

Application and Setting Review Form

Provider Name:

Date new application received:

Provider Status: ☐ New ☐ Existing

Part A To be verified by the Regional Community Services Director

- | | |
|--|---|
| 1. Is there a need for this service in your region? If no, please explain. | ☐ Yes
☐ No |
| 2. Is the agency currently on a Provisional Certification status? | ☐ Yes
☐ No |
| 3. Has the agency been on a Provisional Certification within the last two regular site visits? | ☐ Yes
☐ No |

If the answer to 1 or 2 is "YES", do not proceed with application. Return to OCA. OCA will forward to the Divisional Director for completion.

Part B To be completed by Regional Community Services (RCS) Office

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|--|---|
| 1. Is the setting adjacent to or under the same roof as a building that houses a publicly or privately-operated setting which provides inpatient institutional care: skilled nursing setting (SNF), immediate care setting for individuals with intellectual disabilities (ICF/IID), institute for mental disease (IMD), or hospital? | ☐ Yes
☐ No |
| 2. Is the setting located on the grounds of, or immediately adjacent to, a building that is a public institution which provides inpatient institutional care (Skilled Nursing Setting (SNF), Intermediate Care Setting for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Disease (IMD), or hospital? | ☐ Yes
☐ No |
| 3. Does the setting otherwise have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS and therefore, presumed institutional?
a. If the answer is YES, what evidence is provided to overcome the presumption of an institutional setting? | ☐ Yes
☐ No |
| 4. Does the setting have more than 6 beds? | ☐ Yes ☐ No |
| 5. Would this proposed setting be located on the same street, court, etc., where these types of settings constitute more than 25% of all settings? | ☐ Yes ☐ No |
| 6. Is the setting adjacent (next to or shares a property line) to another setting? | ☐ Yes ☐ No |
| IF EITHER ANSWER TO 4-6 IS YES, DO NOT PROCEED, SIGN FORM AND RETURN TO OFFICE OF CERTIFICATION ADMINISTRATION (OCA). | |
| 7. Is the setting physically accessible, and free from obstructions such as steps, lips in a doorway, narrow hallways, etc., or otherwise have any other safety concerns such as lighting, unsanitary conditions, exposed electrical wiring, area known for violent crimes, drug use, etc.? | ☐ Yes
☐ No |
| 8. Is the site recommended for Life Safety inspection? | ☐ Yes
☐ No |

Additional Comments/Observations:

Name of person completing Assessment:

Date:

9. Is the setting approved for a 6-month Temporary Operating Authority (TOA) following Life Safety Inspection?

☐ Yes
☐ No

Community Services Director Signature:

Date:

Return to the Office of Certification Administration (OCA)

Part C To be completed by the Office of Certification Administration

Sent to Life Safety:

Date:

Additional Comments:

OCA Director Signature:

Date: