[redacted]

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, NH 03301
TDD Access: Relay NH 1-800-735-2964
Agency Phone: 603-271-9039

MAY 31 2023

APPLICATION FOR RESIDENTIAL, HEALTH CARE LICENSE OR SPECIAL HEALTH CARE SERVICES

EXISTING FACILITY LICENSE #: _____
CURRENT FACILITY LICENSE EXPIRATION DATE, IF APPLICABLE: _____

THIS APPLICATION SHALL BE FILLED OUT IN ACCORDANCE WITH RSA 151:4. A SEPARATE APPLICATION MUST BE SUBMITTED FOR EACH LICENSURE CATEGORY. **PLEASE BE SURE TO COMPLETE THE ENTIRE APPLICATION**. IF A SECTION DOES NOT APPLY TO YOUR FACILITY, MARK NOT APPLICABLE (N/A). FAILURE TO COMPLETE THE APPLICATION WILL RESULT IN A DELAY IN THE LICENSURE PROCESS. SEND THE ENTIRE COMPLETED FORM TO THE ADDRESS ABOVE. IF YOU NEED TO REVIEW YOUR LICENSING RULES, THEY CAN BE FOUND ONLINE AT: https://www.dhhs.nh.gov/administrative-rules-health-facilities

Check all applicable items:

- ☐ License renewal:
- ☐ *New owner:
- ☐ **Change in address:
- ☒ *New facility:
- ☐ **Change in # of beds:
- ☐ Other (please explain):
- ☐ ***Change in classification:

* Requires processing as a new application.
** Requires Local Approval Forms
***Requires both

LICENSEE (Legal Owner of Facility): Isabel Bernadette Applegreen TELEPHONE #: 203-788-3611

NAME OF FACILITY (DBA): Elderly Caregivers LLC TELEPHONE #: (203) 682-7438

FAX #: (__) _____

STREET ADDRESS: 31 West Street CITY: Danbury STATE: CT ZIP: 06810

MAILING ADDRESS: 31 West Street CITY: Danbury STATE: CT ZIP: 06810

ADMINISTRATOR: _____

MEDICAL DIRECTOR (IF APPLICABLE): N/A

FACILITY E-MAIL ADDRESS (REQUIRED): clientcare@liveinsfortheelderly.com

IF APPLICABLE:
NUMBER OF BEDS: PRESENTLY LICENSED: N/A TOTAL # TO BE LICENSED: N/A

NUMBER OF HCBC CFI OR STATE PLACED INDIVIDUALS IN HOME (Complete for He-P 804, He-P 805 and He-P 814): N/A

NUMBER OF ESRD STATIONS (Completed for He-P 811 licensees only): N/A

BRANCH OFFICE LOCATIONS (Complete if applies under He-P 809.07, 819.07, 822.07 & 823.07 only):
N/A

OWNERSHIP

a. Type of ownership: ☐ Association ☑ LLC ☐ Partnership ☐ Individual ☐ Corporation ☐ Other (explain

b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility. Bernadette applegreen [redacted] Isabel

c. If the licensee is organized as an association or corporation, list the name of the association or corporation and the name, address, and title of each officer. Elderly Caregivers LLC Bernadette Applegreen owner/manager

d. If the licensee is a partnership, list the name and address of each partner. N/A

e. Is this a certified facility? **(Facilities with deem status under RSA 151)** ☐ YES ☑ NO
Only applies to He-P 802, 803, 809, 811, 812, 815, & 823

If you are already a certified facility, is this an increase in services? If YES, please call 1-800-852-3345 ext. 9049

f. Are you planning on being a certified facility? If YES, please call 1-800-852-3345 ext. 9049 N/A

