



Office of Children and Family Services

Family-Type Home For Adults Certification Training

Alan Lawitz, Esq., Director, Bureau of Adult Services
Debbie Greenfield, FTHA Coordinator, Bureau of Adult Services

February 27, 2017

iLinc Tech Support: 1-800-810-1349

Purpose

- Provide training on the FTHA Certification Process
- Discuss the essential role of FTHA Coordinators/Staff
- Review key components of the FTHA application
- Review regulatory timeframes
- Provide additional resources

LEAN – an governor’s office initiative to improve workflow and streamline certification processes



Basis for District Role

Residential Placement Services 89-ADM-22

18 NYCRR Part 458

- Recruitment
- Community education
- Orientation and assessment of applicants to operate FTHAs
- On-going technical assistance to certified FTHA operators
- Supervision of FTHAs



FTHA Certification Forms

Applicant Forms

- LDSS-2865, Application for Approval Family-Type Homes for Adults
- LDSS-3239, Medical Evaluation (Operator)
- LDSS-4505, Family-Type Home for Adults Certification of Child Support Obligations
- OCFS-LDSS-7014, Personal History of Applicant Family-Type Home for Adults
- OCFS-LDSS-7016, Emergency Plan
- LDSS-4388, Fire/Safety Inspection Report



FTHA Certification Forms (continued)

Clearance Forms

- LDSS-3370, Statewide Central Register Database Check
- NYS Justice Center Staff Exclusion List

District Forms

- OCFS-0934A, Notice of Change Family-Type Home for Adults
- LDSS-2867, Survey Report Family-Type Home for Adults



LDSS-2685 (page 1)

LDSS-2685 (Rev. 09/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
**APPLICATION FOR APPROVAL FAMILY-
TYPE HOME FOR ADULTS**

 Initial Renewal Change**

* Documents to be submitted with renewals are highlighted in bold on pages one and two.

** See attached Notice of Change-Family Type Home for Adults (OCFS-0634-A), Form.

FACILITY INFORMATION:Name or DBA: Address of Facility: County: Proposed Capacity (1-4)

Type of Dwelling:

 Private Residence Apartment
No. of Floors:

Household Composition: List everyone who lives in your household, including yourself, family members, residents, boarders and others. Attach additional sheet(s) if necessary.

Name	Date of Birth	Sex	Relationship	Occupation
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

Does anyone who lives in your household have disabilities (excluding residents, but including boarders)?

 YES NO (If yes, indicate name of individual, nature and extent.)

Person(s) responsible for providing substitute care whenever applicant(s) is away from home.

Name	Address	Phone No.	Hours Per Week	Relationship	Age
<input type="text"/>	<input type="text"/>	<input type="text"/> () <input type="text"/> - <input type="text"/>	<input type="checkbox"/> > 20 <input type="checkbox"/> < 20	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> () <input type="text"/> - <input type="text"/>	<input type="checkbox"/> > 20 <input type="checkbox"/> < 20	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/> () <input type="text"/> - <input type="text"/>	<input type="checkbox"/> > 20 <input type="checkbox"/> < 20	<input type="text"/>	<input type="text"/>

Water Source: Municipal Well (requires a lab report)

The following documents must be submitted to your social services district within **120** days after the application is signed.

The documents required by c, d, and e must be signed and dated within **90** days of the date of submittal. Please see the Internet site <http://www.ocfs.state.ny.us/main/forms/psa> for copies of forms mentioned by number below.

a. Documentation of site control (deed or lease);

b. Legal Type:

1) Sole Proprietor

Certificate of Doing Business Under an Assumed Name (DBA) that is filed with the County Clerk

Yes N/A

OR

2) Partnership of natural persons (No LLC's or corporations)

Partnership Agreement Yes N/A (e.g. married)

Certificate of Doing Business Under an Assumed Name (DBA) that is filed with the County Clerk

Yes N/A



**Office of Children
and Family Services**

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LDSS-2685 (Rev. 06/2016)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

APPLICATION FOR APPROVAL FAMILY- TYPE HOME FOR ADULTS

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<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
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YES NO (If yes, indicate name of individual, nature and extent.)

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Name	Address	Phone No.	Hours Per Week	Relationship	Age
		() -	<input type="checkbox"/> > 20 <input type="checkbox"/> < 20		
		() -	<input type="checkbox"/> > 20 <input type="checkbox"/> < 20		
		() -	<input type="checkbox"/> > 20 <input type="checkbox"/> < 20		
		() -	<input type="checkbox"/> > 20 <input type="checkbox"/> < 20		

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a. Documentation of site control (deed or lease);

b. Legal Type:

1) Sole Proprietor
Certificate of Doing Business Under an Assumed Name (DBA) that is filed with the County Clerk
 Yes N/A

OR

2) Partnership of natural persons (No LLC's or corporations)
Partnership Agreement Yes N/A (e.g. married)
Certificate of Doing Business Under an Assumed Name (DBA) that is filed with the County Clerk
 Yes N/A

Documentation of Site Control

18 NYCRR 485.6(d) (12)

- Deed

OR

- Lease – including a statement authorizing operator to establish an FTHA on the premises



Legal Type of FTHA Applicant

1. Sole Proprietor – Must be a natural person. Applicant cannot be a limited liability company (LLC) or a corporation.

OR

2. Partnership of Natural Persons
No LLCs or corporations.

NYS Social Services Law Section 461-b (1.) (a); 18 NYCRR section 489.3(a)



Legal Documents Relating to Type of Applicant

For a Sole Proprietor: *Certificate of Assumed Name* (DOS-1338-f), filed with county clerk, is needed when applicant will operate under a name other than his/her own (e.g., “Country Living FTHA.”)

