☐B	
7.	Schedule Medical Appointments	☐CRF	☐C	☐B	
8.	Schedule Transportation	☐CRF	☐C	☐B	
	OTHER				

Part 4
MHCRF Owner and Staff Information

55. Name of MHCRF Owner:

56. Doing Business As:

57. Home Address:

58. City	59. State:	60. Zip Code:

61. Owner's Telephone #:	62. Cell #:
63. E-mail:	64. Web Site:

65. Additional Mailing Address:

66. City:	66. State:	67. Zip Code:

68. Have you as the MHCRF Owner been convicted of any crime(s) besides minor traffic offenses? ☐ Yes ☐ No
If yes, state who/title, charge(s), and jurisdiction(s) where conviction occurred.

____

____

69. SSA Number:

70. Date of Birth:

71. Name of MHCRF Residence Director:

72. Doing Business As:

73. Home Address:

74. City	75. State:	76. Zip Code:

77. Residence Director's Telephone #:	78. Cell #:
79. E-mail:	80. Web Site:

81. Additional Mailing Address:

82. City:	83. State:	84. Zip Code:

85. Have you as the Residence Director been convicted of any crime(s) besides minor traffic offenses? ☐ Yes ☐ No
If yes, state who/title, charge(s), and jurisdiction(s) where conviction occurred.

____

____

86. SSA Number:

87 Date of Birth:

88. REQUIRED STAFFING INFORMATION

A. Please list names of all staff including MHCRF owners and volunteers
B. Inform DBH Licensure staff of any changes in staff (new hires, staff dismissals, staff reassigned to other MHCRFs, etc.)
C. Submit resume which describes education, training and prior employment, first-aid, CPR, Health Certificate, job description, results of physical exam, results of criminal background check and a current food handler certificate (if required) for each staff person or volunteer who works or performs duties at the MHCRF and can be in direct contact with any consumer.
D. Attach a week day schedule showing complete staff coverage by the week and day including coverage during periods of peak activity

Staff Name	Date of hire or assignment	Position Title	Live in / full time/ part time/ Volunteer	Days/ Hours

88 c. REQUIRED WEEK DAY STAFFING SCHEDULE AND TIME WORKED

Month and Week of: ______________________

Employee	Position	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

*** List time each person works on the day of the week (ex: Sarah- Monday 8am to 4pm; Tom – 4pm to 7 pm)**

Supported Residence (SR) - Staff to resident ratio 1:8 whenever a resident is present)

Supported Rehabilitative Residence (SRR) - Staff to resident ratio is 1:8 twenty four hours (24 hrs.) per day whenever a resident is present and 2:8 during periods of peak activity, such as meals and when most residents are home and awake.

Intensive Residence (IR) - Staff to resident ratio is 2:8 for sixteen hours (16 hrs.) a day whenever a resident is present and 2:8 during periods of peak activity, such as meals and when most residents are home and awake.

Part 4
Checklist of DBH-Required MHCRF Attachments and Required Documents

	MHCRF Information	Submitted	Reviewed by DBH Initials / Date	Approved by DBH
1.	Appropriate license fee (checks and money orders made to D.C. Treasurer)	☐	☐	
2.	Three letters of reference for MHCRF owners	☐	☐	
3.	Resume for MHCRF Owner (s)	☐	☐	
4.	Resume for all staff (including Residence Director and other staff)	☐	☐	
5.	Employment Applications for Residence Director and other staff	☐	☐	
6.	Position Descriptions for MHCRF owner, staff and volunteers.	☐	☐	
7.	Certification of Good Standing (if incorporated)	☐	☐	
8.	Clean Hands Act Certification	☐	☐	
9.	Certificate of Incorporation (if applicable)	☐	☐	
10.	Insurance policy declaration page sent directly to DBH from Insurance Provider	☐	☐	
11.	Personnel policies reflecting wage scales and listing benefits provided for all staff	☐	☐	
12.	MHCRF Emergency Plan and Policy Continuity of Operation Plan (COOP)	☐	☐	
13.	Emergency Food Supply			
14.	MHCRF Grievance Procedure	☐	☐	
15.	MHCRF Emergency Plan and Policy (including staffing)	☐	☐	
16.	Current Fire Inspection Approval	☐	☐	
17.	MHCRF Admission Contract	☐	☐	
18.	MHCRF Program Statement	☐	☐	
19.	MHCRF new staff orientation plan (prior to beginning work, at 6 months of service and annual thereafter)	☐	☐	
20.	Pest Control Program	☐	☐	
21.	Plan to ensure new employees meet requirements for criminal background checks, first aid, CPR and food handlers prior to beginning work	☐	☐	
22.	Certificate of Occupancy (C of O) and /or DCRA Inspection approvals	☐	☐	
23.	Fire Inspection	☐	☐	

*Combined single limit and aggregate limit

For DBH Use Only	
Date Application Received/Initials:__________ **DBH Surveyor Team Assigned:**__________ **Date:**_____ **Comprehensive Desk Review Date:** ______ **Desk Review Date:**__________	**<u>Application Reviewed By:</u>** **Name:** __________ **Title:**__________ **Date:** __________ **Application is:** ☐ **Accepted** ☐ **Returned** **Date Disposition Letter Mailed:**__________ **Date of Survey Report Mailed to Applicant:** __________

Comments: