Enhanced Services Facility Application

Instructions: Incomplete applications will be returned without action.

The Applicant is responsible for submitting a complete application and all required supporting documents. Submit application and supporting documents at least 90 days prior to the anticipated opening date, but be aware that current application processing may take as long as three to twelve months.

The Enhanced Services Facility license fee is $1040 per bed. Enclose check or money order made payable to Washington State Treasurer. If a check is not included, the application **will not be processed and will be returned to the applicant.**
A Federal Employer Identification Number (EIN) and a Unified Business Identifier (UBI) are needed before applying for a license and contract. Applications without an EIN and UBI **will be returned.**
Please type or print clearly in ink or complete electronically.
Carefully follow all instructions and answer all questions.
Use "N/A" (Not Applicable) when a question does not apply. Do not leave a question blank.
You must include the following forms or supporting documents with this application:

- Individuals Affiliated with Applicant form
- Agreement Not to Enter Facility form for each person listed on the Individuals Affiliated with Applicant form who will not have unsupervised access to residents at any time
- Consent to Release and/or Use Confidential Information for each person listed in the Individuals Affiliated with Applicant section
- Washington Background Authorization Form or a copy of background check results provided by DSHS Background Inquiry Unit.
- Administrator Attestation
- Financial Attestation
- Real Property and/or Building Attestation
- Policies and Procedures Attestation
- Proof of Employer Identification Number (EIN) and Unified Business Identifier (UBI)
- Copy of business license showing facility name as registered trade name
- Copy of proof of liability insurance showing coverage type and limits
- Organizational Structure/Chain of Ownership Chart
- Copy of an admission agreement (between the resident and licensee) that will be used following licensure

You must also include the following attachments with this form, if applicable:

- List of pending criminal charges, convictions, and negative actions associated with individuals listed in Individuals Affiliated with Applicant, printed on a separate page with the individual's name at the top
- Copy of purchase and sale agreement or other document showing ownership or intent to purchase (section 5 of application form)
- Lease or Operating Agreement Attestation (section 6 of application form)
- Copy of the lease, operating agreement or other agreement allowing the applicant to occupy the premises (section 6 of application form; draft is acceptable)
- Management Agreement Attestation (section 8 of application form)
- Copy of written management agreement (section 8 of application form)
- List of other Washington long-term care facilities managed by, or licensed to, the proposed management entity (section 8 of application form)
- List of Individuals Affiliated With Management Company (section 8 of application form)
- Person, Individual, and/or entity business and compliance history (section 9 of the application form)
- Financial history of Applicant and/or affiliated individuals or entities (section 10 of the application form)
- List of individuals named in the Application who are previous or current employees of the State of Washington; the list must include each individual's name, job title, and the person's employing agency or department (section 12 of application form)
- Staff Roster and Credentials – If any individuals are employed at the time of application, complete this section of the form and include a copy of the individuals' credentials (e.g. RN license, pharmacist license, mental health professional)

If you are applying for Change of Ownership/License, you must include the following attachments:

- Letter from current licensee allowing the applicant to use the remainder of the current license fee
- Letter from current licensee relinquishing license when change of ownership (operator) is approved
- Copy of the Change of Ownership Notice to Residents sent by the current licensee

Submitting your application

- Label all attachments
- Complete the checklist
- Retain a copy of the application and all attachments for your files
- Send completed packet and one check for the $1040 fee per bed to:

For US Mail:	For Federal Express or United Parcel Service (UPS):
ALTSA Finance and Contracts	ALTSA Finance and Contracts
PO Box 45600	4500 10th Ave SE (Blake East)
Olympia WA 98504-5600	Lacey WA 98503

Please direct your questions regarding this application to the Business Analysis and Applications Unit at (360) 725-2420.

Remainder of this page intentionally left blank.

Washington State Department of Social & Health Services
Transforming lives

Enhanced Services Facility (ESF) Application

Please type or print clearly in ink or complete electronically.

The Enhanced Services Facility initial license fee is $1040 per bed. If no payment is included, the application **will not be processed and will be returned to the applicant.** Enclose check or money order made payable to Washington State Treasurer.

Carefully follow all instructions and answer all questions.

☐ Initial License or Initial with Contract
☐ Change of Ownership / License, no fee required. If change of ownership, please complete the following:

CURRENT LICENSEE'S NAME
CURRENT ESF NAME
CURRENT LICENSEE'S ESF LICENSE NUMBER
CURRENT ADMINISTRATOR'S NAME

1. Enhanced Services Facility Information

FACILITY NAME		TELEPHONE NUMBER (INCLUDE AREA CODE)		FAX NUMBER (INCLUDE AREA CODE)
PHYSICAL ADDRESS	CITY	STATE WA	ZIP CODE	COUNTY
MAILING ADDRESS	CITY	STATE WA	ZIP CODE	COUNTY
WEB SITE ADDRESS	E-MAIL ADDRESS	NUMBER OF BEDS TO BE LICENSED		ANTICIPATED OPENING DATE

2. Medicaid Contract?

☐ Yes ☐ N/A

3. Contact Person Information

CONTACT PERSON'S NAME	CONTACT PERSON'S E-MAIL ADDRESS
CONTACT PERSON'S TELEPHONE NUMBER (WITH AREA CODE)	CONTACT PERSON'S FAX NUMBER (WITH AREA CODE)

4. Individual / Sole Proprietor or Entity Applicant Information

LEGAL NAME OF INDIVIDUAL OR ENTITY			
MAILING ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)		

For ALTSA Fiscal Office Use Only	For ALTSA Application Unit Use Only
	ESF Control Number: _____
	ALTSA Region / Unit: _____

Remainder of this page intentionally left blank.

5. Administrator

ADMINISTRATOR'S NAME	ADMINISTRATOR'S E-MAIL ADDRESS
ADMINISTRATOR'S TELEPHONE NUMBER (WITH AREA CODE)	ADMINISTRATOR'S FAX NUMBER (WITH AREA CODE)

6. Individual or Entity Property Information

UBI (UNIFIED BUSINESS IDENTIFIER)	FEDERAL EIN (EMPLOYER IDENTIFICATION NUMBER)

UNDER WHAT NAME IS EIN REGISTERED?

Does the applicant own the real property? ☐ Yes ☐ No

If yes, attach purchase and sales agreement or other appropriate document. If no, complete the following:

LANDLORD'S NAME

LANDLORD'S ADDRESS | CITY | STATE | ZIP CODE

Does the applicant lease or operate under an operating agreement? ☐ Yes ☐ No

If yes, complete the Lease Attestation and attach copy of lease or operating agreement.

7. Individual or Legal Entity Information

Check all that apply.

☐ Individual / Sole Proprietor
☐ For-Profit Corporation
☐ Non-Profit Corporation
☐ General Partnership
☐ Limited Partnership
☐ Limited Liability Company
☐ Government agency
☐ Group or association

If out-of-state entity, check box below and complete a – f.

☐ Out-of-State / Foreign Corporation, Partnership, Limited Liability Company, Association (if checked, complete below):

A. NAME OF STATE WHERE ENTITY ORGANIZED	B. OUT-OF-STATE ENTITY'S HEADQUARTERS NAME

C. OUT-OF-STATE ADDRESS | CITY | STATE | ZIP CODE

D. NAME OF REGISTERED AGENCY IN WASHINGTON

E. REGISTERED AGENT'S TELEPHONE NUMBER (INCLUDE AREA CODE)	F. DATE OF APPROVAL TO CONDUCT BUSINESS IN WA

8. Management Agreement

Does the applicant intend to or has the applicant entered into a management agreement authorizing another person, group or entity to manage the facility? ☐ Yes ☐ No

If yes, complete and include the Management Agreement Attestation, a copy of the written management agreement, and a list of other licensed long-term care facilities in Washington managed by or licensed to the management agency (if no Washington facilities, list out-of-state facilities).

Remainder of this page intentionally left blank.

9. Person, Individual and/or Entity Business and Compliance History

Answer for facilities in Washington State and in other states.

		YES	NO
1.	Has the Applicant, any entity having a direct ownership interest in the Applicant or any person named in the "Individuals Affiliated with Applicant Supplemental Information" form:		
a.	Owned, managed, or held a license to operate a business providing services to children, frail elders, vulnerable adults, or persons with mental illnesses or developmental disabilities within the past 10 years? (If yes, provide name of person or entity, name of facility, and effective dates.)	☐	☐
b.	Held a contract to provide services to children, frail elders, vulnerable adults, or persons with mental illnesses or developmental disabilities within the past 10 years? (If yes, provide name of person or entity, name of facility, and effective dates.)	☐	☐
c.	Been imposed with a civil fine, imposed with a stop placement or had a condition placed on the license, contract or certification within the past 10 years? If yes, provide name of person or entity and name of facility.	☐	☐
d.	Ever been denied a contract, license, or license renewal to operate a facility providing care to adults or children? If yes, provide name of person or entity, name of facility, state in which facility is located, type of action taken, and date action taken, if known.	☐	☐
e.	Ever had a license or certification not renewed, revoked, suspended, suspended with stay, or enjoined? If yes, provide name of person or entity, name of facility, state where facility located, type of action taken, and date action taken, if known.	☐	☐
f.	Ever had a Medicaid contract or Medicare provider agreement revoked, canceled, suspended or not renewed? If yes, provide name of person or entity, name of facility, state in which facility is located, type of action taken, and date action taken, if known.	☐	☐
g.	Ever relinquished or returned a license, contract or certification; or did not seek the renewal of a license, contract or certification following notification by the state agency of initiation of denial, suspension, or revocation of that license, contract, or certification? If yes, provide name of person or entity, name of facility, state in which facility is located, type of action taken, and date action taken, if known.	☐	☐
2.	Has the Applicant, any entity having a direct ownership interest in the Applicant, or any person named in the "Individuals Affiliated with Applicant" form:		
a.	Been excluded from participating in Medicare and/or Medicaid? If yes, attach copy of exclusion documents.	☐	☐
b.	Been named in a court order or administrative order stating the person or entity will not hold a license or contract to provide care to children, frail elders, vulnerable adults, or persons with mental illness or developmental disabilities for a specific period or number of years from the date of license surrender or relinquishment? If yes, attach copy of court order.	☐	☐
c.	Been subject to disciplinary action, or been convicted and found guilty by a disciplinary board or other disciplinary authority of a health professional licensing agency? If yes, attach copy of disciplinary board or authority action.	☐	☐
d.	Been convicted of abuse, neglect, exploitation, misappropriation (theft) of property of any person, a crime against children and other persons as defined in Chapter 388-113 WAC or had a finding on a state registry? If yes, attach copy of court documents.	☐	☐

