Certified Community Residential Services and Supports (CCRSS) Initial Application

CCRSS Application Checklist

The checklist below is to help support the applicant in the application process for a CCRSS certification. **Please do not submit the application instruction and resource document when submitting the application.**

- ☐ Copy of the Letter of Intent that includes contact information, geographical area of service and type of service provided.
- ☐ If applying for a group home, submit a copy of your current Adult Family Home (AFH) or Assisted Living Facility (ALF) license.
- ☐ Copy of your Washington State business license issued by Department of Revenue.
- ☐ Copy of document issued by Internal Revenue Service (IRS) showing Employer Identification Number (EIN) for the applicant.
- ☐ Complete and submit with the application packet the online background authorization form located at https://fortress.wa.gov/dshs/bcs/ for each person listed in section 10.
- ☐ Copy of DSHS fingerprint results if completed after January 1, 2012.
- ☐ Copies of the following documents:
  - Mission Statement **Skip if this is an expanded application.**
  - Business Plan **Skip if this is an expanded application.**
  - Policies **Skip if this is an expanded application.**
    - ✓ Reporting of Suspected Abuse, Neglect, Financial Exploitation
    - ✓ Medication management and assistance
  - CCRSS Policies and Procedure Attestation
- ☐ Relevant experiences and qualifications of the individual or agency.
- ☐ Copy of the Administrator Resume
- ☐ Three professional references for the Administrator
- ☐ Proof of high school diploma or GED equivalent for the Administrator **Skip if this is an expanded application**
- ☐ Statements of financial stability from the applicant.
- ☐ If application is for a change of ownership copy of the 60-day notice to the Department and 30 day notice to clients and/or their legal representatives WAC 388-101-3070.

The applicant must submit a revised application, if any information on the application changes before the initial certification is issued.

Submitting Application

Submit your application and supporting documents:

For US Postal Mail:	For Federal Express:
ALTSA BAAU	ALTSA BAAU
PO BOX 45600	4500 10TH AVE SE (BLAKE EAST)
OLYMPIA WA 98504-5600	LACEY WA 98503

Please note: Do not include the instructions / resource document when submitting the application packet. Do not staple or bind submitted documents.

If you have questions about completing the application, please email the Business Analysis and Applications Unit (BAAU) at BAAU@dshs.wa.gov or call 360-725-2573, we will respond within 48 hours.

Certified Community Residential Services and Supports Initial Application

Section 1. Type of Application

☐ **Initial**

☐ **Change of Ownership** (change of business entity ownership or the form of legal organization)
Certification Number for current provider:

Section 2. Type of Service Provided

☐ Supported Living Services
☐ Group Home
☐ Group Training Home

Section 3. Geographic Area of Service

LIST THE COUNTY WHERE SERVICES WILL BE PROVIDED (COMPLETE A SEPARATE APPLICATION FOR EACH COUNTY)

Section 4. Information About the Service Provider

1. NAME OF SERVICE PROVIDER (DOING BUSINESS AS)			
2. BUSINESS STREET ADDRESS	CITY	STATE	ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

4. TELEPHONE NUMBER	5. CONFIDENTIAL. FAX NUMBER	6. CELL PHONE NUMBER
7. EMAIL ADDRESS	8. WEB SITE URL	

Section 5. Legal Entity Information

1. LEGAL NAME OF ENTITY	
2. UBI NUMBER - -	3. EIN NUMBER -

Section 6. Individuals Associated with Service Provider (if sole proprietor skip to Section 8)

List all partners, officers, directors and majority owner of applying entity. If more space is needed attach additional page(s) to the application.