FEES: NO N/A

Hospitals (General, CAH, Psychiatric, Rehabilitation) (802)	$25 per licensed bed
Free Standing Emergency Rooms (802)	$500
Nursing Homes (803)	$25 per licensed bed
Residential and Supported Residential Care Homes (804 & 805)	$15 per licensed bed (NO CHARGE FOR HCBC OR NH STATE PLACED RESIDENTS)
Non-Emergency Walk-In Care Centers (806)	$500
Residential Treatment and Rehabilitation Facilities (807)	$25 per licensed bed
Home Health Care Providers (809)	$250
Birthing Centers (810)	$150
End Stage Renal Disease Dialysis Centers (811)	$500
Ambulatory Surgical Centers (812)	$500
Intermediate Care Facilities for Individuals with Intellectual Disabilities(ICF/IID)(815)	$25 per licensed bed
Educational Health Centers (816)	$500
Adult Day Care Centers (818)	$200
Case Management Agencies (819)	$150
Home Care Service Provider Agencies (822)	Less than ten clients $25; Ten or more clients $250
Home Hospice Care Providers (823)	$250
Hospice Houses (824)	$25 per licensed bed
Substance Use Disorder Residential Treatment Facilities (826)	$25 per licensed bed
Freestanding Megavoltage Radiation Therapy Facility (827)	$500
Psychiatric Residential Treatment Programs (830)	$25 per licensed bed

A check or money order (payable to: TREASURER, **STATE OF NEW HAMPSHIRE)** must be attached to this application.

Applications submitted by those facilities exempt under RSA 151:4 I (a), (b) & (c) are not required to pay the license fee.

ADDITIONAL APPLICATION REQUIREMENTS: NOTE THAT NOT ALL APPLICATION REQUIREMENTS ARE LISTED HERE PLEASE REFER TO THE APPROPRIATE RULE TO DETERMINE OTHER ITEMS THAT NEED TO BE SUBMITTED.

1. N/A Renewal applications must be submitted at least 120 days prior to expiration of the current license. **(Yearly)**

2. Attached Include qualifications, including a resume with education and experience, and copies of all applicable licenses and certifications, for the administrator and medical director **(if applicable). (Initial Application Only, unless changing Administrator or Medical Director)**

3. N/A Include information relative to whether the facility has been granted any waivers, exemptions, or variances to the rules by the Department of Health and Human Services and/or the State Fire Marshal. **(Yearly)**

4. N/A Include a floor plan indicating the location of all rooms, # of beds in each bedroom, and fire exits. **(Initial Application Only – NOT FOR He-P 809, 819, 820 & 823)**

5. Attached Include NH Secretary of State Authority to do business in the State of NH and/or tradename registration **(Initial Application Only)**

6. N/A Include written local approvals from the health officer, the building official, the zoning officer, and the fire chief. For a building under construction, the written approvals required shall be submitted at the time of the application based on the local official's review of the building plans and again upon completion of the construction project. **(Initial Application Only for ALL categories)**

7 N/A Include documentation that the water supply has been tested in accordance with RSA 485 and Env-Dw 702.02 and 704.02 (formerly Env-Ws 313.01 and 314.01). **(Initial Application Only – NOT FOR He-P 809. 819, 820 & 823)**

8. N/A Include documentation that **every 3 years** the water supply has been tested for bacteria and nitrates and determined to be at acceptable levels, in accordance with Env-Dw 702.02 (formerly Env-Ws 313.01) for bacteria and Env-Dw 704.02 (formerly Env-Ws 314.01) for nitrates. **(NOT FOR He-P809. 819, 820 & 823)**

9. N/A Include a list of all employees who have previously been granted waivers for criminal background check results from the Department of Health and Human Services. **(Yearly and on initial application if change of ownership or category)**

10. Attached Include the results of a criminal records check to include results for the state of New Hampshire for the applicant(s), the licensee (owner even if entity) if different than the applicant, the administrator, medical director and, if applicable, each household member 17 years of age or older who resides at the facility. **(Initial Application Only)**

FACILITY SERVICE DESCRIPTION: Complete even on renewal

The following information will be used to determine which licensure category your facility will be placed in.

