Washington State Department of Social & Health Services
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Assisted Living Facility License Application

Instructions

It is the Applicant's responsibility to submit a complete application, and all required and applicable supporting documents. The application and supporting documents must be submitted at least 90 days before the anticipated opening date or effective date of a change of ownership, but be aware that current application processing may take as long as four (4) to six (6) months.

A Federal Employer Identification Number (EIN) is needed before applying for a license and/or contract. A copy of the IRS SS-4 form showing the assigned EIN number will be accepted as verification an EIN was obtained. For more information on EINs go to https://www.irs.gov

A Unified Business Identifier (UBI) is needed before applying for a license and/or contract. A copy of the Washington State business license showing that the trade name has been registered with the Department of Revenue will be accepted as verification a UBI was obtained. For more information on UBIs go to http://dor.wa.gov/content/doingbusiness/

A Certificate of Incorporation or Certificate of Formation issued by the Secretary of State is needed before an entity (Limited Liability Company, For Profit Corp, etc.) may apply for a license and/or contract. For more information on this registration go to https://www.sos.wa.gov/corps/

Please type or print clearly in ink or complete electronically.

Carefully follow all instructions and answer all questions.

Use "N/A" (Not Applicable) when a question does not apply. Do not leave a question blank.

Make a copy of the application and all attachments for your files.

Submit your application, supporting documents, and application fee (if applicable) to:

For US Postal Mail:	For Federal Express or United Parcel Service (UPS):
ALTSA Finance and Contracts	ALTSA Finance and Contracts
PO Box 45600	4500 10th Ave. SE (Blake East)
Olympia WA 98504-5600	Lacey WA 98503

Direct your questions regarding this application to the Business Analysis and Applications Unit at (360) 725-2573 or BAAU@dshs.wa.gov .

Washington State Department of Social & Health Services
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Assisted Living Facility License Checklist

Number or letter all attachments and indicate attachment number below.
If not applicable, write N/A.

- ☐ Assisted Living Facility license fee ($116 / bed).
- ☐ Letter from current licensee allowing the applicant to use the remainder of the current license fee. **Attachment #** _____
- ☐ Letter from current licensee relinquishing license if a change of ownership is approved. **Attachment #** _____
- ☐ Proof of Federal EIN (Employer Identification Number) **Attachment #** _____
- ☐ Copy of Washington State business license showing facility name as a registered trade name **Attachment #** _____
- ☐ Copy of certificate showing registration with Secretary of State **Attachment #** _____
- ☐ Individuals Affiliated with Applicant Supplemental Information form **Attachment #** _____
- ☐ Organizational Structure/Chain of Ownership Chart **Attachment #** _____
- ☐ Compliance History **Attachment #** _____
- ☐ Financial Attestation form **Attachment #** _____
- ☐ Washington Background Check Authorization form for each person that may have unsupervised access to residents (for each person listed on Affiliated with Applicant Supplemental Information form) **Attachment #** _____
- ☐ Copy of DSHS fingerprint check result letter **Attachment #** _____
- ☐ Agreement Not to Have Unsupervised Access **Attachment #** _____
- ☐ Consent (Authorization) to Release and/or Use Confidential Information form(s) **Attachment #** _____
- ☐ Real Property and/or Building Related to Financing and/or Insurance Attestation form **Attachment #** _____
- ☐ Copy of purchase and sale agreement **Attachment #** _____
- ☐ Lease or Operating Agreement Attestation **Attachment #** _____
- ☐ Copy of lease or operating agreement allowing the applicant to occupy the premises (draft is acceptable) **Attachment #** _____
- ☐ Management Agreement Attestation with attachments **Attachment #** _____
- ☐ Copy of Management Agreement (draft is acceptable) **Attachment #** _____
- ☐ Copy of Disclosure of Services **Attachment #** _____
- ☐ Copy of a Resident Agreement between resident and applicant / licensee **Attachment #** _____
- ☐ Copy of proof of liability insurance **Attachment #** _____
- ☐ Assisted Living Facility Policies and Procedures Attestation **Attachment #** _____
- ☐ If Change of Ownership or NH conversion, provide a copy of the Notice to Residents **Attachment #** _____
- ☐ If Change of Ownership, provide a written statement that the Functional Program at the facility will not change or provide a new Functional Program document **Attachment #** _____

Washington State Department of Social & Health Services
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Assisted Living Facility License Application

The Assisted Living Facility license fee is $116 per bed. Enclose a check or money order made payable to Washington State Treasurer, or submit a letter from the current licensee that allows the applicant to use the remainder of the current license fee.

NOTE: If an applicant chooses to proceed with a change of ownership, please be aware that:

- The applicant will be assuming responsibility for correcting any outstanding violations;
- Any outstanding fines must be paid prior to licensing; and
- If there is a stop placement or a condition on the license, it will attach to the new license, unless the Department determines that lifting the action will not compromise the safety of the residents.

☐ Initial License ☐ Change of Ownership

CURRENT ASSISTED LIVING FACILITY NAME	CURRENT ASSISTED LIVING FACILITY LICENSE NUMBER

1. Assisted Living Facility Information

FACILITY NAME			TELEPHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)
PHYSICAL ADDRESS	CITY	STATE ZIP CODE WA		COUNTY
WEB SITE ADDRESS	E-MAIL ADDRESS		NUMBER OF BEDS TO BE INITIALLY LICENSED	ANTICIPATED OPENING DATE

2. Medicaid Contract ☐ N/A

TYPE OF CONTRACT(S) REQUESTED (IF ANY)

☐ Assisted Living (AL) Contract ☐ Adult Residential Care (ARC) Contract
☐ Enhanced Adult Residential Care (EARC) Contract ☐ EARC / Specialized Dementia Care Contract

3. Contact Person Information

CONTACT PERSON'S NAME	
CONTACT PERSON'S TELEPHONE NUMBER (WITH AREA CODE)	E-MAIL ADDRESS

4. Contact Person Information (for initial licensing inspection).

CONTACT PERSON'S NAME (IF DIFFERENT)	
CONTACT PERSON'S TELEPHONE NUMBER (WITH AREA CODE)	E-MAIL ADDRESS

5. Sole Proprietor or Entity Applicant Information

LEGAL NAME OF INDIVIDUAL OR ENTITY			
MAILING ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)		

6. Sole Proprietor or Entity Business Information

UBI (UNIFIED BUSINESS IDENTIFIER)	FEDERAL EIN (EMPLOYER IDENTIFICATION NUMBER)

7. Sole Proprietor or Legal Entity Information

Check one box below.

- ☐ Individual / Sole Proprietor
- ☐ For-Profit Corporation
- ☐ Non-Profit Corporation
- ☐ General Partnership
- ☐ Limited Partnership
- ☐ Limited Liability Company
- ☐ Government agency
- ☐ Group or association

8. Organizational Structure / Chain of Ownership

Provide a chart showing the ownership structure / chain of ownership of the applicant. The chart should show all parent and subsidiary relationships and affiliated entities within the ownership chain.

9. Real Property Ownership Information

1. Does the applicant own the real property? ☐ Yes ☐ No

   If yes, attach proof of property ownership. If no, complete the following:

   PROPERTY OWNER'S NAME

   PROPERTY OWNER'S ADDRESS | CITY | STATE | ZIP CODE

2. Will the applicant lease the facility or operate under an operating agreement? ☐ Yes ☐ No

   If yes, complete the Lease or Operating Agreement Attestation form.

10. Management Agreement

Does the applicant intend to or has the applicant entered into a management agreement authorizing another person, group or entity to manage the Assisted Living Facility? ☐ Yes ☐ No

If yes, complete the Management Agreement Attestation form.

11. Compliance History

Answer for facilities in Washington State and in other states.

