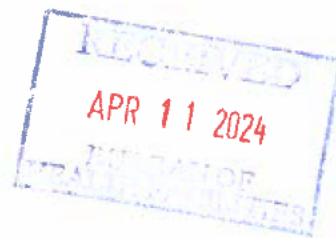


I 19

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



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

EXISTING FACILITY LICENSE #: N/A
CURRENT FACILITY LICENSE EXPIRATION DATE, IF APPLICABLE: N/A

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:
- Case management**
- Other (please explain):
- ***Change in classification:

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

LICENSEE (Legal Owner of Facility): Caroletta Alicea & Kasai Mumpini TELEPHONE #: (603) 836-4400
NAME OF FACILITY (DBA): Community Integrated Services TELEPHONE #: (603) 836-4400
FAX #: (603) 499-7472

STREET ADDRESS: 373 S. willow St D2-3 CITY: Manchester STATE: NH ZIP: 03103

MAILING ADDRESS: 373 S. willow St D2-3 CITY: Manchester STATE: NH ZIP: 03103

ADMINISTRATOR: Pamela Tweed

MEDICAL DIRECTOR (IF APPLICABLE): N/A

FACILITY E-MAIL ADDRESS (REQUIRED): ptweed@cishh.org

IF APPLICABLE: N/A

NUMBER OF BEDS: PRESENTLY LICENSED: _____ TOTAL # TO BE LICENSED: _____

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 applying under 819

OWNERSHIP

- a. Type of ownership: Association Partnership Corporation
 LLC Individual Other (explain)
- b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility *please see enclosed*
- 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.
- d. If the licensee is a partnership, list the name and address of each partner.
- 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

FEES:

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. Renewal applications must be submitted at least 120 days prior to expiration of the current license. **(Yearly)**
2. 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. 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. 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. Include NH Secretary of State Authority to do business in the State of NH and/or tradename registration **(Initial Application Only)**
6. 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. 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. 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. 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. 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: 4/9/24 SIGNED: Jiri Kasai Mumpini co-owner
(NAME AND TITLE)

DATE: 4/10/24 SIGNED: Leopoldetta G. Silveira co-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: 4/9/24 SIGNED: Jiri Kasai Mumpini co-owner
(NAME AND TITLE)

DATE: 4/10/24 SIGNED: Leopoldetta G. Silveira co-owner
(NAME AND TITLE)

HFA OFFICE USE ONLY

CHECK NUMBER: 231689
 APPLICATION COMPLETE: _____

AMOUNT: 150.00
 NOT COMPLETE: _____

(Describe in comments)

NEW RENEWAL CHANGE

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

FEDERAL FACILITY (EXEMPT FROM INSPECTION) YES NO

LICENSURE CATEGORY:

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

To Whom It May Concern:

Community Integrated Services (CIS) is seeking a license in New Hampshire to provide case management services. The primary location for these services is 373 S. Willow St. Suite D2-3, Manchester, NH. The following pages contain additional information required for the application process. Thank you for your time in reviewing the application.

OWNERSHIP:

CIS is a corporation owned by Caroletta Alicea and Kasai Mumpini, located at 64B Old Suncook Rd, Concord, NH, 03310. The licensee is not a corporation or an association there it is not applicable. Community Integrated Services is not a partnership nor is it considering becoming a certified facility.

FEES:

CIS will pay a \$150 fee applying under He-P 819, making some questions on the application not applicable.

ADDITIONAL DOCUMENTS & INFORMATION

This is the initial application for case management services and the administrator is Pamela Tweed, MSW. In addition to this document, enclosed is her resume, completed background check, BAES registry check, and signed statement that reports no convictions of a crime. Her email address is ptweed@cisnh.org. Additionally, there is a CORI background check on the agency.

There have been no waivers provided by DHHS & the State Fire Marshall for CIS.

4. It is not applicable to provide a floor plan.
5. Secretary of State reports CIS is in good standing to do business (enclosed)
6. Zoning approval is enclosed.
7. Not applicable for this application due to being under 819.
8. not applicable for this application due to being under 819
9. No employees have been granted waivers.
10. CORIs required for applicants and owners have been included.

FACILITY SERVICE DESCRIPTION:

CIS is seeking to provide case management services for individuals in the New Hampshire area out of the office located in Manchester, NH in compliance with RSA 151 and He-P 819. These services will include consultation with the client in the client's place of residence for the ongoing assessment, coordination, and monitoring of services to a client by an employee of CIS. Case managers are responsible for a client's ongoing psychosocial & risk assessment, creating a person-centered care plan in conjunction with the individual. Case managers will utilize person-centered planning with individuals while recognizing the client's ongoing needs and progress to be reflected in a client's care plan. They will ensure that services are implemented by frequency and timeframe, as outlined in the care plan. These services will work to meet the physical, emotional, medical, nursing, financial, legal, and social service needs of the client.

