Request for Expansion of Community and Qualifying Facilities

FACILITY INFORMATION

Name of Facility:	
Address of Facility:	

Certification Information:

Date of initial certification: _____

Certified capacity upon opening: _____

Current Certified capacity: _____

Proposed certified capacity: _____

Describe any licensure and/or standards waivers currently in effect or required as a result of the expansion:

Describe any change in facility classification regarding funding and/or licensure as a result of the proposed expansion:

Attach a copy of the most recent facility survey results along with any plan of corrective action which is in effect or is proposed for approval.

Description of Facility Location

Is this facility freestanding? _____

Is this facility on the grounds of a developmental center, hospital, or other institution? (If so, specify)

Are there any other freestanding or attached structures used for mental health or mental retardation or correctional services adjacent to this facility? (If so, specify configuration and names of facilities)

Is this facility included on ATTACHMENT C of *Willowbrook Settlement* (2/25/1987)?

YES_____ NO_____

Is this an EMERGENCY Request? (I.E.: Has the operating certificate of another facility been revoked, suspended, or surrendered? Has another facility been rendered unsafe for habilitation? If so, complete section immediately below:

YES_____ NO_____

(If no, skip next section)

Emergency Status

Name of Facility Closing: _____

Operating Certificate Number: _____

Address of Facility Closing:

Names of *Willowbrook* class members in closure facility:

Reason for closure (If certificate was revoked, who made the decision?):

Actions taken to prevent loss of facility:

Alternative placement sites explored:

PURPOSE OF PROPOSED EXPANSION

Target Date for proposed expansion: _____

Brief summary of the rationale for the proposed facility expansion:

IMPACT ON CLASS MEMBERS

Population: Current and Proposed Cass Members

Complete "Client Characteristics Chart for Consent Judgment Staffing Audit Data." (Form is attached) Instructions for completing the form are:

- Enter names of all class members currently residing in the facility and enter NYS ID numbers (instead of names) for non-class clients currently residing in the facility.
- Draw a double line following the names of the current clients and add the names or ID numbers of clients proposed to be placed in the facility as a result of this expansion.
- Place a checkmark in any of the categories of description which apply to any client as follows:
  - Non-ambulatory
  - Blind
  - Deaf
  - Other Disability: other physical impairments
  - Intensive Behavior Modification Program: needs or receives intensive behavior modification services
  - Psychotropic Drugs for behavioral reasons: receives psychotropic drugs for behavioral reasons
  - Enriched staffing: client is receiving 1:1; 1:2; or 1:3 staffing ratio
  - Recommended for enriched staffing: client is recommended for 1:1; 1:2; or 1:3 staffing ratio

Attached a summary of the most recent ITT recommendations for each class member listed above, including recommendations for community placement.

IMPACT ON STAFFING

Clinical/Professional Staff (include all staff other than direct care staff)

- Attach list of current positions and full-time equivalency of each position which is designated for services to this facility.
- Attach list of positions to be added and full-time equivalency of each position which would be designated for services to this facility.

Direct Care Staff

- Number of direct care staff positions currently: _____
- Number of direct care staff positions to be added as a result of the expansion: _____

Proposed direct care staffing pattern

	Minimum # Direct Care Staff on Duty	
	PRESENTLY:	AFTER EXPANSION:
Weekday morning shift:	X	X
Weekday afternoon/evening shift:	X	X
Weekday night shift:	X	X
Weekend morning shift:	X	X
Weekend afternoon/evening shift:	X	X
Weekend night shift:	X	X

Identify any other scheduling, organizational, or activity changes which will occur as a result of the proposed expansion:

IMPACT ON PHYSICAL PLANT

Attach a copy of the physical layout of the facility and identify any structural or physical changes which will alter the interior and the exterior as a result of the proposed expansion.

IMPACT ON TRANSPORTATION RESOURCES

Attach a description of current transportation resources, including vehicles, the number of passengers which any vehicles hold, etc. Describe changes to occur in transportation resources after expansion:

CONSENT OF AGENCY

Attach a copy of written consent of agency and other supportive comments from any of the parties involved.

PERSONS / AGENCY RESPONSIBLE FOR INFORMATION

Signature of Facility / Agency Representative	Title
Date	Telephone
Signature of OPWDD Representative	Title
Date	Telephone

Individual Characteristics

Willowbrook Staffing Audit Data

Facility Address: ____________________ Date: ____________________

NYS ID #	Non-Ambulatory	Blind	Deaf	Other Disability	Intensive Behavior Mod.	Psycho-tropic for Behavior	Psychiatric Unit	Enriched Staffing	Recommended for Enriched Staffing

LOSS OF OPERATING CERTIFICATE / LICENSURE

1. Provide a copy of the following to the Office of the Special Master:
   a. The last annual survey by the certifying/licensing agency
   b. The most recent Plan of Correction in response to the last annual survey.
   c. The latest verification survey (if any) of completion of the Plan of Correction or corrections of deficiencies.
   d. The decertification/licensure revocation notice (if any).
2. Were there any rate appeals pending or filed since the last annual survey or within ninety (90) days prior to the last annual survey?

   Yes ☐ *No* ☐

If ***'Yes'***, indicate what the provider expects to gain from an increased rate (check all that apply):

☐ More staff for:

- ☐ *Direct Care*
- ☐ *Clinical*
- ☐ *Administrative*
- ☐ *Other* (state)

☐ Purchase of vendor/professional services:

State the Services:

☐ Facility Capital Improvement:

Describe:

☐ Facility Maintenance/Repair

Describe:

☐ Other

Describe:

LOSS OF LEASE

1. Names of parties:

LESSOR:

Company Name

Address

City / State / Zip

Telephone Number

LESSEE:

Agency Name

Address

City / State / Zip

Telephone Number

2. Lease Term (current or most recent lease):

Beginning Date: _____ **End Date**: _____

3. Has the Lessor requested a rate increase as a condition of renewal?

Yes ☐ *No* ☐ **Current Rate**: $ _____ **Proposed Rate**: $ _____

4. State the Lessor's or Lessee's reason(s) for non-renewal:

Lessor ☐ *Lessee* ☐

5. Date of Notice of non-renewal: _____

CLOSURE FOR OTHER REASONS

If the closure is for reasons other than loss of a lease or loss of an operating certificate, then provide a detailed written explanation explaining the circumstances and actions taken or to be taken to continue operation.

FACILITY INFORMATION:

Operating Agency Name

Facility Address

City / State / Zip

Operating Certificate Number | Type (VOICF, VOCR, etc.)

Certified Bed Capacity | Date Facility Opened

Contact Name | Telephone Number

FACILITY RELOCATION:

Is this a relocation of an existing program into a newly created residential site?

Yes ☐ (complete information below) *No* ☐

ADDRESS OF NEW SITE:

Operating Agency Name

Facility Address

City / State / Zip

Operating Certificate Number | Type (VOICF, VOCR, etc.)

Certified Bed Capacity | Date Facility Opened

Plaintiffs have reviewed and agreed to this closure:

☐ Yes (Provide documentation of approval and complete only this page of this form)

☐ No (Complete all applicable sections of this form)

PERSON COMPLETING FORM:

NAME:
TITLE:
AFFILIATION:
DATE:

COMPLETE ALL APPLICABLE SECTIONS OF THE FORM FOR THE CLOSURE OR RELOCATIONS:

- **Loss of Operating Certificate/Licensure**
- **Loss of Lease**
- **Closure for Other Reasons**