Office of Health Facilities Application for Intermediate Care Facilities for Individuals with Intellectual Disabilities Reference Guide for New Applicants





Log In to the platform

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Enter your username and password.

TIP: If you don't have an account click the

Click the **Log In** button.

Create New Account link.

	DEC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA GOVERNMENT OF THE DISTRICT OF COLUMBIA
	Welcome to the Office of Health Facilities Portal The Health Regulations and Licensing Administration (HRLA) promotes public safety by ensuring medical facilities maintain compliance with district mandates and health codes. Login or Create an Account to:
Forgot username?	About DC Health DC health promotes health, wellness, and equity, across the Disctrict, and protects the safety of residents, visitors and those doing business in our nation's Capital. Our Responsibilities include identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.





Navigate to the New Application screen



Once you Log in to the Office of Facilities Portal, click the **New Application** tab.

	DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA	DOMORIEL DOM
DC HEALTH Home New Application Application History Support	٩	Search
Welcome to the Office of Facilities Portal DC Health protects our citizens by ensuring proper licensure for various intermediate and healthcare facilities in the Dist What's the status of my application?	trict of Columbia.	





Select the Facilities New Application

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Select the Intermediate Care Facilities for Individuals with Intellectual Disabilities option from the list.



Click the **Next** button.

		Facilities New Application	
	Please Select Application Type: Ambulatory Surgery Center		
	Assisted Living Residency		
	Child Placement Agency Community Residential Facility for the Elderly		
	Community residential Facility for the Eldeny Community Residential Facility for the Intellectually Disabled		
	O Home Care Agency		
	Home Support Agency		
7	Hospital Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIID)		
ч	Maternity Center		
	Nurse Staffing Agency		
	O Nursing Home		
			2
			Next





Select the Application Sub Type

Select the **Initial** option from the drop-down list.

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Click the **Next** button.

HEALTH Home <u>Ne</u>	w Application Application History	Support		Q. Sunt et aliquam voluptatem sunt ad.	Dani Biancio
	Application	on for Intermediate Care Facilities for	Individuals with Intellectual Disab	bilities (ICFIID) Licensure	
Please Select Applicat	tion Sub Type:				
Initial					\$
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				Prev	ious Next





Accept Disclosure

Read the **Disclosure** text.

Click the **Next** button.

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	Disclosure
or group home for mentally retarded persons, and annually thereafter. Licenses, except for provisional and	Care Licensure Act of 1983, licensees and prospective licensees must file an application prior to operating a CRF Id restrictive licenses, are effective for a 12-month period following the date of issue and are not transferable and n
property of the District Government and shall be returned to the Director immediately upon any of the fo	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.	
	L <mark>2</mark>





Fill out the Facility Information

Fill out all the required fields.

Click the Save & Next button.

TIP: If needed, select the **Mailing Address** (if different from Street Address) check box.

	Facility Information	
* Type of Facility Level 1 (GHPID)		;]
* Facility Name Rosario Klocko	"Street Address	
*City Alanshire	-State	
		_
* Zip Code	*Telephone Number	
85897	780-863-0266	
* Fax		
123-046-5401		
Website (if applicable)	* Relationship of licensee to facility	
62767-5990	Lease	:
* Number of Beds	* Females	
440	10	
* Males	* Number of rotating Direct Support Staff	
	30	
30		
* Do you provide 24 hour nursing care?		
	÷	
* Do you provide 24 hour nursing care?	;	
* Do you provide 24 hour nursing care?	;	Save & Next

The fields marked with * are mandatory and must be filled out to continue.



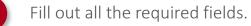
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Fill out the Licensee Information

The licensee is the legal entity who has the ultimate responsibility and authority for the conduct of the facility.



Click the Save & Next button.

TIP: If needed, use the **Upload Files** button to attach needed documentation.

ALTH Home <u>New Application</u> Application History Support	Q, Ut in ex debitis labore sapiente fugi	iat iusto. Dani Bian
10920	VT	•
10220		•
Business Owner Address:		
*Address	°City	
941 Kling Terrace	Mariloutown]
* State	*Zip Code	
↓ WY	01148	
* Profit or Non-Profit?		
Non-Profit		\$
*Business Type 🕚		`
Sole Proprietorship		\$
*Have you previously operated or been licensed to operate a group home/CRF in the District of Columbia?		
Yes		
If yes, was the license ever suspended or revoked?		
No		
If yes, provide explanation.		
* 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?		
No		
If yes, provide explanation.		
·		
1 Upload Files Or drop files		
· · · · · · · · · · · · · · · · · · ·		
		2 Save & Next





Fill out the Principals/Officers Information

Fill out all the required fields.

Click the Save & Next button.

TIP: If needed, select the **Add more Principal/Officers?** check box and complete the fields with the required information.

1 Principal/Officer of the Liv	censee - 1					
* First Name		Middle Name			* Last Name	
Marcus		Eulalia Harvey]	Shields	
* Street Address			*City			
10752 Nicolas Ville			Marquardtton			
* State	*State		*Zip code			
WY	WY t		14032			
*Telephone Number		*Email				
602-353-2735			your.email+fakedata90390@gm	mail.c	om	
*Title						
Product Configuration Strateg	ist					
			Add more Principal/Officers?			
			Add more Principal/onders?			
					Pri 2 Save	e & Next





Fill out the Facility Staffing Information

Fill out all the required fields.

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Click the Save & Next button.