Professional Summary

Experienced Youth and Family Support Specialist with over 15 years working in the mental health field. Skilled in Behavior Management, Training, Public Speaking, Working with Adolescents, Nannying, Collaborative Care Planning, Crisis Management, Documentation, and working with individuals who are neurodivergent or struggle with serious emotional disturbances. Proficient in Microsoft Office, excellent writing skills, and open to learning new platforms. Master's Degree holder with a special focus in Social Work from Salem State University. Excellent rapport with clients, families, and colleagues.

Education

Salem State University, Salem, MA
Master of Social Work, Child and Family Services, 2018

Merrimack College, North Andover, MA
Bachelor of Arts Degree, Sociology, *Magna cum Laude* May 2009

Experience

Latitude Learning Resources

Guidance and Support Specialist

Derry, NH
September 2021-May 2023

- Enforce non-profit values through teaching and curriculum planning
- Create a curriculum with a focus on behavioral reinforcement and individualized skill attainment outcomes
- Monitor and support unique developmental needs
- Documentation and assessment of student behavioral patterns and intervention planning
- Crisis management for children with special needs
- Summer program management
- Personal training and development for staff
- Management of co-operations in a collaborative way alongside teachers and students

Nanny

Nanny for neurodivergent youth

Auburn, NH
January 2019-September 2021

- Collaborating with caregivers to supply developmentally appropriate curriculum
- Monitoring three children with unique needs
- Supplying ongoing emotional and social supports
- Social and pragmatic skill training for youth as needed

Neighbors in Need

Volunteer

Lawrence, MA
September 2018-2020
April 2017-September 2017

- Connect clients to community resources including food pantries, WIC, clothing, hot meals, and shelters
- Assist with fundraising opportunities, and work with new volunteers to train on company policies

Beverly Bootstraps

Social Work Internship (600-Hour Internship)

Beverly, MA
December 2017-May 2018

- Organized Hi-Set (formerly GED) classes, kept material up to date for students
- Witness ongoing daily operations of non-profit business entity

Federal Probation

Social Work Internship (464-hour Internship)

Lawrence, MA
September 2014-June 2015
June 2015-September 2015

- Coordinated care for individuals on probation which ensured their medical and mental health needs were met
- Mentored and trained upcoming Intern for the following academic school year
- Provide support, coaching, mentoring to dual diagnosis individuals based on personal and court-appointed goals

Pamela L. Tweed



Lowell Treatment Center: Community Services

Lowell, MA

Outpatient Service Counselor

December 2010-July 2016

- Teach children with a variety of mental health diagnoses, to understand, direct, interpret, manage, and control feelings and emotional responses to situations according to treatment plan goals
- Counsel at-risk individuals in age-appropriate behaviors, interpersonal communication, problem-solving, and conflict resolution, relating appropriately to others
- Provide orientation and training to new staff
- Complete directorial duties in the director's absence, including overseeing staff, assigning cases, facilitating staff meetings & training, and mentoring new staff members