10. Person, Individual or Entity Applicant Financial History

Answer this section for the individual applicant, spouse co-applicant or state registered domestic partner co-applicant, entity applicant, partners, officers, directors, and owner of 5% or more of the entity. Check the appropriate "yes" or "no" boxes below. Attach additional sheets of paper if needed.

1. Have you ever filed for bankruptcy? ☐ Yes ☐ No If "yes", provide the following:

NAME	TYPE OF BANKRUPTCY	STATE FILED	DATE FILED	DATE CONCLUDED
	☐ CH 7 ☐ CH 13			
	☐ CH 7 ☐ CH 13			

2. Have any judgments ever been filed against you or the entity? ☐ Yes ☐ No If "yes", provide the following:

NAME THE INDIVIDUAL	DATE OF JUDGMENT	COUNTY AND STATE

DESCRIBE THE CIRCUMSTANCES

11. Out-of-State Information

Has any person named in the application lived in another state during the past three (3) years? ☐ Yes ☐ No
If yes, provide each person's name, home address, city, state, zip code, and dates of residence as an attachment.

12. Previous or Current Employee of the State of Washington

1. Was any person named in the application an employee of the State of Washington within the past five (5) years? ☐ Yes ☐ No
2. Is any person named in the application a current employee of the State of Washington? ☐ Yes ☐ No

If the answer to either of the questions above is yes, provide the person's name, agency or department, and job title as an attachment.

12. Certification

I/we certify, under the penalty of perjury under the laws of the State of Washington and by my signature, that the information provided in this application and all additional documents and forms required for license of an enhanced services facility are true, complete, and accurate. I/we understand that the department may obtain additional information, verification and/or documentation related to the answers or information provided.

I/we understand that if I/we enter into an agreement with an individual or entity to manage the facility on a day-to-day basis, I am/we are wholly responsible for the conduct of the individual or entity and its employees. I/we understand that I/we are legally responsible for the operational decisions and care of the residents at the facility.

I/we understand any license or contract granted pursuant to this application is nontransferable.

I/we understand that failure to accurately answer or fully complete the questions on this application may result in denial of the application, termination of a license or contract, or other sanctions as allowed by law.

I/we understand and agree that the information I/we give to the department will be used to verify the representations made in this application. Any information I/we give to the department may be used by the department for this purpose.

I/we understand that the department may check the credit of the corporation or business and its principals, obtain a credit report; and verify any responses provided. The department and its contracting process will use such information and may disclose this information to other parts of the department as appropriate to further program purposes. The department may define some or all of such information as public information and also disclose this information to third parties when requested according to law to the extent that such information is not exempt from such disclosure by state or federal law.

I/we certify that I/we have read, understood, and agree to comply with Chapters 70.97, 71.05 and 10.77 RCW, and Chapters 388-106, 388-107, 388-112, and 388-110 WAC and the Rules, Regulations, and Standards adopted thereunder.

No residents receiving care and service in the facility will be subject to discrimination because of race, color, national origin, gender, age, religion, creed, marital status, disabled or Vietnam veteran's status, or the presence of any physical, mental, or sensory disability.

I/we understand that if this application for an enhanced services facility license is denied, I/we may request an administrative fair hearing within 28 days of receiving the denial letter from DSHS. I/we understand that a written request for fair hearing must be submitted to: Office of Administrative Hearings, PO Box 42489, Olympia, Washington 98504-2489.

<u>In addition to the above certifications, if applying for a contract:</u>

I/we understand that if a contract is granted, I/we as the contractor(s) shall be responsible for compliance with all applicable state and federal laws and regulations, as now existing or hereafter amended, and shall be held responsible by the department for the residents' care. I am/we are responsible for day-to-day control of the facility operation and business enterprise.

