NEW YORK STATE DEPARTMENT OF HEALTH
MEDICAL RESPITE PROGRAM
APPLICATION FOR CERTIFICATION

Type of Application *(Select one)*

☐ Initial certification

☐ Recertification

☐ Change in program capacity

Current number of beds:

Proposed number of beds:

☐ Change in population served

Current population:

Proposed population:

☐ Transfer of program ownership

Legal name of current program operator:

Certificate number for current program:

Proposed date of transfer:

PART 1 | BASIC INFORMATION

Instructions. Provide all information requested below. The program **operator** is the entity responsible for the administrative and business functions of the medical respite program. The program **facility** is the physical space in which medical respite services are provided. Depending on how your program is organized, the operator and the facility may share the same address and contact information, or they may each have a different address and contact information.

1.1 PROGRAM OPERATOR		
Legal Name (*Enter the name of your organization exactly as it appears on your Certificate or Articles of Incorporation*)		
Doing Business As (DBA)/Assumed Name *(DBA/assumed name must be registered with county clerk or NYS Department of State)*		
Federal Employer ID #		
Full Name of Contact Person		
Title of Contact Person	**Email Address**	
Telephone Number *(Include extension if applicable)*	**Fax Number**	
Street Address		
City	**Zip Code**	**County**
Mailing Address *(If different from street address)*		
City	**Zip Code**	**County**

1.2 PROGRAM FACILITY

The program facility has:

- ☐ Same contact information as program operator *(Skip to section 1.3)*
- ☐ Different contact information from program operator *(Provide facility contact details below; then proceed to section 1.3)*

Email Address	**Telephone Number**	**Fax Number**

Street Address		
City	**Zip Code**	**County**
Mailing Address *(If different from street address)*		
City	**Zip Code**	**County**

1.3 PROGRAM PRIMARY CONTACT

The primary contact person for the medical respite program is:

- ☐ Same as **contact person for program operator** identified in section 1.1
- ☐ Different contact person *(Provide details below)*

Full Name	
Title	**Email Address**
Telephone Number *(Include extension if applicable)*	**Fax Number**
Address	
City	**Zip Code**	**County**

1.4 APPLICATION PRIMARY CONTACT

The primary contact person for this application is:

- ☐ Same as **contact person for program operator** identified in section 1.1
- ☐ Same as **primary contact person for program** identified in section 1.3
- ☐ Different contact person *(Provide details below)*

Full Name	
Title	**Email Address**
Telephone Number *(Include extension if applicable)*	**Fax Number**
Address	
City	**Zip Code**	**County**

PART 2 | PROGRAM LEADERSHIP

2.1 CORPORATE STRUCTURE

Does the program operator have a parent organization or any subsidiaries?

- ○ Yes; I will **attach a full corporate organizational chart** that includes the following information for each entity listed:
  - Legal entity name;
  - Tax identification number; and
  - For-profit or not-for-profit status.
- ○ No

2.2 ADMINISTRATOR

Pursuant to 10 NYCRR §1007.6, the operator must designate an individual to be responsible for operating the program in compliance with applicable regulations and executing through direct performance or coordination the services and functions required by applicable law.

☐ By checking this box, I hereby certify that the administrator named below meets the minimum educational requirements defined by NYS Department of Health (DOH) in *Guidance on Staffing*, available on the DOH Medical Respite Program webpage. Additionally, I will:

- Attach a copy of the administrator's resume to this application; **and**
- Describe the administrator's relevant qualifications in Part 3: Description of Community Relationships.

Full Name		
Title	**NPI or NY Medicaid ID** *(If applicable)*	
Telephone Number	**Email Address**	
Mailing Address		
City	**Zip Code**	**County**

2.3 OTHER OFFICERS

Provide contact information for each board member or corporate officer associated with the medical respite program; attach additional pages if needed. (Note: If the administrator identified in section 2.2 is also a board member or corporate officer, you do **not** need to list their information again below.)

Officer #1 Full Name	
Title	**NPI or NY Medicaid ID** *(If applicable)*
Telephone Number	**Email Address**
Officer #2 Full Name	
Title	**NPI or NY Medicaid ID** *(If applicable)*
Telephone Number	**Email Address**

2.3 OTHER OFFICERS *(CONTINUED)*	
Officer #3 Full Name	
Title	**NPI or NY Medicaid ID** *(If applicable)*
Telephone Number	**Email Address**
Officer #4 Full Name	
Title	**NPI or NY Medicaid ID** *(If applicable)*
Telephone Number	**Email Address**
Officer #5 Full Name	
Title	**NPI or NY Medicaid ID** *(If applicable)*
Telephone Number	**Email Address**
Officer #6 Full Name	
Title	**NPI or NY Medicaid ID** *(If applicable)*
Telephone Number	**Email Address**
Officer #7 Full Name	
Title	**NPI or NY Medicaid ID** *(If applicable)*
Telephone Number	**Email Address**
Officer #8 Full Name	
Title	**NPI or NY Medicaid ID** *(If applicable)*
Telephone Number	**Email Address**

2.4 MORAL CHARACTER

Does the program operator, or any parent organization:

- Appear on the Internal Revenue Service charities revocation list, or have any other material deficiencies with respect to the operator's not-for-profit status? ○ Yes ○ No

- Have a deficiency regarding its registration status with the New York State Attorney General's Charities Bureau, or any other deficiency that would preclude it from being in good standing with any agency within the State of New York? ○ Yes ○ No

Has the program operator, its administrator, any of its directors or officers, or any parent organization:

- Been listed on any federal or state list of persons excluded from participation in the Medicaid or Medicare programs, or any similar exclusion lists for other public programs? ○ Yes ○ No

- Have a record of poor performance in the results of monitoring reviews, complaint investigations, or fiscal or quality control audits performed by the Department of Health or any other governmental entity? ○ Yes ○ No

- Been convicted for any crime (felony or misdemeanor), including pleading guilty or nolo contendere, in any court? ○ Yes ○ No

- Been accused of criminal conduct for which charges are currently pending in any court? ○ Yes ○ No

- Had an application for licensure or license renewal denied by a health care agency, social services agency, or professional licensing body? ○ Yes ○ No

- Been the subject of disciplinary action by a health care agency, social services agency, or professional licensing body, such as having a license revoked, annulled, cancelled, surrendered, suspended, placed on probation; or receiving fines, censures, reprimands, or other disciplinary action? ○ Yes ○ No

If *Yes* to any of the above questions, you *must* attach:

- A statement of moral character describing the circumstances and current status; **and**
- Appropriate documentation.

PART 3 | DESCRIPTION OF COMMUNITY RELATIONSHIPS

Please attach a short memorandum or letter describing the character, experience, competency, and standing in the community of the medical respite program operator and, as applicable, the administrator, directors, and officers named in sections 2.2 and 2.3 above. Please briefly describe any existing or anticipated relationships with partners such as State or local agencies, hospitals, outpatient healthcare providers, and relevant community-based organizations.

PART 4 | INTENT TO SERVE SPECIAL SUBPOPULATION

Pursuant to 10 NYCRR §1007.2, the medical respite program may exclusively serve a special subpopulation of homeless individuals if such limitation is necessary to ensure the availability of a funding source that will support program operations.

Will the medical respite program **exclusively** serve a special subpopulation of homeless individuals (e.g., clients of NYS Office for People with Developmental Disabilities, clients of NYS Office of Mental Health, women, veterans)?

○ Yes *(Answer both questions below; attach additional pages and/or supporting documentation if desired)*

○ No *(Proceed to section 5.1)*

Briefly describe the special subpopulation.

Identify any funding sources that are contingent on the medical respite program **exclusively** serving the special subpopulation.

PART 5 | MEDICAL SERVICES

5.1 REQUIRED MEDICAL CARE

Pursuant to 10 NYCRR §1007.6, the operator must provide staff sufficient in number and qualified by training, background and experience to render all required medical respite services.

☐ By checking this box, I hereby certify that the medical respite program has a plan to ensure the availability of appropriate medical care as defined in DOH's *Guidance on Staffing*, available on the DOH Medical Respite Program webpage. Additionally, I will:

- Attach documentation of the medical respite program's plan for providing the minimum required medical services (e.g., service contract with a telehealth provider, nursing agency contract, copies of relevant licenses for permanent staff).

5.2 MEDICATION STORAGE

Pursuant to 10 NYCRR §1007.12, the facility must provide storage for recipient medications, including refrigeration for medications requiring cold storage.

☐ By checking this box, I hereby certify that the medical respite program has a plan to ensure the availability of appropriate secure storage for recipient medications as defined in DOH's *Guidance on Medication*, available on the DOH Medical Respite Program webpage. Additionally, I understand that DOH or its contractor will verify the presence of all required technical features during an on-site inspection of the program's storage units.

PART 6 | PROGRAM POLICIES AND TEMPLATES

Each medical respite program must develop internal policies and/or procedures related to all topic areas identified below:

- Eligibility assessment and service plan
- Care coordination *(including telehealth)*
- Services
- Medication *(including storage and disposal)*
- Discharge planning *(including length of stay and involuntary discharge)*
- Discharge appeals process
- Staff *(including staffing pattern, minimum qualifications, and training)*
- Infection control
- Incident Reporting
- Grievance and complaint process
- Quality Improvement Program process

Note that each topic area does not necessarily require a separate policy and/or procedure; rather, multiple topic areas may be addressed within the same policy and/or procedure, depending on the program operator's preferences.

Each medical respite program must also develop forms or adopt DOH templates for the following:

- Eligibility Assessment
- Recipient Rights
- Recipient Rules and Code of Conduct
- Medication Rules
- Admission Agreement
- Service Plan
- Discharge Summary
- Complaint/Grievance Form
- Recipient Transfer Form
- Daily Census
- Certificate of Interpretation
- Certificate of Translation

To assist program operators, DOH anticipates offering a downloadable toolkit of template forms on the DOH Medical Respite Program webpage. Programs may adopt the templates, modify the templates to suit program needs, or make their own forms. Please submit copies of all forms listed above, even if the program plans to adopt the DOH template.

Please submit copies of all policies, procedures, and templates your program currently uses or intends to adopt as a certified medical respite program. All policies/procedures and templates must satisfy the requirements established in 10 NYCRR Part 1007 and in DOH guidance posted on the DOH Medical Respite Program webpage. DOH will review the submitted materials and notify the program operator of any deficiencies. The program operator will then have an opportunity to update and resubmit the materials.

PART 7 | ATTESTATION

The undersigned affirms under penalty of perjury that the answers and statements made in this application are true and have been made and given with the intent of having the New York State Department of Health (DOH) rely on the truth thereof. The undersigned agrees to keep and make available for inspection and submit such statistical, financial, program, business or other information, records or reports relating to the medical respite program for a minimum of ten years as requested by DOH or a contractor acting on DOH's behalf.

Print full name of signatory *(Must be corporate officer or another authorized person*)*	
Title of signatory	
Signature	**Date**

**Proof of authorization is required.*