I. Provide a detailed description of the services and programs you wish to provide.

*II. Describe the facility's health care you wish to provide to residents.

*III. Identify who will provide the health care listed in II.

*To be completed if applying for beds

SIGNATURES: This application must be signed by:

1. The owner if a private facility;
2. Two officers if a corporation;
3. Two authorized individuals if an association or partnership; or
4. The head of the government agency if a government unit.

I affirm that I am familiar with the requirements of RSA 151 and the rules adopted thereunder and that the premises are in full compliance. I understand that providing false information shall be grounds for denial, suspension, or revocation of the license and the imposition of a fine.

DATE: 05-26-23 SIGNED: Isabel B. Applegren Owner
(NAME AND TITLE)

DATE: 05-26-23 SIGNED: Isabel B Applegren Owner
(NAME AND TITLE)

For all facilities to be newly licensed as an ambulatory surgical center (He-P 812), hospital (He-P 802), birthing center (He-P 810), walk in care center (He-P 806), dialysis center (He-P 811), or special health care service (He-P 802 and He-P 827) located within a 15 mile radius of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c):

I affirm that I have complied with 151:4-a and a determination is on file with the department that finds the proposed health care facility shall be allowed to apply for licensure.

DATE: _____ SIGNED: _____
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

HFA OFFICE USE ONLY

CHECK NUMBER: 375 AMOUNT: $25

APPLICATION COMPLETE: _____ NOT COMPLETE: _____ (Describe in comments)

NEW ☑ RENEWAL ☐ CHANGE ☐

QUALIFICATIONS OF ADMINISTRATOR	Required ☐	Not Required ☐	Received ☐
COPY OF ADMINISTRATOR LICENSE	Required ☐	Not Required ☐	Received ☐
LIST OF EMPLOYEES WITH WAIVERS	Required ☐	Not Required ☐	Received ☐
WATER TEST (INITIAL OR 3YR)	Required ☐	Not Required ☐	Received ☐
FLOOR PLAN*	Required ☐	Not Required ☐	Received ☐
SECRETARY OF STATE INFORMATION	Required ☐	Not Required ☐	Received ☐
LOCAL APPROVAL	Required ☐	Not Required ☐	Received ☐
LSC INSPECTION	Required ☐	Not Required ☐	Received ☐
LSC PLAN OF CORRECTION	Required ☐	Not Required ☐	Received ☐
LICENSURE INSPECTION	Required ☐	Not Required ☐	Received ☐
PLAN OF CORRECTION	Required ☐	Not Required ☐	Received ☐
COMPLIED WITH RSA 151:4-a	Required ☐	Not Required ☐	Received ☐

FEDERAL FACILITY (EXEMPT FROM INSPECTION) YES ☐ NO ☑

LICENSURE CATEGORY:

- ☐ 02 Hospitals (General, CAH, Psychiatric, Rehabilitation)
- ☐ 03 Nursing Homes
- ☐ 04 Residential Care Home Facility
- ☐ 05 Supported Residential Health Care Facility
- ☐ 06 Non-Emergency Walk-in Care
- ☐ 07 Residential Treatment & Rehabilitation Facility
- ☐ 09 Home Health Care Provider
- ☐ 10 Birthing Center
- ☐ 11 End Stage Renal Disease Dialysis
- ☐ 12 Ambulatory Surgical Center
- ☐ 14 Community Residence
- ☐ 15 ICF/IID
- ☐ 16 Educational Health Services
- ☐ 18 Adult Day Care
- ☐ 19 Case Management
- ☐ 22 Home Care Service Provider
- ☐ 23 Home Hospice Care Provider
- ☐ 24 Hospice House
- ☐ 26 Substance Use Disorder Res Treatment Facility
- ☐ 27 Freestanding Megavoltage Radiation Therapy
- ☐ 30 Psychiatric Residential Treatment

REVIEWED BY: _____
(NAME & TITLE) (DATE)

ISSUE ANNUAL LICENSE: YES ____ NO ____

LICENSE CERTIFICATE DATES: FROM _____ TO _____

NUMBER OF PATIENTS/STATIONS/BEDS: _____

NOTES:

COMMENTS ON CERTIFICATE:

Bernadette Applegreen

Owner/Operator Elderly Caregivers LLC CT & MA

2012 - Present

Opened Elderly Caregivers to address the special needs of her private clients.