If applicant Daniel Webster will be operating under his own name (e.g., “Daniel Webster FTHA”) no DBA is needed. Applicant can then check off N/A.



Legal Documents Relating to Type of Applicant (continued)

For a Natural Person Partnership:

- Partnership Agreement: Required by 485.6 (d)(5), unless partners are married.
- Certificate of Assumed Name, (DOS-1338-f): sometimes also called a “business certificate,” filed with county clerk, is required by the law for any partnerships, even where the partnership will operate under the partners’ actual names. Here, it should really be called a “certificate of doing business as a partnership,” because the certificate is needed even when there is no assumed name.



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- c. **Fire inspection report (LDSS-4388) (Fire/Safety Inspection Report is recommended);**
 d. **Lab report which meets the standards of the New York State Department of Health on the quality of your drinking water if a municipal source is not available;**
 e. Sketch of floor plan showing all rooms in the building, resident bedroom dimensions and locations of exits, interior stairways, smoke detectors, fire extinguishers and carbon monoxide detectors;
 f. **Emergency Plan (OCFS-LDSS-7016)** (Section 489.10(b) (5) of OCFS regulations); and
 g. **Proof of Coverage or No Need for Worker's Compensation and Disability Benefits.**

OPERATOR INFORMATION

Applicant 1

Name of Applicant(s) (Last, First, MI)	Birth Date	Maiden Name	Marital Status* M-Married S-Single	Telephone and Area Code
	/ /		<input type="checkbox"/> M <input type="checkbox"/> S	() -
Do you live in the home: <input type="checkbox"/> No <input type="checkbox"/> Yes				
Income (other than from residents): \$				

1. Have you ever applied for a license or approval, excluding this home, to provide care for children or adults?

No Yes If Yes, date of approval) / / Outcome:

Facility involved: City: State:

2. Have you ever been convicted of any violation of law, other than minor traffic violations, or been a party in any administrative proceeding involving state, federal or local agencies:

No Yes If Yes: date of violation: / / Outcome:

Facility Involved: City: State:

3. Have you ever been required to be registered on a Sex Offender Registry of any jurisdiction?

No Yes If Yes: date of violation: / / Outcome:

Facility Involved: City: State:

The following documents must be submitted to your social services district within 120 days after the application is signed. Please see the internet site <http://www.ocfs.state.ny.us/main/forms/pba> for copies of forms mentioned by number below.

- h. Physician's statement indicating the applicant(s) and designated responsible substitute caretaker(s) providing 20 or more hours of care per week are in good health and capable of providing the residents with adequate care and services, Medical Evaluation (Operator) (LDSS-3739).
 i. Statement of education, experience and community activities for each applicant; Family Type Home for Adults Personal History of Applicant (OCFS-LDSS-7014).
 j. Statewide Central Register Database Check (LDSS-3370).
 k. Request for Staff Exclusion List Check Form (JC BCB15), found at <https://pocr.justicecenter.ny.gov/SEL/> and,
 l. Certification of Child Support Obligations (LDSS-4505).

List Two Non-Relative Character References

Name	Address	Zip Code	Telephone No.	Relationship

The applicant(s) represents that all of the above is true and the buildings, equipment, staff standards of care and records to be employed in the operation of this proposed family type home for adults will comply with applicable provisions of the law and regulations of the New York State Office of Children and Family Services and that any license or permit required by law for the operations of said home has been or will be issued by the appropriate agency, prior to operation.

SIGNATURE (APPLICANT 1):

DATE:

/ /



Office of Children
and Family Services

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Facility Involved:	City:	State:		
3. Have you ever been required to be registered on a Sex Offender Registry of any jurisdiction?				
<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes: date of violation: / / Outcome:				
Facility Involved:	City:	State:		
<p>The following documents must be submitted to your social services district within 120 days after the application is signed. Please see the Internet site http://www.ocfs.state.ny.us/main/forms/psa for copies of forms mentioned by number below.</p> <p>h. Physician's statement indicating the applicant(s) and designated responsible substitute caretaker(s) providing 20 or more hours of care per week are in good health and capable of providing the residents with adequate care and services, <u>Medical Evaluation (Operator) (LDSS-3239)</u>;</p> <p>i. Statement of education, experience and community activities for each applicant; <u>Family Type Home for Adults Personal History of Applicant (OCFS-LDSS-7014)</u>;</p> <p>j. <u>Statewide Central Register Database Check (LDSS-3370)</u>;</p> <p>k. <u>Request for Staff Exclusion List Check Form (JC CBC15)</u>; found at https://vpcr.justicecenter.ny.gov/SEL/ and,</p> <p>l. <u>Certification of Child Support Obligations (LDSS-4505)</u>.</p>				
List Two Non-Relative Character References				
Name	Address	Zip Code	Telephone No.	Relationship
<p>The applicant(s) represents that all of the above is true and the buildings, equipment, staff standards of care and records to be employed in the operation of this proposed family type home for adults will comply with applicable provisions of the law and regulations of the New York State Office of Children and Family Services and that any license or permit required by law for the operations of said home has been or will be issued by the appropriate agency, prior to operation.</p>				
SIGNATURE (APPLICANT 1):				DATE: / /

LDSS-4388 (page 1)

LDSS-4388 (08/2016)

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
**FIRE/SAFETY INSPECTION REPORT
FOR FAMILY TYPE HOMES FOR ADULTS**

Name of Operator(s): Address: Telephone:

Family Type Homes for Adults provide long term residential care to a maximum of four individuals who are unable or substantially unable to live alone. A typical resident may be a frail elderly person or an intellectually disabled person who requires supervision or assistance with the activities of daily living such as dressing and bathing. Family Type Homes for Adults are not nursing homes. All residents will be ambulatory and will need minimal or no assistance to evacuate the premises in the event of a fire or other emergency.

