

State of New York  
OFFICE OF MENTAL RETARDATION  
AND DEVELOPMENTAL DISABILITIES

OMR LS 22  
Application for  
FAMILY CARE HOME CERTIFICATION  
(Rev. 10/05)

Instructions to Applicant(s):

- Applicant(s) with assistance of Sponsoring Agency staff, completes, signs and have notarized one (1) copy of the LS 22. Please Note: LS 22 must be used upon Recertification when there are changes in or to the home.
- OMRDD will conduct the necessary inspections and evaluations of the home.
- If approved, an Operating Certificate may be valid for a period of up to three (3) years.

(For Sponsoring Agency Use Only)

Initial Certification: Date of Certification \_\_\_ / \_\_\_ / \_\_\_ State Sponsored \_\_\_ Agency Sponsored \_\_\_

Recertification: Date of Recertification \_\_\_ / \_\_\_ / \_\_\_ Agency Name/DDSO \_\_\_\_\_

I. PROVIDER INFORMATION

A. Name of Applicant \_\_\_\_\_

Name of Co-Applicant \_\_\_\_\_

Employed by Sponsoring Agency

Yes  No

Employed by Sponsoring Agency

Yes  No

Source of Income \_\_\_\_\_

Source of Income \_\_\_\_\_

Yearly Income \$ \_\_\_\_\_

Yearly Income \$ \_\_\_\_\_

Attach an employment history, together with a signed release for employment verification.

B. Address

Street \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

Zip Code \_\_\_\_\_

Mailing Address if different

Street \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

Zip Code \_\_\_\_\_

C. Telephone Number(s)

Land Line \_\_\_\_\_ Cellular \_\_\_\_\_

(Home Phone)

D. Current Marital Status  Married  Never Married  Separated  Widowed  Divorced

Social Security # Applicant \_\_\_\_\_ Social Security # Co-Applicant \_\_\_\_\_

E. Religion

Protestant  Catholic  Jewish  Jehovah's Witness  Muslim  None  Other, specify \_\_\_\_\_

F. Primary Language

English  Spanish  Sign  Other spoken, specify \_\_\_\_\_

G. Education (circle highest grade completed)

Applicant

School 1 2 3 4 5 6 7 8 9 10 11 12

College 1 2 3 4

Grad School  Yes  No

Professional License  Yes  No

Type \_\_\_\_\_

Name and address of high school or college

\_\_\_\_\_  
\_\_\_\_\_

Co-Applicant

School 1 2 3 4 5 6 7 8 9 10 11 12

College 1 2 3 4

Grad School  Yes  No

Professional License  Yes  No

Type \_\_\_\_\_

Name and address of high school or college

\_\_\_\_\_  
\_\_\_\_\_

H. Applicant's Driver's License

License No. \_\_\_\_\_

Issuing State \_\_\_\_\_

Expiration Date \_\_\_\_\_

Co-Applicant's Driver's License

License No. \_\_\_\_\_

Issuing State \_\_\_\_\_

Expiration Date \_\_\_\_\_

Please provide information regarding any moving violations, including alcohol and drug-related offenses. Indicate any suspension, revocation or occurrence involving harm to human beings or property.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I. Name and age of each person, including the applicant(s), living in the home and relationship to the applicant(s).

Name

Date of Birth

Relationship

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

J. Attach a physician's statement indicating that the applicant provider(s) is in good health and physically and emotionally capable of providing Family Care services, along with all required testing.

K. Name(s) of Agency(ies), OTHER THAN OMRDD or the SPONSORING AGENCY, from which individual(s) will be or have moved into the home.

\_\_\_\_\_  
\_\_\_\_\_

L. Number of years at current address \_\_\_\_\_  Own  Rent Lease Expiration Date: \_\_\_\_\_

Name and Address of owner of residence at which (proposed) family care home is (will be) located, if other than applicant(s).

Name		Street	
City	State	Zip Code	Phone Number

**II. PERSONAL REFERENCE/INFORMATION**

A. Name and Address of 3 people NOT related to the applicant(s) who can attest to the applicant(s)' character.

1) \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street City Zip Code

2) \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street City Zip Code

3) \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street City Zip Code

B. Do you have any financial interest in any other agency subject to certification by OMRDD, such as community residence, IRA, ICF/DD, Family Care, or any day services; or building(s) occupied by such a program?  Yes  No If Yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Have you or any member of your household been approved, denied, licensed, or certified under present or any other names by any state, county, or private agency to provide services in the home?  Yes  No  
If Yes, please describe  Approved  Denied  Licensed  Certified  
\_\_\_\_\_  
\_\_\_\_\_

D. Have you or any member of your household ever been convicted of a crime (misdemeanor or felony)?  
If Yes, please provide name and information on the crime, including date of conviction and court of jurisdiction. You may also supply information about your/their good conduct and rehabilitation.