- Assists with recruitment, selection, hiring, orientation, and evaluation of home care site personnel
- Manage clinical and administrative staffing in the local home care site(s)
- Facilitate care coordination between home care site and regional home care center
- Manage and provide ongoing education, in-service training programs and competency evaluations to improve patient care and employee efficiency for all health care personnel
- Positively represent the Company to the customer; and the customer to the Company
- Develop professional rapport with key partners within the respective geographic area. Provide support to the sales force

Owner/Operator Live-Ins for the Elderly

2000 – Present

Started her own home agency when she saw how important the need was for the aging to live in their own homes for as long as possible. They functioned better and were happier and more assured in a familiar environment. In addition, Bernadette saw that home care could be less expensive than the nursing home option. Bernadette manages the entirety of business operations.

Licensed Practical Nurse

1988 – Present

35 years of experience includes work in nursing homes, hospitals, and patient's private homes in both South Africa and the United States.

State of New Hampshire

Department of State

ELDERLY CAREGIVERS LLC
Isabel Applegreen
31 West St
Danbury, CT 06810

State of New Hampshire

Department of State

2/14/2023 4:30:00 PM

Isabel Applegreen
31 West St
Danbury, CT, 06810, USA

Enclosed is the acknowledgment copy of your creation filing. It acknowledges this office's receipt and filing of your documents.

This business is required to file an annual report and pay a $100.00 filing fee annually due by April 1st of each year. Reports filed after the due date will be assessed a late fee of $50.00. As a courtesy our office will send a reminder notice in January of each year by mail or email. Annual reports may be filed on-line or downloaded from our website at https://quickstart.sos.nh.gov/online.

If you are unable to obtain a report through our website, you should contact this office to request one. Please Note: It is the responsibility of this business to obtain a report and submit for filing prior to April 1st of each year.

Businesses that do not file their annual reports and/or fees will be administratively dissolved or suspended.

Please Note: A benefit corporation must also prepare an annual benefit report 120 days following the end of the fiscal year, please refer to RSA 293-C:12 & RSA 293-C:13.

Should you have any questions, you may contact this office at the phone number or email address below. Please reference your Business ID Number when contacting our office.

Please visit our website for helpful information regarding all your business needs.

Sincerely,
Corporation Division

Business ID: **923807**
Filing No: **6119204**

State of New Hampshire

Filing fee: $100.00
Use black print or type.

Filed
Date Filed : 02/14/2023 04:30:00 PM
Effective Date : 02/14/2023 04:30:00 PM
Filing # : 619204 Pages : 2
Business ID : 923807
David M. Scanlan
Secretary of State
State of New Hampshire

CERTIFICATE OF FORMATION
NEW HAMPSHIRE LIMITED LIABILITY COMPANY

THE UNDERSIGNED, under the New Hampshire Limited Liability Company Laws submits the following certificate of formation:

FIRST: The name of the limited liability company is Elderly Caregivers LLC

Principal Business Information:

Principal Office Address: 31 West Street Danbury, CT 06810
(no. & street) (city/town) (state) (zip code)

Principal Mailing Address (if different): _____
(no. & street) (city/town) (state) (zip code)

Business Phone: (203) 628-7438

Business Email: clientcare@elderlycaregivers.com

✔ Please check if you would prefer to receive the courtesy Annual Report Reminder by email.

SECOND: Describe the nature of the primary business or purposes (and if known, list the NAICS Code and Sub Code): We provide non medical health care services for the elderly.