I/we understand that failure to promptly supply any of the following requested by the department is a basis for the department to deny or terminate my contract: any documentation, any additional information, any verifications, or any authorizations to verify or obtain information deemed relevant by the department to this application. I/we understand that misrepresentation, by omission or expressly, of any information on the contract application or supporting material is a basis for the department to deny or terminate my contract.

I/we understand that if this application for contract is denied, I/we may request an adjudicative proceeding within 28 days of receiving the denial letter from DSHS. I/we understand that a written request an adjudicative proceeding must be submitted to: Board of Appeals, PO Box 45803, Olympia, Washington 98504-5803.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

SIGNATURE OF OFFICER, DIRECTOR, MEMBER, ETC. OF APPLICANT		TITLE
DATED	CITY AND STATE WHERE SIGNED	PRINTED NAME

Remainder of this page intentionally left blank.

Individual Affiliated with Applicant

Instructions:

1. Mark all applicable boxes for each officer, director, member, partner, owner of 5% or more of the applicant entity, and Administrator.
2. Complete all columns for each person with one or more boxes checked.
3. Complete a Background Authorization Form for each person listed who will have unsupervised access to residents at any time during licensure.
4. Complete an Agreement Not to Enter Facility form for each person listed who will not have unsupervised access to residents at any time during licensure.
5. Attach a completed Consent (Authorization) to Release and/or Use Confidential Information for each person listed, including the Administrator

PERSON'S NAME	HAS CONTROL* OF APPLICANT**	MAY HAVE UNSUPERVISED ACCESS TO RESIDENTS	IS DIRECTLY INVOLVED IN ENHANCED SERVICES FACILITY OPERATIONS	TITLE OR POSITION	SSN AND DATE OF BIRTH (MM/DD/YYYY)	OTHER NAMES YOU HAVE BEEN KNOWN BY: BIRTH NAME***, OTHER MARRIED NAME(S) AND NICKNAME(S) / OTHER NAME(S). **WRITE NONE IF NONE.**	% OF OWNER-SHIP
	☐	☐	☐	**Administrator**			
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				

* Control means the possession, directly or indirectly, of the power to direct the management, operation, and/or policies of the applicant / licensee or enhanced services facilities, whether through ownership, voting control, by agreement, by contract or otherwise.

** The Applicant is the Individual / Sole Proprietor or the Entity applying for the enhanced services facility license.

*** Birth Name if different than column 1.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

Agreement Not to Enter Facility

Print or type all information.

FACILITY NAME			
ADDRESS	CITY	STATE	ZIP CODE

This is an agreement between the Washington State Department of Social and Health Services (DSHS),

_____, and _____.
APPLICANT'S NAME PERSON'S NAME

_____ is associated with _____ as
PERSON'S NAME APPLICANT'S OR OTHER ENTITY'S NAME

_____.
IDENTIFY RELATIONSHIP

_____ has applied to obtain an enhanced services facility license through DSHS.
APPLICANT'S NAME

Prior to issuing such licenses, DSHS requires a state background check and fingerprint-based national background check for all persons having unsupervised access to enhanced services facility residents.

_____ will not have unsupervised access to Washington residents at any time
PERSON'S NAME

during licensure. Therefore, _____ is not required to have a State of Washington
PERSON'S NAME
and fingerprint background check completed.

_____ agrees to ensure that _____ shall not have
APPLICANT'S NAME PERSON'S NAME

unsupervised access to enhanced services facility residents and _____ agrees _____
PERSON'S NAME HE / SHE
shall not have unsupervised access to enhanced services facility residents at any time during licensure.

_____ agrees to ensure that _____ will have a
APPLICANT'S NAME PERSON'S NAME

State of Washington and fingerprint-based national background check completed before _____
PERSON'S NAME
has unsupervised access to Washington enhanced services facility residents.

This Agreement will remain in effect until terminated by DSHS.

Licensee:

_____
APPLICANT'S NAME
By: _____
SIGNATURE

_____
TITLE
Date: _____

Named Individual:

_____
PERSON'S NAME
By: _____
SIGNATURE

_____
TITLE
Date: _____

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

Consent to Release and/or Use Confidential Information

Must be completed by any person named on the "Individuals Affiliated with Applicant Supplemental Information" form, including the Administrator. Submit a separate page for each person.

☐ Officer ☐ Director ☐ Owner of more than 5% ☐ Administrator ☐ Other

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I consent to the release and use of confidential information about me within Department of Social and Health Services (DSHS) for purposes of licensing and contracting. I grant permission to DSHS and any agency, division, office, or the police to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, mail, or hand delivery.

I am aware that the Department is required to respond to requests for disclosure of information from the public. The Department may only withhold requested information if a specific disclosure exemption exists. (Chapter 42.56 RCW; Chapter 388-01 Washington Administrative Code (WAC))

This consent is valid for as long as I am an officer, director, owner of 5% or more or the Applicant, or Administrator of the Enhanced Services Facility named in this application. A copy of this form (instead of the original) may be used to authorize release and use this information.

