**Class Two Residential Facility**

**Application for Residential Licensure**

Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Licensure and Certification

30 E. Broad St., Suite 742

Columbus OH 43215

**Definition:** A “Class Two” residential facility provides accommodations, supervision, & personal

care services to any of the following: (1) One or two unrelated persons with mental illness; (2) One or two unrelated adults receiving residential state supplement payments; (3) Three to sixteen unrelated adults.

**Instructions.** Complete all applicable sections, and attach all supporting documentation along with a Class Two Application Fee of $75. Failure to include the correct application fee will result in the application being returned. Mail (no faxed or e-mailed applications) to the address above. Make fee payable to “Treasurer, State of Ohio”.

**1. Application Type Population License Number** (Renewal)

|  |  |  |
| --- | --- | --- |
| Initial  Renewal | Children/Adolescents  Adults | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**2. Residential Facility Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Facility Name | | | Facility Phone (include area code) |
| Street Address | | | |
| City | Zip | County | Facility Fax (include area code) |

**3. Mailing Address (for official correspondence)**

|  |  |  |  |
| --- | --- | --- | --- |
| Mail to Facility Address  Mail to Owner/Operator Address on Pg 2  Mail to Address Below | | | |
| Street Address | | | Phone (include area code) |
| City | Zip | County | Fax (include area code) |

**4. Emergency Contact Information. Provide number different than facility phone number. If this information changes, you must provide updated information within 48 hours of the change.**

|  |  |
| --- | --- |
| Owner/Operator Name | Emergency Phone Number |
| Manager Name | Emergency Phone Number |

**5. Ownership/Organization Structure**

|  |
| --- |
| Non-Profit Corporation  For Profit Corporation  Limited Liability Company  Partnership  Government  Sole Proprietorship/Individual Owner |

**6A. Owner/Operator Information –** who owns the business **(Sole Proprietorship/Individual Owner or Partnership)**

|  |  |  |  |
| --- | --- | --- | --- |
| Main Contact Name | | | Title/Position |
| Street Address | | | Phone (include area code) |
| City | Zip | County | Fax (include area code) |
| E-Mail | | | |

**6B. Owner/Operator Information –** who owns the business **(For-Profit Corporation or LLC)** or operates the business **(Non-Profit Corporation or Government)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Business/Government Name | | | | Corporation/LLC Charter Registration Number (Corporation or LLC) | |
| Street Address | | | | Phone (include area code) | |
| City | Zip | County | | Fax (include area code) | |
| President/Executive Director (ED)/CEO/LLC Manager (Circle One) Name | | | | | |
| Pres/ED/CEO/LLC Manager Phone Number | | | Pres/ED/CEO/LLC Manager E-Mail | | |
| Main Contact Name, if different | | | | | Title/Position |
| Main Contact Phone Number | | | Main Contact E-Mail | | |

**7. Organization Information**

**Instructions:** Attach a document with the requested information, marked as “Attachment One: Organization Information”.

Corporation for Non-Profit

Attach list with names and e-mail addresses of current Board of Directors, and expiration date of current term. Identify all officers and position held by each officer. Identify relationship to Executive Director/CEO/President, if any.

Corporation for Profit

Attach list with names and e-mail addresses of Corporate Officers, including: president, vice president, secretary, treasurer, CEO, CFO, or any equivalent position.

Limited Liability Company

Attach list with names, home or business address (specify), and e-mail addresses of all members of the LLC.

Partnership

Attach list with names, home or business address (specify), and e-mail addresses of all partners.

Sole Proprietorship/Individual Owner

Attach list with name, home or business address (specify), and e-mail address of sole

proprietor/Individual Owner.

Government

Attach list with names, business addresses and e-mail addresses of government agency executive

director/director/superintendent/other title, and chief legal counsel.

**8. Have any of the individuals listed in the attached document titled “Organization Information” been affiliated through ownership or employment with any residential facility licensed by the OhioMHAS (Adult Care Facility, Adult Foster Home, Type 1, Type 2 or Type 3 Residential Facility, or Class One, Class Two or Class Three) or licensed by another state agency? Do not include a non-profit board member who served as a Board member for another facility.**

Yes  No **If yes, complete the section below. Attach additional sheet if needed.**

|  |  |  |  |
| --- | --- | --- | --- |
| Individual Name (from attached document titled “Organization Information) | Facility Name | Facility Address | State Agency |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**9. Other residential facilities (or similar type) owned or operated by the corporation, LLC, partnership, sole proprietorship/individual owner or government agency that are licensed by OhioMHAS or another State of Ohio agency or state agency in another state.**  Check if None