	YES	NO
1. Has the Applicant, any entity having a direct ownership interest in the Applicant or any person named in the Individuals Affiliated with Applicant Supplemental Information form:		
a. Owned, managed, or held a license to operate a business providing services to children, vulnerable adults, or persons with mental illnesses or developmental disabilities within the past 10 years? (If yes, provide name of person or entity, name of facility, and effective dates.)	☐	☐
b. Held a contract to provide services to children, vulnerable adults, or persons with mental illnesses or developmental disabilities within the past 10 years? (If yes, provide name of person or entity, name of facility, and effective dates.)	☐	☐
c. Had a civil fine or stop placement imposed or had a condition placed on the license, contract or certification within the past three (3) years? (If yes, provide name of person or entity and name of facility.)	☐	☐
d. Ever been denied a contract, license, or license renewal to operate a facility providing care to adults or children? (If yes, provide name of person or entity, name of facility, state where facility located, type of action taken, and date action taken, if known.)	☐	☐
e. Ever had a license or certification not renewed, revoked, suspended, or enjoined. (If yes, provide name of person or entity, name of facility, state where facility located, type of action taken, and date action taken, if known.)	☐	☐
f. Ever had a Medicaid contract or Medicare provider agreement revoked, canceled, suspended or not renewed. (If yes, provide name of person or entity, name of facility, state where facility located, type of action taken, and date action taken, if known.)	☐	☐
g. Ever relinquished or returned a license, contract or certification; or did not seek the renewal of a license, contract or certification following notification by the state agency of initiation of denial, suspension, or revocation of that license, contract, or certification? (If yes, provide name of person or entity, name of facility, state where facility located, type of action taken, and date action taken, if known.)	☐	☐
2. Has the Applicant or any entity having a direct ownership interest in the Applicant, or any person named in the Individuals Affiliated with Applicant Supplemental Information form:	YES	NO

a. Been excluded from participating in Medicare and/or Medicaid? (If yes, attach copy of exclusion documents.) ..... ☐ ☐

b. Been named in a court order or administrative order stating the person or entity will not hold a license or contract to provide care to children, vulnerable adults, or persons with mental illness or developmental disabilities for a specific period or number of years from the date of license surrender or relinquishment? (If yes, attach copy of court order.) ..... ☐ ☐

c. Been subject to disciplinary action board or other disciplinary authority of a health professional licensing agency? (If yes, attach copy of disciplinary board or authority action.) ..... ☐ ☐

d. Been convicted and found of abuse, neglect, exploitation, misappropriation (theft) of property of any person, a crime against children and other persons or had a finding on a state registry? (If yes, attach copy of court documents.) ..... ☐ ☐

12. 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 for license 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 or information.

I/we understand that if I/we enter into an agreement with an individual or entity to manage the facility on a day-to-day basis, I am/we are wholly responsible for the conduct of the individual or entity and its employees. I/we understand that I/we are legally responsible for the operational decisions and care of the residents at the facility.

I/we understand any license granted pursuant to this application is nontransferable.

I/we understand that failure to accurately answer or fully complete the questions on this application may result in denial of the application, revocation or termination of a license or contract, 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 this purpose.

I/we understand that the department may check the credit of the applicant and its principals; obtain a credit report; and verify any responses provided. The department and its contracting process will use such information and may disclose this information to other parts of the department as appropriate to further program purposes. Some or all of the information provided by applicant will be public records under Chapter 42.56 RCW. As such, the Department will be required to disclose the information to third parties, when requested in accordance with state or federal law, unless it is exempt from such disclosure. .

I/we certify that I/we have read, understood, and agree to comply with Chapters 18.20 and 70.129 RCW and the Rules, Regulations, and Standards adopted thereunder, including Chapters 388-78A, and 388-112.

Residents receiving care and service in the Assisted Living Facility must not 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 if this application for an Assisted Living Facility license is denied, I/we may request an administrative fair hearing within 28 days of receiving the denial letter from DSHS. I/we understand that a written request for fair hearing must be submitted to: Office of Administrative Hearings, PO Box 42488, Olympia, Washington 98504-2488.

SIGNATURE OF OFFICER, DIRECTOR, MEMBER, ETC. OF APPLICANT	TITLE
LEGAL NAME OF INDIVIDUAL OR ENTITY	TELEPHONE NUMBER (INCLUDE AREA CODE)
DATE	CITY AND STATE WHERE SIGNED

Individuals Affiliated with Applicant Supplemental Information

List each officer, director, member, partner, owner of 5% or more of the applicant entity, and Administrator.

PERSON'S NAME	HAS CONTROL* OF APPLICANT**	MAY HAVE UNSUPERVISED ACCESS TO RESIDENTS	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH	%
	☐	☐	**Administrator**			
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				

* Control means the possession, directly or indirectly, of the power to direct the management, operation, and/or policies of the applicant / licensee or Assisted Living Facility, whether through ownership, voting control, by agreement, by contract or otherwise.

