

Ohio Department of Mental Health

**Adult Care Facility  
Change of Ownership Application**

**General Information and Instructions**

The Ohio Revised Code (ORC) requires you to notify the Ohio Department of Mental Health, in writing, of any change of ownership in an adult care facility (ACF) no later than ten days after the change occurs. No fee is required for the change of ownership.

The following items must be submitted with your application for an **Adult Family Home**:

1. Consent form or copy of the bill of sale.
2. Reference forms.

The following items must be submitted with your application for an **Adult Group Home**:

1. Consent form or copy of the bill of sale.
2. Reference forms.
4. Asset and Liability.
5. Projected Revenue and Expenses.

Please complete the above forms thoroughly and mail them to the address below.

Ohio Department of Mental Health  
Gregory Lewis; Licensure Program  
30 East Broad Street, Suite 742  
Columbus, OH 43215

**Reference Forms**: All ACF owners/managers must submit reference forms. Enclosed are six reference forms. Three reference forms are to be completed for the owner and three for the manager. If the owner and manager are the same, only three reference forms are required. 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 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](mailto:liccertliccert@odmh.ohio.gov) or by calling our office at (614) 752-8880.

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

# ADULT CARE FACILITY Licensure Application

As defined in 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?

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?

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 residential or housing facility?

No  Yes, provide the following

Facility Type	Name	Address/City/State/Zip

	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 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 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 #
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This reference form is being completed for the: <input type="checkbox"/> Owner <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Are you in any way related to the owner/manager of this facility?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Do you consider this owner/manager to be capable of budgeting his/her money to operate a facility?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Would you trust this owner/manager to take care of someone close to you?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7. Do you know of any reasons why this owner/manager should not be an owner/manager of a facility?	<input type="checkbox"/> No <input type="checkbox"/> 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  
30 East Broad Street, Suite 742, Columbus, OH 43215-3430

# Instructions for Completing the Asset and Liability Statement

## **INTRODUCTION**

The adult group home (AGH) Asset and Liability Statement identifies the assets which will be available as of the date of this form is completed for use in operating an AGH and the current liabilities which represent claims of creditors against these assets.

You may use the attached form to submit the required information or as a guideline to submit the information on forms used by your business.

## **INSTRUCTIONS**

Because this form has been designed to accommodate the spectrum of AGHs from individual businesses to corporations, not all of the blanks will be applicable to all AGHs. As a result, it is anticipated that in many cases, several additional lines will need to be added under the "other" categories.

If you need assistance with completing this form, it is suggested that you contact an accountant or a financial person.

Filling in the applicable blanks of the current and fixed asset category and totaling completes the left hand or asset side of the form as indicated. Similarly, current liabilities, other liabilities and stockholders' or owners' equity should be totaled to obtain total equities for the right hand or liability and equity side of the balance sheet. Total assets must equal total equity. Definitions of the individual components of the balance sheet are below.

## **ASSETS**

**Current assets** - These are assets which can be converted to cash quickly; and are therefore, reserved as ready sources of cash to meet immediate requirements.

**Cash** - Enter the total of all forms of cash you have available which will be used to support the operation of the AGH. Items to be used to compute this value include currency, cash in checking accounts and in passbook savings accounts. The amount shown must be available to support the operations of the AGH.

**Accounts Receivable** - Any monies owed to the applicant, which are due within one year and would be used as they materialize, if necessary, in support of the AGH operations.

**Other** - Any other assets such as prepaid expenses, which could be converted into cash within the operating year and used for operation of the AGH.

**Fixed Assets** - These are tangible, relatively long-lived resources. If they have been acquired in the last year, they must be listed at the actual measurable money amount they were acquired for. If they have been owned form more than one year, such a person who is converting a home into an AGH, they should be listed at their fair market value. Although this method of determining value is needed to adequately analyze an AGH's ability to operate, operators are cautioned that generally accepted accounting principles require that assets be listed at the dollar amount actually paid for them. As a result, this statement may not be appropriate for other uses by the AGH such as income tax preparation

**Land** - Enter the amount paid for the land or fair market value as applicable.

**Buildings** - Enter the amount paid for the building or fair market value as applicable.

**Equipment** - Enter the amount paid for the equipment or the fair market value as applicable.

## **LIABILITIES**

Liabilities are claims of outsiders against the AGH. Liabilities are reported, as the amount owned as of the asset and liability statement date, including interest accumulated to the date. Interest that will be owed subsequent to the asset and liability statement date is excluded.

