DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street
Concord, New Hampshire 03301
(603) 271-8818 Fax (603) 271-4968 TDD Access 1-(800)-735-2964

REQUEST FOR CERTIFICATION OF ADULT FAMILY CARE

GENERAL INFORMATION

☐ Initial Certification Requested Start Date: ____________________ ☐ Other ______________

☐ Renewal Certification Expiration Date if Currently Certified: ____________________

Residence or program name: ____ Cert #________

Location: ____
(Street) (Town) (State) (Zip)

Mailing: ____
(Street) (Town) (State) (Zip)

Contact for Site Visit (Name): ________________________________ Contact Phone: ________________________

E-Mail Address: ____

RESIDENTIAL

Number of beds currently certified: _____ Number of beds requested: _____

Home provider's name and telephone number:____

Is this residence currently under Emergency Certification? ☐ Yes ☐ No **If yes, certification #:** _________

Is this residence currently licensed? ☐ Yes ☐ No **If yes, Type and #:** ___________________________

INDIVIDUAL INFORMATION

Individual Name(s)	**Date of Birth**	**Male/ Female**	**Hrs Per Day or Wk Supervised Per Care Plan**

APPLICANT

Name / Entity: ____

Mailing Address: ____

E-Mail Address: ________________________________ Day Phone: __________________

OVERSIGHT AGENCY

Agency Name: ____

Mailing Address: ____

Agency Rep.: __________________________________ Day Phone: __________________

List all non-family members currently receiving services in the home not listed under individual information. Specify Date of Birth and funding source, if any:

____

____

____

PLEASE CHECK INFORMATION ATTACHED TO APPLICATION

- ☐ Directions to all Residential Programs with initial applications.
- ☐ Current Life Safety Code Report: If this is a new Residential Program or a bed increase the LSC report cannot precede the date of this application by more than 90 days.
- ☐ Copies of any request for waiver for the new certificate period or for renewals attach a copy of the waiver.
- ☐ Results of a physical exam / health screening and TB test completed within the previous 12 months.
- ☐ The full name, date of birth, and relationship to the applicant of all household members.
- ☐ Documentation that all family pets have current vaccinations and are licensed, if required.
- ☐ A copy of the water test completed within the past 12 months (for all homes not served by public water supply).
- ☐ Documentation of current automobile registration.
- ☐ Results of criminal record checks, BEAS checks, and motor vehicle checks for all household members 17 years of age or older. Also must include a written disclosure, as per He-P 813.08(c)(10).
- ☐ Documentation by the oversight agency that they agree to monitor the residence.

Has any provider or adult household member, excluding the Individual(s), been convicted of a felony or misdemeanor, or had a substantiated complaint by a state agency? Reference RSA 161-F:49, He-P 813.05(b)(3), 813.11(a)(1-3)

☐ Yes (if yes attach waiver) ☐ No

I swear or affirm that the information provided on this application is accurate to the best of my knowledge and belief. I believe that this residence/day service program is in full compliance with the statutes and regulations governing these services. I understand that providing false information shall be grounds for denial, suspension or revocation of the certification.

Authorized Signature

____ ____________________

Residential Coordinator or Director *Date*

____

Print name and title

Please send a copy of this application to the Oversight Agency QA department

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF OPERATIONS SUPPORT
BUREAU OF LICENSING AND CERTIFICATION
HEALTH FACILITIES

129 PLEASANT STREET, BROWN BUILDING, CONCORD, NH 03301-3857
603-271-9499 FAX: 603-271-4968 TDD Access: 1-800-735-2964

LIFE SAFETY REPORT FOR
TWO PERSON PLACEMENTS

RSA 151: allows for the placement of Nursing Home level of care residents in one and two family homes. Prior to an elder moving in Department of Health and Human Services – Health Facilities Administration is requesting that the local Fire Inspector verify the following in regards to fire safety.

NAME OF RESIDENCE: ____

ADDRESS: ____

PRIMARY CAREGIVER:__________________________ PHONE #__________________________

Number of Beds for Family: _________
Number of Beds for Resident(s):_______
Number of Beds for non-family and non-resident(s):_______
Location of Residents Bedroom:____
____

This city/town uses the following fire codes: (ex. NFPA 101, 2003, 2006) Note: The local authority must at a minimum utilize the edition adopted by the SFMO.

This home also has smoke detectors that are:
- ☐ Placed on every level of the AFCR
- ☐ Interconnected and hardwired or a wireless system
- ☐ Placed in every bedroom
- ☐ Powered by the AFCR's electrical services
- ☐ Has at least one ABC type fire extinguisher on every level.
- ☐ Is free from fire hazards
- ☐ Has at least one CO detector on each level of the home and in the basement

Occupancy Chapter: ____

I certify that I inspected the above named Adult Family Care on_____________ and found it to be
Date
in compliance with the life safety code edition circled above.

Signature of Inspector: ______________________________

Print Name:______________________________

Title/Department:______________________________

Additional information: ____
____
____
____
____
____

State Copy – White Fire Department Copy – Canary Vendor Copy - Pink