Instructions for Completing HRD Form 100
Application for License to Operate a
Community Residence Facility (CRF) or Group Home for Persons with Intellectual Disabilities (GHPID)

PURPOSE: In accordance with D.C. Law 5-48, the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983,, licensees and prospective licensees must file an application prior to operating a CRF or group home for mentally retarded persons, and annually thereafter. Licenses, except for provisional and restrictive licenses, are effective for a 12-month period following the date of issue and are **not transferable** and remain the property of the District Government and shall be returned to the Director immediately upon any of the following events:

(a) Suspension or revocation of the license;
(b) Refusal to renew the license;
(c) Forfeiture consistent with § 3102.9; or
(d) If operation is discontinued by the voluntary action of the licensee.

INSTRUCTIONS: This application must be used when submitting a request for an initial license, license renewal or to request specific changes as reflected below:

Line 1 Check the appropriate box as to the reason for submitting the application.

If you are renewing your license, the name and address must appear exactly as it did before on your current license.

If this is an initial license, we recommend that the name of the facility on line 3.A. should be consistent with the name of the facility as it appears on other documents submitted during the initial application process.

If this application is being submitted to reflect a change of address or bed size, a copy of the Certificate of Occupancy must be included (7 beds or more).

Line 2 Select the facility type that corresponds to your intended operation.

Line 3.A. Enter the name of the facility.

Line 3.B. Enter the street address where the facility is physically located.

Line 3.C. Enter the city, zip code, and facility telephone and fax numbers.

Line 3.D. Enter the business mailing address, if different. If it is the same, enter "Same".

Line 3.E. Enter the business office telephone and fax numbers.

Line 3.F. Enter the business E-mail address.

Line 3.G. Enter the agency website, if applicable, or indicate NA.

Line 3.H. Select the appropriate box to reflect if the facility is owned or leased.

Line 4.A. Fill in the total number of facility beds.

Line 4.B. Fill in the number of male and female clients residing on this premises.

Line 4.C. Indicate the number of rotating Direct Support Staff working at this location.

Line 4.D. Indicate if this facility provides 24-hour nursing care.

Line 5 Indicate the appropriate application fee that corresponds to the facility type (refer to the fee schedule on page 1).

Line 6.A. Enter the name of the legal entity who, or whose governing body, has the ultimate responsibility and authority for the conduct of the facility.

Line 6.B. Enter the business mailing address.

Line 6.C. Enter the business owner's home address.

Line 6.D. Only one block per category (1) and (2) shall be checked. If the license is for a renewal, and you check any block different from the previous application, you must attach a full explanation and any other pertinent documentation to support the change. (Note: You cannot arbitrarily change from a sole proprietorship to any other category without submitting articles of incorporation, or other official notarized agreement if a partnership.

Line 6.E. Enter the name, title, mailing address, and phone number of the licensee's governing body. If a sole proprietorship, enter the individual's name. Generally, the governing body is a board of directors elected or appointed and is usually within the organization or entity that is the licensee.

Line 6.F. Self explanatory

Line 6.G. Self explanatory

Line 6.H. Self explanatory

Line 7.A. Select the appropriate prefix for the facility's residence director.

Line 7.B. Enter the name of the facility's residence director.

Line 7.C. Enter the title and date of birth of the facility's residence director.

Line 7.D. Self explanatory

Line 7.E. Self explanatory

Line 7.F. Self explanatory

Line 7.G. Self explanatory

Line 7.H. Self explanatory

Line 7.I.Self explanatory

Line 7.J. Self explanatory

Line 8.A. Enter the information regarding hazard insurance coverage and attach documentary evidence or binder.

Line 8.B. Enter the information regarding liability insurance coverage and attach documentary evidence or binder.

Line 9 Self explanatory

FEES: A fee in the amount of **$50.00** shall be charge to a CRF for each inspection after the first follow-up annual license renewal inspection

A fee in the amount of **$50.00** shall be charge for the validation or duplication of any license (s).

Should you have any questions or require assistance, please call (202) 724-8800 and one of the Intermediate Care Facilities Division Specialists will be able to assist you.

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION

APPLICATION FOR COMMUNITY RESIDENCE FACILITIES (CRF) & GROUP HOMES FOR PERSON WITH INTELLECTUAL DISABILITIES LICENSURE (GHPID)

In accordance with **D.C. Law 5-48, the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983,** licensees and prospective licensees must file an application prior to operating a community residence facility or a group home for mentally retarded persons, and annually thereafter. Licenses, except for provisional and restricted licenses, are effective for a 12-month period following the date of issue. License applications shall be notarized.

A fee in the amount of **$50.00** shall be charge to a CRF for each inspection after the first follow-up annual license renewal inspection

A fee in the amount of **$50.00** shall be charge for the validation or duplication of any license (s).

