~~APPLICATION TO OPERATE~~
~~RESIDENTIAL, DAY OR RESPITE FACILITY~~

~~Date of Application:~~ ______________________________

~~Reason for Application:~~ ☐ ~~Initial Licensing of a New Facility~~

☐ ~~Termination/Closure~~
~~Reason for termination/closure:~~ ______________________________

☐ ~~Change~~
☐ ~~in location~~ ☐ ~~in facility type~~
☐ ~~in number of people served~~

~~1. Facility Information (Name):~~ ______________________________

~~Address:~~ ______________________________

~~County:~~ ____________ ~~Telephone Number (*include area code*):~~ ____________

~~Type of Facility:~~

☐ ~~SLP-II~~ ☐ ~~CIRS~~ ☐ ~~CTH-I~~ ☐ ~~CTH-II~~ ☐ ~~ASW~~

☐ ~~AAC~~ ☐ ~~WAC~~ ☐ ~~Respite~~ ☐ ~~Camp~~ ☐ ~~Unclassified Program~~

~~Capacity (Number of):~~ ~~Children:~~ ________ ~~Adult(s):~~ ________ ~~Respite:~~ ________
~~(under age 21)~~

~~2. Changed Information (Updated):~~ ______________________________

~~Address:~~ ______________________________

~~County:~~ ____________ ~~Telephone Number (*include area code*):~~ ____________

~~Type of Facility:~~

☐ ~~SLP-II~~ ☐ ~~CIRS~~ ☐ ~~CTH-I~~ ☐ ~~CTH-II~~ ☐ ~~ASW~~

☐ ~~AAC~~ ☐ ~~WAC~~ ☐ ~~Respite~~ ☐ ~~Camp~~ ☐ ~~Unclassified Program~~

~~Capacity (Number of):~~ ~~Children:~~ ________ ~~Adult(s):~~ ________ ~~Respite:~~ ________
~~(under age 21)~~

3. For CTH-I or Respite locations: Please Identify all household members (including child(ren) 21 years or younger):

Full Name	Age	Relationship to Caregiver
Add/Delete/Same		
Add/Delete/Same		
Add/Delete/Same		
Add/Delete/Same		

4. List all licenses and/or certificates maintained by the facility:

Type of license and/or certificate	By Whom

5. Provider organization having jurisdiction over the facility:

Name:____

Address:____

County:____________________ Telephone Number (*include area code*):____________________

When requesting a new license, please submit Electrical, HVAC and State Fire Marshal Inspection reports. If a consumer is under 21 years of age and moving into a CTH-I or CTH-II, also submit DHEC Sanitation Inspection. Send to Central Office Attn: Quality Management/Licensing. Documents should be submitted as a single packet.

Statements contained in this application are correct. I understand the facility must be in compliance with all applicable Federal, State, and local laws and regulations, and all applicable DDSN contracts, policies, procedures, and standards, and that noncompliance with these terms may results in enforcement actions as identified in DDSN Directive 104-01-DD and/or DDSN/Provider Contract.

____________________________________ ____________________________________
Signature/Head of the Provider Organization Title

____
Notary Public
____________________County, South Carolina

My Commission Expires: ____________________

SOUTH CAROLINA DEPARTMENTOF DISABILITIES AND SPECIAL NEEDS
APPLICATION TO OPERATE/CHANGE
RESIDENTIAL, DAY OR RESPITE FACILITY

Date of Application: ____________________

REASON FOR APPLICATION

☐ Initial Application for Contracted Operation with other Agency License (DHEC or DSS) ☐ Renewal

- ☐ DDSN Contracted Operation of DHEC Licensed Facility (Residential Habilitation)
- ☐ DDSN Contracted Operation of DHEC Licensed Facility (ICF/IID Services)

☐ Initial Application for DDSN License ☐ Renewal

Facility Type: ☐ SLP-I ☐ SLP-II ☐ CIRS ☐ CTH-I ☐ CTH-II ☐ Respite ☐ Adult Activity Center ☐ Work Activity Center ☐ Unclassified Program

Termination/Closure: ☐ Permanent ☐ Temporary

Reason for Termination/closure: ____________________

Change: ☐ In Location ☐ In Facility Type ☐ In Number of people Served

Notes: ____________________

LICENSEE INFORMATION

(The Licensee is the name of the legal entity licensed to operate the business at the facility named below. This entity must be qualified as a provider with DDSN).