INSTRUCTIONS: The following statements should be completed by either a local code or state enforcement officer or building inspector for the jurisdiction in which the premises is located; or a third party with current New York State certification as either a code enforcement official, or building safety inspector, or other authority approved by a waiver submitted in accordance with part 489 of OCFS regulations. A Family Type Home for Adults is considered to be a family residence and therefore must comply with the New York State Uniform Fire Prevention and Building Code as it applies to family residences. There are **two** sections to this fire/safety inspection report.

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LDSS-4388 (06/2016)

SECTION B: GENERAL FIRE/SAFETY REQUIREMENTS-Continued			
	Compliance		
	Yes	No	N/A
15. Smoke detectors are tested by operator(s) monthly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Smoke detectors have not been in service longer than 10 years from the manufacture date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Carbon monoxide detectors are required in all multilevel and single level FTHA that have a fuel fired and/or solid fuel burning appliances, equipment, devices, and systems, and any other items that may emit carbon monoxide such as fire places and attached garages.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Combination smoke and carbon monoxide detectors are permitted, provided the alarm is listed for such use. The combination detector must have distinctly different alarm signals for smoke and carbon monoxide alarm activation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Carbon monoxide detectors have not been in service longer than 5 years of the date of manufacture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Underwriters Laboratory (UL) listed battery/ or plug-in detectors with battery backup carbon monoxide detectors are placed and operational in the following locations of single and multi-level FTHA: <ul style="list-style-type: none"> a) All levels of the home that contains sleeping areas. Carbon monoxide detectors shall be located within 15 feet of the sleeping area; b) Basement (not in the immediate area of a heating system or hot water tank). 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Inspected by: [REDACTED]

- | | |
|--|--------------------------|
| 1. Local or state code enforcement officer or building inspector | <input type="checkbox"/> |
| 2. A third party with current New York State certification as either a code enforcement official, or building safety inspector and is the authority having jurisdiction. | <input type="checkbox"/> |
| 3. Other authority approved by waiver. | <input type="checkbox"/> |

If violations are present during the initial inspection, a re-inspection is required to confirm that the violations have been corrected. The caseworker from the local department of social services can do the re-inspection if the violations are not technical in nature.

COMMENTS: [REDACTED]

Re-inspected by: [REDACTED]

Date of re-inspection: [REDACTED] / [REDACTED] / [REDACTED]

If a Family Type Home for Adults is NOT inspected by a code enforcement officer or building inspector, a waiver must be submitted in accordance with part 489 of the department's regulations, 88 INF-17 and 91 INF-31.

LDSS-7016 (page 1)

OCFS-LDSS-7016 (Rev. 06/2016)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
EMERGENCY PLAN

- This plan must be reviewed with all staff, volunteers and residents before an emergency
- This plan must be reviewed or updated annually or as necessitated by changes in staff assignments, occupancy, or the physical arrangement of the building
- The safe evacuation of residents is the **FIRST priority**. Residents must never be left without supervision.

Operator Name: [REDACTED]	FTHA Name: [REDACTED]
------------------------------	--------------------------

Emergency Plan:

This plan is meant to cover basic response to emergencies which may arise at the FTHA site. Although this plan addresses response to specific events, the intent is that the program has the capability to notify staff and volunteers of any emergency situation, and take action to protect the health and safety of occupants in care.

Alerting Emergency Services:

911 or the local emergency number will be called in case of evacuation involving smoke, fire, carbon monoxide, or anything that poses an immediate threat. The emergency numbers WILL be posted on or next to the phone(s).

EMERGENCY
911

BACK-UP NUMBERS			
FIRE	[REDACTED]	AMBULANCE	[REDACTED]

LDSS-7016 (page 2)

OCFS-LDSS-7016 (Rev. 06/2016)

If a smoke or other hazardous condition is observed prior to the alarm going off, employees and volunteers will notify building occupants using smoke detectors. Building residents will also be alerted vocally such as someone yelling "fire" or "danger, get out."

Evacuation Procedures and Accountability

Following notification of an emergency requiring evacuation, staff and volunteers will:

- ✓ Remain calm and account for all occupants
- ✓ Leave the building, closing doors behind you when possible
- ✓ Gather contact information & emergency supplies
- ✓ Take attendance after leaving the building

Other

Accountability for occupants, staff and volunteers will be handled as follows:

The FTHA Operator will take attendance. The operator, or the person assigned to supervision functions in the absence of the operator is designated to make sure that everyone has left the building and is accounted for.

Other:

Method of Evacuation:

All the residents will be evacuated unless otherwise specified in this plan. The following will be used to assist in the evacuation of residents:

- Physical Assistance
- Assistive devices (wheelchair, walker, etc.)
- Leading by hand

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Evacuation Assembly Areas

Primary Exit	Primary Assembly	2nd Exit	2nd Assembly Area
█	█	█	█
█	█	█	█
█	█	█	█
█	█	█	█

Relocation:

The following are the relocation site(s) where residents will stay until alternative plans can be made. Permission has been granted by the person in charge of each location to utilize the site for relocation of this FTHA.

Primary relocation site (required): █

Name

█
Street Address

█
City

█
Phone Number

LDSS-7016 (page 3)

OCFS-LDSS-7016 (Rev. 06/2016)

Transportation to this site will require the following:

Walking Bus Car Other

The following items will be taken from the site as time and safe evacuation allow (select all that apply):

Medications

Phone

Emergency Supplies

Flashlight

Coats

Shoes

Food

Other:

Shelter in Place:

The program will initiate Shelter in Place procedures in response to a non-fire related emergency where it is safer to remain in the building. The safest space for sheltering in place will be determined based on the situation. The program will follow any recommendations made by emergency services personnel. Shelter in Place will include some combination of the following:

- Staying indoors
- Closing all windows
- Closing all window shades
- Locking all doors and windows (lockdown)
- Moving residents and staff to an interior space with no/minimal windows
- Turning off heat and air conditioning systems
- Other
- Remaining in a room away from windows

911 will be called immediately upon recognizing a hazard that threatens the health and safety of residents, staff or volunteers.

LDSS-7016 (page 3)

Depending on the situation, notification of the need to shelter in place will be made to staff, residents and volunteers using the following methods (select one or more options):

In-person notification

Code words

Phone calls

Other

Radio or cell phones

The following space(s) have been identified where the program can Shelter in Place away from exterior doors and windows:

Primary space (required):

Secondary space (recommended):

Other space (recommended):

LDSS-7016 (page 4)

OCFS-LDSS-7016 (Rev. 08/2016)

Shelter in Place Supplies:

A variety and sufficient quantity of supplies including non-perishable food, water, first aid and other safety equipment is on site. These supplies will be on site in case residents need to remain at the site. Required supplies are checked below; additional supplies for this program include:

- | | |
|--|---|
| <input checked="" type="checkbox"/> First Aid kit | <input type="checkbox"/> Assistive device for residents unable to evacuate on their own |
| <input checked="" type="checkbox"/> Flashlight | <input type="checkbox"/> Battery-powered radio |
| <input checked="" type="checkbox"/> Food & Water | <input type="checkbox"/> Materials to cover windows & vents, |
| <input checked="" type="checkbox"/> Medications (if applicable) | If needed |
| <input checked="" type="checkbox"/> Telephone | <input type="checkbox"/> Games & books |
| <input checked="" type="checkbox"/> Toileting/diapering supplies | <input type="checkbox"/> Other: <input type="text"/> |
| <input type="checkbox"/> Extra batteries | |

Shelter in Place supplies will be kept in the following location(s):

Food supplies will be maintained as follows (select at least one of the following):

- This program will maintain food supplies for shelter in place

The following will have access to Shelter in Place supplies (select all that apply):

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Operator | <input type="checkbox"/> Household members |
| <input type="checkbox"/> All Staff | <input type="checkbox"/> Other <input type="text"/> |

LDSS-7016 (page 4)

Operators will be inspected for emergency supplies for condition, quantity, expiration date, and in consideration of the age, number and needs of residents with the following frequency (check one):

Monthly

Every 3 months

Weekly

Every 6 months

Communication:

Following any emergency which requires the program to evacuate, relocate or Shelter in Place, LDSS will be notified as soon as possible, as required by regulation.

In the event of any emergency which requires the program to evacuate and relocate, the family will be notified as soon as possible.

Conducting Drills:

Every new occupant to the Family Type Home for Adults (FTHA) will be promptly instructed on plans for safe emergency evacuation procedures.

For the purpose of creating a realistic evaluation of the evacuation plan, there will be a fire and disaster drill at least semiannually. These drills will be simulations of a fire or disaster that could occur within each part of the house. The house fire alarm will be sounded during the evacuation drill. The occupants are to respond to this alarm in the same manner they would in an actual emergency. I will record the date and time of each drill, along with how long it took for all occupants to successfully evacuate.

In the event of an actual emergency, I will take all steps possible to ensure all occupants are safely evacuated from the FTHA. Occupants will be instructed to remain with me in our assembly area. As soon as all occupants are accounted for, I will call 911 and report the emergency. In the event that I cannot return to my home, emergency arrangements and assistance will be sought from Red Cross, and local Department of Social Services.

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OCFS-LDSS-7016 (Rev. 06/2016)

I understand that under no circumstances are the occupants to return to the house once an emergency has been declared.

	<input type="text"/> / <input type="text"/> / <input type="text"/>
Operator	Date
	<input type="text"/> / <input type="text"/> / <input type="text"/>
Operator	Date

The plan should be reviewed or updated annually, or as necessitated by changes in staff assignments, occupancy, the physical arrangement of the building, or for changes to any elements of the plan. The space below is provided to assist in documentation of this requirement. If you update your plan, a new copy must be submitted to the LDSS FTHA Coordinator.

Date Reviewed: <input type="text"/> / <input type="text"/> / <input type="text"/>	Reviewed by: <input type="text"/>
Reason: <input type="text"/>	
Date Reviewed: <input type="text"/> / <input type="text"/> / <input type="text"/>	Reviewed by: <input type="text"/>
Reason: <input type="text"/>	
Date Reviewed: <input type="text"/> / <input type="text"/> / <input type="text"/>	Reviewed by: <input type="text"/>
Reason: <input type="text"/>	

DSS-296EL (page 1)



George E. Pataki
Governor

State of New York
Office of Children and Family Services

John A. Johnson
Commissioner

Capital View Office Park

52 Washington Street - Rensselaer, NY 12144

OCFS INFORMATIONAL LETTER

TRANSMITTAL: 98 INF-009

TO: **Commissioners of
Social Services**

DIVISION: Development
and Prevention
Services

DATE: June 19, 1998

SUBJECT: Family-Type Homes for Adults: Operators Required to Prove
Workers' Compensation and Disability Benefits Insurance Coverage
for Substitute Caretakers

**SUGGESTED
DISTRIBUTION:**

Directors of Services
Family Type Home for Adults Coordinators
Staff Development Coordinators

CONTACT PERSON:

Any questions concerning this release should be
directed to:
Janet Morrissey (518) 432-2987 or USER ID OPM100 or
Carole Fox (518) 432-2864 or USER ID AX5050

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Date June 19, 1998

Trans. No. 98 INF-009

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Background Information

The purpose of this release is to advise social services districts that in order to obtain Family Type Homes for Adults (FTHA) certification, applicants and operators of Family Type Homes for Adults must prove that they have obtained Workers' Compensation and disability benefits coverage, or that such coverage is not required under New York State Worker's Compensation Law.