The Edinburg Center

Lexington, MA

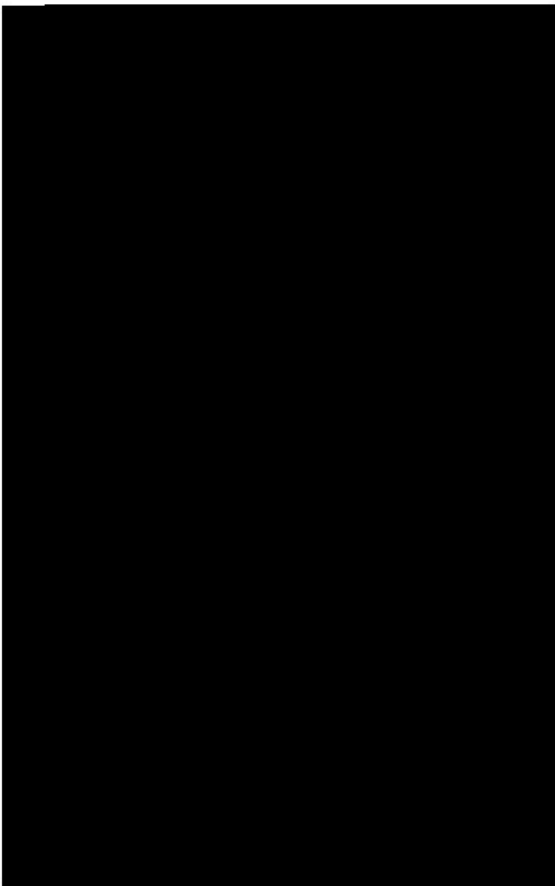
In-Home Behavior Monitor

October 2012-July 2016

- Provide in-home behavioral services monitoring for at-risk youth with mental health diagnoses including mood disorder, bipolar disorder, intermittent explosive disorder, ADHD, PTSD, dual diagnoses, developmental disabilities, and autism spectrum disorders
- Model, coach, and support caregivers on how to implement strategies identified in the behavior management plan
- Collaborate with the Masters-level behavior therapist (Board Certified Behavior Analyst) to ensure behavior management plans and risk-management and safety plans are implemented
- Identify needs for plan modifications if the youth is not achieving goals and objectives identified in behavior management plans

Professional Development & Training:

- Behavior Management
- Suicide Prevention
- Effective Strategies to Teach Social Skills to Young Children
- Evidenced Based Practices & Treatment for Children with Autism
- OSHA Standards, First Aid & CPR
- Mandt Certification





Regional Office
373 South Willow Street D2-3
Manchester, NH 03103
Phone: (603) 836-4400 | Fax: (603) 499-7472
Web: www.cisnh.org

To Whom It May Concern:

Community Integrated Services is seeking approval to provide case management services for individuals out of the Manchester, NH office. Pamela's email address is Ptweed@cisnh.org
Pamela Tweed, case manager of CIS attests to the following:

I, Pamela Tweed, do not have a felony conviction in this or any other state. I have not been convicted of sexual assault, assault fraud, abuse, neglect, exploitation, or pose a threat to the health safety, and well-being of any person. I have not had a finding by the department of any administrative agency in this or any other state for assault, fraud, abuse, neglect, or exploitation of any person.

Pamela Tweed
Pamela Tweed

3/25/24

Pamela Tweed
Pamela Tweed

3/25/24

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that COMMUNITY INTEGRATED SERVICES, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on June 19, 2014. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: 710585

Certificate Number: 0006631196



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 25th day of March A.D. 2024.

A handwritten signature in black ink, appearing to read "D. Scanlan", written over a horizontal line.

David M. Scanlan
Secretary of State

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
603-271-9039

Dear Local Authority,

In accordance with RSA 151:4,III(3) the entity/individual listed below requires certification that the operation of a home health/case management agency at the address below conforms with applicable local rules, regulations and ordinances having to do with health and safety. Please sign the approval acknowledgment to confirm you are aware that a business is operating at the identified location and that the business complies with all local ordinances. For questions or comments please contact hfa-licensing@dhhs.nh.gov. Thank you.

AGENCY NAME: Community Integrated Services
STREET ADDRESS: 373 South Willow St Unit D2-3 Manchester, Nh
OWNERS'S NAME: Kasai Mumpini
ADMINISTRATOR NAME: Chet Bowen
PROPOSED TYPE OF AGENCY: Case Management

ZONING REGULATIONS

I HEREBY CERTIFY THAT THE AGENCY COMMUNITY INTEGRATED SERVICES COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF MANCHESTER.

or

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

DATE: 3-21-24

SIGNATURE: 
(NAME AND TITLE OF ZONING OFFICIAL)

Curran, Marilee

From: Curran, Marilee
Sent: Friday, April 12, 2024 3:29 PM
To: Pamela Tweed
Cc: Beyer, Paulette
Subject: Case Management Application Community Integrated Services

Good afternoon, Pamela:

In accordance with RSA 151-A:14, the Office of Legal and Regulatory Services hereby acknowledges receipt of your application and fees in the amount of \$ 150.00 for a Case Management Agency.

Review of your application indicates that it has been completed in accordance with RSA 151:4, and He-P 819, the rules of the Office of Legal and Regulatory Services for a Case Management Agency

Staff from this office are available for consultation visits to assist you in achieving compliance. In order to receive a license you must be in full compliance with all applicable laws and rules at the time of your inspection.

Accordingly, an inspection of your facility/agency will occur within the next 60 days to determine compliance with RSA 151, and He-P 819. After the inspection is complete, you will be notified as to the Office of Legal and Regulatory Services decision to approve or deny your application for licensure as a Case Management Agency under RSA 151.

If you have any questions regarding your application the application process or the provisions of RSA 151 and the rules of the Office of Legal and Regulatory Services which apply to your licensure request, Please do not hesitate to contact me.

Take Care

Marilee D. Curran, MS
Licensing Database Administrator
DHHS
Health Facilities Administration-Licensing
129 Pleasant St.
Concord, NH 03301
Phone (603) 271-9041
Fax (603) 271-4968

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