** The Applicant is the Individual / Sole Proprietor or the Entity applying for the Assisted Living Facility license.

INDIVIDUAL SIGNATURE	DATE

PRINTED NAME	TITLE

Agreement Not to Have Unsupervised Access

FACILITY NAME			
APPLICANT / LICENSEE NAME			
FACILITY ADDRESS	CITY	STATE	ZIP CODE

This is an agreement between the Washington State Department of Social and Health Services (DSHS) and the applicant / licensee listed above.

The applicant / licensee has applied to obtain an Assisted Living Facility license through DSHS. Prior to issuing such licenses, DSHS requires background and fingerprint checks for all persons having unsupervised access to Assisted Living Facility residents.

The applicant / licensee agrees that the individual listed below will not have unsupervised access to residents, resident's financial records, resident funds and/or resident medical records at any time. Therefore, the individual listed below is not required to have background checks completed.

The applicant / licensee agrees to ensure that the individual listed below will have the required background and fingerprint checks completed before he/she has unsupervised access to Assisted Living Facility residents, resident's financial records, resident funds and/or resident medical records.

APPLICANT/LICENSEE SIGNATURE	DATE
PRINTED NAME	TITLE
INDIVIDUAL SIGNATURE	DATE
PRINTED NAME	TITLE

Lease or Operating Agreement Attestation – Assisted Living Facility

This attestation form must be completed and submitted to the Business Analysis and Applications Unit if the applicant / licensee does not own the real property upon which the boarding home is located and occupies the property under a lease or other type of agreement. The attestation must be verified and signed by an officer, director, or owner of 5% or more of the applicant / licensee who has signature authority.

FACILITY'S NAME	
APPLICANT / LICENSEE'S NAME	REAL PROPERTY OWNER'S NAME
FORM OF AGREEMENT UNDER WHICH APPLICANT / LICENSEE HAS RIGHT TO OCCUPY REAL PROPERTY (LEASE, SUBLEASE, OPERATING AGREEMENT, ETC.)	
DATE AND TERM OF AGREEMENT SPECIFIED	
PRINTED NAME OF PERSON COMPLETING FORM	TITLE OF PERSON COMPLETING FORM

The signatory must initial each statement below.

I certify and declare under penalty of perjury that the following is true and correct:

_____The applicant / licensee has a written agreement (the "Agreement") allowing it to occupy and operate a licensed Assisted Living Facility upon the real property on which the Assisted Living Facility is located.

_____The Agreement identifies applicant/licensee as the entity that holds, or will hold, the Assisted Living Facility license.

_____The Agreement does not authorize or require transfer or assignment of applicant/licensee's Assisted Living Facility license to any other party upon default, termination or otherwise.

_____The Agreement does not provide any party or entity other than applicant/licensee with "ownership" rights or interests in resident agreements or records; all resident agreements are between the resident and the applicant / licensee as parties.

_____The Agreement does not require or permit the transfer of resident agreements or records to any party or entity upon termination of the Agreement without such other party or entity first being licensed by the Department of Social and Health Services to operate the Assisted Living Facility.

_____The Agreement does not give any party or entity, other than applicant/licensee (or its managing agent), the department, or other parties authorized by law, the right to review resident records.

_____The Agreement does not provide any party or entity with the right to dictate occupancy levels.

_____The Agreement does not allocate, assign, or otherwise convey an interest in the "bed rights" to any party or entity other than applicant/licensee or the owner of the real property.

_____The Agreement does not make any party or entity other than applicant/licensee legally responsible for the daily operations of the Assisted Living Facility.

_____The Agreement does not provide any party or entity other than applicant/licensee with the right to request 1) an informal dispute resolution in response to state or federal survey reports; or 2) an administrative appeal of deficiencies cited on the state survey or enforcement actions imposed by the Department of Social and Health Services.

_____The Agreement does not give any party or entity other than the applicant/licensee authority to submit plans of correction for violations of Assisted Living Facility laws or regulations or dictate terms of a plan of correction.