Section 461-b(2)(a) of Social Service Law (SSL) allows approval to operate an adult care facility such as a FTHA only to an operator who satisfactorily demonstrates that any license or permit required by law for the operation of such facility has been issued to such operator. Section 460-e(1) permits the New York State Office of Children and Family Services (OCFS) to require an operator of a Family Type Home for Adults to provide such information and records in such form and at such times as this Office shall determine for the purpose of establishing and maintaining such facilities.

The New York State Workers' Compensation Law Section 57 and Section 220.8 of the Disability Benefits Law requires that prior to issuance of a certificate to operate a Family Type Home for Adults by the SOCFS, the applicant/operator must submit proof that the operator has obtained the required workers' compensation and disability benefits insurance coverage for any substitute caretakers in the operator's employ, or that the operator is not required to provide such coverage. This law applies both to issuance of new certificates and renewal of such certificates.

DSS-296EL (page 2)

The information in this release addresses the requirements necessary for operators and districts to comply with these laws and submit the required documentation to OCFS to obtain an operating certificate.

Workers' Compensation and Disability Benefits Coverage Requirements

a. Who Must be Covered

The New York State Workers' Compensation Board has determined that Workers' Compensation Law requires workers' compensation insurance coverage for any Family Type Home for Adults employing "substitute caretakers." Workers' Compensation Law requires that all workers in this industry must be covered by workers' compensation insurance coverage regardless of the number of hours worked, the workers' relationship to the owners, or whether workers are "volunteering" their services for the family business. Since under Social Services Law only natural persons may operate a Family Type Homes for Adults, the only exclusion that may be made for Workers' Compensation and Disability Benefits is a family type home owned by one individual with no employees.

New York State Insurance Fund

<http://ww3.nysif.com/Home/FooterPages/Column1/ContactNYSIF>

New York State Workers' Compensation Board

http://www.wcb.ny.gov/content/ebiz/wc_db_exemptions/wc_db_exemptions.jsp



LDSS-3239

<p align="center">STATEMENT PURPOSE</p> <p>Adult Family Type Care is a plan for 24-hour care in a family setting for 1-4 dependent adults. It is not a medical facility. Only persons who, by reason of age, physical or mental limitation, are in need of assistance with the basic activities of daily living, can be cared for in adult residential care settings.</p> <p>The information solicited on this medical evaluation will aid in determining the suitability of the individual as an ADULT FAMILY TYPE HOME operator. It will be used by the Local Department of Social Services and the Office of Children and Family Services, which are responsible for supervision and certification of Family Type Homes for Adults.</p>		<p>LDSS-3239 (Rev. 12/2006)</p> <p align="center">MEDICAL EVALUATION (Operator)</p>	
		<p>NAME: _____</p>	
		<p>ADDRESS: _____</p>	
		<p>SEX: <input type="checkbox"/> M <input type="checkbox"/> F</p>	<p>DATE OF BIRTH: _____</p>
		<p>EXAMINATION DATE: _____</p>	
<p>SECTION I: MEDICAL HISTORY</p>			
<p>RECENT SURGERY (TYPE OF PROCEDURE AND DATE): _____</p>		<p>RECENT ACUTE ILLNESS (TYPE AND DATE): _____</p>	
<p>CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS: _____</p>		<p>ACTIVITY RESTRICTIONS: _____</p>	
<p>SECTION II: EVALUATION</p> <p>In your opinion is the individual physically and mentally capable of providing the dependent adults living in the home with adequate care and services. <input type="checkbox"/> Yes <input type="checkbox"/> No (Please fully describe.) _____</p>			
<p>PHYSICIAN'S NAME AND ADDRESS (TYPE OR PRINT): _____</p>		<p>PHYSICIAN'S SIGNATURE: X</p>	<p>DATE: _____</p>



LDSS-3239

STATEMENT PURPOSE

Adult Family Type Care is a plan for 24-hour care in a family setting for 1-4 dependent adults. It is not a medical facility. Only persons who, by reason of age, physical or mental limitation, are in need of assistance with the basic activities of daily living, can be cared for in adult residential care settings.

The information solicited on this medical evaluation will aid in determining the suitability of the individual as an ADULT FAMILY TYPE HOME operator. It will be used by the Local Department of Social Services and the Office of Children and Family Services, which are responsible for supervision and certification of Family Type Homes for Adults.

LDSS-3239 (Rev. 12/2006)

MEDICAL EVALUATION (Operator)

NAME:

ADDRESS:

SEX

 M F

DATE OF BIRTH:

EXAMINATION DATE:

SECTION I: MEDICAL HISTORY

RECENT SURGERY (TYPE OF PROCEDURE AND DATE):

RECENT ACUTE ILLNESS (TYPE AND DATE):

CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS:

ACTIVITY RESTRICTIONS:

LDSS-3239

SECTION II: EVALUATION

In your opinion is the individual physically and mentally capable of providing the dependent adults living in the home with adequate care and services.

