



STATE OF CONNECTICUT
 DEPARTMENT OF PUBLIC HEALTH
 FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

[] INITIAL [] RENEWAL

NOTE: A separate application must be completed for each licensed level of care which is located at a different address. One (1) application may be submitted for multiple levels of care provided each level of care has the same name and the same licensee and is located at the same address.

In accordance with Section 19a-491 and/or Section 19a-506 of the Connecticut General Statutes, application is hereby made for a license to operate the following (please check the appropriate box/boxes that apply):

- | | |
|--|---|
| <input type="checkbox"/> Assisted Living Services Agency | <input type="checkbox"/> Infirmary Operated by an Educational Institution |
| <input type="checkbox"/> Children’s Hospital | <input type="checkbox"/> Maternity Home |
| <input type="checkbox"/> Chronic and Convalescent Nursing Home | <input type="checkbox"/> Maternity Hospital |
| <input type="checkbox"/> Chronic Disease Hospital | <input type="checkbox"/> Outpatient Clinic |
| <input type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> Outpatient Dialysis Unit |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Outpatient Surgical Facility |
| <input type="checkbox"/> Home Health Care Agency | <input type="checkbox"/> Residential Care Home |
| <input type="checkbox"/> Homemaker-Home Health Aide Agency | <input type="checkbox"/> Rest Home with Nursing Supervision |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Well Child Clinic |
| <input type="checkbox"/> Hospital for Mentally Ill Persons | <input type="checkbox"/> Mental Health Day Treatment |
| <input type="checkbox"/> Mental Health Psychiatric OutPat. | <input type="checkbox"/> Mental Health Community Residence |
| <input type="checkbox"/> Mental Health Intermediate Tmt. | <input type="checkbox"/> Mental Health Residential Living |
| <input type="checkbox"/> Substance Abuse & Dependence | |

Please respond to all of the following questions:

1. _____
 Facility “d/b/a” (doing business as) Name

Business Address	City	State	Zip Code	Telephone
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Mailing Address (if applicable)	City	State	Zip Code
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Phone: (860) 509-7444
 Telephone Device for the Deaf (860) 509-719
 410 Capitol Avenue - MS # 12HFL
 P.O. Box 340308 Hartford, CT 06134



An Equal Opportunity Employer

9. Respond to the specific question that reflects the ownership structure of the licensee. **The Licensee is the legal entity which will be issued the license to operate.**
- A. If the Licensee is a **general partnership, limited partnership or limited liability company**, complete Form 1 (attached).
 - B. If the Licensee is a **trust**, complete Form 2 (attached) for the Licensee.
 - i. Attach a list including the name, address and telephone number of all trustees.
 - C. If the Licensee is a **corporation (profit or non-profit)**, complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.
 - i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
 - ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.
10. Attach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement.
11. Attach evidence of current compliance with the worker's compensation insurance coverage requirements in the form of one of the following:
- A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
 - B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
 - C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)
12. Ownership of Real Property
-
- Name _____
-
- Business Address City State Zip Code Telephone
13. Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Local Fire Marshal. **NOTE: Hospitals must have a separate Fire Marshal's Certificate of Inspection completed for each building on the hospital's campus and each satellite listed on the hospital's license. Additional forms may be copied if necessary. Each completed Fire Marshal's Certificate of Inspection that is submitted must have an original signature. (Not applicable for ALSA's, Homemaker Home Health and Home Health Agencies).**

FOR OFFICE USE ONLY

CHECK # _____ AMOUNT \$ _____

DATE RECEIVED _____ INITIALS _____

14. Affidavit of Owner:

I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

Signature

Date Signed

Check one as applicable:

- Individual/Sole Proprietor
- General/Managing Partner
- President of Corporation
- Secretary of Corporation
- Municipal Officer
- Trustee

State of Connecticut)

County of _____) ss _____ 20_____

Personally appeared before me the above named _____ and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

- _____
Notary Public []
- Justice of the Peace []
- Town Clerk []
- Commissioner of the Superior Court []

My Commission Expires:
(If Notary Public)



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 1

FACILITY/AGENCY NAME: _____

Form 1 must be completed if the facility/agency is owned/operated by, or the Real Property Owner is, a partnership or a limited liability company. Please copy additional sheets if necessary.

