Application for Home Care Licensure: Schedule 1

Personal Identifying Information (Print or Type)

1. Name

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name_____ Middle Initial_____ Last Name_____

Street Address _____

City_____ State_____ Zip _____

Telephone_____ Social Security Number_____

Date of Birth _____ Place of Birth _____

2. Formal Education

Institution	Address	Attended From	Attended To	Degree	Date Received

3. Professional Licenses/Certifications Held

If Not Applicable, Please Check Here: ☐

Type of Professional License/Certification (Include Specialty)	License/ Certification Number	Institution Granting License/Certification (Mailing Address, Phone & E-mail)	Effective Date	Expiration Date

4. Affirmative Statement of Qualifications

All individuals must provide an affirmative statement explaining why they are qualified to operate the proposed facility/agency. Attach additional pages as necessary.

5. Employment History for the Past 7 Years

☐ Currently Employed ☐ Currently Unemployed ☐ Retired If retired, please specify date of retirement ____________________

Start with MOST RECENT employment including employment with the applicant, if applicable. All employment during the last 7 years must be included. A resume or curriculum vitae (CV) may be substituted for this portion of the application but any additional information requested below and not contained in such resume or CV must be added. Please photocopy and attach additional sheets, if necessary.

Name of Employer ____________________

Street Address ____________________

City ____________________ State __________ Zip ____________________

Dates of Employment From ____________________ To ____________________

Position/Title ____________________

Reason for Departure ____________________

Name of Employer ____________________

Street Address ____________________

City ____________________ State __________ Zip ____________________

Dates of Employment From ____________________ To ____________________

Position/Title ____________________

Reason for Departure ____________________

Name of Employer ____________________

Street Address ____________________

City ____________________ State __________ Zip ____________________

Dates of Employment From ____________________ To ____________________

Position/Title ____________________

Reason for Departure ____________________

Name of Employer ____________________

Street Address ____________________

City ____________________ State __________ Zip ____________________

Dates of Employment From ____________________ To ____________________

Position/Title ____________________

Reason for Departure ____________________

Name of Employer ____________________

Street Address ____________________

City ____________________ State __________ Zip ____________________

Dates of Employment From ____________________ To ____________________

Position/Title ____________________

Reason for Departure ____________________

6. Offices Held or Ownership Interests in Health Facilities

Start with MOST RECENT affiliation and include any affiliations as referenced below during the last 7 years. Please photocopy and attach additional sheets, if necessary.

The purpose of this section is to obtain a listing of all affiliations as referenced below with which the owners, board officers, directors, controlling persons or partners of the proposed organization have been associated in the past 7 years. Affiliation, for the purposes of this section, includes serving as an owner/operator, voting officer, director or principal stockholder of any health care, adult care, behavioral or mental health facility, program or agency requiring licensure or certification in New York State. If you have served as an owner/operator, voting officer, director or principal stockholder in similar facilities or programs outside of New York State, you must also disclose that information. Include facilities for which applications were previously disapproved or withdrawn.

Provide documentation from the appropriate regulatory agency in the states (other than New York State) where you note affiliations, reflecting that the affiliated facilities, programs and agencies operated in substantial compliance with applicable codes, rules and regulations for the past 7 years (or for the period of your affiliation, whichever is shorter). Instructions for the out-of-state review, a sample letter of inquiry and a recommended form are provided in Schedule 2D to assist you in securing this information.

If Not Applicable, Please Check Here: ☐

From___________ To___________ Name of Facility/Agency ______________________________

Address of Facility/Agency ______________________________

Type of Facility/Agency ______________________ Office Held/Nature of Interest ______________________

Name of Licensing Agency ______________________ License/Operating Certificate Number ______________________

Address of Licensing Agency ______________________________

From___________ To___________ Name of Facility/Agency ______________________________

Address of Facility/Agency ______________________________

Type of Facility/Agency ______________________ Office Held/Nature of Interest ______________________

Name of Licensing Agency ______________________ License/Operating Certificate Number ______________________

Address of Licensing Agency ______________________________

From___________ To___________ Name of Facility/Agency ______________________________