_____The Agreement does not authorize any party or entity other than the applicant/licensee to enter, take possession and operate the facility as an Assisted Living Facility, unless such party or entity first obtains an Assisted Living Facility license from the Department of Social and Health Services.

Check below as applicable:

☐ The Agreement does not provide budget approval to any party or entity other than applicant/licensee; or

☐ The Agreement provides budget approval to another party or entity, but does not prohibit applicant/licensee from expending its own funds to secure regulatory compliance as necessary.

I further certify and declare as follows:

- The applicant/licensee understands and agrees that the applicant/licensee is legally responsible for the daily operations of the Assisted Living Facility.
- The applicant/licensee understands and agrees that nothing in the Agreement, including the authority of a party or entity other than applicant/licensee to approve the facility budget, absolves applicant/licensee of its legal responsibility to ensure compliance with Assisted Living Facility laws and regulations.
- Agreements with residents for Assisted Living Facility care and services are between the applicant/licensee and the resident.
- I am duly authorized to sign this attestation on behalf of the applicant/licensee. I am an officer, director, or owner of 5% or more of the applicant/licensee.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

DATED	CITY AND STATE WHERE SIGNED	PRINTED NAME

SIGNATURE*	TITLE

*** May not be signed by Management Company or Facility Administrator.**

NOTICE

Receipt by the Department of Social and Health Services (DSHS) of a copy of Applicant's lease or other agreement allowing the applicant to occupy and operate a licensed Assisted Living Facility upon the real property does not constitute approval of such by DSHS. DSHS may choose to review the lease or other agreement on a random basis, or in response to a specific complaint covering the agreement that falls within the scope of DSHS' regulatory authority.

Management Agreement Attestation
Information and Attachments

Information:

Name of Facility	
Name of Applicant / Licensee	
Name of Management Entity	
Mailing Address of Management Company	
City, State, Zip Code	
UBI (Unified Business Identifier) of Management Company	
Federal EIN (Employer Identification Number) of Management Company	
Name of Contact Person (for management agreement)	
Telephone Number of Contact Person	
Email Address of Contact Person	
Management Agreement Effective Date	

Attachments:

1) Copy of written management agreement.

2) "Individuals Affiliated with Management Company Supplemental Information" form.

Management Agreement Attestation – Assisted Living Facility License

This attestation form must be completed and submitted with a management agreement to the Business Analysis and Applications Unit if the applicant / licensee will use a management company at the Assisted Living Facility. The attestation must be verified and signed by an officer, director or owner of 5% or more of the applicant / licensee who has signature authority.

FACILITY'S NAME	
APPLICANT / LICENSEE'S NAME	MANAGEMENT COMPANY'S NAME

The signatory must initial each statement.

I certify and declare under penalty of perjury that the following is true and correct:

_____The applicant/licensee has a written management agreement with the above management entity.

_____The management agreement complies with the Assisted Living Facility licensing requirements in Chapter 18.20 RCW and Chapter 388-78A WAC.

_____The written management agreement creates a principal/agent relationship between the applicant/licensee and the management entity;

_____The management agreement does not delegate to the management entity the licensee's legal responsibility to ensure that the Assisted Living Facility is operated in a manner consistent with applicable laws and regulations;

_____The management agreement does not delegate to the management entity the responsibility to review for accuracy, acknowledge and sign all initial and renewal license applications;

_____The management agreement does not authorize the management entity to represent itself as the licensee or give the appearance that it is the licensee;

_____All resident agreements shall be agreements between the resident(s) and the applicant/licensee as parties, even if they are executed by the management entity on behalf of the applicant/licensee;

_____The applicant/licensee agrees to notify all residents and prospective residents in advance of the identity of the management entity, the fact that the management entity is retained on behalf of applicant/licensee, and shall be given contact information for the management entity and the licensee;

_____The management entity may use resident records and information to fulfill its obligations under the management agreement, but shall preserve the confidentiality of such records and shall not disclose or release them except as authorized by law. The applicant/licensee shall retain responsibility for such records and shall not transfer such responsibility to the management entity unless the management entity first becomes duly licensed to operate the Assisted Living Facility as licensee.