Yes

No

(Please fully describe.):

PHYSICIAN'S NAME AND ADDRESS (TYPE OR PRINT):

█

PHYSICIAN'S SIGNATURE:

X

DATE:

█



SCR Form LDSS-3370

Who needs them?

- Operators
- Substitute care
- Boarders
- Family members over the age of 18 who reside in the FTHA

Send to OCFS/BAS.

Do NOT send directly to the SCR.



SCR Form LDSS-3370 (page 2)

LDSS-3370 (Rev. 10/2014)-DCCS version FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK

SCR USE ONLY
REQUEST ID: [REDACTED]

Agency Use Only

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE: [REDACTED]	RESOURCE I.D. (RID): [REDACTED]	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER: [REDACTED]	CATEGORY USE ALPHA CODE: [REDACTED]	PHONE NUMBER (AREA CODE): [REDACTED] - [REDACTED]
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER: AGENCY NAME: [REDACTED] AGENCY: [REDACTED] LIAISON: [REDACTED] STREET ADDRESS: [REDACTED] CITY: [REDACTED] STATE: [REDACTED] ZIP CODE: [REDACTED]			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form. FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other persons in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE NONE. List RELATIONSHIP in the fields below. (see reverse side for instructions) Attach additional page if necessary.	

The purpose of collecting the demographic data on other persons in your household who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA PLEASE TYPE OR PRINT CLEARLY

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
MAIDEN/ALIAS	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Please provide your current address and any other addresses at which you have resided for the last 20 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE [REDACTED]	DATE [REDACTED]	APPLICANT'S SIGNATURE [REDACTED]	DATE [REDACTED]
----------------------------------	-----------------	----------------------------------	-----------------

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE [REDACTED]	DATE [REDACTED]	SIGNATURE [REDACTED]	DATE [REDACTED]
----------------------	-----------------	----------------------	-----------------



SCR Form LDSS-3370 (page 2)

LDSS-3370 (Rev. 10/2014)-DCCS version FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

SCR USE ONLY	
REQUEST I.D.:	<input type="text"/>

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE: <input type="text"/>	RESOURCE I.D. (RID) <input type="text"/>	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER: <input type="text"/>	CATEGORY USE ALPHA CODE: <input type="text"/>	PHONE NUMBER (Area Code): (<input type="text"/>) <input type="text"/> - <input type="text"/>
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER: AGENCY NAME: <input type="text"/> AGENCY LIAISON: <input type="text"/> STREET ADDRESS: <input type="text"/> CITY: <input type="text"/> STATE: <input type="text"/> ZIP CODE: <input type="text"/>			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form <u>FOR ALL CATEGORIES:</u> Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below <i>(see reverse side for instructions) Attach additional page if necessary.</i>	

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA

***PLEASE TYPE OR PRINT CLEARLY**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MAIDEN/ALIAS	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SCR Form LDSS-3370 (page 2)

Please provide your current address and any other addresses at which you have resided for the last 26 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM 1/2015	TO Present
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE	SIGNATURE	DATE

Addresses: No P.O. Boxes, No time gaps



SCR Form LDSS-3370 (page 4)

LDSS-3370 (Rev. 10/2014) -DCCS version

STAPLE TO LDSS-3370 (IF NEEDED)

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME:

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Request for SEL Check Form

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464	Request for Staff Exclusion List Check Form	
<p>The Justice Center maintains a Vulnerable Persons Central Register (VPCR) that includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse and are deemed ineligible to work in a position involving regular and substantial contact with a service recipient. Providers must request the Justice Center to conduct a check of the SEL before determining whether to hire or otherwise allow "any person" to have regular and substantial contact with a service recipient. "Any person" can include an employee, administrator, consultant, intern, volunteer, or contractor.</p>		
<p>Instructions:</p> <ol style="list-style-type: none"> 1. The provider's Authorized Person must complete this form and fax it to the Justice Center's Criminal Background Check (CBC) unit for an applicant under serious consideration to be hired or otherwise permitted to have regular and substantial contact with a service recipient. 2. The Justice Center's CBC unit will send the Authorized Person an email indicating the results of the SEL check. 3. If the Applicant is on the SEL, he or she may <u>not</u> be hired in a position involving regular and substantial contact with a service recipient in a facility or provider agency defined in Social Services Law §488(4) or by other providers of services in programs licensed or certified by the Office of Mental Health, Office for People With Developmental Disabilities, Office of Alcohol and Substance Abuse Services, Office of Children and Family Services, Department of Health and State Education Department. 4. If the Applicant is on the SEL, certain other providers have discretion whether to hire the individual as provided in Social Services Law §495(3). 5. If the Applicant is not on the SEL, a criminal background check through the Justice Center, if required, and an inquiry of the Statewide Central Register of Child Abuse and Maltreatment through the Office of Children and Family Services, if required, must be conducted. 		
<p>Part 1. Applicant Information (Please Print)</p>		
Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	Alien Reg#:
Applicant address:		Applicant type:
Facility/Provider Name: Address:		
State Oversight Agency: OMH OPWDD OCSF DOH SED OASAS <small>Please circle appropriate agency(ies)</small>		
<p>Part 2. Authorized Person Information Please print clearly</p>		
Name: <small>(Please Print)</small>	Email:	
Signature:	Phone:	
Facility/Provider name:	Address:	
<small>JC CBC 3 (7/13)</small>		



LDSS-2867 (page 1)

