

Department of Health and Human Services
Office of Legal and Regulatory Services
Health Facilities Administration
129 Pleasant St. Concord, N.H. 03301
Phone (603)271-9044 Fax (603)271-4968 TDD Access 1-800-735-2964
<https://www.dhhs.nh.gov/oos/bhfa/community-residences.htm>

REQUEST FOR CERTIFICATION OF COMMUNITY RESIDENCE AND/OR COMMUNITY PARTICIPATION SERVICES PROVIDER

Certification Type:	Physical Address of Certified Residence		Certification #
<input type="checkbox"/> New	Mailing Address of Certified Residence		Requested Start Date if New
<input type="checkbox"/> Renewal	Current Number of Slots	0 Residential 0 CPS	Expiration Date if Currently Certified
<input type="checkbox"/> Addition/Removal	Number of Slots Requested	0 Residential 0 CPS	
<input type="checkbox"/> Other	Type of Residence:	<input type="checkbox"/> Staffed Residence <input type="checkbox"/> Family Residence	
<input type="checkbox"/> Residential <input type="checkbox"/> CPS <input type="checkbox"/> Both Residential and CPS			
<i>Please Document Contact Information Below</i>			
Site Visit Contact Person Name			
Site Visit Contact Person Email			
Site Visit Contact Person Phone Number			
<i>Please Document Contact Information Below</i>			
Provider Name			
Provider Phone Number			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this home currently licensed?	
		If Yes above, please enter the type of license, and the license number in the space provided to the left.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this home currently under emergency certification?	
		If Yes above, please enter the emergency certification number in the space provided to the left.	
Community Participation Services (CPS)			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is any individual at the CPS program for more than one (1) hour per day?	
		If Yes above, please enter the date of the Life Safety Code Report in the space provided to the left, and attach the original to this form.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the CPS program located in a currently certified community residence?	
		If Yes above, please enter the certification number of the certified residence where the program is located in the space provided to the left.	

Please attach a separate list if there are more than four (4) people. Please answer "Yes" or "No" in the last two (2) columns

Individual Name	Date of Birth	Served By DS/ABD/BH	Number of hours of supervision as required by the ISA per day or week.	CPS Provider	Behavior Plan? "Yes" or "No"	Self-Administer Medications? "Yes" or "No"

Vendor Agency

Vendor Agency	
Vendor Agency Mailing Address	
Vendor Agency Phone Number	
Vendor Agency Contact Name	
Vendor Agency Contact Email	

Area Agency

Area Agency	
Area Agency Mailing Address	
Area Agency Phone Number	
Area Agency Contact Name	
Area Agency Contact Email	

List all non-family members currently receiving services in the home or CPS program not listed under individual information. Specify Date of Birth and funding source, if any:

Individual Name	Date of Birth	Funding Source

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was a Current Life Safety Code Report Attached? If this is a new Residential Program, a new facility based CPS program, or an addition of a certified bed, the LSC report cannot precede the date of this application by more than 90 days.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are any waivers required? If yes, please attach the most recent approved waiver, or a copy of the request.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any provider or adult household member, excluding the Individual(s), been convicted of a felony or misdemeanor, or had a substantiated report of abuse, neglect, or exploitation? If Yes, please attach a current waiver. RSA 161-F:49, He-M 507.10(f)-(i), He-M 1001.15(a)(1)-(3) and He-M 1002.14(a)(1)-(3).

I swear or affirm that the information provided on this application is accurate to the best of my knowledge and belief. I believe that this residence/community participation service program is in full compliance with the statutes and regulations governing these services. I understand that providing false information shall be grounds for denial, suspension or revocation of the certification.

Please enter the name, title and authorized signature of the Residential or CPS Director above

Please enter the date the application was signed above