_____Applicant/licensee shall provide notice to DSHS in case of any of the following:

- Discharge of management entity;
- Change of management entity;
- Modification of existing management agreement, except regarding a change in the duration of the agreement.

I am duly authorized by applicant / licensee to sign this attestation on its behalf. I am an officer, director, or owner of 5% or more of the applicant/licensee.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

DATED	CITY AND STATE WHERE SIGNED	PRINTED NAME
SIGNATURE*	TITLE	

*** May not be signed by Management Company or Facility Administrator.**

Individuals Affiliated with Management Company Supplemental Information

List each officer, director, member, partner, and owner of 5% or more of the management company.

PERSON'S NAME	HAS CONTROL* OF APPLICANT	MAY HAVE UNSUPERVISED ACCESS TO RESIDENTS	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH	%
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
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	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				

* Control means the possession, directly or indirectly, of the power to direct the management, operation, and/or policies of the applicant / licensee or Assisted Living Facility, whether through ownership, voting control, by agreement, by contract or otherwise.

NOTICE

Receipt by the Department of Social and Health Services (DSHS) of a copy of Applicant's Management Agreement does not constitute approval of such by DSHS. DSHS **may choose to review** the Management Agreement **on a random basis, or** in response to a specific complaint covering the agreement that falls within the scope of DSHS' regulatory authority.

Financial Attestation – Assisted Living Facility License

The attestation must be verified and signed by an officer, director, or owner of 5% or more of the applicant / licensee who has signature authority.

FACILITY'S NAME
APPLICANT / LICENSEE'S NAME

The signatory must initial each statement below.

I certify and declare under penalty of perjury that the following is true and correct:

_____The applicant has not been adjudged insolvent or bankrupt in a State or Federal court.

_____A court proceeding to make a judgment of bankruptcy or insolvency with respect to the applicant is not pending in a State or Federal court.

_____The applicant will ensure that the Assisted Living Facility is operated in a manner consistent with applicable laws and regulations despite any limitation or insufficiency of funds.

_____Applicant will provide notice to DSHS in the event a State or Federal court proceeding seeking a judgment of insolvency or bankruptcy is initiated with respect to the applicant, a subsidiary, an affiliated entity or its parent entity.

I further certify and declare as follows:

I am duly authorized to sign this attestation on behalf of the applicant. I am an officer, director, or owner of 5% or more of the applicant.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

DATED	PRINTED NAME	SIGNATURE*

*** May not be signed by Management Company or Facility Administrator.**

Consent (Authorization) to Release and/or Use Confidential Information

Must be completed by any person named on the Individuals Affiliated with Applicant Supplemental Information form, including the Administrator.

☐ Officer ☐ Director ☐ Owner of more than 5% ☐ Administrator

I consent to the release and use of confidential information about me within Department of Social and Health Services (DSHS) for purposes of licensing and contracting. 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 not withhold requested information unless required to do so under Chapter 42.56 RCW or other state or federal law. (RCW 42.56, Chapter 388-01 WAC)

The completion of this form allows the use and sharing of confidential information within DSHS. DSHS will be able to disclose and receive confidential information from outside agencies, divisions, offices and/or the police.

This consent is valid for as long as I am an officer, director, owner of 5% or more or the Applicant, or Administrator at the Assisted Living Facility named in this application and located at the address named in this application. A copy of this form is valid to give my permission to release and use this information.

SIGNATURE	DATE

PRINTED NAME

"Real Property and/or Building" Attestation
Related to Financing and/or Insurance

_____ declares and states as follows:
PRINT NAME

1. I am _____ of _____ the ("Applicant"),
   TITLE APPLICANT / LICENSEE'S NAME
   which has applied for a Washington State Boarding Home license to operate

   _____ (the "Assisted Living Facility"). I make this
   FACILITY NAME
   declaration based on personal knowledge and certify that I have been duly authorized by Applicant to make the representations stated herein.

2. The Assisted Living Facility's real property and/or building are or will be financed and/or insured by private and/or public entities (the "Entities"). "Entities" refer to banks, mortgage lenders, HUD, etc. Applicant has executed or will execute agreements granting such Entities certain rights concerning the Assisted Living Facility. Notwithstanding, Applicant acknowledges full responsibility for operating the Assisted Living Facility and providing care and services to residents as licensee. Applicant may not transfer any of its legal responsibilities as licensee to the Entities or any other person or entity. Applicant is aware that should the Entities unreasonably interfere with the licensed operations at the Assisted Living Facility, the Department of Social and Health Services may deem it necessary to take enforcement action against the Assisted Living Facility as authorized by RCW 18.20.190.

