Washington State Department of Social & Health Services

Transforming lives

Temporary Manager and/or Receiver Application
Nursing Home and Assisted Living Facility

Instructions

When completing this application you must:

- Type or print clearly in BLUE or BLACK ink.
- Answer all questions or mark "N/A" if the question does not apply. You must complete the entire application (i.e. all of the sections must be filled out and/or marked "N/A") and you must include the required documents; otherwise your application will be returned to you without further action. Note: No application fee is required.
- If you have questions about completing the application, please call the Business Analysis Manager at 360-725-2416.
- Submit all required supporting documentation and label all of the attachments.
- Use the application checklist to make sure you have submitted all required documentation.
- Sign the completed application. (All persons named in the application must sign Section 12.)
- Make a copy of your application and all supporting documents for your files.
- Mail your completed application and required documents to:

  Business Manager
  Consumer Services
  PO Box 45600
  Olympia, WA 98504-5600

- You must notify the department in writing if <u>any</u> information in this application changes. Mail the corrected information to: Business Analysis at the address above. <u>Be sure to identify the applicant's name and the temporary manager and/or receiver application</u>.

Application Processing

It is extremely important that the application is complete and that all documentation is provided with the application. Otherwise, there will be a delay in the application review process.

If the application is incomplete, you will receive a written notice of what is incomplete. You will have 60 days from the date of that written notice to complete the application and return it to our office. If you do not respond with a complete application within 60 days of the date of our request, your application will become void.

You will be notified if the applicant's name has been placed on the department's list of temporary managers and/or receivers.

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Nursing Home and Assisted Living Facility

(This checklist must be included with the application)

NAME OF APPLICANT

Check all that apply:

The applicant is interested in serving as a:

- ☐ Nursing Home Temporary Manager
- ☐ Nursing Home Receiver
- ☐ Assisted Living Facility Temporary Manager

Checklist

Please check below to show that you have included the following with your application.

☐ A copy of the Applicant's:

- ☐ Certificate from the State of Washington Secretary of State's office
- ☐ Washington State Business License showing the Unified Business Identifier (UBI)
- ☐ Internal Revenue Service (IRS) document showing the Employer Identification Number (EIN)

☐ Description of the applicant's experience in long-term care.

☐ List of facilities, facility type, and location of the facility (city and state) where the applicant gained experience as a temporary manager and/or receiver.

☐ Copy of a State of Washington Administrator's license for anyone who is part of the applicant's business organization.

☐ Completed State of Washington background authorization forms for all persons listed in Section 11. NOTE: Background results cannot be submitted in lieu of the background authorization forms.

☐ Original out-of-state background results for all persons listed in Section 11. Results must be no more than 30 days old at the time of application.

☐ Additional sheets of paper documenting the response(s) to questions in the application.

For ALTSA Business Use Only

Washington State Department of Social & Health Services

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Temporary Manager and/or Receiver Application
Nursing Home and Boarding Home

Section 1. Information About the Client

1. LEGAL NAME OF ENTITY (NAME LISTED ON UBI AND EIN)			
2. BUSINESS ADDRESS	CITY	STATE	ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
4. TELEPHONE NUMBER	5. CELL PHONE NUMBER	6. FAX NUMBER	

You must notify the department if the above address information changes.

Section 2. Contact Person Information

7. NAME OF CONTACT PERSON	8. TELEPHONE NUMBER FOR CONTACT PERSON
9. FAX NUMBER FOR CONTACT PERSON	10. EMAIL ADDRESS FOR CONTACT PERSON

Section 3. UBI and EIN

The Unified Business Identifier and Employer Identification Number are required for this application.

11. APPLICANT'S UBI NUMBER	12. APPLICANT'S EIN NUMBER

Section 4. Applicant Entity Information

13. APPLICANT'S ENTITY TYPE (MARK THE APPROPRIATE BOX)

☐ Individual/Sole Proprietorship ☐ Corporation ☐ Limited Liability Company
☐ General Partnership ☐ Limited Partnership

Section 5. Applicant Entity Organized Out-of-State

Complete this section only if the applicant entity was organized in a state other than Washington. If the applicant entity was organized in the State of Washington, skip this section and proceed to Section 6.

14. NAME OF STATE WHERE ORGANIZED

Section 6. Licensed Administrator

15. Are you or is anyone in the applicant entity currently a nursing home administrator licensed in the State of Washington? ☐ Yes ☐ No

Section 7. Individual Affiliated with the Applicant (for entities only)

Fill out this section ONLY if an entity (a corporation, partnership or limited liability company) is submitting this application. If you are applying as a sole proprietorship (individual), check the box below and go to Section 8.

☐ N/A (I am applying as an individual)

Complete the following table for all Owners, Officers, Directors, and Managerial Employees of the entity. List the percentage of ownership for all stockholders with **5% or greater** ownership. If you need more space, provide the information on a separate sheet of paper and attach it to this application.

NAME OF PERSON	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH	PERCENT OWNERSHIP
				%
				%
				%
				%

				%

Section 8. Temporary Manager and/or Receiver Experience

Has the applicant or any person named in Section 8:

16. Had experience as a Temporary Manager? ☐ Yes ☐ No
17. Had experience as a Receiver? ☐ Yes ☐ No
18. If you answered "yes" to Question 17, were you appointed as a receiver by the Court? ☐ Yes ☐ No

If you answered "yes" to any of the questions in this section, summarize each experience and include the facility type (nursing home, assisted living facility, etc.), facility name, dates acted as temporary manager and/or receiver, length of time, and state where the facility was located. Provide the information on a separate sheet of paper and attach it to this application.

Section 9. Compliance History

Has the applicant or any person named in Section 7:

	YES	NO
19. Owned, held an interest in, managed or held a license for an adult family home, boarding home, nursing home, or other business providing services to children, vulnerable adults, or persons with mental illness or developmental disabilities?	☐	☐
20. Been denied a state or federal contract, license, or license renewal to operate a facility providing care to children, vulnerable adults, or persons with mental illness or developmental disabilities?	☐	☐
21. Been certified, licensed, or contracted with to provide care and services to children, vulnerable adults, or persons with mental illness or developmental disabilities, and:		
a. Had such certification or license revoked, suspended, suspended with stay, enjoined, or imposed with conditions, civil fine or stop placement?	☐	☐
b. Had a Medicaid contract or Medicare provider agreement revoked, cancelled, suspended or not renewed?	☐	☐
c. Relinquished or returned such certification or license; or did not seek the renewal of certification or license when notified by the state agency or initiation of denial, suspension, cancellation, or revocation of the certificate, license or contract?	☐	☐

If you answered "yes" to any of the questions in this section, provide the following information on a separate sheet of paper and attach it to this application. Provide a separate sheet for each individual.

- Name of the individual
- Effective date of the license or certification
- Date action was taken
- Type of action taken
- Name of facility and where located
- Name and address of agency that tool the action
- Circumstances

Section 10. Financial Assessment Information

Has the applicant or any person named in Section 7:

22. Ever filed for bankruptcy? ☐ Yes ☐ No If yes, provide the following. Attach additional pages if needed.

NAME OF ENTITY OR INDIVIDUAL	TYPE OF BANKRUPTCY FILED	DATE FILED	DATE CONCLUDED
NAME OF ENTITY OR INDIVIDUAL	TYPE OF BANKRUPTCY FILED	DATE FILED	DATE CONCLUDED

23. Ever had any judgments or liens within the past five (5) years? ☐ Yes ☐ No
If yes, provide the following. Attach additional pages if needed.

NAME OF ENTITY OR INDIVIDUAL	DATE OF JUDGEMENT OR LIEN	COUNTY AND STATE

DESCRIBE THE CIRCUMSTANCES

Section 11. Background Information

Background Authorization forms must have ALL blanks filed in or this application will be returned to you without action. **Results from a State of Washington Background Inquiry are not accepted.**

You can print out the Background Authorization form from: http://www.dshs.wa.gov/bccu/bccuforms.shtml

24. Attach a completed Washington Background Authorization form for the following:

- Individual applicant
- Any person named in Section 7
- Administrator, if known
- Any person associated with or employed by the applicant who may have unsupervised access to residents at any time the applicant is operating as a temporary manager or receiver.