For each partner or manager with a 10% or greater ownership interest in the Licensee/Real Property Owner, provide the information requested below. **Please complete a separate form for each legal entity listed below that is not an individual.**

This information is for: Licensee _____
 Real Property Owner _____

1. Name: _____
 Address: _____
 Telephone: _____
 Please indicate the category which best describes this entity:
 Manager General Partner Limited Partner
 Partner's/Manager's percentage of ownership: _____

2. Name: _____
 Address: _____
 Telephone: _____
 Please indicate the category which best describes this entity:
 Manager General Partner Limited Partner
 Partner's/Manager's percentage of ownership: _____

3. Name: _____
 Address: _____
 Telephone: _____
 Please indicate the category which best describes this entity:
 Manager General Partner Limited Partner
 Partner's/Manager's percentage of ownership: _____

4. Name: _____
 Address: _____
 Telephone: _____
 Please indicate the category which best describes this entity:
 Manager General Partner Limited Partner
 Partner's/Manager's percentage of ownership: _____
 Manager General Partner Limited Partner



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 2

FACILITY/AGENCY NAME: _____

Form 2 must be completed if the facility/agency or Real Property Owner is owned/operated by a trust. Please copy additional sheets if necessary.

For each beneficiary having an ownership interest of 10% or more in the trust, provide the information requested below:

This information is for: Licensee _____
 Real Property Owner _____

1. Name: _____
Address: _____
Telephone: _____
Beneficiary's percentage of ownership: _____
2. Name: _____
Address: _____
Telephone: _____
Beneficiary's percentage of ownership: _____
3. Name: _____
Address: _____
Telephone: _____
Beneficiary's percentage of ownership: _____
4. Name: _____
Address: _____
Telephone: _____
Beneficiary's percentage of ownership: _____
5. Name: _____
Address: _____
Telephone: _____
Beneficiary's percentage of ownership: _____
6. Name: _____
Address: _____
Telephone: _____
Beneficiary's percentage of ownership: _____



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

Attachment 3

FORM 3

FACILITY/AGENCY NAME: _____

Form 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or non-profit). Please copy additional sheets if necessary.

For each stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no owner owns 10% or more of the total shares, please indicate the two largest stockholders. **Please complete a separate form for each legal entity listed below that is not an individual.**

This information is for: Licensee _____
 Real Property Owner _____

1. Name: _____
Address: _____
Telephone: _____
Stockholder's percentage of ownership: _____
Stockholder's occupation with the owner: _____

2. Name: _____
Address: _____
Telephone: _____
Stockholder's percentage of ownership: _____
Stockholder's occupation with the owner: _____

3. Name: _____
Address: _____
Telephone: _____
Stockholder's percentage of ownership: _____
Stockholder's occupation with the owner: _____

4. Name: _____
Address: _____
Telephone: _____
Stockholder's percentage of ownership: _____
Stockholder's occupation with the owner: _____

Department of Public Safety
Division of Fire, Emergency & Building Services
Office of State Fire Marshal



STATE OF CONNECTICUT

On (date) _____, the (Town/City) _____ Office of the Fire Marshal conducted at inspection of (name of facility) _____ located at (address) _____ in the City/Town of _____ to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as a (new/existing) _____ (occupancy classification) _____ as classified by the *CONNECTICUT FIRE SAFETY CODE*. As a result of this inspection, the following conditions were found:

- I. At the time of inspection, no code violations were identified. **Certificate of approval recommended.**
- II. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (See attached information) **Certificate of approval recommended.**
- III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. (See attached information) **Certificate of approval NOT recommended.**
- IV. Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. (See attached information) **Certificate of approval NOT recommended.**

Fire Marshal

Date

City or Town: _____



LICENSURE APPLICATION – ADDITIONAL INFORMATION REQUIRED
HOME HEALTH CARE AGENCY AND HOMEMAKER-HOME HEALTH AIDE AGENCY

1. _____
Facility d/b/a name

2. _____
Address City State Zip Code Telephone

3. _____
Supervisor of Clinical Services
(Your name must appear as it is shown on your professional license)

4. Number of Patient Service Office (if applicable) ____ . Number of Towns Served ____ .

Please provide the addresses for the Patient Services Offices:

(1) _____ (2) _____

(3) _____ (4) _____

(5) _____ (6) _____

5. Services provided by agency staff and/or individual contract:

Nursing ____ Speech Therapy ____ Occupational Therapy ____

Physical Therapy ____ Social Work Services ____ Hospice _____

Homemaker-Home Health Aide ____

Other _____

Forms/hhaddinfo

Home Health Care/Homemaker Home Health Care Agencies.