SIGNATURE	DATE
PRINTED NAME	TITLE

Remainder of this page intentionally left blank.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

Administrator Attestation

Name of Enhanced Services Facility where employed	
Administrator name	
Social Security Number	
Date of birth	
Daytime telephone number (include area code)	
Cellular telephone number (include area code)	
E-Mail address	
Is the Administrator an officer, director, or an owner of 5% or more of the Applicant?	☐ Yes ☐ No

I attest that all of the following statements are true and accurate.

1. I am at least 21 years of age and meet the qualification standards per WAC 388-107-1180.
2. I assume responsibility for overall 24 hour-per-day operation of the facility including care and residents and complying with administrative rules and policies.
3. I have no record of criminal or civil conviction or have attached an explanation of the facts surrounding such actions.
4. I acknowledge that a background inquiry will be made in accordance with Chapter 388-107 WAC. I will complete a State of Washington Department of Social and Health Services Enhanced Services Background Authorization form and provide it to the License Applicant or Licensee as required.

ADMINISTRATOR'S SIGNATURE DATE

Remainder of this page intentionally left blank.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

Financial Attestation – Enhanced Services Facility

This attestation form must be completed and submitted to the DSHS Applications Unit. The attestation must be verified and signed by an officer, director, or owner of 5% or more of the applicant/licensee who has signature authority.

APPLICANT'S NAME	
PRINTED NAME OF PERSON COMPLETING FORM	TITLE OF PERSON COMPLETING FORM

The signatory must initial each statement below.

I certify and declare under penalty of perjury that the following is true and correct:

_____The applicant has not been adjudged insolvent or bankrupt in a State or Federal court.

_____A court proceeding to make a judgment of bankruptcy or insolvency with respect to the applicant is not pending in a State or Federal court.

_____The applicant will ensure that the enhanced services facility is operated in a manner consistent with applicable laws and regulations despite any limitation or insufficiency of funds.

_____Applicant will provide notice to DSHS in the event a State or Federal court proceeding seeking a judgment of insolvency or bankruptcy is initiated with respect to the applicant, a subsidiary, an affiliated entity or its parent entity.

I further certify and declare as follows:

I am duly authorized to sign this attestation on behalf of the applicant. I am an officer, director, or owner of 5% or more of the applicant.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

DATED	PRINTED NAME	SIGNATURE*

*** May not be signed by Management Company or Facility Administrator.**

Remainder of this page intentionally left blank.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

"Real Property and/or Building" Attestation Related to Financing and/or Insurance

_____ declares and states as follows:
PRINT NAME

1. I am _____ of _____ the ("Applicant / Licensee"),
   TITLE APPLICANT'S NAME
   which has applied for a Washington State Enhanced Services Facility license to operate
   _____ (the "Enhanced Services Facility"). I make this
   FACILITY NAME
   declaration based on personal knowledge and certify that I have been duly authorized by Applicant / Licensee to make the representations stated herein.

2. The Enhanced Services Facility's real property and/or building are or will be financed and/or insured by private and/or public entities (the "Entities"). "Entities" refer to banks, mortgage lenders, HUD, etc. Applicant / Licensee has executed or will execute agreements granting such Entities certain rights concerning the Enhanced Services Facility. Notwithstanding, Applicant / Licensee acknowledges full responsibility for operating the Enhanced Services Facility and providing care and services to residents as licensee. Applicant / Licensee may not transfer any of its legal responsibilities as licensee to the Entities or any other person or entity. Applicant is aware that should the Entities unreasonably interfere with the licensed operations at the Enhanced Services Facility, the Department of Social and Health Services may deem it necessary to take enforcement action against the enhanced services facility as authorized by RCW 70.97.110.

   I am duly authorized to sign this attestation on behalf of the applicant / licensee. I am an officer, director, or owner of 5% or more of the applicant / licensee.

   I certify and declare under penalty of perjury under the laws of the State of Washington that the forgoing is true and correct to the best of my knowledge.

DATED	CITY AND STATE WHERE SIGNED	PRINTED NAME

SIGNATURE*	TITLE

May not be signed by Management Company or Facility Administrator.

Remainder of this page intentionally left blank.

Washington State Department of Social & Health Services
Transforming lives

Enhanced Services Facilities
Policies and Procedures Attestation

_____ declares and states as follows:
(PRINT NAME)

1. I am the Administrator / designee of _____ and I make this declaration
(NAME OF FACILITY)
based on personal knowledge and certify that I have been duly authorized by the Facility to make the representations stated herein.

