Department of Health and Human Services
Office of Legal and Regulatory Services
Health Facilities Administration
129 Pleasant St. Concord. N.H. 03301
Phone (603)271-9044 Fax (603)271-4968 TDD Access 1-800-735-2964

REQUEST FOR CERTIFICATION OF COMMUNITY RESIDENCE AND/OR COMMUNITY PARTICIPATION SERVICES PROVIDER

Certification Type:	**Physical Address of Certified Residence**		**Certification #**	
☐ **New**	**Mailing Address of Certified Residence**		**Requested Start Date if New**	
☐ **Renewal**	**Current Number of Slots**	☐ Residential ☐ CPS	**Expiration Date if Currently Certified**	
☐ **Addition/Removal**	**Number of Slots Requested**	☐ Residential ☐ CPS		
☐ **Other**	**Type of Residence:**	☐ Staffed Residence ☐ Family Residence		

☐ **Residential** ☐ **CPS** ☐ **Both Residential and CPS**

Please Document Contact Information Below

Site Visit Contact Person Name	
Site Visit Contact Person Email	
Site Visit Contact Person Phone Number	

Please Document Contact Information Below

Provider Name	
Provider Phone Number	

☐ Yes ☐ No	**Is this home currently licensed?**
	If Yes above, please enter the type of license, and the license number in the space provided to the left.
☐ Yes ☐ No	**Is this home currently under emergency certification**?
	If Yes above, please enter the emergency certification number in the space provided to the left.

Community Participation Services (CPS)

☐ Yes ☐ No	**Is any individual at the CPS program for more than one (1) hour per day?**
	If Yes above, please enter the date of the Life Safety Code Report in the space provided to the left, and attach the original to this form.
☐ Yes ☐ No	**Is the CPS program located in a currently certified community residence?**
	If Yes above, please enter the certification number of the certified residence where the program is located in the space provided to the left**.**

Please attach a separate list if there are more than four (4) people. Please answer "Yes" or "No" in the last two (2) columns

Individual Name	Date of Birth	Served By DS/ABD/BH	Number of hours of supervision as required by the ISA per day or week.	CPS Provider	Behavior Plan? *"Yes" or" No"*	Self-Administer Medications? *"Yes" or "No"*
		DS			y	n
		DS			n	n
		DS			n	n
		DS			n	n

Vendor Agency

Vendor Agency	
Vendor Agency Mailing Address	
Vendor Agency Phone Number	
Vendor Agency Contact Name	
Vendor Agency Contact Email	

Area Agency

Area Agency	
Area Agency Mailing Address	
Area Agency Phone Number	
Area Agency Contact Name	
Area Agency Contact Email	

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

Individual Name	Date of Birth	Funding Source

☐ Yes	☐ No	**Was a Current Life Safety Code Report Attached? If this is a new Residential Program, a new facility based CPS program, or an addition of a certified bed, the LSC report cannot precede the date of this application by more than 90 days.**
☐ Yes	☐ No	**Are any waivers required? If yes, please attach the most recent approved waiver, or a copy of the request.**
☐ Yes	☐ No	**Has any provider or adult household member, excluding the Individual(s), been convicted of a felony or misdemeanor, or had a substantiated report of abuse, neglect, or exploitation? If Yes, please attach a current waiver. RSA 161-F:49, He-M 507.10(f)-(i), He-M 1001.15(a)(1)-(3) and He-M 1002.14(a)(1)-(3).**

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/community participation 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.

Please enter the name, title and authorized signature of the Residential or CPS Director above	***Please enter the date the application was signed above***