



North Carolina Department of Health and Human Services
Division of Health Service Regulation
2701 Mail Service Center • Raleigh, North Carolina 27699-2701
<http://www.ncdhhs.gov/dhstr/>

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MEMORANDUM

TO: Adult Care Homes

FROM: Jeff Horton, Chief Operating Officer
Division of Health Service Regulation

DATE: January 13, 2012

SUBJECT: Application for "Pilot Program To Allow Certain Inmates Released From Confinement To Be Placed In Adult Care Homes To Receive Personal Care Services and Medication Management" in Accordance with Session Law 2011-389, House Bill 678

Following is an application to be used for adult care providers interested in participating in the Pilot Program to allow certain inmates released from confinement to be placed in an adult care home in accordance with Session Law 2011-389, Senate Bill 678 (<http://www.ncleg.net/Sessions/2011/Bills/House/PDF/H678v4.pdf>).

The Law gives the Department of Health and Human Services (DHHS) authority to choose one adult care home to participate in the Pilot Program; however, since the adult care home will be expected to admit inmates released from confinement from the Department of Correction (DOC), DHHS will be collaborating with staff in the DOC during the entire Program.

It should be noted, based on review data of the current inmate population that may be eligible for release to an adult care home, it is expected anywhere from 15 – 40 released inmates may be eligible for housing in the adult care home chosen for the Pilot Program. Therefore, applicants are advised that the pool of potential residents may vary from year to year. In addition, Section 1 of Session Law 2011-389, House Bill 678 states:

"The selected adult care home is prohibited from having or admitting any residents other than the inmates selected to participate in the pilot program."

Therefore, the home that is chosen for the Pilot Program will be prohibited from filling empty beds with individuals from the general population.

Please carefully read the instructions for completing the application. Per the instructions on the application, a signed and original copy must be received by DHSR **not later than 5 p.m. on February 29, 2012** in order to be considered for the Pilot Program. If there are questions, do not hesitate to contact me via email: jeff.horton@dhhs.nc.gov or phone: (919) 855-3757 if you have any questions regarding the completion of this application.

INSTRUCTIONS FOR SUBMITTING THE
APPLICATION FOR THE PILOT PROGRAM TO ALLOW CERTAIN INMATES RELEASED FROM
CONFINEMENT TO BE PLACED IN ADULT CARE HOMES TO RECEIVE PERSONAL CARE SERVICES
AND MEDICATION MANAGEMENT

Contact Jeff Horton with the Division of Health Service Regulation at 919-855-3750 regarding questions about this document. Assemble the application according to the following instructions.

- (1) If you use the electronic version of the application (i.e., in Word 97), type the response immediately after each question. If you do not use the electronic version of the application, retype each question from the application and type the response after each question.
- (2) Completed tables should be located in the same place they appear in the blank application form.
- (3) If you conclude that a question is not applicable to your facility, type "NA" after the question and briefly state your reasons for concluding that the question is not applicable.
- (4) Type any number of questions and answers on a single page, as space permits, but begin the first question of each of the twelve sections at the top of a new page so that a tabbed divider can be placed in front of each section. Use only one side of the page (i.e., do not duplex).
- (5) If exhibits are provided, please provide a table of contents for the exhibits.
- (6) Do not forget to complete the "Authenticating Signature" on the last page.
- (7) Submit the signed original and one copy of the completed application to:

Jeff Horton
Division of Health Regulation
Department of Health and Human Services
By US Mail
2701 Mail Service Center
Raleigh NC 27699-2701

or

In person or express
809 Ruggles Drive
Raleigh, NC 27603
Telephone: (919) 855-3750

Both the signed original and the copy of the completed application must be received by the Division of Health Service Regulation **not later than 5 p.m. on February 29, 2012.**

All information submitted in an application received by this Agency is public information and is subject to disclosure upon written request and availability.

**APPLICATION TO PARTICIPATE IN THE PILOT PROGRAM TO ALLOW CERTAIN INMATES
RELEASED FROM CONFINEMENT TO BE PLACED IN AN ADULT CARE HOME TO RECEIVE
PERSONAL CARE SERVICES AND MEDICATION MANAGEMENT AS ALLOWED BY SESSION LAW
2011-389 AND HOUSE BILL 678**

For the purpose of this application the follow definitions apply:

The following definitions shall apply throughout this application:

- (1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.**
- (2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.**
- (3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.**
- (4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.**
- (5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.**

Part A. Facility Information

The name on this line is the name of your facility, as it will be printed on your license

Facility Name: _____

Facility Site Address: _____
(This address is the physical location of your facility)

County: _____

Facility Telephone: _____

Facility Fax: _____

Correspondence Mailing Address (where you want to receive your mail, including the license):

Contact Person _____ (Person who can make licensure and operational decision about the facility)

Address: _____

Part B. Operation Disclosure

1. **CERTIFIED OR QUALIFIED ADMINISTRATOR(S)**: (If the home is 6 beds or less, lists your qualified administrator. If the home is 7 beds or more, you **must** include the administrator's certificate number)

Name: _____

Address: _____ City _____

State ____ Zip _____ County _____ Telephone#: ____ (____) _____

Fax (____) _____

Administrator Certificate No. (if 7 beds or more) _____ Percentage Interest in this Facility: _____