**Initial Application:** Include residential facilities licensed by OhioMHAS

**Renewal Application:** Include ONLY residential facilities licensed by another State of Ohio agency or state agency in another state.) Attach additional page if necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| Facility # 1 Name | | Licensing Agency | |
| Facility Address | City | Zip | County |

|  |  |  |  |
| --- | --- | --- | --- |
| Facility # 2 Name | | Licensing Agency | |
| Facility Address | City | Zip | County |

|  |  |  |  |
| --- | --- | --- | --- |
| Facility # 3 Name | | Licensing Agency | |
| Facility Address | City | Zip | County |

|  |  |  |  |
| --- | --- | --- | --- |
| Facility # 4 Name | | Licensing Agency | |
| Facility Address | City | Zip | County |

**10. Property Owner Information** (Who owns the property, i.e. land and building)

Check here if the owner is the same as the business owner. If business owner does not own the property, complete the box below and attach copy of lease or rental agreement

|  |
| --- |
| Owner Name |

**11. Resident Rights Advocate**

|  |  |
| --- | --- |
| Name | Contact Phone Number |

**12. Requested License Capacity**

“Household Members” includes **resident(s)** along with the following IF they reside in the facility: live-in staff, operator(s), owner(s), family member(s), friend(s) and other persons residing in the facility. Do not include shift staff who do not reside in the facility.

|  |  |
| --- | --- |
| **Category** | **Number** |
| Requested Maximum Number Licensed Beds (The approved number will appear on your license) |  |
| Requested Maximum Number of Household Members (Residents plus other persons living in the facility.) (The approved number will appear on your license) |  |

**13. Facility will serve the following individuals:**

|  |  |
| --- | --- |
| Mental Illness | Yes  No |
| Substance Use Disorder (This will not show on your license) | Yes  No |
| Receiving Residential State Supplement (RSS) Benefit | Yes  No |

**14. Occupancy Information**

|  |  |
| --- | --- |
| **Category** | **Number** |
| Current Number of Residents |  |
| Current Number of Residents with Mental Illness |  |
| Current Number of Household Members (Residents plus other persons living in the facility) |  |
| Number of non-ambulatory residents who lived in the facility at any time since the last licensure survey |  |
| Number of current residents who are blind |  |
| Number of current residents who are deaf/hard of hearing |  |
| Number of residents that received skilled nursing care since the date of the last initial/renewal on-site survey |  |
| Number of additional persons (non-household members) who temporarily resided in the facility for at least 24 hours since the date of the last initial/renewal on-site survey |  |

This section intentionally left blank

**15. Owner/Manager Questions**

Complete the following, then see “Additional Instructions” below.

Check “Same” if manager is the same person as owner and skip “Manager” column.  Same

**Owner Manager**

|  |  |  |
| --- | --- | --- |
| 1. Have you lived outside Ohio at any time during the five years prior to submitting this application? | Yes  No | Yes  No |
| 1. Have you ever been convicted or adjudicated of any crime other than a traffic violation? | Yes  No | Yes  No |
| 1. Are there any pending criminal prosecutions against you? | Yes  No | Yes  No |
| 1. 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? | Yes  No | Yes  No |
| 1. Have you ever been convicted of an offense where the victim was a person under eighteen years of age, a functionally impaired person as defined in section 2903.10 of the Revised Code, a mentally retarded person as defined in section 5123.01 of the Revised Code, a developmentally disabled person as defined in section 5123.01 of the Revised Code a person with a mental illness as defined in section 5122.01 of the Revised Code, or a person sixty years of age or older. | Yes  No | Yes  No |
| 1. Have you ever had a license or certificate of approval to care for unrelated dependent children or adults withdrawn or denied? | Yes  No | Yes  No |
| 1. Have you ever had a professional license denied, suspended or revoked? | Yes  No | Yes  No |
| 1. Have you ever been convicted or adjudicated of any crime involving financial or business management, theft, fraud or embezzlement? | Yes  No | Yes  No |
| 1. Have you ever been convicted or adjudicated of any crime related to the provision of care? | Yes  No | Yes  No |
| 1. 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? | Yes  No | Yes  No |

**Additional Instructions:**

* If the answer to question 1 is “yes”, attach a separate page listing all addresses, include address, city and state.
* If the answer to any of questions 2 through 9 is "Yes", attach a separate letter of explanation with a full clarification of each answer stating the charge(s), date(s), outcome (including conviction, probation, parole, etc.) and current legal status for each incident.
* Attach copy of official court documents verifying current status of or final disposition of all criminal charges.