Please "X" each town served by the Agency

001	Andover	036	Deep River	071	Lebanon	106	Old Saybrook
002	Ansonia	037	Derby	072	Ledyard	107	Orange
003	Ashford	038	Durham	073	Lisbon	108	Oxford
004	Avon	039	Eastford	074	Litchfield	109	Plainfield
005	Barkhamstead	040	East Granby	075	Lyme	110	Plainville
006	Beacon Falls	041	East Haddam	076	Madison	111	Plymouth
007	Berlin	042	East Hampton	077	Manchester	112	Pomfret
008	Bethany	043	East Hartford	078	Mansfield	113	Portland
009	Bethel	044	East Haven	079	Marlborough	114	Preston
010	Bethlehem	045	East Lyme	080	Meriden	115	Prospect
011	Bloomfield	046	Easton	081	Middlebury	116	Putnam
012	Bolton	047	East Windsor	082	Middlefield	117	Redding
013	Bozrah	048	Ellington	083	Middletown	118	Ridgefield
014	Branford	049	Enfield	084	Milford	119	Rocky Hill
015	Bridgeport	050	Essex	085	Monroe	120	Roxbury
016	Bridgewater	051	Fairfield	086	Montville	121	Salem
017	Bristol	052	Farmington	087	Morris	122	Salisbury
018	Brookfield	053	Franklin	088	Naugatuck	123	Scotland
019	Brooklyn	054	Glastonbury	089	New Britain	124	Seymour
020	Burlington	055	Goshen	090	New Canann	125	Sharon
021	Canaan	056	Granby	091	New Fairfield	126	Shelton
022	Canterbury	057	Greenwich	092	New Hartford	127	Sherman
023	Canton	058	Griswold	093	New Haven	128	Simsbury
024	Chaplin	059	Groton	094	Newington	129	Somers
025	Cheshire	060	Guilford	095	New London	130	Southbury
026	Chester	061	Haddam	096	New Milford	131	Southington
027	Clinton	062	Hamden	097	Newtown	132	South Windsor
028	Colchester	063	Hampton	098	Norfolk	133	Sprague
029	Colebrook	064	Hartford	099	North Branford	134	Stafford
030	Columbia	065	Hartland	100	North Canaan	135	Stamford
031	Cornwall	066	Harwinton	101	North Haven	136	Sterling
032	Coventry	067	Hebron	102	North Stonington	137	Stonington

	033	Cromwell		068	Kent		103	Norwalk		138	Stratford
	034	Danbury		069	Killingly		104	Norwich		139	Suffield
	035	Darien		070	Killingworth		105	Old Lyme		140	Thomaston
	142	Tolland		151	Waterbury		160	Willington		169	Woodstock
	143	Torrington		152	Waterford		161	Wilton			
	144	Trumbull		153	Watertown		162	Winchester			
	145	Union		154	Westbrook		163	Windham			
	146	Vernon		155	West Hartford		164	Windsor			
	147	Voluntown		156	West Haven		165	Windsor Locks			
	148	Wallingford		157	Weston		166	Wolcott			
	149	Warren		158	Westport		167	Woodbridge			
	150	Washington		159	Wethersfield		168	Woodbury			

R/forms/hhtowns.doc
Rev. 10-10-01

8. Affidavit of Applicant:

I attest that this agency will only provide hospice services that have complied with Section 19-13-D72(b)(2) of the regulations of Connecticut State Agencies.

I attest that this agency will provide hospice services on an individual basis to clients who fully understand and agree to the provision of services and are made aware of the costs involved prior to the initiation of such services.

Signature

Date Signed

Check one as applicable:

- Individual/Sole Proprietor
- General/managing Partner
- President of Corporation
- Secretary of Corporation
- Municipal Officer
- Trustee

State of Connecticut)
County of _____) ss _____ 20 _____

Personally appeared before me the above named _____ and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

- _____
Notary Public []
- Justice of the Peace []
- Town Clerk []
- Commissioner of the Superior Court []

My Commission Expires:
(If Notary Public)