2. **MANAGEMENT COMPANY**: If facility is managed by a company **other than the licensee**, provide the following information about the Management Company:

Name: _____

Address: _____

Telephone Number (____) _____ Fax Number (____) _____

Percentage of Ownership Interest in this Facility: _____

3. **LEGAL IDENTITY OF LICENSEE:** Full legal name of individual, partnership, corporation or other legal entity, which owns the Family care home business or the legal designee of that entity. Owner means any person who has legal or equitable title to or a majority interest in an adult care home. This entity is responsible for financial and contractual obligations of the business and will be recorded as the licensee on the license

Licensee of License _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: (____) _____ Fax (____) _____

Percentage of Ownership Interest in this Facility: _____

Legal entity is: _____ For Profit _____ Not for Profit

Legal entity is: _____ Proprietorship
_____ Corporation _____ Limited Liability Company
_____ Partnership _____ Limited Liability Partnership
_____ Government Unit

4. *If the "licensee" is a corporation or partnership list the name of the Executive Officer or General Partner.*
Executive Officer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: (____) _____ Fax (____) _____

Percentage of Ownership Interest in this Facility: _____

5. **Building Owner:** If the above entity (partnership, corporation, etc.) **does not** own the building from which services are offered, provide the following information:

Name: _____ Phone #: (____) _____ Fax (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Percentage of Ownership Interest in this Business not the building: _____

Part C. Ownership Disclosure

1. OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS

Complete the information below on **all** individuals or entities who are owners, principles, affiliates or shareholders holding an interest of **5% or more** of the applicant entity. Attach additional pages if necessary.

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # of Shareholder: (_____) _____ Fax (_____) _____
Percentage interest in this facility: _____ Title: _____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # of Shareholder: (_____) _____ Fax (_____) _____
Percentage interest in this facility: _____ Title: _____
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # of Shareholder: (_____) _____ Fax (_____) _____
Percentage interest in this facility: _____ Title: _____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

I attest that this is a true account of all owners, principles, partners, and affiliates of shareholders who hold an interest of 5% or more of the entity applying for or renewing this license:

Signature Title Date
Print Name _____ Phone Number _____

2. EXTENSIONS IN OWNERSHIP

North Carolina General Statute also requires information about "affiliates" of the applicant entity.

- (a) Is the applicant entity controlled by any other organization that operates licensed adult care facility?
Yes _____ No _____

- (b) Does the applicant entity control any other organizations that control any other licensed adult care facilities? Yes _____ No _____

- (c) Does the applicant entity control other adult care homes? Yes _____ No _____

- (d) If the answer to (a), (b) or (c) above is "Yes" list the name of the other organization(s) and provide the requested information on the individuals who control 5% or more of that organization. Attach additional pages if necessary.

Person/Organization Name: _____
Facility Name: _____ Federal Tax ID Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Organization Phone #: (_____) _____ Fax (_____) _____
Percentage of ownership Interest _____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

Person/Organization Name _____
Facility Name: _____ Federal Tax ID Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Organization Phone #: (_____) _____ Fax (_____) _____
Percentage of ownership Interest _____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

Person/Organization Name: _____
Facility Name: _____ Federal Tax ID Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Organization Phone #: (_____) _____ Fax (_____) _____
Percentage of ownership Interest _____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate _____

The following information will be used for internal compliance history checks as required by G.S. 131D-2b(1). We ask that you voluntarily provide your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing. Incomplete data will delay the renewal application being processed.

Category	Name	SSN	Contact Number	Percentage of interest as reported on pages 2-5
Administrator				
Licensee				
Licensee				
Building Owner				
Executive Officer				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				

Please use additional paper and attach if needed.

Part D. Capacity and Population

Licensed Capacity (as it appears on License) _____

1. If chosen for the Pilot Program, would your facility be willing to admit individuals that are registered sex offenders pursuant to N.C.G.S. § 14, Article 27A? YES___ NO___

2. If you answered YES to #1 above, does your facility have any *child care facility's or **schools (public or non-public) located within 1,000 of the facility's location? YES___ NO___

*(For purposes of this application, child care facility, defined in N.C.G.S. § 110-86(3) - Includes child care centers, family child care homes, and any other child care arrangement not excluded by G.S. 110-86(2), that provides child care, regardless of the time of day, wherever operated, and whether or not operated for profit.

- a. A child care center is an arrangement where, at any one time, there are three or more preschool-age children or nine or more school-age children receiving child care.
- b. A family child care home is a child care arrangement located in a residence where, at any one time, more than two children, but less than nine children, receive child care.

** (For purposes of this application, the term "schools" does not include home schools)

3. Is the facility which is to be used for the Pilot Program sprinkled in accordance with the North Carolina State Building Code? ___YES ___NO

4. If chosen for the Pilot Program, since Session Law 2011-389, House Bill 678 prohibits having or admitting any residents other than former inmates selected to participate in the Pilot Program, if your facility currently has residents in it, what are your plans to relocate, transfer or discharge these residents?

Please use additional paper and attach if needed.

Authenticating Signature: The undersigned submits this application for consideration to participate in the Pilot Program as allowed by Session Law 2011-389, House Bill 678 and certifies the accuracy of this information.

Signature: _____ Date: _____

Print Name _____ Phone Number _____