2. I hereby certify that _____ has developed and will implement the policies
(NAME OF FACILITY)
and procedures necessary to:

   - Maintain or enhance the quality of life for residents including resident decision making rights and mandated reporting requirements;
   - Provide the necessary care and services for residents, including those with special needs;
   - Safely operate the facility; and
   - Operate in compliance with applicable state and federal laws including, but not limited to, Chapters 70.97, 71.05, 71.69 and 74.34 RCW, and any applicable rules under these statutes.

3. I also certify that the facility's policies and procedures agree with all of the laws and rules that apply to the facility and the facility's operations. At a minimum the policies and procedures cover all of the care and services the facility provides including but not limited to the following:

   1) Transitioning new residents.
   2) Security precautions to meet the safety needs of the residents and the surrounding community.
   3) Crisis prevention and response protocol.
   4) Discharge planning.
   5) Compliance with resident rights, consistent with WAC 388-107-0190.
   6) Suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident.
   7) Situations in which there is reason to believe resident is not capable of making necessary decisions and no substitute decision maker is available.
   8) Situations in which a substitute decision maker is no longer appropriate.
   9) Situations in which a resident stops breathing or resident's heart appears to stop beating, including, but not limited to, any action staff persons take related to advance directives and emergency care.
   10) Response to emergencies.
   11) Urgent situations in the enhance service facility requiring additional staff support.
   12) Appropriate responses to residents engaging in aggressive or assaultive behavior, including, but not limited to:
      - Preventative actions for a behavioral crisis or violent behavior to ensure the safety of residents and the community.
      - Actions to take to protect other residents.
      - When and how to seek outside intervention.
      - Training on de-escalation techniques for managing resident's challenging behavior before it reaches the state of physical aggression or assault.
      - Techniques for staff to use in response to aggressive behaviors when de-escalations techniques have not succeeded.
      - Evaluation of the safety of the physical environment.
      - Issues of respect and dignity of the client.
      - Use of the least restrictive physical and behavioral interventions depending upon the situation, including the use of holding techniques to physically restrain residents.
   13) Preventing and limiting the spread of infections, including tuberculosis, consistent with WAC 388-107-0440.
   14) Providing subacute detoxification services approved by an authorized health care provider and ensuring resident health and safety.
   15) Prohibition of restraints, except when medically necessary.
   16) Use of medications, including marijuana, for staff or residents.
   17) Presence of firearms in the facility, including provisions for keeping firearms locked and accessible to authorized persons.

18) Safe transportation of residents and the qualifications of the drivers.
19) Management of pets in the enhanced services facility.
20) Medication process for resident outings.
21) Medications to include:
    - Medication services.
    - Pharmacy services.
    - Storing, securing and accounting for medications.
    - Resident controlled medications.
    - Medication refusals, including refusals of court ordered medication.
    - Are reviewed and updated annually.

I certify and declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

DATED	CITY AND STATE WHERE SIGNED	PRINTED NAME
SIGNATURE*	DATE	TITLE

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

Lease or Operating Agreement Attestation – Enhanced Services Facility

This attestation form must be completed and submitted to the DSHS Applications Unit if the applicant/licensee does not own the real property upon which the facility is located and occupies the property under a lease or other type of agreement. The attestation must be verified and signed by an officer, director, or owner of 5% or more of the applicant/licensee who has signature authority. Receipt by the Department of Social and Health Services (DSHS) of a copy of Applicant's lease or other agreement allowing the applicant to occupy and operate a licensed enhanced services facility on the real property does not constitute approval of such by DSHS. DSHS may choose to review the lease or other agreement on a random basis, or in response to a specific complaint covering the agreement that falls within the scope of DSHS' regulatory authority.

FACILITY'S NAME	
APPLICANT/LICENSEE'S NAME	REAL PROPERTY OWNER'S NAME
FORM OF AGREEMENT UNDER WHICH APPLICANT/LICENSEE HAS RIGHT TO OCCUPY REAL PROPERTY (LEASE, SUBLEASE, OPERATING AGREEMENT, ETC.)	
DATE AND TERM OF AGREEMENT SPECIFIED	
PRINTED NAME OF PERSON COMPLETING FORM	TITLE OF PERSON COMPLETING FORM

The signatory must initial each statement below.

I certify and declare under penalty of perjury that the following is true and correct:

_____ The applicant/licensee has a written agreement (the "Agreement") allowing it to occupy and operate a licensed enhanced services facility on the real property on which the facility is located.

_____ The Agreement identifies applicant/licensee as the entity that holds, or will hold, the enhanced services facility license.

_____ The Agreement does not purport to authorize or require transfer or assignment of applicant/licensee's enhanced services facility license to any other party upon default, termination or otherwise.

_____ The Agreement does not give the applicant/licensee the right to transfer, sell, or assign any interest in resident admission agreements or resident records to any other party or entity; all resident agreements are between the resident and the applicant/licensee.

_____ The Agreement does not require or permit the transfer of resident agreements or records to any party or entity upon termination of the Agreement without such other party or entity first being licensed by the Department of Social and Health Services to operate the enhanced services facility.