**Current liabilities** - These are existing liabilities which must be paid within the next 12 months.

**Accounts payable** - The amount entered here should include the sum of the total unpaid salaries and payments of all unpaid bills and financial obligations which fall due within the next 12 months with the exception of mortgage payments and installment loans. Examples include: utility bills, unpaid wages to current employees, if any, charge accounts and credit cards such as VISA, MasterCard, American Express, etc.

**Other** - This amount should include any other existing obligations, which are due the next 12 months. It includes payments of obligations, which are in arrears such as income taxes, property taxes, insurance, etc. Each item in this category must be itemized separately.

**Mortgage Payable** - These include all first, second and other mortgages owed. Includes the unpaid balance of mortgage owed on land, building, equipment or other assets.

**ASSET AND LIABILITY STATEMENT  
Adult Group Home Use Only**

Facility ID #

Asset and Liability Statement as of \_\_\_\_/\_\_\_\_/\_\_\_\_

Facility Name	
Owner's Name	

<b>Current Assets</b>		<b>Current Liabilities</b>	
Cash	\$	Accounts payable	\$
Monetary investment	\$	Other - itemize	\$
Accounts receivable	\$	Other - itemize	\$
<b>Total Current Assets</b>	\$	<b>Total Current Liabilities</b>	\$

<b>Fixed Assets</b>		<b>Other Liabilities</b>	
Land	\$	Mortgage payable	\$
Buildings	\$	Other - itemize	\$
Equipment	\$	Other - itemize	\$
Equipment	\$	Other - itemize	\$
Other - itemize	\$	Other - itemize	\$
<b>Total Fixed Assets</b>	\$	<b>Total Other Liabilities</b>	\$

<b>Total Assets (Current + Fixed)</b>	\$	<b>Total Liabilities &amp; Equity (Current + Other)</b>	\$
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# Instructions for Completing the Statement of Projected Revenues and Expenses

## INTRODUCTION

The Statement of Projected Revenues and Expenses provides financial information regarding anticipated revenue (income) to the Adult Group Home (AGH) as well as anticipated operating expenses for the first 12 months of operation from the date of the application for a license.

You may use the attached forms to submit the required information or as a guideline to submit the information on forms used by your business.

## INSTRUCTIONS

The Statement of Projected Revenues and Expenses has been designed to accommodate the spectrum of AGHs from small individual owners to corporations. As a result, in some cases many of the lines will not be applicable and should be left blank. In other cases, additional items will need to be added to the "other" categories. Amounts entered are to be based on valid sources of revenue and a realistic determination of anticipated expenses. The requested data is critical to the evaluation of the AGH's capacity to operate effectively and meet essential financial obligations during the first 12 months of operation. When completing this form, do not include any revenue or expenses, which are not directly associated with the operations of the AGH.

To predict the success or failure of the AGH as accurately as possible, the revenue and expenses are to be displayed monthly for the first 12 months of operation. In this matter, it can be demonstrated when probable early losses become profits. At the option of the AGH operator, additional months may be projected.

## DEFINITIONS

- 1. Private Pay Residents** - Indicate the anticipated number of private pay residents in the AGH the last day of each month.
- 2. Number of SSI Residents** - Indicate the anticipated number of SSI residents on the last day of each month.
- 3. Number of RSS Residents** - Indicate the anticipated number of RSS residents on the last day of each month.
- 4. Resident Fee - Private Pay** - Indicate the proposed fee to be charged each private pay resident. If variable rates are charged, list the average fee.
- 5. Average Resident Fee - SSI** - Indicate the current SSI rate.
- 6. Average Resident Fee - RSS** - Indicate the current RSS rate.

## Anticipated Revenue (Income)

This section should reflect anticipated monthly income from valid sources to the AGH. It should not include the personal income of the applicant(s) unless this income is to be used for operating the AGH. Amounts shown should be as accurate as possible and supported by confirming documentation to the maximum extent feasible.