THIRD: The name of the limited liability company's registered agent is:
Registered Agents Inc

The complete address of its registered office (agent's business address) is:
84 W Broadway, Ste 200, Derry, NH 03038
(no. & street) (city/town) (state) (zip code)

FOURTH: The management of the limited liability company is ☒ vested in a manager or managers.

CERTIFICATE OF FORMATION OF A
NEW HAMPSHIRE LIMITED LIABILITY COMPANY

Form LLC-1
(Cont.)

MANAGER / MEMBER INFORMATION (List all Managers and/or Members you wish to be placed on record)		
NAME	BUSINESS ADDRESS	TITLE
Isabel Applegreen	31 West Street Danbury, CT 06810	Manager

*Signature: Isabel B. Applegreen

Print or type name: Isabel Applegreen

Title: Manager
(Enter "manager" or "member")

Date signed: 2-13-23

Note: The sale or offer for sale of membership interests of the limited liability company will comply with the requirements of the New Hampshire Uniform Securities Act (RSA 421-B). The membership interests of the limited liability company: 1) have been registered or when offered will be registered under RSA 421-B; 2) are exempted or when offered will be exempted under RSA 421-B; 3) are or will be offered in a transaction exempted from registration under RSA 421-B; 4) are not securities under RSA 421-B; OR 5) are federal covered securities under RSA 421-B. The statement above shall not by itself constitute a registration or a notice of exemption from registration of securities within the meaning of sections 448 and 461(i)(3) of the United States Internal Revenue Code and the regulation promulgated thereunder.

* The document shall be signed by a "manager" and if there is no manager, by a "member" or see RSA 304-C:28 V for alternative signatures.

DISCLAIMER: All documents filed with the Corporation Division become public records and will be available for public inspection in either tangible or electronic form.

State of New Hampshire

Department of State

Work Order #: 20230130089261

Receipt Date/Time: 02/15/2023 09:59:12 AM

Payer Information:

Isabel Applegreen
31 West St
Danbury, CT, 06810, USA

Payer Customer ID: 492966

Filer Information:

Isabel Applegreen
31 West St
Danbury, CT, 06810, USA

Filer Customer ID: 492966

Payment Information:

Date	Payment Type	Payment Reference	Authorization #	Payment Status	Payment Amount
02/15/2023 09:59:04 AM	Rejection Funds	Transaction ID#: 20220130087443001	N/A	Paid	$100.00
				Total Payment Received:	**$100.00**

Transaction Description:

Transaction #	Description	Reference Information
20230130089261-001	Business Formation - Domestic Limited Liability Company	ELDERLY CAREGIVERS LLC

Transaction Information:

Date Received	Transaction #	Processing Status	Invoice Status	Amount
02/14/2023 04:30:00 PM	20230130089261-001	Accepted	Paid	$100.00
			Total	**$100.00**

Drawdown Account Balance:	$0.00	**Total Due:**	$0.00
Credit Account Balance:	$0.00	**Total Refunded:**	$0.00
		Total Change To Credit Account Balance:	$0.00

State of New Hampshire

Department of State

CERTIFICATE OF EXISTENCE

OF

ELDERLY CAREGIVERS LLC

This is to certify that **ELDERLY CAREGIVERS LLC** is registered in this office as a **New Hampshire Limited Liability Company** to transact business in New Hampshire on 2/14/2023 4:30:00 PM.

Business ID: **923807**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 14th day of February A.D. 2023.

David M. Scanlan
Secretary of State

To: DHHS Licensing Dept.

From: Isabel Bernadette Applegreen Owner/Manager

For Elderly Caregivers LLC

4/18/2023

Please let this letter serve as signed statement for employment acceptance that I:

1. Do not have a felony conviction in this or any other state
2. 2. Have not been convicted of a sexual assault, other violent crime, assault, fraud, theft, abuse, neglect, or exploitation or pose a threat to the health, safety, or well-being of a client; and
3. Have not had a finding by the department or any administrative agency in this or any other state for assault, fraud, theft, abuse, neglect, or exploitation of any person.

