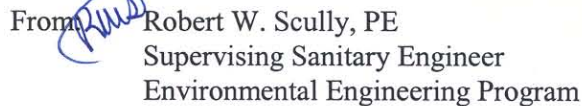
STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEATLH SECTION

EHS Circular Letter #2007-60

Date: December 19, 2007

To: Directors of Health, Chief Sanitarians & Design Engineers



From: Robert W. Scully, PE
Supervising Sanitary Engineer
Environmental Engineering Program

Subject: Design Flows for Group Homes/Community Living Arrangements

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The January 1, 2007 Technical Standards for Subsurface Sewage Disposal Systems includes a stipulation in Table No. 4, which requires, in absence of metered water usage documentation, that design flows for group homes/community living arrangements be determined based on maximum occupancy unless the facility's state license restricts occupants and requires local health department approval, in accordance with Public Health Code (PHC) Section 19-13-B100a, for increased occupancy.

This Department has reached agreement with the Department of Developmental Services (DDS), previously known as Department of Mental Retardation (DMR), on provisions in the DDS application process that will insure occupancy increases are pre-approved by the Local Director of Health. DDS has agreed to modify their application for community living arrangements (CLAs) and has agreed not to license new or expanded CLAs without local health approval. The following language is included in DDS's new community living arrangement licensure application:

> ***In accordance with Connecticut Public Health Code regulation Section 19-13-B100a, approval from the Local Director of Health must be obtained for all new and expanded Community Living Arrangements served by an onsite sewage disposal system. Along with this application the provider must provide documentation from the Local Health Department confirming compliance with the regulation. Applications will not be processed without such documentation.***

A copy of the complete application is attached for your information. As a result of the new DDS licensure protocol for CLAs, design flows can now be calculated based on licensed occupancy rather than maximum possible occupancy. Please note that this allowance only applies to DDS regulated CLAs. Design Flows for all other group homes and community living arrangements regulated by other agencies are required, in the absence of metered flow documentation, to be determined based on maximum possible occupancy.

cc: Suzanne Blancaflor, Chief, EHS, DPH
Pamela Kilbey-Fox, Chief, LHAB, DPH
William Gerrish, Director, Office of Communication, DPH
Carmen Onaflo, DDS

Enclosure

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An Equal Opportunity Employer

DDS

APPLICATION FOR CLA LICENSURE

STATE OF CONNECTICUT

DEPARTMENT OF DEVELOPMENTAL SERVICES

QUALITY MANAGEMENT SERVICES

LICENSING AND CERTIFICATION UNIT

RESIDENCE: ______________________________

LICENSE NUMBER: ______________________

RDID NUMBER: ________________________

APPLICATION RENEWAL FROM __________ __________ **TO** __________ __________

month year Month year

APPLICATION FOR THE ANNUAL LICENSE TO OPERATE A HABILITATIVE NURSING FACILITY ☐ COMMUNITY LIVING ARRANGEMENT ☒ : FOR PERSONS WITH MENTAL RETARDATION AND/OR AUTISM UNDER the provision of the General Statutes Sec. 17a-277.

SECTION I: General Information

A) Ownership of the residence (Check one):

Individual ______________________________
Name and Address

Corporation, leased ______________________________
Name and Address

Other (explain) ______________________________

B) Name of licensee: ______________________________

Address: ______________________________
Street City/Town Zip

Telephone number: ____________ **Fax Number:** ____________

C) Name of corporation, or management company who will operate the residence:

Name: ______________________________

Address: ______________________________
Street City/Town Zip

Telephone number: ______________________________

D) Name of administrator (person with direct responsibility for the total operation of the Agency, i.e. Executive Director, CEO, President, etc.):

Name: ______________________________

Address: ______________________________
Street City/Town Zip

Telephone number: ______________________________

E) In the absence of the administrator, who is in charge of the agency's residential operations:

Name: ____________________

Telephone number: ____________________

Business Address: ____________________
Street **City/Town** **Zip**

F) Attach names and business addresses of partners, board members or officers of the corporation or organization.

SECTION II: Residence Information

A) Name of residence: ____________________

Residence Telephone number: ____________________

Residence Address: ____________________
Street **City/Town** **Zip**

Check as Applicable:

Public Water ______ **Private Water** ______

Public Sewer ______ **Private Septic** ______

In accordance with Connecticut Public Health Code regulation section 19-13-B100a, approval from the Local Director of Health must be obtained for all new and expanded Community Living Arrangements served by an onsite sewage disposal system. Along with this application the provider must provide documentation from the Local Health Department confirming compliance with the regulation. Applications will not be processed without such documentation.