- Applicant  Yes  No
- Co-Applicant  Yes  No  No co-applicant
- Household Member  Yes  No  No household member(s)
- Household Member  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Are you or any member of your household currently the subject of any pending criminal charges?

If Yes, please provide name, information on the crime, and date of charge.

Applicant  Yes  No

Co-Applicant  Yes  No  No co-applicant

Household Member  Yes  No  No household member(s)

Household Member  Yes  No

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F. Have you or any member of your household been the subject of an indicated case of child abuse or maltreatment? If Yes, please provide information on the child abuse or maltreatment and date.

Applicant  Yes  No

Co-Applicant  Yes  No  No co-applicant

Household Member  Yes  No  No household member(s)

Household Member  Yes  No

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G. Why do you want to become a Family Care Provider? \_\_\_\_\_

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H. What life experiences do you have with individuals with developmental disabilities?

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**III. CERTIFICATION/RECERTIFICATION**

I hereby request an Operating Certificate in accordance with Article 16 of the Mental Hygiene Law be issued in my/our name(s).

For purposes of initial certification or, if certified, I understand that this Family Care home is subject to inspection by the Commissioner of OMRDD or his or her authorized representative(s) at any time, with or without notice.

If an Operating Certificate is granted, I agree:

1. To maintain the Family Care home at the certified address, with the understanding that the certification applies ONLY to this address.
2. To guarantee and protect the civil rights of all individuals in my home.
3. To not exceed the certified capacity.
4. To make all reports as required by the Commissioner.
5. To notify in writing and obtain approval of the Commissioner 60 days prior to voluntarily terminating operation of the Family Care home.
6. To notify in writing and include reason(s) for wanting the individual(s) removed from the home.
7. To notify the sponsoring agency if the individual(s) poses a threat to himself or herself or others.
8. To operate the Family Care home in accordance with all applicable laws, regulations, and policies.
9. To notify sponsoring agency prior to making any renovations or environmental modifications to the Family Care home.
10. To notify sponsoring agency of any prospective household members who intend to move into the home including family members, boarders, and/or individuals placed by other agencies.
11. To provide Family Care services in such a manner as to assure that I will not discriminate against an individual because of his or her race, color, gender, sexual orientation, military status, creed, religion, age, disability, or national origin.
12. To notify the sponsoring agency of any legal involvement, actions or proceedings concerning or affecting any member of the household. This requirement covers, but is not limited to, any arrests, criminal investigations, criminal convictions, restraining orders, orders of protection, income executions, lawsuits, separation agreements, and divorce proceedings involving or affecting any member of the household, and any calls made to the police, or visits made to the home by the police or other law enforcement officials. If I have requested a criminal history record check, I have read and signed the attached disclosure statement.
13. To obtain approval for scheduled absences from the Family Care home (i.e., vacations).

I certify that all information included in this application is accurate and true to the best of my knowledge and understand that any untrue statement, knowingly given, is grounds for revocation, non-renewal or disapproval.

Signature

Print Name

Date

Signature

Print Name

Date

**IV. VERIFICATION UNDER OATH**

STATE OF NEW YORK

COUNTY OF \_\_\_\_\_  
AND \_\_\_\_\_

Being duly sworn, deposes, and says that he or she or they is/are the person(s) who has/have executed the above application that the statements in the forgoing application are true of his or her or their own knowledge.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Applicant/Provider Signature

\_\_\_\_\_  
Co-Applicant/Co-Provider Signature

**V. SUMMARY (For Sponsoring Agency Use Only)**

**A. Recommendation(s)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. Other Comments**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Certified Capacity Excluding Respite/Tubs \_\_\_\_\_ Respite/Tubs Capacity \_\_\_\_\_ Total Capacity \_\_\_\_\_

Print Name of Person Reviewing the Form \_\_\_\_\_

Print Title of Person Reviewing the Form \_\_\_\_\_

Signature \_\_\_\_\_ Date Reviewed \_\_\_\_\_

Approved by \_\_\_\_\_ Title \_\_\_\_\_ Date of Approval \_\_\_\_\_

Date of Disapproval \_\_\_\_\_ Further Action Required  Yes  No

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_