Respectfully submitted,

Isabel Bernadette Applegreen

Isabel Bernadette Applegreen

#10

To: DHHS Licensing Dept.

From: Isabel Bernadette Applegreen Owner/Manager

For Elderly Caregivers LLC

4/18/2023

Please let this letter serve as signed statement for employment acceptance that I:

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2. 2. Have not been convicted of a sexual assault, other violent crime, assault, fraud, theft, abuse, neglect, or exploitation or pose a threat to the health, safety, or well-being of a client; and
3. Have not had a finding by the department or any administrative agency in this or any other state for assault, fraud, theft, abuse, neglect, or exploitation of any person.

Respectfully submitted,

Isabel B. Applegreen

Isabel Bernadette Applegreen

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
Bureau of Licensing and Certification
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, New Hampshire 03301-3857
TDD Access: Relay NH 1-800-735-2964
Agency Phone Number: 603-271-9039

☑ Initial Licensing – This includes a change in ownership or address other than a 911 change
☐ A change in current licensing category
☐ New Construction and/or Renovation of Existing Building
☐ An increase in occupancy (ie: Beds, ESRD Stations or Clients)

Please note: All applicants must have each final inspection signed by local officials, even if they do not see clients at their place of business. This is to confirm that the local authorities are aware that a business is operating at the identified location and that the business complies with all local ordinances pursuant to RSA 151:4,III(3).

Please note: Applicants that are planning new construction, modifying/renovating or requesting a bed increase that involves modifications to the building must have both the plan review sections as well as the final inspection sections of the form completed and signed by building and fire officials.

FACILITY NAME: Elderly Caregivers
STREET ADDRESS: 31 West Street
OWNERS'S NAME: Isabel Applegren
ADMINISTRATOR NAME: Dale Applegren
TELEPHONE NUMBER: 203-628-7138
PROPOSED TYPE OF FACILITY: Home Care Agency

Local authorities please complete and sign each section:

HEALTH OFFICER ✓

I HEREBY CERTIFY THAT THE ENTITY _____ COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE CITY/TOWN OF _____.

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ DOES NOT REQUIRE HEALTH, SEWAGE AND WATER APPROVAL OF THIS FACILITY/ESTABLISHMENT.

NUMBER OF BEDS/CLIENTS: N/A beds 4/clients

FINAL INSPECTION: DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF HEALTH OFFICIAL)

BUILDING REGULATIONS ✓

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ BUILDING DEPARTMENT HAS REVIEWED THE PLANS FOR _____ ON _____ APPROVED___ DENIED___

PLAN REVIEW: DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF BUILDING OFFICIAL)

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ BUILDING DEPARTMENT HAS INSPECTED _____ ON _____ AND OBSERVED THE FOLLOWING VIOLATIONS:

_____

_____

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ BUILDING DEPARTMENT HAS INSPECTED _____ ON _____ AND ALL PREVIOUS VIOLATIONS HAVE BEEN CORRECTED.

53 New town

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ BUILDING DEPARTMENT HAS INSPECTED _____ ON _____ AND FOUND NO VIOLATIONS OF THE BUILDING CODE.

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ DOES NOT HAVE LOCAL BUILDING CODES OR REGULATIONS.

NUMBER OF BEDS/CLIENTS: _____

FINAL INSPECTION: DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF BUILDING OFFICIAL)

ZONING REGULATIONS

I HEREBY CERTIFY THAT THE ENTITY _____ COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF _____

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ DOES NOT HAVE LOCAL ZONING REGULATIONS.

NUMBER OF BEDS/CLIENTS: _____

FINAL INSPECTION: DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF ZONING OFFICIAL)

FIRE REGULATIONS ✓

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 CHAPTER _____.)