**16. Facility Space:**

Complete the following. Do not include hallways, unfinished basements, storage, laundry, lavatory and bathing facilities. Copy or use additional paper as needed. You may submit all of this information on an attached sheet if it contains all of the required information.  Check here if submitting an additional copy/paper. Submit a copy of a line drawing (floor plan) or description of the location and function of all resident and staff areas.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Room** | **No of Beds** | **Floor Location** | **Length of Room** | **Width of Room** | **Total Square Footage** | **Residents Permitted Access?** |
| Living Room | N/A |  |  |  |  | Yes  No |
| Family Room | N/A |  |  |  |  | Yes  No |
| Dining Room | N/A |  |  |  |  | Yes  No |
| Kitchen | N/A |  |  |  |  | Yes  No |
| Activity/  Recreation Room | N/A |  |  |  |  | Yes  No |
| Bedroom 1 |  |  |  |  |  | Yes  No |
| Bedroom 2 |  |  |  |  |  | Yes  No |
| Bedroom 3 |  |  |  |  |  | Yes  No |
| Bedroom 4 |  |  |  |  |  | Yes  No |
| Bedroom 5 |  |  |  |  |  | Yes  No |
| Bedroom 6 |  |  |  |  |  | Yes  No |
| Bedroom 7 |  |  |  |  |  | Yes  No |
| Bedroom 8 |  |  |  |  |  | Yes  No |
| Bedroom 9 |  |  |  |  |  | Yes  No |
| Bedroom 10 |  |  |  |  |  | Yes  No |
| Bedroom 11 |  |  |  |  |  | Yes  No |
| Bedroom 12 |  |  |  |  |  | Yes  No |
| Other (specify): \_\_\_\_\_\_\_\_ |  |  |  |  |  | Yes  No |
| Other (specify): \_\_\_\_\_\_\_\_ |  |  |  |  |  | Yes  No |
| Other (specify): \_\_\_\_\_\_\_\_ |  |  |  |  |  | Yes  No |
| Other (specify): \_\_\_\_\_\_\_\_ |  |  |  |  |  | Yes  No |

**17. Lavatory/Bathing Facilities**

|  |  |  |
| --- | --- | --- |
|  | **Total Number in Facility** | **Total Number in Facility Available to Residents** |
| Lavatories |  |  |
| Toilets |  |  |
| Bathtubs (w/ or without shower) |  |  |
| Showers (w/o bathtub) |  |  |

**18A. Initial Application. Approved Inspections/Licenses/Certificates. Submit a copy of each required inspection/license/certificate.**

|  |  |  |
| --- | --- | --- |
| **Required (1 – 5 Household Members)** | **Required (6 or more Household Members)** | **Required if applicable (all)** |
| Fire Inspection (Exempt if submitting certificate of occupancy dated within 12 months of MHAS receipt of application) | Certificate of Occupancy or Building Inspection | Food Service License |
| Electrical Inspection (Exempt if submitting Certificate of Occupancy) | Fire Inspection (Exempt if submitting certificate of occupancy dated within 12 months of MHAS receipt of application) | Boiler Inspection Certificate |
| Heating/Cooling Inspection (Exempt if submitting Certificate of Occupancy) |  | Elevator Inspection |
|  |  | Combined Smoke Detector Fire Alarm System Testing (ONLY if 9 or more residents) |
|  |  | Automatic Fire Extinguishing System/Sprinkler System (ONLY if one or more residents is non-ambulatory) |
|  |  | Sewage (non-public) |
|  |  | Water (non-public) |

**18B. Renewal Application. Approved Inspections/Licenses/Certificates. Submit a copy of each required inspection/license/certificate obtained since your last renewal survey. For example, submit a copy of each fire inspection.**

|  |  |  |
| --- | --- | --- |
| **Required (1 – 5 Household Members)** | **Required (6 or more Household Members)** | **Required if applicable (all)** |
| Fire Inspection at least every twelve months from most recent inspection | Fire Inspections within twelve months of most recent inspection | Food Service License |
| Heating/Cooling Inspection (Exempt if submitted Certificate of Occupancy) | Certificate of Occupancy, Building Inspection or Certificate of Completion, (ONLY if building alterations/modifications) | Boiler Inspection Certificate |
| Electrical Inspection if alterations or updates to wiring (Exempt if submitting updated Certificate of Occupancy) |  | Elevator Inspection |
|  |  | Fire Alarm System Testing (ONLY if 9 or more residents) |
|  |  | Automatic Fire Extinguishing System/Sprinkler System (ONLY if one or more residents is non-ambulatory) |
|  |  | Sewage (non-public) |
|  |  | Water (non-public) |

**19. Supplemental Questions**

**19.1.** Does your facility lock all exterior doors, i.e. entering the residence, at any time during each 24-hour day?

Yes  No

If yes, does your facility (choose one):

Maintain 24/7 staffing unless on outing with all residents  Provide each resident a key

**19.2.** Are any bedrooms located on/in a (check all that apply)

Floor higher than the second floor  Basement  Neither

**19.3**. Do any of the bedroom doors have keyed locks?

Yes  No

**19.4.** Are resident medications stored (check all that apply):

In facility’s central locked storage

In a separately licensed residential facility. List license number where stored: \_\_\_\_\_\_\_\_\_\_\_

Individual locked storage in resident bedrooms

**19.5.** Does the facility provide a central locked storage for resident’s funds or other valuables?

Yes  No

**19.6.** Are meals (choose one):

Prepared in facility only for facility residents.