Far	cility Staffing
Residence Director:	
* Prefix	*Name
Ms. or Mrs.	\$ Shanny Mayer
*Title	* Highest Level of Education Completed
Investor Markets Consultant	Gerlach LLC
* Name of Qualified Mental Retardation Professional (QMRP)	
Chaz Smith	
	onals on Staff, if applicable
Director of Nursing	Primary Care Physician(s)
Name	Name
Tressie Lebsack	Maudie Deckow
Licensed Practical Nurse(s)	Trained Medication Employee(s)
Name	Name
Abelardo Mayer	Immanuel Bergnaum
Live-In Staff	
Name	
Noah Kertzmann	





Fill out the Insurance Coverage Information

Fill out all the re	equired fields
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Click the Save & Next button.

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TIP: If needed, use the **Upload Files** button to attach needed documentation.

Insurance Coverage Attach documentary evidence of financial responsibility on the part of the applicant as stipulated below		
Action documentary ervence or manual reportations on the part of the applicant as supplied before		
Hazard (F)	e and extended coverage) Minimum of \$500 per resident or \$2000 per facility	
* Agency Name	*Street Address	
Melany Runolfsdottir	652 Dylan Crescent	
*City	*State	
New Rosanna	MA	
* Zip Code	*Amount of Coverage	
52862	500	
*Agency Name Devan Beier	* Street Address 87903 Trantow Via	
° City	- State	
Beatriceside	AL	
* Zip Code	*Amount of Coverage	
95077	2,000	
Professional Liability (Explain)		
1 Upload Files Or drop files		





Payment Selection

The Payable Amount depends on the number of beds filled out in the Facility Information screen.



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Check if **Payable Amount** is correct.

Click the **Save & Next** button.

				Payment Selection				
 In orde	r your application to be pro	ocessed, you must submit	payment. Upon transaction app	 proval, please click next to	Certify & Submit.			
			Number of Beds : 440	1	Payable Amount : \$520.	00		
							2 Sav	e and Next
L								





Payment Wizard



Fill out the **Billing Address** and **Payment Info** fields.



Click the **Pay** button.

	- ease complete the payment for your application using the form below. Click "Pay" when you are done inputting y		Wizard payment details. If you are unable to	o pay at this time, you ma	y exit this saved draft and return to	it in the
	pplication History" tab of the portal header later. ter your payment has processed, click "Next" below to certify and submit the application. Your ap	pplic	ation will not be reviewed unti	il these steps have bee	n completed.	
1				-	-	
	Billing Address	1		Payment Info	D	
	4104 Franecki Lodge	J	Duncan Franecki			
	1317 Stracke Key	J	3714 496353 98431			9211135920 D5240353
	East Ernafurt]	10 / 25			?
	North Dakota]				
	56442					
		, 				
					2 Pay 5	520.00
	Click the Next button at the bottom of t	his I	page to Certify & Submit	the application.		
					Previou	us Next

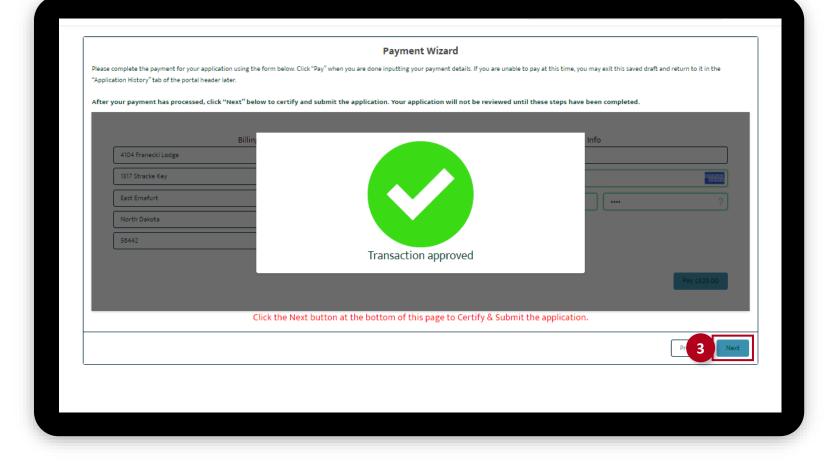


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Payment Wizard

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Once the **Transaction** is approved, click the **Next** button.







Certify and Submit

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Fill out the Name field.

Click the **Submit** button.

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	Certify and Submit					
	By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penaltie Health.					
	*(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columbia Official Code, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect;					
	(b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days Attorney General for the District of Columbia or one of the Attorney General's assistants.	or both. A violation of this section shall be prosecuted by the				
	By electronically entering my name on this form, I attest that all statements are true and accurate.					
	*Name					
	Damion Batz					
	Date					
	January 24, 2023					
		2 Submi				





Close the Application

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You have finished submitting your application. Click the **Close** button.

HEALTH Home New Application A	pplication History Support		Q Officiis dolorem repellat dolores cupiditate asperiores ex	Dani Bianciotti 👻
	Succe	ssful Submission		
You have successfully submitted your ICF	application. Once review is complete, you will be notified by our tea	m. You may now hit the "Close" button or clo	se your browser.	
			1	Close



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E-mail Confirmation

Thank you for your payment! You have successfully completed payment for an application on the Program of Facilities portal. Transaction details: Date and time: 10/31/2022 10:14 AM Transaction ID: TRX-000212207 Application Type: intermediate Care Facility for Individuals Amount pairs(5520.00	Dear Dani Blanclotti, You are receiving this email because we have received your application for intermediate Care Facility for individuals via the Facilities Portal. The Department of Health will review your application within 30 calendar To check the continued status of your application log in to the portal: https://dohuat-doh.cs133.force.com/Facilities Need support? <u>Submit your question to the help desk</u>
Need support related to this payment? Submit your question to the help desk and reference Transaction ID TRX-000212207 in your request.	DC Health Emergency Preparedness and Response Administration Program of Emergency Medical Services DCCENERATION OF THE DISTRET OF COLUMNER



Check if you have received confirmation of payment.



Check if you have received confirmation for your application.





Thank you!

