

Ohio Department of Mental Health

Adult Care Facility New Manager Application

General Information and Instructions

The Ohio Revised Code (ORC) requires you to notify the Ohio Department of Mental Health, in writing, if there is a change in the identity of the manager in your adult care facility (ACF) not later than ten days after the change occurs.

Please complete the new manager section of the application, submit three reference forms and mail them to the address below.

Ohio Department of Mental Health
Attention Gregory Lewis
30 East Broad Street, Suite 742
Columbus, OH 43215-3430

The owner is to answer questions 1, 3 – 19, 46 and sign the application.

The manager is to answer questions 47 - 59 and sign the application.

Reference Forms: The new manager must submit three reference forms. These reference forms are to be completed by persons ***not employed by or associated in business with the owner who can provide information about the character, reputation, competence of the owner and the manager and the financial responsibility of the owner.***

To obtain online information regarding the licensure process; e.g. forms, rules (Ohio Administrative Code (OAC) and regulations (Ohio Revised Code (ORC)), visit the Ohio Department of Mental Health web site at <http://www.odmh.ohio.gov>. Questions regarding the licensure process may be directed to our e-mail address, liccertliccert@odmh.ohio.gov or by calling our office at (614) 752-8880.

If you have specific survey questions, please call Deb Givens at the Columbus Office at (614) 466-1323.

10/14/09

ADULT CARE FACILITY Licensure Application

As defined the Ohio Revised Code

App # _____

OHL # _____

Please Print In Ink or Type

1. Application type - **check one only**

Initial Change of Ownership New Manager

Anticipated opening/effective date _____

2. Type of license - **check one only**

Adult family home (3 - 5 residents) Adult group home (6 - 16 residents)

Requested Capacity _____

3. Facility name (DBA)

4. Previous facility name, if applicable

5. Facility address

6. Facility city

7. Facility Zip

8. Facility county

9. Facility phone number

10. E-mail address

Mailing address if different from above

11. Name

12. Address

13. City

14. State

15. Zip

16. How many residents are currently in this home? _____

17. Are there any RSS (Residential State Supplement) residents in this home? No Yes, how many? _____

18. Are there any residents with mental illness in this home? No Yes, how many? _____

19. Does this home plan to admit persons referred by or persons who receive services from ADAMHS board or mental health agency? No Yes, how many? _____

20. **Statement of Ownership:** Individual Association Corporation Limited Liability Partnership

Ownership type: For profit Not for profit

Individual

| | | | |
|----------------------|-----------|----------------|--|
| 21. Name | | | |
| 22. Home address | | | |
| 23. City | 24. State | 25. Zip | 26. Home phone number () |
| 27. Business address | | 28. Occupation | |
| 29. City | 30. State | 31. Zip | 32. Business phone number () |

Association, Corporation, Limited Liability or Partnership

| | | | |
|----------------------------|-----------|-----------------------|-------------------------------|
| 33. Business name | | | |
| 34. Address | | | |
| 35. City | 36. State | 37. Zip | 38. Phone Number () |
| 39. Charter/Registration # | | 40. Date incorporated | |

41. Name of each person who owns 5% or more of this adult care facility business.

42. Name each person who owns 5% or more of this building which will house this adult care facility.

43. Does the operator of this adult care facility currently hold or has the operator ever held a license or certificate from any of the following. **Check "yes" or "no" for each agency below.**

| | | | |
|--|--|-------|---------------------|
| Ohio Department of Job and Family Services | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type: | Date expired / / |
| County Department of Job and Family Services | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type: | Date expired / / |
| Ohio Department of Mental Health | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type: | Date expired / / |
| Ohio Department of Health | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type: | Date expired / / |
| Ohio Department of Mental Retardation and Developmental Disabilities | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type: | Date expired / / |
| Other: | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type: | Date expired / / |

44. Does the owner have 5% or more ownership interest in any adult care facility or any residential or housing facility type listed in rule?

No Yes, provide the following

| Facility Type | Name | Address/City/State/Zip |
|---------------|------|------------------------|
| | | |
| | | |
| | | |

45. Within the last five years prior to the date of this application, has the owner been affiliated through ownership or employment in any adult care facility or any residential or housing facility type listed in rule?