_____ The Agreement does not give any party or entity, other than applicant/licensee (or its managing agent), the department, or other parties authorized by law, the right to review resident records.

_____ The Agreement does not provide any party or entity with the right to dictate occupancy levels.

_____ The Agreement does not allocate, assign, or otherwise convey an interest in the "bed rights" to any party or entity other than applicant/licensee or the owner of the real property.

_____ The Agreement does not make any party or entity other than applicant/licensee legally responsible for the daily operations of the enhanced services facility.

_____ The Agreement does not provide any party or entity other than applicant/licensee with the right to request 1) an informal dispute resolution in response to state or federal survey reports; or 2) an administrative appeal of deficiencies cited on the state survey or enforcement actions imposed by the Department of Social and Health Services.

_____ The Agreement does not give any party or entity other than the applicant/licensee authority to submit plans of correction for violations of enhanced services facility laws or regulations or dictate terms of a plan of correction.

_____ The Agreement does not authorize any party or entity other than the applicant/licensee to re-enter, take possession and operate the facility as an enhanced services facility unless such party or entity first obtains an enhanced services facility license from the Department of Social and Health Services.

Check below as applicable:

☐ The Agreement does not provide budget approval to any party or entity other than applicant/licensee; or

☐ The Agreement provides budget approval to another party or entity, but does not prohibit applicant/licensee from expending its own funds to secure regulatory compliance as necessary.

I further certify and declare as follows:

- The applicant/licensee understands and agrees that the applicant/licensee is legally responsible for the daily operations of the enhanced services facility.
- The applicant/licensee understands and agrees that nothing in the Agreement, including the authority of a party or entity other than applicant/licensee to approve the facility budget, absolves applicant/licensee of its legal responsibility to ensure compliance with enhanced services facility laws and regulations.
- Agreements with residents for care and services provided by the facility are between the applicant/licensee and the resident.
- I am duly authorized to sign this attestation on behalf of the applicant/licensee. I am an officer, director, or owner of 5% or more of the applicant/licensee.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

DATED	CITY AND STATE WHERE SIGNED	PRINTED NAME

SIGNATURE*	TITLE

*** May not be signed by Management Company or Facility Administrator.**

Remainder of this page intentionally left blank.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 9504-5600

Management Agreement Attestation – Enhanced Services Facility

This attestation form must be completed and submitted to the DSHS Applications Unit if the applicant/licensee will use a management company at the enhanced services facility. The attestation must be verified and signed by an officer, director or owner of 5% or more of the applicant/licensee who has signature authority. Receipt by the Department of Social and Health Services (DSHS) of a copy of Applicant's Management Agreement does not constitute approval of such by DSHS. DSHS **may choose to review** the Management Agreement **on a random basis, or** in response to a specific complaint covering the agreement that falls within the scope of DSHS' regulatory authority.

FACILITY'S NAME	
APPLICANT / LICENSEE'S NAME	MANAGEMENT ENTITY'S NAME
PRINTED NAME OF PERSON COMPLETING FORM	TITLE OF PERSON COMPLETING FORM
Name of Facility	
Name of Applicant	
Name of Management Entity	
Mailing Address	
City, State, Zip Code	
UBI (Unified Business Identifier) of Management Entity	
Federal EIN (Employer Identification Number) of Management Entity	
Name of Contact Person (for management agreement)	
Telephone Number of Contact Person	
Email Address of Contact Person	
Fax Number of Contact Person	
Management Agreement Effective Date	

The signatory must initial each statement.

I certify and declare under penalty of perjury that the following is true and correct:

_____The applicant/licensee has a written management agreement with the above management company.

_____The management agreement complies with the enhanced services facility licensing requirements in Chapter 70.97 RCW and Chapter 388-107 WAC.

_____The written management agreement creates a principal/agent relationship between the applicant/licensee and the management company;

_____The management agreement does not delegate to the management company the licensee's legal responsibility to ensure that the enhanced services facility is operated in a manner consistent with applicable laws and regulations;

_____The management agreement does not delegate to the management company the responsibility to review for accuracy, acknowledge and sign all initial and renewal license applications;

_____The management agreement does not authorize the management company to represent itself as the licensee or give the appearance that it is the licensee;

_____All resident agreements shall be agreements between the resident(s) and the applicant/licensee as parties, even if they are executed by the management company on behalf of the applicant/licensee;

_____The applicant/licensee agrees to notify all residents and prospective residents in advance of the identity of the management company, the fact that the management company is retained on behalf of applicant/licensee, and shall be given contact information for the management company and the licensee;

_____The management company may use resident records and information to fulfill its obligations under the management agreement, but shall preserve the confidentiality of such records and shall not disclose or release them except as authorized by law. The applicant/licensee shall retain responsibility for such records and shall not transfer such responsibility to the management company unless the management company first becomes duly licensed to operate the enhanced services facility as licensee.