(Anyone who is used by the Applicant and who may have unsupervised access to residents will need to have a State of Washington background check, unless the background inquiry form submitted with this application is still current.)

NAME OF PERSON	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TITLE/POSITION

25. Attach out-of-state background results for any person identified in Question 24 who currently lives or has lived in another state during the past three (3) years and who will have unsupervised access to residents at any time while operating as a temporary manager or receiver.

NAME OF PERSON	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TITLE/POSITION

Section 12. Consent to Release and/or Use Confidential information		
26. The individual applicant, any person named in Section 7, and any person associated with or employed by the applicant **must each** sign this section. I consent to the release and use of confidential information about me within the Department of Social and Health Services (DSHS) for the purpose of serving as a nursing home or assisted living facility temporary manager or nursing home receiver. I grant permission to DSHS and any agency, division, office, or the police to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, mail, or hand delivery. I am aware that the department is required to respond to requests for disclosure of information from the public. The department may only withhold information if a specific disclosure exemption exists. (RCW 42.56, Chapter 388-01 WAC). Completion of this form allows the use and sharing of confidential information within DSHS for application processing purposes. DSHS may disclose and receive confidential information from outside agencies divisions, offices, and/or law enforcement. This consent is valid for as long as I am the person named in this application. A copy of this section is valid for my permission to release and use this information.		
NAME OF INDIVIDUAL APPLICANT	SIGNATURE	DATE
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NAME OF INDIVIDUAL APPLICANT	SIGNATURE	DATE

Certification

I/We certify, under the penalty of perjury under the laws of the State of Washington and by my signature that the information provided in this application and all additional documents and forms required to act as a temporary manager and/or receiver of a nursing home or temporary manager of an assisted living facility are true, complete, and accurate. I/We understand that the department may obtain additional information, verification, and/or documentation related to the foregoing answers and information.

I/We understand if a license is granted or a Medicaid contract is executed pursuant to appointment as a temporary manager or receiver, the license or Medicaid contract would be nontransferable. I/We understand that failure to accurately answer or fully complete the questions on this application may result in failure to be considered for appointment as a temporary manager and/or receiver or other sanctions as allowed by law.

I/We understand and agree that the information I/we give to the department will be used to verify the representations made in this application. Any information I/we give to the department may be used by the department for that purpose.

I/We understand that the department may check the credit of the corporation or business and its principles; obtain a credit report; and verify any responses provided. The department will use such information and may disclose this information to other parts of the department as appropriate to further program purposes. The department may define some or all of such information as public information and also disclose this information to third parties when requested according to law to the extent that such information is not exempt from such disclosure by state or federal law.

Assisted Living Facilities I/We certify that I/we have read, understood, and if appointed as a temporary manager in a boarding home, agree to comply with Chapters 18.20 and 70.129 RCW, and Chapters 388-78A WAC.

Nursing Homes I/We certify that I'/we have read, understood, and if appointed as a temporary manager or receiver in a nursing home agree to comply with Chapters 18.51, 74.42, and 74.46 RCW and Chapters 388-96 and 388-97 WAC.

No residents receiving care and service in the nursing home or assisted living facility will be subject to discrimination because of race, color, national origin, gender, age, religion, creed, marital status, disabled or Vietnam veteran's status, or the presence of any physical, mental, or sensory disability.

I/We understand that decisions to include an entity on the list of potential temporary managers or receivers and to select an entity to serve as a temporary manager or receiver are solely within the discretion of the Department of Social and Health Services and do not create any appeal rights. Further, I/we understand that the Department may make an appointment from the list of temporary managers or receivers, but it is not required to select an entity from the list.

In addition to the above certifications, if the facility has a Medicaid contract:

I/We understand that if appointed, I/we shall be responsible for compliance with all applicable state and federal laws and regulations that exist at the time of appointment or are thereafter amended, and shall be held responsible by the department for the resident's care.

SIGNATURE OF INDIVIDUAL APPLICANT OR PERSON AUTHORIZED BY THE APPLICANT TO SIGN THIS APPLICATION	DATE SIGNED

PRINT NAME	TITLE	CITY AND STATE WHERE SIGNED