NAME OF PERSON	TITLE OR POSITION	DATE OF BIRTH (MM/DD/YYYY)	PERCENT OWNERSHIP
			%
			%
			%
			%
			%

Section 7. Administrator Information

1. NAME OF ADMINISTRATOR (LAST, FIRST, MIDDLE)	2. DATE OF BIRTH	3. TELEPHONE NUMBER
4. EMAIL ADDRESS		

Section 8. Sole Proprietors Only

1. NAME OF OWNER (LAST, FIRST, MIDDLE)	2. DATE OF BIRTH	3. TELEPHONE NUMBER

4. EMAIL ADDRESS

Section 9. Licensing, Contracting and Certification History

1. Has any person or entity named in this application ever owned, held an interest in, managed, or held a license or certification for an adult family home, assisted living facility, nursing home, community residential services, support agency or other business providing services to vulnerable adults, children or persons with mental illness or developmental disabilities? ☐ Yes ☐ No
2. Has any person or entity named in this application ever held a Medicaid or other social services contract to provide services to vulnerable adults, children or persons with mental illness or developmental disabilities? This includes Individual Provider contracts. ☐ Yes ☐ No
3. Has any person or entity named in this application ever had a contract terminated or a certification or license revoked or denied by the Department, or has been subjected to department enforcement actions? ☐ Yes ☐ No
4. Has any person or entity named in this application ever had an out-of-state contract or license involving the provision of services to children or vulnerable adults terminated, revoked or denied or has been a subject of an enforcement action related to the out-of-state contract or license? ☐ Yes ☐ No
5. Has any person or entity named in this application ever obtained or attempted to obtain a license or certification by fraudulent means or misrepresentation? ☐ Yes ☐ No
6. Has any person or entity named in this application ever relinquished or been denied a license or license renewal to operate a home or facility that was licensed for the care of children or vulnerable adults? ☐ Yes ☐ No
7. Has any person or entity named in this application ever had a court issue a permanent restraining order or order of protection, either active or expired, against a person that was based upon abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult? ☐ Yes ☐ No
8. Has any person or entity named in this application been registered as a sex offender? ☐ Yes ☐ No
9. Has any person or entity named in this application ever been listed on a registry based upon a final finding of abuse, neglect or financial exploitation of a vulnerable adult, unless the finding made by adult protective services prior to October 2003? ☐ Yes ☐ No
10. Has any person or entity named in this application ever had a founded finding of abuse or neglect of a child, unless the finding was made by child protective services prior to October 1, 1998? ☐ Yes ☐ No
11. Has any person or entity named in this application been found in any dependency action to have sexually assaulted or exploited any child or to have physically abused any child? ☐ Yes ☐ No
12. Has any person or entity named in this application been found by a court in a domestic relations proceeding under Title 26 RCW, or under any comparable state or federal law, to have sexually abused or exploited any child or to have physically abused any child? ☐ Yes ☐ No
13. Has any person or entity named in this application ever had a contract or license denied, terminated, revoked, or suspended due to abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult? ☐ Yes ☐ No
14. Has any person or entity named in this application ever relinquished a license or terminated a contract because an agency was taking an action against the individual related to alleged abuse, neglect, financial exploitation or mistreatment of a child or a vulnerable adult? ☐ Yes ☐ No

If "Yes" to any questions in this section, the following information is required to accompany the application packet:

- Name of the individual:
- Type of license, certification, or contract (if yes in numbers 1 – 6 above):
- Name and address of facility (if yes in numbers 1 – 6 above):

Date of action (if applicable): _____ * If more space is needed, attach additional page(s) to the application.

Section 10. Background Information

Complete an online background authorization form located at https://fortress.wa.gov/dshs/bcs/. Print and submit the completed background authorization form for each of the following:

- Partners, officers, directors and owner(s) of applying entity and for sole proprietor the spouse/domestic partner of the applicant
- Administrator

* If a Fingerprint check was performed on any person listed in this section after January 1, 2012, submit the results with application packet.

NAME OF PERSONS (ATTACH ADDITIONAL SHEETS OF PAPER IF NEEDED)	DATE OF BIRTH	JOB TITLE

Section 11. Current Employee of the State of Washington

Are any partners, officers, directors, and majority owner of applying entity currently employed by the Department of Social and Health Services? ☐ Yes ☐ No

If "yes" to the above question, list below the name and State job title of the person(s) in this application that is employed by the Department of Social and Health Services

NAME OF PERSON / JOB TITLE	ADMINISTRATION / DIVISION

Section 12. Consent to Release and/or Use Confidential Information

Each person listed in the application **must sign** this section.

I consent to the release and use of confidential information about me within the Department of Social and Health Services (DSHS) for purposes of certification. 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 information if a specific disclosure exemption exists. (RCW 42.56, Chapter 388-101 WAC and Chapter 388-101D WAC).

Completion of this form allows the use and sharing of confidential information within DSHS and with the individual applicant / agency for application processing purposes. DSHS may disclose and receive confidential information from outside agencies, divisions, offices and/or the police.

This consent is valid for as long as I am the person named in this application. A copy of this form is valid for my permission to release and use this information.

NAME OF INDIVIDUAL (PLEASE PRINT)	SIGNATURE	DATE

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NAME OF INDIVIDUAL (PLEASE PRINT)	SIGNATURE	DATE

Section 13. Applicant Certification

I 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 Certified Community Residential Services and Support Agency are true, complete, and accurate. I understand that the department may obtain additional information, verification and/or documentation related to my answers or information.

