



**II. PROPOSED PROGRAM INFORMATION**

1. Anticipated Clientele to be served:	Age Range	Expected Number From		% Ambulatory	% Non-Ambulatory
		D.C.	Community State Op. Vol. Op.		
a. <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Mentally Retarded <input type="checkbox"/> Cerebral Palsied <input type="checkbox"/> Epileptic <input type="checkbox"/> Neurologically Impaired <input type="checkbox"/> Autistic  b. <input type="checkbox"/> Other (specify diagnosis) _____ _____					

2. In narrative format, describe the proposed project (incorporating program description). Include the following, when relevant to the proposal:

- a. Outline of unmet needs to be served; why the clientele to be served is in need of the services proposed; and confirmation that alternative, less costly or more effective methods of accomplishing the proposed results are absent.
- b. Goals and objectives of proposed program and consistency of these goals and objectives with applicant's long range plan.
- c. Outline description of the proposed program.
- d. Proposed plan of organization or description of the impact of the proposal on the existing organization.
- e. Special or unusual services, activities or equipment to be provided by the applicant.
- f. Support services (e.g., Transportation), to be provided by the applicant.
- g. Description of geographic area to be served.
- h. Description of location in which program site is expected to be located. If known, give complete address, description of site and zoning information.
- i. Anticipated start-up cost.
- j. How project will foster cost containment and improved quality of care through improved efficiency and productivity, including promotion of cost-effectiveness factors.

**II. 3. Statement of Need**

Has contact been made with the Health Systems Agency relative to the proposed project?

Yes

No

Has contact been made with the Local Governmental Unit relative to the proposed project?

Yes

No

The proposed project is currently included in the Health Systems Agency plan.

The proposed project is currently included in the Local Governmental Unit plan.

If the proposed project is not currently included in the Health Systems Agency and Local Governmental Unit (county) plan, indicate how this project will be included.

**How will this proposed project contribute to attainment of short-term and long-term goals of local, regional and statewide plans for the developmentally disabled? Is this proposed project consistent with statewide, regional and county plans for the developmentally disabled?**



**II. 6. Service Information**

a. Number of years applicant has been in operation and/or providing services for developmentally disabled individuals. \_\_\_\_\_

b. What programs for developmentally disabled individuals does applicant currently operate? <i>Check appropriate box(es)</i>	Number of Persons in Existing Programs		No. of Persons Who will Move to or Use New Program		Anticipated Additional New Admissions		Anticipated Total Number of Persons in Proposed Program	
	DD	Other	DD	Other	DD	Other	DD	Other
<input type="checkbox"/> ICF/DD								
<input type="checkbox"/> CR - Supervised								
<input type="checkbox"/> CR - Supportive								
<input type="checkbox"/> Specialty Hospital								
<input type="checkbox"/> Private Residential School								
<input type="checkbox"/> Day Treatment-Full Time								
<input type="checkbox"/> Day Treatment-Part Time								
<input type="checkbox"/> Clinic Treatment								
<input type="checkbox"/> Day Training								
<input type="checkbox"/> Sheltered Workshop-Full Time								
<input type="checkbox"/> Sheltered Workshop-Part Time								
<input type="checkbox"/> Work Activity-Full Time								
<input type="checkbox"/> Work Activity-Part Time								
<input type="checkbox"/> Client Education								
<input type="checkbox"/> Other: (Specify)								
<b>Totals:</b>								

c. Specify other services or programs this organization provides to persons other than those who are developmentally disabled. Also specify those in the planning stage.

**III. Anticipated Operating Budget Information (for first year)**

**ANTICIPATED OPERATING INCOME**

a. Client Fees (Billing) (based on fee information available at this time)

b. Medicaid (based on fee information available at this time)

c. SSI

d. State Assistance

(1) State Lease

(2) Education 853

(3) Education Aid

(4) Education

(5) O.V.R.

(6) Article 41 Operating Funds

(7) Other \_\_\_\_\_

e. Direct State Expenditures (for state operated programs only)

f. Federal Funding

(1) Section 8 Rental Subsidy

(2)

(3)

g. Contributions from Individuals

h. Contributions from Organizations

i. Other (specify)

**Totals**

**ANTICIPATED OPERATING EXPENSES**

a. Administrative Overhead

b. Staffing Salaries (From Page 4)

c. Staff Fringe Benefits

d. Rent

e. Mortgage

f. Equipment

g. Office Supplies

h. Utilities

i. Insurance

j. Travel - Staff

k. Travel - Client

l. Food

m. Housekeeping Supplies

n. Program Supplies

o. Other Expenses (Specify)

**Totals**

*Last Three Years' C.P.A. Audited Financial Statements: (Attach)*

**IV. PROPOSED CONSTRUCTION (erection, building, alteration, reconstruction, improvement, modification) INFORMATION**

Provide a narrative description of any construction to be performed, including the following as may be known:

- Description of architectural services to be provided .
- Preliminary estimate of the construction time schedule
- Estimates of the costs of construction and sources of financing

**V. INCORPORATION/PARTNERSHIP INFORMATION****1. If not currently incorporated, complete the following (if applicable):**

a. Under what name has the applicant been operating?

b. How long?

c. At what location?

d. For what purpose?

**2. Is a current certificate of incorporation/amendment or partnership agreement on file with OMRDD?**  Yes  No  
*(If not on file, please attach).*

**3. Is the corporation limited to operation in a designated geographical area?**  Yes  No

a. If "Yes", identify area.

**4. If the current certificate of incorporation/amendment is appropriate to cover proposed services, state the section of the certificate of incorporation/amendment that allows for such services:**

**5. If the current certificate of incorporation/amendment is not appropriate to cover proposed services, and approval of a certificate of amendment is requested, complete the following and attach the certificate of amendment.**

a. How long has the agency been incorporated?

b. At what location?

c. For what purpose?

d. Provide a brief description of services provided (other than those which are currently certified by OMRDD).

**6. On a separate attachment, identify each incorporator, member of the Board of Directors, major stockholder or partner, and include the following information.**

a. Name

b. Home address

c. Occupation

d. Business address

e. Community and philanthropic experience

f. Previous positions as board member or owner of any Health, Mental Retardation/Developmental Disability, Mental Health, or other human services facility within the last 10 years.

g. A statement that the individual has never had a criminal conviction, nor has any criminal actions pending against him or her; or explanation of conviction for any offense against the law except traffic charges and explanation of charges pending in any court.

**VI. STATEMENT OF UNDERSTANDING**

**(I am) (We are) aware that**

1. Certification of need for this proposed program does not constitute automatic approval of the project.
2. Certification of need for this proposed program does not constitute confirmation of availability of anticipated capital funding or operating funds.
3. Certification of need for this proposed program does not constitute authorization to proceed with contractual arrangement for property, construction, staffing, equipment, etc.
4. Certification of need for this proposed program does not constitute authorization to initiate the program.
5. In order to initiate operation of the proposed program, the program must be issued an "Operating Certificate."
6. An Operating Certificate can only be issued when the proposed program has complied with existing standards for the class of program proposed, and these standards are known to (me) (us).

\_\_\_\_\_  
(Authorized Official's Signature\*)

\_\_\_\_\_  
(Authorized Official's Signature\*)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)

\* Board President, Executive Director, Partners as applicable

**FOR OMRDD USE ONLY:**