Please note that no inspection will be conducted unless a completed application and the appropriate licensure fee has been received to this office. **The appropriate license fee should be submitted in the form of a check or money order made payable to "D.C. Treasurer."**

License Fees for **ICF/ID** (certified homes)

No. of Beds	Annual	Late
1 – 4	$65.00	$32.50
5 – 8	$130.00	$65.00
9 and above	$195.00	$97.50

License Fees for **CRFs & GMPID** (licensed only)

No. of Beds	Annual	Late
1 – 5	$65.00	$32.50
6 –10	$97.00	$48.50
11 – 20	$130.00	$65.00
21 – 40	$195.00	$97.50
41 – 60	$260.00	$130.00
61– 80	$325.00	$162.50
81– 100	$390.00	$195.00
101– 150	$455.00	$227.50
151– MORE	$520.00	$260.00

1. REASON FOR APPLICATION:

☐ Initial Licensure

☐ License Renewal # _____ which expires _____.

☐ Change of (Check one or more)

☐ (1) address of facility from _____

to _____

☐ (2) number of beds from _____ to _____. (A copy of Certificate of Occupancy must be attached that reflects the change when there is increased capacity) – (7 or more beds)

2. TYPE OF FACILITY: _____ Level 1 (**GHPID**) _____ Level 2 (**ICF/ID**) _____ Level 3 (**GHPID - Medicaid Waiver**) _____Level 4 (**CRF CHAPTER 34**)

3. FACILITY IDENTIFICATION:

A. _____
(Name of facility to be licensed)

B. _____
(Street Address)

C. _____
(City) **(Zip Code)** **(Telephone #)** **(Fax #)**

D. _____
(Business Mailing Address, if different) **(City)** **(State)** **(Zip Code)**

E. _____
(Business Office Telephone #) **(Business Office Fax #)**

G. Facility or agency website, if applicable _____

H. Relationship of licensee to Facility is (Check one) [ ] Owner [ ] Lease

4. DESCRIPTION OF FACILITY:

A. Number of Beds: _____

B. _____Females _____Males

C. Number of rotating Direct Support Staff _____

D. Do you provide 24 hour nursing care? Yes No

5. APPLICATION FEE $_____ Make check payable to D. C. Treasurer (fee is not refundable)

6. Licensee: (The legal entity who, or whose governing body, has the ultimate responsibility and authority for the conduct of the facility: the owner of the business; with whom rests the ultimate responsibility for maintaining applicable licensing requirements for the facility).

A. _____
(Name)

B. _____
(Business Mailing Address) (City) (State) (Zip Code)

C. _____
(Home Address of Business Owner) (City) (State) (Zip Code)

D. Check one of the following characteristics in each of the two categories that applies to the licensee:

(1) Profit Not for Profit (Non Profit)

(2) Sole Proprietorship Partnership Limited Partnership Corporation (Submit current letter of Good Standing)

E. Name the principals/officers of the licensee: (such as CEO, President, VP, Secretary, Treasurer, Director – attach additional sheet if needed)

Name: Address: Title: Phone:

_____

_____

_____

_____

F. Have you previously operated or been licensed to operate a group home/CRF in the District of Columbia? __Yes __No

G. If yes, was the license ever suspended or revoked? ____Yes ____No
If yes, provide explanation _____

H. Is there any license application, Notice of Infraction or enforcement action pending as a result of your operation of a business in the District of Columbia? ____Yes ____No

If yes, provide explanation _____

7. FACILITY STAFFING:

A. Name of Residence Director: Prefix: Mr. □ Mrs. □ Ms. □ Other: _____

B. First Name: _____MI: _____ Last Name: _____

C. Title: _____ Date of Birth: _____ / _____ / _____
mm dd yy

D. Highest Level of Education Completed: _____

E. Name of Qualified Mental Retardation Professional (QMRP): _____

Other Professionals on Staff, if applicable

F. Name of Director of Nursing: _____

G. Name of Primary Care Physician(s): _____

H. Name of Licensed Practical Nurse(s): _____

I. Name of Trained Medication Employee(s): _____

J. Names of Live-in Staff (if applicable): _____

8. INSURANCE COVERAGE:

(Attach documentary evidence of financial responsibility on the part of the applicant as stipulated below):

A. Hazard (Fire and extended coverage) Minimum of $500 per resident or $2000 per facility.

Name/Address of Company _____

Amount of Coverage: _____

B. Liability Insurance - Minimum of three hundred thousand ($300,000) per occurrence.

Name/Address of Company _____

Amount of Coverage: _____

Professional Liability (Explain): _____

9. AFFIDAVIT:

I, _____ hereby swear or affirm that the information provided in or with this application is true and correct and does comply with administrative and procedural requirements.

Sworn and subscribed to before me this _____day of_____20___.

_____ _____

Notary Public **Signature(s) of Applicant**

_____

Title

My commission expires_____ **(Seal)**

Mail completed application to:

DOH-Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol Street, NE, 2nd Floor
Washington, DC 20002

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.