_____

_____

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ FD HAS REVIEWED THE PLANS FOR _____ ON _____ APPROVED ___ DENIED ___

PLAN REVIEW: DATE: _____ SIGNATURE: _____
(FIRE CHIEF OR DESIGNEE)

I HEREBY CERTIFY THAT THE CITY/TOWN OF DANBURY Fire Marshal FD HAS INSPECTED 31 West St. Emergency Lighting ON 7/10/22 AND OBSERVED THE FOLLOWING VIOLATIONS:

Emergency Lighting R32:0 in office Area.

_____

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ FD HAS INSPECTED _____ ON _____ AND ALL PREVIOUS VIOLATIONS HAVE BEEN CORRECTED.

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ FD HAS INSPECTED _____ ON _____ AND FOUND NO VIOLATIONS OF THE STATE AND/OR LOCAL MUNICIPAL FIRE CODE.

NUMBER OF BEDS/CLIENTS: Ø

FINAL INSPECTION: DATE: _____ SIGNATURE: Timothy St... D.P. Fire Marshal
(FIRE CHIEF OR DESIGNEE)

CITY OF DANBURY

DEPARTMENT OF PUBLIC UTILITIES
155 DEER HILL AVENUE
DANBURY, CT 06810
(203) 797-4637
FAX (203) 796-1590

31 WEST ST

[redacted] 04-01 6/01/23 7/03/23

Total Current Charges
Past Due Balance
Total Amount Due [redacted]

00001168300015136

141 MAIN LLC
31 WEST ST 1ST FLOOR
DANBURY CT 06810

1

31 WEST ST

[redacted] 04-01 6/01/23 7/03/23

Last Bill Amoun
Payments
Adjustments
Past Due Balanc

Rate Class : COMMERCIAL
Last payment amount/date: 210.05 4/04/23

	Service Period		Days	Meter Number	Mult	Units	Current	Previou
WA	1/18/23	4/19/23	91	22092785	1.000	MGAL	702	69

	Service	Consumption	Charge
WA	USAGE OF 8 MG	8.00	[redacted]
SW	O&M - 95%/WA @ $3.19	7.60	
SW	DEBT- 95%/WA @ $9.16	7.60	
	TOTAL SEWER		

Total Current Charges
Past Due Balance
Total Amount Due

Please note: Interest on past due balance is calculated throug
Any additional interest accrued will be included
bill. Call the Tax Office for current amount due.

Average cost per day

CITY OF DANBURY
155 DEER HILL AVENUE
DANBURY, CONNECTICUT 06810

PLANNING & ZONING DEPARTMENT
www.danbury-ct.gov

(203) 797-4525
(203) 797-4586 (FAX)

June 26, 2023

Re: 31 West Street (I14148)
Owned by 141 Main LLC

To Whom It May Concern:

The above referenced property consists of approximately 9,147± sq.ft. and is located in the Residential High-Rise Zone (RH-3). The purpose of this zone is to provide for: a compatible mix of high density residential, limited commercial, institutional and neighborhood uses in the urban core of the City.

The Tax Assessor's records indicate that the building was originally constructed in 1888 and remodeled in 1948. The historic use of the building has been business or professional office space since at least 1965. Building Department records indicate that there was a permit for interior alterations issued in 1973. There is no site plan on file for this location but in 2021, site approval was granted to permit a 1,180 sq.ft. church in the lower level of this building. The other approved uses in the building are business & professional offices on the first and second floor. There are twelve parking spaces located in the rear of the site and that was determined to be adequate for the uses within the building. Churches currently are a permitted use in this zone and in 2005 the Zoning Regulations were amended and business and professional offices became a special exception use. So, the use of this property as business or professional office and a church in accordance with the 2021 site approval is legal non-conforming.

Additionally, I am not aware of any outstanding zoning violations or outstanding Cease & Desist Orders on this property.

Sincerely,

Sean P. Hearty
Director of Permit Coordination/
Zoning Enforcement Officer

SPH/jr