NEW YORK STATE DEPARTMENT OF HEALTH
Division of Long Term Care

Internal Use Only
Tracking Number: _____
Date Received: _____

Assisted Living Program (ALP) 6000 – OPPORTUNITY FOR DEVELOPMENT (OFD)

IMPORTANT: Please read the **ALP 6000 – OPPORTUNITY FOR DEVELOPMENT FORM INSTRUCTIONS** before completing this form.

1. ELIGIBLE APPLICANT

FACILITY INFORMATION

Facility Name	Operating Certificate Number	
Facility Address (Street and Number, Building and Floor)	City	Zip Code
	County	

APPLICANT INFORMATION* (Please check one: ☐Lead Applicant ☐Co-applicant)

Name	Title	
Address (Street and Number, Building and Floor)	City	Zip Code
	Telephone No.	E-Mail Address

*Must be an eligible applicant (see Form Instructions, Section 3)

NAME & ADDRESS TO WHOM CORRESPONDENCE SHOULD BE SENT (If different from Applicant)

Name	Title	
Address (Street and Number, Building and Floor)	City	Zip Code
	Telephone No.	E-Mail Address

2. OFD PROPOSAL SUMMARY

A concise summary of your proposal must be attached. The proposal must specifically state the following:

- the Economic Development Region and County in which ALP beds will be located (List of Regions available at http://www.health.ny.gov/health_care/medicaid/redesign/index.htm);
- how your proposal fits into the current long-term care continuum in the Region;
- documented information to support your proposal to expand access to Assisted Living Program (ALP) beds and where there may be unmet demand; include incidences of those moving from an Adult Care Facility (ACF) or hospital setting to a Residential Health Care Facility (RHCF) due to their care needs;
- if a new licensed ACF, the type of ACF proposed (i.e., Adult Home or Enriched Housing Program);
- the total number of new licensed ACF beds proposed and the total number of ALP beds proposed;
- if already licensed as an ACF, clearly indicate whether you are proposing to convert licensed ACF beds to ALP beds and/or proposing to add new ACF/ALP beds;
- the number of RHCF beds you propose to decertify, if any. **Note**: Decertification of RHCF beds is not a requirement for selection under this opportunity;
- the projected timeline for the ALP beds to become operational (i.e., when the ALP beds become licensed) and;
- your commitment to the admission and retention of individuals eligible for or in receipt of Supplemental Security Income, safety net assistance or Medical Assistance Your proposal must indicate the expected number and percentage of ALP residents upon admission by payer source.

3. PROGRAM INFORMATION

Provide information as stated in the Form Instructions, (Section 3.), and complete the chart below.

ACF RESIDENTIAL SERVICES - Bed Complement

TYPE	Adult Home or Enriched Housing Beds	Assisted Living Program (ALP) Beds	Skilled Nursing Facility Beds	Other Beds (specify)	Total
Licensed Adult Care Facilities:					
1.Licensed ACF Beds: ☐AH ☐EHP					
2.Licensed ALP Beds					
3.Change in licensed ACF Beds					
Unlicensed beds/facilities:					
4.Proposed ACF Beds: ☐AH ☐EHP					
5.Proposed ALP Beds					
Total Current and Proposed ACF beds					
6.RHCF Beds being Decertified, if any					

4. LEGAL REQUIREMENTS

The entity must have ownership of or right of access to real property (18 NYCRR 485.6(d)(11),(12) and (13)) for example, a deed, lease, sales contract or agreement.

5. FINANCIAL INFORMATION

Estimate of Total Project Cost: The total cost must be provided by applicants who are proposing new construction or rehabilitation/purchase of an existing structure, or are planning to purchase a licensed ACF. Examples of costs that should be included are land acquisition (if applicable), cost of building (purchase price of licensed facility, cost of new construction or cost of rehabilitation of existing building), site development, architect cost, soft costs, an any applicable RHCF decertification costs.

6. ARCHITECTURAL COMPONENT(S)

The process for completing the architectural component is addressed in the Assisted Living Program (ALP) Certificate of Need (CON) application.

7. LICENSED HOME CARE SERVICES AGENCY (LHCSA)

The applicant proposing to operate an Assisted Living Program must obtain licensure as a LHCSA or a Certified Home Health Agency (CHHA) with approval to serve the county in which the ALP will operate.

Is the applicant shown above an existing LHCSA, or a CHHA? ☐ Yes ☐ No

If yes, provide the following:

LHCSA License # _____ CHHA Operating Certificate # _____

Agency Name _____

Counties currently served: _____

Operator _____

Please be advised that a $2,000.00 application fee is required for submitting a LHCSA Addendum. After submission of your LHCSA addendum, you will be contacted by the Department's Bureau of Project Management regarding payment of the application fee.

8. CERTIFICATION

I/We certify that the information submitted on this form and on any attachment to this form is true, accurate and complete in all material respects. (Attach additional sheets if necessary.)

APPLICANT SIGNATURE(S):

By: _____ Date: _____
(signature)

Printed Name: _____

Title: _____

By: _____ Date: _____
(signature)

Printed Name: _____

Title: _____

STATE OF NEW YORK)
)SS.:
County of _____)

On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Signature and office of the individual taking acknowledgement)