Prepared elsewhere from entity with food service license.

Prepared in facility for facility residents and for residents at a second facility, combined census is more than sixteen residents, and the facility has a food service license.

Prepared in facility for residents at a second facility or multiple off-premise locations and is exempt from the requirement to have a food service license.

**19.7.** Does the facility use portable heaters?

Yes  No

**19.8.** Does your facility maintain pets or domestic animals in the facility or on the premise?

Yes  No

If yes, type(s) (cat, dog, horse, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**19.9.** How many facility vehicles are used to transport residents? \_\_\_\_\_\_\_ (Enter #)  None

**19.10.** Does your facility use volunteers or students?

Yes  No

If yes, in what capacity (describe roles or job duties): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**19.11.**  Does your facility accept students for field practicum experience?

Yes  No

**20. Supplemental Documentation**

**Instructions:** Submit the following documentation with the application, as specified below.

* **Submit copies of the following:**

**20.1.** A line drawing or description of the location and function of all resident and staff areas

**20.2.** All required inspections from Section 18A or 18B.

**20.3.** Driver’s license, BCI, and FBI if applicable, of all partners, members or sole proprietor/individual owner (Class Two and Class Three)

**20.4.** Prior thirty day’s menu.

* **Submit copies of the following, IF APPLICABLE:**

**20.5.**  Certificate or other verification of completion by manager of general orientation for persons with mental illness or substance use disorder if the facility plans to accept these residents. (Initial Application ONLY)

(Choose one)  Attached.  Not yet completed.  N/A Do not intend to accept persons with mental illness or a substance use disorder.

**20.6.** Lease or other written agreement allowing the facility to be used as a residential facility. Submit ONLY if applicant does not own the property)

(Choose one)  Attached  N/A Applicant owns property

**20.7.** Waiver or variance request, if applicable, in the form required by rule 5122-30-07 of the Ohio Administrative Code (OAC).

* **Initial Application:** Submit copies of the following.
* **Renewal application**: Submit copies of the following ONLY if revised since last full survey.

**20.8.**  Disaster plan required by OAC 5122-30-12

(Choose One)  Attached  Have not revised

**20.9.**  Policy regarding the facility's access to the resident's locked storage space in accordance with OAC 5122-30-14 (H)

(Choose One)  Attached  Have not revised

**20.10.**  Plan required by OAC 5122-30-15 (K) for responding to temperatures in the facility above 81 degrees, to assure the health, safety, and comfort of residents

(Choose One)  Attached  Have not revised

**20.11.** Resident rights and grievance procedure required by OAC 5122-30-22.1

(Choose One)  Attached  Have not revised

**21. Copy of Application to Board**

If the facility will serve individuals with mental illness, send a completed copy of this application to the ADAMH/MHRS Board that services your county.

|  |
| --- |
| Yes  No  N/A Do not intend to accept persons with mental illness or a substance use  disorder  If, “Yes”, Name of Board:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**22. Attestation**

If granted licensure, I agree to maintain compliance with Ohio Revised Code Section 5119.34 and Ohio Administrative Code Chapter 5122-30. I agree to notify the Ohio Department of Mental Health and Addiction Services of any changes in this building and its use of operation. To the best of my knowledge, the information contained in this application is accurate and complete. Submitting false or misleading information as part of a license application, renewal, or investigation may be grounds to deny or revoke a license. A person who knowingly makes a false statement as part of the licensure process may be found guilty of the offense of Falsification under section 2921.31 of the Ohio Revised Code.

Attach additional signature page if necessary:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of CEO/President/Executive Director Date Printed Name

(Corporation or Government)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Residential Care Facility Individual Date Printed Name

Owner/Sole Proprietor/Partner/LLC Member # 1

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Residential Care Facility Individual Date Printed Name

Owner/Sole Proprietor/Partner/LLC Member # 2

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Residential Care Facility Individual Date Printed Name

Owner/Sole Proprietor/Partner/LLC Member # 3

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Residential Care Facility Individual Date Printed Name

Owner/Sole Proprietor/Partner/LLC Member # 4

**Mail (no faxed or e-mailed copies) application and application fee to:**

Ohio Department of Mental Health and Addiction Services

Licensure and Certification

30 East Broad Street, Suite 742

Columbus OH 43215

***Make fee payable to “Treasurer, State of Ohio”***