_____Applicant/licensee shall provide notice to DSHS in case of any of the following:

- Discharge of management company;
- Change of management company;
- Modification of existing management agreement, except regarding a change in the duration of the agreement.

I am duly authorized by applicant/licensee to sign this attestation on its behalf. I am an officer, director, or owner of 5% or more of the applicant/licensee.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

DATED	CITY AND STATE WHERE SIGNED	PRINTED NAME

SIGNATURE*	TITLE

*** May not be signed by Management Company or Facility Administrator.**

Remainder of this page intentionally left blank.

Washington State Department of Social & Health Services

Transforming lives

Enhanced Services Facility (ESF)
Staff Roster and Credentials

ENHANCED SERVICES FACILITY'S NAME
DATE

NAME	ROLE / TITLE

Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

Enhanced Services Facility (ESF) Application Checklist

Must be submitted with application.

Number or letter all attachments and indicate attachment number below.

If not applicable, write N/A.

- ☐ License fee ($1040/bed). Make check or money order payable to Washington State Treasurer. If no payment is included, the application **will not** be processed and **will be returned**.
- ☐ Individuals Affiliated with Applicant Supplemental Information form **Attachment Number** _____
- ☐ Agreement Not to Enter Facility **Attachment Number** _____
- ☐ Consent (Authorization) to Release and/or Use Confidential Information form for each person listed **Attachment #** _____
- ☐ Washington background authorization form for each person **Attachment Number** _____
- ☐ Administrator Attestation form **Attachment Number** _____
- ☐ Financial Attestation form **Attachment Number** _____
- ☐ Real Property and/or Building Related to Financing and/or Insurance Attestation form **Attachment Number** _____
- ☐ Policies and Procedures Attestation form **Attachment Number** _____
- ☐ Proof of EIN (refer to application instructions for acceptable document) **Attachment Number** _____
- ☐ Proof of UBI (refer to application instructions for acceptable document) **Attachment Number** _____
- ☐ Copy of business license showing facility name as registered trade name **Attachment Number** _____
- ☐ Copy of proof of liability insurance **Attachment Number** _____
- ☐ Organizational Structure/Chain of Ownership Chart **Attachment Number** _____
- ☐ Copy of an admission agreement (between resident and applicant) **Attachment Number** _____

If needed:

- ☐ Copy of purchase and sale agreement or appropriate document (section 6 of application form) **Attachment Number** _____
- ☐ Lease or Operating Agreement attestation (section 6 of application form) **Attachment Number** _____
- ☐ Copy of lease or other operating agreement (section 6 of the application form) **Attachment Number** _____
- ☐ Management agreement attestation with attachments (section 8 of application form) **Attachment Number** _____
- ☐ Copy of written management agreement (section 8 of application form) **Attachment Number** _____
- ☐ Staff Roster and Credentials **Attachment Number** _____
- ☐ Copies of staff credentials **Attachment Number** _____
- ☐ List of other licensed long-term care facilities in Washington managed by or licensed to management entity (if no Washington facilities, list out-of-state facilities) **Attachment Number** _____
- ☐ "Individuals Affiliated With Management Company Supplemental Information" form (section 8 of application form) **Attachment Number** _____
- ☐ Person, Individual and/or Entity Business and Compliance History details (section 9 question 1 of application form) **Attachment Number** _____
- ☐ Person, Individual and/or Entity Business and Compliance History details (section 9 question 2 of application form) **Attachment Number** _____
- ☐ Person, Individual or Entity Applicant Financial History (section 10 of application form) **Attachment Number** _____
- ☐ Out-of-state information on each person not living in WA for past three years: name, home address, city, state, zip code, dates of residence **Attachment Number** _____
- ☐ List of names, agencies or departments, and job titles of previous or current employees of the State of Washington listed in the application (section 12 of application form) **Attachment Number** _____

For Transfer of Ownership / License

- ☐ Letter from current licensee allowing the applicant to use the remainder of the current license fee **Attachment Number _____**
- ☐ Letter from current licensee relinquishing license when change of licensee (operator) is approved **Attachment Number _____**
- ☐ Copy of the Change of Ownership Notice to Residents **Attachment Number _____**
- ☐ Copy of certificate of authority, etc. from Secretary of State **Attachment Number _____**
- ☐ Financial History **Attachment Number _____**
- ☐ Other:

_____ **Attachment Number _____**

_____ **Attachment Number _____**

_____ **Attachment Number _____**

Before mailing this application, please:

- Ensure all questions have been answered. Do not leave any questions blank.
- Use "N/A" (Not Applicable) when question does not apply.
- Ensure any additional documents are attached.
- Enclose either a letter from the current licensee allowing license fees to be applied OR a check or money order made payable to **Washington State Treasurer**.
- Sign the application (an officer, director or owner of 5% or more of the applicant entity with signatory authority).