Address of Facility/Agency ______________________________

Type of Facility/Agency ______________________ Office Held/Nature of Interest ______________________

Name of Licensing Agency ______________________ License/Operating Certificate Number ______________________

Address of Licensing Agency ______________________________

From___________ To___________ Name of Facility/Agency ______________________________

Address of Facility/Agency ______________________________

Type of Facility/Agency ______________________ Office Held/Nature of Interest ______________________

Name of Licensing Agency ______________________ License/Operating Certificate Number ______________________

Address of Licensing Agency ______________________________

C. Enforcement Actions

During the period of your affiliation listed above, were any of the facilities subject to an enforcement or administrative action taken by the State regulatory agency due to the facility's violation of applicable laws and regulations? Attach additional pages as necessary.

☐ Yes ☐ No ☐ Not Applicable

If Yes, please provide the following information:

Nature of Violation

Agency or Body Enforcing Violation (Name & Address)

Has the enforcement or administrative action been resolved? ☐ Yes ☐ No If No, please provide an explanation:

7. Record of Legal Actions

1. Except for minor traffic violations, have you ever been convicted of, or had a sentence imposed for a crime? ☐ Yes ☐ No
2. Are there any criminal actions pending against you? ☐ Yes ☐ No
3. Have you ever been named as a defendant in any civil action, including but not limited to malpractice, fraud or breach of fiduciary responsibility? ☐ Yes ☐ No
4. Are there now or have there ever been any civil or administrative actions pending against you involving Medicaid or Medicare issues? ☐ Yes ☐ No
5. Are there now or have there ever been any civil or administrative actions pending against you or any professional/business entity with which you are affiliated? ☐ Yes ☐ No
6. Are there now or have there ever been any insurance arbitration awards against you or any professional/business entity with which you are affiliated? ☐ Yes ☐ No
7. Have you ever been involved in a hearing before an official body in relation to the operation of a home or institution caring for people? ☐ Yes ☐ No

   If the answer to any of the above questions is "Yes," complete the section below. Attach additional sheets if necessary.

   Date of Action_____ Type of Action _____

   Location of Action _____

   Persons and/or Facilities Involved _____

8. Have you ever changed your name (including a maiden name) or used an alias? ☐ Yes ☐ No

   If Yes, provide details

9. During the last 7 years, have you been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period been suspended, revoked or otherwise subjected to administrative action? ☐ Yes ☐ No
10. Have you ever been involved in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of any securities, insurance, workers compensation, taxes, labor law or regulation or health law or regulation? ☐ Yes ☐ No

11. Have you ever been an officer, trustee, management employee or controlling stockholder of a company, including the applicant company, where you occupied any such position or served in any such capacity wherein the company:

a. Became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship? ☐ Yes ☐ No

b. Was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation? ☐ Yes ☐ No

c. Was the subject of an investigation by either federal or state law enforcement agencies on issues related to Medicare or Medicaid fraud? ☐ Yes ☐ No

d. Was required to enter into a Corporate Integrity Agreement as part of a settlement with the Office of Inspector General of the U.S. Department of Health and Human Services? ☐ Yes ☐ No

e. Suffered the suspension or revocation of its certificate of authority or license to do business in any state? ☐ Yes ☐ No

f. Was denied a certificate of authority or license to do business in any state? ☐ Yes ☐ No

If the answer is Yes to Questions 9, 10, or 11, attach an explanation, including, where applicable, the date, type, and location of the action and all relevant details.

12. Have you ever been in a position that required a fidelity bond? ☐ Yes ☐ No
Were any claims made against that bond? If Yes, provide details below: ☐ Yes ☐ No

13. Have you ever been denied a fidelity bond or had such fidelity canceled or revoked? ☐ Yes ☐ No
If Yes, provide details below:

8. Confirmatory Statement

I have reviewed the above document and attest that all information is complete, true and accurate.

Please sign in witness of a Notary Public. **Please Note:** The Notary Public cannot be associated with the application.

Signature _____ Date _____

Print or Type Name_____ Title _____

STATE OF _____, COUNTY OF _____

ss:

On the _____ day of _____ in the year _____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____ personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Signature of Notary Public _____

Notary Public: State of _____