- 7. Fees for Residents** - The anticipated revenue, which will be received each month as, fees or payments for residents' care should be entered here. This figure can be obtained by multiplying the number of residents by the applicable monthly resident fees.
- 8. Endowments/Trust Funds** - Enter the revenue to be received for the next 12 months from any endowments or trust funds, which currently exist and would provide income to be used to support the AGH operations.
- 9. Donations/Solicitations** - Enter income to be received from such sources as religious or fraternal organizations, United Way, fund drives and solicitations and any other fund-raising activity.
- 10. Income from Investments** - Enter income to support AGH operations which will be provided by any existing investments.
- 11. Other (Specify)** - Enter the amount of income to be received from any other source(s) which will be used to operate the AGH. Specify each source and the amount.

- 12. Total Revenue** - Add lines 1 through 11.
- 13. Food/Groceries** - The amount to be entered here is the anticipated cost to be used in the AGH. It includes the food required for three meals each day, and the cost of snacks, which are required to be available on a daily basis. This amount should not include the cost of food that is provided for the staff.
- 14. Salaries of Wages** - The cost of salaries and wages for all staff.
- 15. Utilities** - The cost of gas, electric, heating oil, water and sewage should be listed here.
- 16. Maintenance and Repairs** - This entry should reflect the cost of all items used to maintain and carry out necessary repairs on the home. This would include such items as paint, lumber, nails, roofing materials and grass seeds.
- 17. Rent or Mortgage** - The cost of AGH rent or mortgage should be entered here.
- 18. Taxes** - Enter the amount of all taxes that must be paid by the home. This would include employer's FICA (Social Security) taxes and Federal Unemployment taxes which must be paid on employees' salaries and wages, as well as business licenses taxes, property taxes and real estate taxes (if not included as part of the mortgage payment, etc.)
- 19. Laundry and Linens** - This item would reflect the cost of soap, detergents, etc., required for laundry of table linens, bed linens, etc. used by the AGH and the cost, if any, for outside laundry services.
- 20. Transportation** - Include here all expenses related to the maintenance, operation and insurance costs of cars, vans, trucks, etc. owned by the AGH and/or used in support of the operation of the AGH.
- 21. Insurance** - The cost of all insurance for the physical plant, such as fire and liability insurance, is shown here, as well as interest payments on any outstanding long-term debts not included in the rent or mortgage payments.
- 22. Other** - Include the cost of any items of expenses not included in the above items. Specify each item of expense included here and the expense amount.
- 23. License Fee** - Cost of license fees, e.g. AGH, food service.
- 24. Total Expense** - Include the total of all the expenses listed in lines 13 through 23.
- 25. Net Income (Loss)** - Subtract the total expense line (line 24) from the total revenue line (line #12) to get the net income (loss).

**STATEMENT OF PROJECTED REVENUES AND EXPENSES**

**ODMH Adult Group Home Use Only**

Facility ID #
---------------

Facility Name
Owner's Name

	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	<b>TOTALS</b>
<b>Number and amount on last date of month</b>													
1. Number of private pay residents													
2. Resident fee - Private pay													
3. Number of SSI residents													
4. Resident fee - SSI													
5. Number of RSS residents													
6. Resident fee - RSS													
<b>Anticipated Revenues</b>													
7. Fees from residents													
8. Endowment/trust funds													
9. Donations/solicitations													
10. Income from investments													
11. Other													
<b>12. Total Revenue (7 - 11)</b>													
<b>Anticipated Expenses</b>													
13. Food/groceries													
14. Salaries/wages													
15. Utilities													
16. Maintenance and repairs													
17. Rent/mortgage payment													
18. Taxes (property, sales, etc.)													
19. Laundry/linens													
20. Transportation													
21. Property & liability insurance premiums													
22. Other													
23. License fees													
<b>24. Total Expenses (13 - 23)</b>													
<b>25. NET INCOME</b>													
SUBTRACT LINE 24 FROM LINE 12 = LOSS													

## CHANGE OF OPERATOR/OWNER CONSENT FORM

I/We, \_\_\_\_\_, current licensed operator of the home/facility listed below hereby grant notification to the Ohio Department of Health that a new individual or entity will be applying for a license for this home/facility.

### **CURRENT**

Operator/Owner Name		
Home/Facility Name	ID #	
Home/Facility Address		
City	State	Zip

### **NEW**

Operator/Owner Name		
Address		
City	State	Zip

I understand that operation of the facility may continue while the above individual or entity's application is being processed as long as my license remains in effect. I hereby agree to preserve the validity of my license until final action is taken upon the application, unless I notify you in writing to the contrary. I understand that my license will be terminated upon issuance of a license to the applicant.

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Ohio Department of Mental Health  
(614) 752-8880