B) Contact Person for residence: ____________________
Name and Title

Business Address: ____________________
Street **City/Town** **Zip**

Business Telephone number: ____________________________________

C) DMR Regional Office and contact person: ____________________________________

D) Licensed/certified capacity in this residence:

Total __________

Respite __________

Change in maximum occupancy from previous license: ______ None ______ Increase ______ Decrease

Number of individuals not requiring 24-hour supervision:
In the community _____ **In the residence** _____

E) To which degree is the residence physically accessible to persons using a wheelchair or whom have difficulty with ambulation?

Not accessible _____

Fully accessible _____

Partial accessibility _____ **Explain:** ____________________________________

____

F) Program objectives of this residence (be as specific as possible):

G) Day and/or employment services which individuals will be attending:

Agency Name	Type of Service	Address

A) List professional/clinical services provided to each individual residing in this residence
(use attachments, as necessary):

1a.Name of primary physician: ______________________________
(Please Print)

Telephone number: ______________________

Address: ____
Street City/Town Zip

CT License number: ____________ **Expiration date:** ____________

Affiliated with a hospital: ______ **Yes** ______ **No**

Name of hospital: ______________________________

Services (Comment): ______________________________

____

2. Walk-in or hospital clinic utilized, if appropriate:

Name: ______________________________

Telephone number: -----______________________

Address: -----____________________________________
Street City/Town Zip

3. Name of dentist: ______________________________
(Please Print)

Telephone number: ______________________

Address: ____
Street City/Town Zip

CT License number: ____________ **Expiration date:** ____________

4. Registered nurse providing nursing supervision/consultation for this residence:

Name: ______________________________
(Please Print)

Telephone number: ____________________

Business Address: ______________________________
Street City/Town Zip

CT License number: ______________ **Expiration date:** ______________

5. Name of DMR case manager: ______________________________
(Please Print)

Telephone number: ____________________

Business Address: ______________________________
Street City/Town Zip

6. List other contracted professional services for this home including but not limited to (nursing, PT, OT, speech, psychology, dietary.) Include average number of hours by each per month.

B. 1. Number of direct personnel (as contracted with region):

		Average hours Per week
Full time	__________	__________
Part time	__________	__________
Volunteers	__________	__________

2. Attach a staffing pattern which includes the hours per shift and the number of direct contact personnel per those hours.

The following, as appropriate, should be included with the application:

INITIAL APPLICATION

____ **certificate of occupancy*----------------------**

***only if:**
1. **bedroom escape window doesn't meet 5.0 sq. ft. opening which includes minimum measurements.**
2. **new construction**
3. **structural changes to home (include bldg. permits) as required by state and local codes which govern construction building safety and local ordinances.**

____ **staffing pattern**

____ **fire marshal's certificate (4 or more)**

____ **bacteriological report (private system only)**

____ **report for septic system (private system only)**

____ **insurance binder**

____ **financial audit (as requested)**

____ **$50.00 licensing fee (5 or more individuals)**

____ **new administrator's employment history**

____ **board of directors**

____ **directions (from Hartford)**

____ ANNUAL APPLICATION

____ **certificate of occupancy (see #3 above)**

____ **staffing pattern**

____ **fire marshal's certificate (4 or more individuals)**

____ **bacteriological report (as requested)**

____ **report for septic system (as requested)**

____ **$50.00 licensing fee (5 or more individuals)**

____ **board of directors**

C. Affidavit of applicant:

Name of Residence: ______________________________
Address: ______________________________
____

State of Connecticut
County of ____________________

This is to certify that I will assure the provision of all routine and emergency medical

and dental services as indicated for each individual, with additional follow-up and

testing as needed.

I also assure that medications shall be administered by those who are certified or

licensed in accordance with Sec. 20-14h CGS and the regulations promulgated there-

under.

Being duly sworn, ____________________________________ **is the**

administrator identified in the application for licensure/certification to operate a

residence in the State of Connecticut and that the statements herein contained are

each and all true in every respect.

____
Signature of Applicant

Sworn to before me this ________ **day of** ________ **20** ______

____
Notary Public

My commission expires ______ **20** ______