Licensee Name: ____________________ County: ____________________

Physical Address *(include zip code)*: ____________________

The License is: ☐ For Profit ☐ Not Profit

Executive Director *(Name)*: ____________________

Mailing Address *(include zip code)*: ____________________

Phone Number *(include area code)*: ____________________ Email Address: ____________________

Name of Alternate Staff for Licensing Contact: ____________________

Phone Number *(include area code)*: ____________________ Email Address: ____________________

FACILITY INFORMATION

Facility Name: ____________________

Physical Address *(include zip code)*: ____________________

Phone Number *(include area code)*: ____________________ Contact Person: ____________________

Will this location be licensed by any other agency? ☐ Yes ☐ No If yes, state agency: ____________________

Occupancy Requested:

(The maximum capacity for CTH-II Settings is four (4). SLP-I, SLP-II, and CTH-I settings may not exceed two (2) occupants per setting, unless prior approval has been granted.)

☐ Children (under 21): ☐ Adult(s): ☐ Respite: ☐ Male ☐ Female ☐ Co-Ed

Is the building where services are offered leased/rented? ☐ Yes ☐ No

If yes, please complete the following on the building property owner and provide a copy of the lease agreement.

Name: ____________________

Address *(include zip code)*: ____________________

Phone Number *(include area code)*: ____________________ Fax Number *(include area code)*: ____________________

INDIVIDUALIZED SETTINGS – REQUIRED ATTACHMENTS

For SLP-I settings, please attach the Supported Living Assessment. This assessment is individual and location specific and non-transferrable. An explanation must be provided for any indicators scored "no." For CTH-I's, please submit the CTH-I Application Attachment.

HOME AND COMMUNITY-BASED SETTINGS RULE REQUIREMENTS

The Home and Community-Based Services (HCBS) Settings Regulation, issued by the Centers for Medicare and Medicaid Services (CMS) requires that all home and community-based settings meet certain requirements. The DDSN Licensing Standards reflect the agency's values and incorporate the HCBS Settings Rule requirements which are listed below:

- The setting is integrated in and supports full access to the greater community.
- The setting is selected by the individual from among setting options.
- The setting is physically accessible.
- Individual rights of privacy, dignity and respect, and freedom from coercion and restraint are ensured.
- Autonomy and independence in making life choices are optimized.
- Choice regarding services and who provides them is facilitated.
- The individual has a lease or other legally enforceable agreement providing similar protections.
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit.
- The individual controls his/her own schedule including access to food at any time.
- The individual can have visitors at any time.

For settings initially licensed on or after July 1, 2020, the setting must be free from qualities that may be presumed institutional. Settings that may have qualities presumed to be institutional include:

- Settings in a publicly or privately-owned facility that provides inpatient treatment; and
- Settings on the grounds of or adjacent to a public institution.

Refer to: 42 CFR§441.301(c)(5) (i-iv)

For settings initially licensed on or after July 1, 2020, the setting must be free from characteristics that have the effect of discouraging integration of residents from the broader community. Settings that may have characteristics that have the effect of discouraging integration of residents from the broader community include, but may not be limited to:

- Settings completely enclosed by walls or fences with locked gates;
- Settings in a multi-unit housing complex whose owners or lessees are limited to only those with ID/RD, HASCI or Autism Spectrum Disorder; and
- An additional setting added to an existing cluster (i.e., 2 or more) of DDSN-licensed residential or day settings.

Refer to: 42 CFR§441.301(c)(5)(v)

OTHER INSPECTIONS REQUIRED FOR SUBMISSION

When requesting a new license, please submit Electrical, HVAC and State Fire Marshal Inspection reports with the Application to Operate. All documents should be submitted together as a single packet. Submit the packet to Licensing/Quality Management at License@ddsn.sc.gov. Please allow a minimum of two (2) weeks from the receipt of the completed packet to schedule the licensing inspection.

ATTESTATION

The Licensee listed above attests to their ability to demonstrate compliance with DDSN Directives, Administrative and Service Standards, and Medicaid Policies. This includes, but is not limited to: compliance with Staff Qualifications and Training Requirements, Medication Administration Requirements, Infection Control Procedures, Incident Management Reporting (including allegations of Abuse/Neglect/Exploitation, Critical Incidents, and Death Reporting), Human Rights Committees, Risk Management, Quality Management, and timely handling of participant grievances.

Statements contained in this application are correct. I understand the facility must be in compliance with all applicable Federal, State, and local laws and regulations, and all applicable DDSN contracts, policies, procedures, and standards, and that noncompliance with these terms may results in enforcement actions as identified in DDSN Directive 104-01-DD: Certification and Licensure of DDSN Residential and Day Facilities, and/or the DDSN/Provider Contract. The provider is responsible for maintaining evidence of service delivery to support claims.

____________________________________ Date: __________________

Signature of Executive Director/CEO of Provider Organization