LDSS-2867 (Rev. 9/2006) Page 1 of 5

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
SURVEY REPORT
FAMILY-TYPE HOME FOR ADULTS

LOCAL DISTRICT: []		REGION: []	
NAME OF APPLICANT: []		TELEPHONE NO. []	WORKER'S NAME: []
ADDRESS: []		ZIP CODE: []	SURVEY DATE(S): []

SECTION A

RATE RANGE: From [] To [] FAMILY-TYPE HOME CAPACITY: [] PRESENT OCCUPANTS: Family [] Family Type Home Residents [] Other Residents [] Office of Mental Hygiene Dischargee's Residing Premises [] Office of Mental Retardation/Developmental Disabilities Dischargee's on Premises []	For each area below, fill in the number of residents in the appropriate category. AGE PAYMENT STATUS TIME IN HOME PERSONAL CARE STATUS	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">RESIDENT CHARACTERISTICS</td> </tr> <tr> <td style="text-align: center;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">UNDER 50</td> <td style="text-align: center;">50-64</td> <td style="text-align: center;">65-74</td> <td style="text-align: center;">75-84</td> <td style="text-align: center;">Over 84</td> </tr> <tr> <td style="text-align: center;">[]</td> </tr> </table> </td> </tr> <tr> <td style="text-align: center;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">SSI</td> <td style="text-align: center;">HR</td> <td style="text-align: center;">Private</td> </tr> <tr> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table> </td> </tr> <tr> <td style="text-align: center;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Less than 1 year</td> <td style="text-align: center;">1-4 years</td> <td style="text-align: center;">Over 4 years</td> </tr> <tr> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table> </td> </tr> <tr> <td style="text-align: center;"> Residents requiring help: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Dressing</td> <td style="text-align: center;">Walking</td> <td style="text-align: center;">Bathing</td> <td style="text-align: center;">Eating</td> </tr> <tr> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table> </td> </tr> <tr> <td style="text-align: center;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Taking Medication</td> <td style="text-align: center;">Transfer</td> <td style="text-align: center;">Toileting</td> <td style="text-align: center;">Other (specify)</td> </tr> <tr> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table> </td> </tr> </table>	RESIDENT CHARACTERISTICS	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">UNDER 50</td> <td style="text-align: center;">50-64</td> <td style="text-align: center;">65-74</td> <td style="text-align: center;">75-84</td> <td style="text-align: center;">Over 84</td> </tr> <tr> <td style="text-align: center;">[]</td> </tr> </table>	UNDER 50	50-64	65-74	75-84	Over 84	[]	[]	[]	[]	[]	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">SSI</td> <td style="text-align: center;">HR</td> <td style="text-align: center;">Private</td> </tr> <tr> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table>	SSI	HR	Private	[]	[]	[]	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Less than 1 year</td> <td style="text-align: center;">1-4 years</td> <td style="text-align: center;">Over 4 years</td> </tr> <tr> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table>	Less than 1 year	1-4 years	Over 4 years	[]	[]	[]	Residents requiring help: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Dressing</td> <td style="text-align: center;">Walking</td> <td style="text-align: center;">Bathing</td> <td style="text-align: center;">Eating</td> </tr> <tr> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table>	Dressing	Walking	Bathing	Eating	[]	[]	[]	[]	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Taking Medication</td> <td style="text-align: center;">Transfer</td> <td style="text-align: center;">Toileting</td> <td style="text-align: center;">Other (specify)</td> </tr> <tr> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table>	Taking Medication	Transfer	Toileting	Other (specify)	[]	[]	[]	[]
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SECTION B - Action by County Department of Social Services

EVALUATION (i.e. superior home, weaknesses exist, close supervision needed, etc.): []	RECOMMENDATION: []
---	------------------------

SIGNATURE OF WORKER: X	DATE SIGNED: []	SUPERVISOR'S APPROVAL: X	DATE SIGNED: []	DATE TO R.O.: []
---------------------------	---------------------	-----------------------------	---------------------	----------------------

SECTION C - For State Office Use - Leave Blank

REGIONAL OFFICE RECOMMENDATION: []	CENTRAL OFFICE ACTION: Date Received: [] <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved Certificate No. : []		
REVIEW BY: []	DATE SIGNED: []	APPROVED BY: []	DATE SIGNED: []

OCFS-0934A

OCFS-0934-A (Rev. 07/2016)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICE
NOTICE OF CHANGE FAMILY TYPE HOME FOR ADULTS

