

## Certified Community Residential Services and Supports (CCRSS) Initial Application

### CCRSS Application Checklist

The checklist below is to help support the applicant in the application process for a CCRSS certification. **Please do not submit the application instruction and resource document when submitting the application.**

- Copy of the Letter of Intent that includes contact information, geographical area of service and type of service provided.
- If applying for a group home, submit a copy of your current Adult Family Home (AFH) or Assisted Living Facility (ALF) license.
- Copy of your Washington State business license issued by Department of Revenue.
- Copy of document issued by Internal Revenue Service (IRS) showing Employer Identification Number (EIN) for the applicant.
- Complete and submit with the application packet the online background authorization form located at <https://fortress.wa.gov/dshs/bcs/> for each person listed in section 9.
- Copy of DSHS fingerprint results if completed after January 1, 2012.
- Copies of the following documents:
  - Mission Statement
  - Policies
    - ✓ Roles and Responsibilities of administrators, program managers, direct care professionals, business operations, etc
    - ✓ Reporting of Abuse, Neglect, Financial Exploitation
    - ✓ Medication management and assistance
    - ✓ Financial management and assistance
    - ✓ Emergency Response Procedures
    - ✓ Client Rights
    - ✓ Individual Instruction and Support Plan development and service delivery
  - Protection of Privacy of Client Records
  - Job Descriptions
  - Business Plan for financial solvency
- If application is for a change of ownership you must provide a copy of the 60-day notice to the Department and 30 day notice to clients and/or their legal representatives [WAC 388-101-3070](http://www.wa.gov/wac/388-101-3070).
- Copy of the Administrator Resume.
- Include three professional references for the Administrator.

### Submitting Application

Submit your application and supporting documents:

For US Postal Mail:

ALTSA BAAU  
PO BOX 45600  
OLYMPIA WA 98504-5600

For Federal Express:

ALTSA BAAU  
4450 10<sup>TH</sup> AVE SE (BLAKE WEST)  
LACEY WA 98503

**Please note: Do not include the instructions / resource document when submitting the application packet.**

If you have questions about completing the application, please email the Business Analysis and Applications Unit (BAAU) at [BAAU@dshs.wa.gov](mailto:BAAU@dshs.wa.gov) or call 360-725-2573, we will respond within 48 hours.

## Certified Community Residential Services and Supports Initial Application

<b>Section 1. Type of Application</b>				
<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Change of Ownership</b> (change of business entity ownership or the form of legal organization)				
<b>Section 2. Type of Service Provided</b>				
<input type="checkbox"/> Supported Living Services <input type="checkbox"/> Group Home <input type="checkbox"/> Group Training Home <input type="checkbox"/> Community Protection				
<b>Section 3. Geographic Area of Service</b>				
LIST THE COUNTY WHERE SERVICES WILL BE PROVIDED (SUBMIT A SEPARATE APPLICATION FOR EACH COUNTY)				
<b>Section 4. Information About the Service Provider</b>				
1. NAME OF SERVICE PROVIDER (DOING BUSINESS AS)				
2. BUSINESS STREET ADDRESS			CITY	STATE
3. MAILING ADDRESS (IF DIFFERENT FROM ABOVE)			CITY	STATE
4. TELEPHONE NUMBER		5. CONFIDENTIAL FAX NUMBER		6. CELL PHONE NUMBER
7. EMAIL ADDRESS			8. WEB SITE URL	
<b>Section 5. Legal Entity Information</b>				
1. LEGAL NAME OF ENTITY				
2. UBI NUMBER - -			3. EIN NUMBER -	
<b>Section 6. Individuals Associated with Service Provider</b>				
List all partners, officers, directors and majority owner of applying entity. If more space is needed attach additional page(s) to the application.				
NAME OF PERSON	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	PERCENT OWNERSHIP
				%
				%
				%
				%
				%
<b>Section 7. Administrator Information</b>				
1. NAME OF ADMINISTRATOR (LAST, FIRST, MIDDLE)		2. SOCIAL SECURITY NUMBER - -		3. DATE OF BIRTH
4. TELEPHONE NUMBER		5. EMAIL ADDRESS		

**Section 8. Licensing, Contracting and Certification History**

Has any person or entity named in this application ever owned, held an interest in, managed, or held a license or certification for an adult family home, assisted living facility, nursing home, community residential services, support agency or other business providing services to vulnerable adults, children or persons with mental illness or developmental disabilities?  Yes  No

Has any person or entity named in this application ever held a Medicaid or other social services contract to provide services to vulnerable adults, children or persons with mental illness or developmental disabilities? This includes Individual Provider contracts.  Yes  No

Has any person or entity named in this application ever had a contract terminated or a certification or license revoked or denied by the Department, or has been subjected to department enforcement actions?  Yes  No

Has any person or entity named in this application ever had an out-of-state contract or license involving the provision of services to children or vulnerable adults terminated, revoked or denied or has been a subject of an enforcement action related to the out-of-state contract or license?  Yes  No

Has any person or entity named in this application ever obtained or attempted to obtain a license or certification by fraudulent means or misrepresentation?  Yes  No

Has any person or entity named in this application ever relinquished or been denied a license or license renewal to operate a home or facility that was licensed for the care of children or vulnerable adults?  Yes  No

Has any person or entity named in this application ever had a court issue a permanent restraining order or order of protection, either active or expired, against a person that was based upon abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult?  Yes  No

Has any person or entity named in this application been registered as a sex offender?  Yes  No

Has any person or entity named in this application ever been listed on a registry based upon a final finding of abuse, neglect or financial exploitation of a vulnerable adult, unless the finding made by adult protective services prior to October 2003?  Yes  No

Has any person or entity named in this application ever had a founded finding of abuse or neglect of a child, unless the finding was made by child protective services prior to October 1, 1998?  Yes  No

Has any person or entity named in this application been found in any dependency action to have sexually assaulted or exploited any child or to have physically abused any child?  Yes  No

Has any person or entity named in this application been found by a court in a domestic relations proceeding under Title 26 RCW, or under any comparable state or federal law, to have sexually abused or exploited any child or to have physically abused any child?  Yes  No

Has any person or entity named in this application ever had a contract or license denied, terminated, revoked, or suspended due to abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult?  Yes  No

Has any person or entity named in this application ever relinquished a license or terminated a contract because an agency was taking an action against the individual related to alleged abuse, neglect, financial exploitation or mistreatment of a child or a vulnerable adult?  Yes  No

If "Yes" to any questions in this section, the following information is required to accompany the application packet:

- Name of the individual:
- Type of license, certification, or contract:
- Name and address of facility:

Date of action (if applicable): \_\_\_\_\_ \* If more space is needed, attach additional page(s) to the application.

**Section 9. Background Information**

Complete an online background authorization form located at <https://fortress.wa.gov/dshs/bcs/>. Print and submit the completed background authorization form for each of the following:

- Applicant
  - Partners, officers, directors and owner(s) of applying entity and for sole proprietor the spouse/domestic partner of the applicant
  - Administrator
- \* If a Fingerprint check was performed on any person listed in this section after January 1, 2012, submit the results with application packet.

NAME OF PERSONS (ATTACH ADDITIONAL SHEETS OF PAPER IF NEEDED)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	JOB TITLE
		- -	
		- -	
		- -	
		- -	
		- -	
		- -	
		- -	
		- -	

**Section 10. Current Employee of the State of Washington**

Are any partners, officers, directors and majority owner of applying entity currently employed by the Department of Social and Health Services?  Yes  No

If "yes" to the above question, list below the name and State job title of the person(s) in this application that is employed by the Department of Social and Health Services

NAME OF PERSON / JOB TITLE	ADMINISTRATION / DIVISION

**Section 11. Consent to Release and/or Use Confidential Information**

Each person listed in the application **must 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 purposes of certification. 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 388-101 WAC and Chapter 388-101D WAC).

Completion of this form allows the use and sharing of confidential information within DSHS and with the individual applicant / agency for application processing purposes. DSHS may disclose and receive confidential information from outside agencies, divisions, offices and/or the police.

This consent is valid for as long as I am the person named in this application. A copy of this form is valid for my permission to release and use this information.

NAME OF INDIVIDUAL (PLEASE PRINT)	SIGNATURE	DATE
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NAME OF INDIVIDUAL (PLEASE PRINT)	SIGNATURE	DATE

**Section 12. Applicant Certification**

I 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 Certified Community Residential Services and Support Agency are true, complete, and accurate. I understand that the department may obtain additional information, verification and/or documentation related to my answers or information.

I certify that the administrator is at least 21 years of age or older, has a high school diploma or GED equivalent, and meets the qualification standards per WAC 388-101D.

Copies of all documents needed to verify the items in this application are attached, and original documents will be readily available to the department.

I understand that failure to accurately answer or fully complete the questions on this application may result in denial of the certification and / or contract, or other sanctions as allowed by law.

I understand that the department may check the credit of the corporation, individual or business and its principals; 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. 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.

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

I understand that if my application for a Certified Community Residential Services and Support Agency is denied, I may request an administrative review within 28 days of receiving the denial letter from DSHS.

I have read [RCW Chapters 71A.12, 74.34](#) and [WAC 388-101, WAC 388-101D and WAC 388-828](#), and any other applicable laws and rules.

If/when I am certified:

- I understand that each staff I employ must meet the requirements of [WAC 388-829](#).
- No clients receiving care and services by the certified community residential services and support provider will be subject to discrimination on the basis 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 certify and declare under penalty of perjury under the laws of the State of Washington that the information in this application and all of the supporting documents are true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE	PRINT NAME
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