   I am duly authorized to sign this attestation on behalf of the applicant. I am an officer, director, or owner of 5% or more of the applicant.

   I certify and declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

DATED	CITY AND STATE WHERE SIGNED	PRINTED NAME

SIGNATURE*	TITLE

Washington State Department of Social & Health Services
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Assisted Living Facility Policies and Procedures Attestation

_____ declares and states as follows:
PRINT NAME

1. I am the Administrator / designee of _____ and I make this
NAME OF ASSISTED LIVING FACILITY
declaration based on personal knowledge and certify that I have been duly authorized by the Assisted Living Facility to make the representations stated herein.

2. I hereby certify that _____ has developed and will implement
NAME OF ASSISTED LIVING FACILITY
the policies and procedures necessary to:
   - Maintain or enhance the quality of life for residents including resident decision making rights and mandated reporting requirements;
   - Provide the necessary care and services for residents, including those with special needs;
   - Safely operate the assisted living facility; and
   - Operate in compliance with applicable state and federal laws including, but not limited to, chapters 7.70, 11.88, 11.92, 11.94, 18.20, 18.79, 69.41, 70.122, 70.129, and 74.34 RCW, and any applicable rules promulgated under these statutes.

3. I also certify that these policies and procedures agree with all of the laws and rules that apply to the assisted living facility and the assisted living facility operations. At a minimum the policies and procedures cover all of the care and services the assisted living facility provides including but not limited to the following:
   a) Mandated reporter requirements: specifically including the protection of residents, investigations of incidents, required notification and non-interference with the reporting requirements.
   b) Resident decision making, including advance directives.
   c) Emergency care of residents and medical emergency issues.
   d) Lack of a resident's personal physician or health care provider.
   e) Supervision of residents, including accounting for residents who leave the premises.
   f) Response to residents' challenging behaviors.
   g) Resident Assessment and ongoing monitoring of resident condition.
   h) Coordination of services and sharing resident information with outside resources.
   i) Receipt and response to resident grievances.
   j) Staff qualifications and background checks.
   k) Urgent situations requiring additional staff support.
   l) Emergency preparedness, including internal and external disasters.
   m) Medication management and systems.
   n) Nursing services, including nurse delegation.
   o) Food services.
   p) Safe operation of assisted living facility vehicles used to transport residents.

I certify and declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

Dated: _____ in _____
CITY STATE

SIGNATURE	DATE
TITLE	PRINT NAME

Important

You must complete and submit the Assisted Living Facility Policies and Procedures Attestation, DSHS 16-197.

Washington Administrative Code (WAC) 388-76A-2600 requires Assisted Living Facilities to develop, implement, and maintain policies and procedures.

As part of the Assisted Living Facility licensing process, you must submit a completed and signed copy of the Assisted Living Facility Policies and Procedures Attestation form, DSHS 16-197. Your signature attests to the Assisted Living Facility having policies and procedures that meet all applicable requirements.

If you have questions about completing the Assisted Living Facility Policies and Procedures Attestation form, please contact your local Residential Care Services field office and speak with an ALF Licensor.

When submitting your Assisted Living Facility license application, please do NOT send a copy of your facility's policies and procedures with your application.

Instructions for Completing Assisted Living Facility Policies and Procedures Attestation, DSHS 16-197

Washington Administrative Code (WAC) 388-76A-2600 requires assisted living facilities (ALFs) to develop, implement, and maintain policies and procedures.

As part of the ALF licensing process, you must submit a completed and signed copy of this form (DSHS 16-197). Your signature attests to the ALF having policies and procedures that meet all applicable requirements.

If you have questions about completing the Assisted living facility Policies and Procedures Attestation form, please contact your local Residential Care Services field office and speak with an ALF Licensor.

When submitting your ALF license application, please do NOT send a copy of your facility's policies and procedures with your application.

Thank you.