TO: NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES BUREAU OF ADULT SERVICES	FROM: (County) _____																		
NAME AND ADDRESS OF FACILITY (No. Street, City, State, Zip Code): _____ _____ _____																			
<input type="checkbox"/> CLOSING <input type="checkbox"/> CHANGE <input type="checkbox"/> OTHER _____	DATE OF ACTION:																		
<input checked="" type="checkbox"/> TYPE OF CHANGE	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">FROM</th> <th style="width: 40%;">TO</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Name of FTHA: _____ <small>(new business certificate or DBA)</small> </td> <td style="padding: 5px;"> _____ / _____ / _____ </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Location (address)*: _____ <small>(under Facility Documents (a)(c)(d)(e)(f). Will result in new certificate number)</small> </td> <td style="padding: 5px;"> _____ / _____ / _____ </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Bed Capacity – Increase <small>(no documents, unless the increase is due to new construction.) Forms then needed (e) (f)</small> </td> <td style="padding: 5px;"> _____ / _____ / _____ </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Bed Capacity – Decrease <small>(no documents required)</small> </td> <td style="padding: 5px;"> _____ / _____ / _____ </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Add Operator* <small>(all documents (a-e) under Operator Section, revised Partnership Agreement and Business Certificate if applicable)</small> </td> <td style="padding: 5px;"> _____ / _____ / _____ </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Delete Operator <small>(statement signed by both operators that dissolves the partnership)</small> </td> <td style="padding: 5px;"> _____ / _____ / _____ </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Telephone Number (Include area code) email address </td> <td style="padding: 5px;"> _____ / _____ / _____ </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Other </td> <td style="padding: 5px;"> _____ / _____ / _____ </td> </tr> </tbody> </table>	FROM	TO	<input type="checkbox"/> Name of FTHA: _____ <small>(new business certificate or DBA)</small>	_____ / _____ / _____	<input type="checkbox"/> Location (address)*: _____ <small>(under Facility Documents (a)(c)(d)(e)(f). Will result in new certificate number)</small>	_____ / _____ / _____	<input type="checkbox"/> Bed Capacity – Increase <small>(no documents, unless the increase is due to new construction.) Forms then needed (e) (f)</small>	_____ / _____ / _____	<input type="checkbox"/> Bed Capacity – Decrease <small>(no documents required)</small>	_____ / _____ / _____	<input type="checkbox"/> Add Operator* <small>(all documents (a-e) under Operator Section, revised Partnership Agreement and Business Certificate if applicable)</small>	_____ / _____ / _____	<input type="checkbox"/> Delete Operator <small>(statement signed by both operators that dissolves the partnership)</small>	_____ / _____ / _____	<input type="checkbox"/> Telephone Number (Include area code) email address	_____ / _____ / _____	<input type="checkbox"/> Other	_____ / _____ / _____
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* Requires a signed application form. EXPLANATION OF CLASSIFICATION CHANGE: _____ _____																			
FTHA COORDINATOR SIGNATURE: _____	TITLE: _____																		
DATE SIGNED: _____																			



OCFS-0934A

OCFS-0934-A (Rev. 07/2018)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICE
NOTICE OF CHANGE FAMILY TYPE HOME FOR ADULTS

TO: NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES BUREAU OF ADULT SERVICES	FROM: (County) [REDACTED]	
NAME AND ADDRESS OF FACILITY (No. Street, City, State, Zip Code): [REDACTED]		
<input type="checkbox"/> CLOSING <input type="checkbox"/> CHANGE <input type="checkbox"/> OTHER [REDACTED]	DATE OF ACTION:	
<input checked="" type="checkbox"/> TYPE OF CHANGE	FROM	TO
<input type="checkbox"/> Name of FTHA: [REDACTED] (new business certificate or DBA)	[REDACTED] / [REDACTED] / [REDACTED]	[REDACTED] / [REDACTED] / [REDACTED]
<input type="checkbox"/> Location (address)*: [REDACTED] (under Facility Documents (a)(c)(d)(e)(f). Will result in new certificate number)	[REDACTED] / [REDACTED] / [REDACTED]	[REDACTED] / [REDACTED] / [REDACTED]
<input type="checkbox"/> Bed Capacity – Increase (no documents, unless the increase is due to new construction.) Forms then needed (e) (f)	[REDACTED] / [REDACTED] / [REDACTED]	[REDACTED] / [REDACTED] / [REDACTED]

OCFS-0934A

<input type="checkbox"/>	Bed Capacity – Decrease (no documents required)	■ / ■ / ■	■ / ■ / ■
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EXPLANATION OF CLASSIFICATION CHANGE: ■			
FTHA COORDINATOR SIGNATURE: ■		TITLE: ■	DATE SIGNED: ■

Key Regulatory Time Frames

(i) Initial Application

- The date of applicant's signature is considered the date of the application submittal. 18 NYCRR 489.4
- All supporting documentation required to complete the application must be submitted to LDSS within 120 days after the date of submittal. Failure to do so may be grounds for denial. 489.4 (c) (2)
- LDSS must conduct a Survey Report – FTHA (DSS-2867) within 45 days of the date of submittal of the application. 489.4



Key Regulatory Time Frames (cont.)

(i) Initial Application

- LDSS must submit the application, the Survey Report and a recommendation of approval or disapproval to OCFS within 45 days of a completed application. 489.4 (c) (2)
- OCFS must, within 90 days of receipt of the completed application, survey and recommendation, make a determination to issue or deny an operating certificate. If within 225 days of the application date all supporting documentation has not been submitted to OCFS, the application will be considered to have been withdrawn by the applicant. 489.4 (d)



Key Regulatory Time Frames (cont.)

(ii) Renewal Application

- OCFS shall notify operator and LDSS 90 days before expiration of the operating certificate. 489.4 (f) (1)
- Within 60 days after the receipt of such notifications, the operator must submit completed renewal application and required documents to LDSS. 489.4 (f) (2)
- At least 15 days prior to the expiration of the operating certificate, the LDSS must submit to OCFS the renewal application, supporting documents and a Survey Report completed within six months of the expiration date of the certificate, along with a recommendation of approval or disapproval. 489.4 (f)(3)



FTHA Component of the NYS OCFS Website

<http://ocfs.ny.gov/main/ftha>

- Descriptions of:
 - The Family Type Home for Adults program
 - The application process
 - Inspection and supervision of FTHAs
 - The enforcement process
 - The role of the Bureau of Adult Services in overseeing the program
- Frequently asked questions about FTHAs
- Listing of local district FTHA coordinators and contact information
- Interactive map of showing locations of licensed FTHAs in each county
- FTHA regulations
- FTHA forms
- How to apply to operate an FTHA