I certify that the administrator is at least 21 years of age or older, has a high school diploma or GED equivalent, and meets the qualification standards in WAC 388-101D.

Copies of all documents needed to verify the items in this application are attached, and original documents will be readily available to the department.

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

I understand that the department may check the credit of the corporation, individual or business and its principals; obtain a credit report; and verify any responses provided. The department will use such information and may disclose this information to other parts of the department as appropriate. 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 understand and agree that the information I give to the department will be used to verify the information in this application. Any information I give to the department may be used by the department for this purpose.

I understand that if my application for a Certified Community Residential Services and Support Agency is denied, I may request an administrative review within 28 days of receiving the denial letter from DSHS.

I have read and understand Chapters 71A.12, 74.34 71A.26 RCW and Chapters 388-101, 388-101D, and 388-828 WAC, and any other applicable laws and rules.

If/when I am certified:

- I understand that each staff I employ must meet the requirements of Chapter 388-829 WAC.
- I will not discriminate against any client or employee.
- No clients receiving care and services by the certified community residential services and support provider will be subject to discrimination on the basis 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 certify and declare under penalty of perjury under the laws of the State of Washington that the information in this application and all of the supporting documents are true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE	PRINT NAME

Section 14. CCRSS Policies and Procedures Applicant Attestation

_____ declares and states as follows:

PRINT APPLICANT'S NAME

1. I am the Applicant / Service Provider of _____ and I make this declaration
   AGENCY NAME
   based on personal knowledge and certify that I have been duly authorized by the CCRSS Service Provider to make the representations stated herein.
2. I hereby certify that _____ has developed and will implement
   AGENCY NAME
   and train staff on all policies and procedures, prior to serving clients. Policies and procedures will be updated as necessary, to meet WAC and RCW requirements to:
   - Maintain or enhance the quality of life for clients including client decision-making rights and mandated reporting requirements.
   - Provide the necessary care and services for all clients.
   - Operate in compliance with applicable state laws including, but not limited to, RCW 71A.12, RCW 74.34, RCW 71A.26, Chapters 388-101 WAC, Chapters 388-101D WAC, and Chapters 388-828 WAC.
3. I also certify that these policies and procedures meet all of the laws and rules which apply to the CCRSS Service Provider requirements to maintain compliance at all times with applicable laws and rules pertaining to certification requirements.
4. The service provider must develop, implement, and train staff on policies and procedures to address what staff must do:
   - Related to client rights, including a client's right to file a complaint or suggestion without interference or retaliation;
   - Related to soliciting client input and feedback on instruction and support received;
   - Related to reporting suspected abuse, neglect, financial exploitation, or abandonment;
   - To protect clients when there have been allegations of abuse, neglect, financial exploitation, or abandonment;
   - In emergent situations that may pose a danger or risk to the client or others, such as in the event of death or serious injury to a client;
   - In responding to missing persons and client emergencies;
   - Related to emergency response plans for natural or other disasters;
   - When accessing medical, mental health, and law enforcement resources for clients;
   - Related to notifying a client's legal representative, and/or relatives in case of emergency;
   - When receiving and responding to client grievances; and
   - To respond appropriately to aggressive and assaultive clients.
5. The service provider must develop, implement, and train staff on written policies and procedures for:
   - Immediately reporting mandated reporting incidents to:
     - The department and law enforcement;
     - Appropriate persons within the service provider's agency as designated by the service provider; and
     - The alleged victim's legal representative.
   - Protecting clients;
   - Preserving evidence when necessary; and
   - Initiating an outside review or investigation.
   - The service provider must not have or implement any policies or procedures that interfere with a mandated reporter's obligation to report.
6. The service provider must develop, implement, and train staff on policies and procedures in all aspects of the medication support they provide, including but not limited to:
   - Supervision;
   - Client refusal;
   - Services related to medications and treatments provided under the delegation of a registered nurse consistent with Chapter 246-840 WAC;
   - The monitoring of a client who self-administers their own medications;
   - Medication assistance for clients needing this support; and
   - What the service provider will do in the event they become aware that a client is no longer safe to take their own medications.
7. The service provide must maintain current written policies and procedures and make them available to all staff; and to clients and legal representative upon request.

DATED	CITY AND STATE WHERE SIGNED	APPLICANT'S PRINTED NAME
APPLICANT'S SIGNATURE		TITLE