No Yes, provide the following

| Facility Type | Name | Address/City/State/Zip |
|---------------|------|------------------------|
| | | |
| | | |
| | | |

46. Names, ages and work hours of staff members, including the manager.

| Name | Ages | Works Hours |
|------|------|-------------|
| | | |
| | | |
| | | |

47. Manager's name

| |
|--|
| |
|--|

48. What special type of training and educational background related to the care of adults does the manager have?

If none, check here. **None**

| Course Title | School Name/Trainer | Address/City/State/Zip | Dates |
|--------------|---------------------|------------------------|--------------------|
| | | | From: to |
| | | | From: to |
| | | | From: to |

49. What type of work experience related to the care of adults does the manager have?

If none, check here. **None**

| Employer | Address | Duties | Dates |
|----------|---------|--------|--------------------|
| | | | From: to |
| | | | From: to |
| | | | From: to |

50. Within the last five years prior to the date of this application, has the manager been affiliated through ownership or employment in any adult care facility or any housing or residential facility type?

No Yes, provide the following

| Facility Type | Name | Address/City/State/Zip |
|---------------|------|------------------------|
| | | |
| | | |
| | | |

If the owner and manager are not the same persons, answer all of the following questions for both the owner and manager. If the owner is also the manager, answer all of the following questions for the owner.

| | OWNER | MANAGER |
|--|--|--|
| 51. Have you ever been convicted or adjudicated of any crime other than a traffic violation? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 52. Are there any pending criminal prosecutions against you? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 53. Have you ever forfeited bail bond posted to guarantee your appearance in court to answer any criminal charge? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 54. Have you ever been involved as a defendant or respondent in a civil or administrative investigation or action, involving the provision of care or misappropriation of resident funds in any home, facility or institution caring for people? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 55. Have you ever had a license or certificate denied or withdrawn or approval to care for unrelated dependent children or adults, or had any such approval withdrawn? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 56. Have you ever had a professional license denied, suspended or revoked? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 57. Have you ever been convicted or adjudicated of any crime involving financial or business management, theft, fraud or embezzlement? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 58. Have you ever been convicted or adjudicated of any crime related to the provision of care? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 59. Have you ever been convicted or adjudicated of any crime or civil offense relating to assault, battery, abuse, neglect or any other violent crime against an individual? | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |

If the answer to any of the above questions is "YES", attach a separate letter of explanation with a full clarification of each answer stating the charge(s), date(s) and outcome for each incident.

Manager

I, _____, hereby sign this statement of attestation, certifying that I am in compliance

Print manager's name

with the Ohio Administrative Code and the questions 46 through 59 have been answered to the best of my knowledge and belief.

Signature _____

Date ____/____/____

Owner/Representative

I certify that, to the best of my knowledge, the information in the application and any accompanying material is true and accurate and that to the best of my knowledge and belief, all persons in ownership or employment are of good moral character, and that the ownership of the adult care facility possesses sufficient funds to operate this facility in a satisfactory manner.

I understand that section the Revised Code and the Ohio Administrative Code requires the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership, not later than 10 days after the change occurs.

I have access to (paper or electronic) and have read the Ohio Administrative Code the licensure rules for Adult Care Family Homes and Adult Care Group Homes and declare that, to the best of my knowledge, the facility for which this license is requested is in compliance with the rules therein.

Print owner/representative's name

Signature of owner/representative

Date

____/____/____

If a representative of the owner is signing this application, please submit documentation that you are an authorized representative of the owner.

**Adult Care Facility
Reference Form for an Owner/Manager**

Ohio Administrative Code

Facility ID #

This reference form is being completed for the: Owner Manager

Owner/manager name

Facility Name

Address

City

Zip

County

1. Are you employed by or associated in business with the owner/manager of this facility? No Yes

2. Are you in any way related to the owner/manager of this facility? No Yes

3. In your opinion, does the owner/manager have the mental and physical ability to provide personal care services and supervision to residents in this facility? No Yes

4. Do you consider this owner/manager to be capable of budgeting his/her money to operate a facility? No Yes

5. Do you know if the owner/manager has been arrested for or convicted of a criminal offense related to the provision of care to others? No Yes

6. Would you trust this owner/manager to take care of someone close to you? No Yes

7. Do you know of any reasons why this owner/manager should not be an owner/manager of a facility? No Yes

8. How long have you known the owner/manager?

9. How do you know the owner/manager?

If you answered "**YES**" to questions 5 and 7, please explain fully, indicating the number to which question(s) you are responding on the reverse side of this form.

Print your name

Your address

City

State

Zip

Day time phone number

Signature

Date

Please return this form to: Ohio Department of Mental Health, Licensure Program, Attention: Gregory Lewis, 30 East Broad Street, suite 742, Columbus, OH 43215