NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services ■ Regulatory and Licensing Services
952 Old US Highway 70 ■ Black Mountain, North Carolina 28711

INITIAL INQUIRY: RESIDENTIAL MATERNITY HOME

1. AGENCY NAME: _____

- Name of the agency as filed with the Secretary of State. This is the name that will be printed on your license. Refer to this agency name in all documents.

2. FACILITY SITE ADDRESS: (NO P.O. BOXES)

Facility Name (if different from agency): _____

Street: _____

City: _____ Zip Code: _____ County: _____

*Facility Telephone Number: _____ Fax Number: _____

*must be installed and operable prior to licensing – not allowed to be a cell phone.

3. AGENCY CORRESPONDENCE MAILING ADDRESS:

Name: _____

Street: _____

City: _____ Zip Code: _____ County: _____

Email Address: _____

4. NAME OF EXECUTIVE DIRECTOR: _____

Email Address: _____

5. NAME OF CONTACT PERSON: _____

Email Address: _____

Title: _____ Fax Number: _____

Telephone Number: _____ Cell Number: _____

6. SIGNATURE OF LICENSEE OR PERSON WITH SIGNATORY AUTHORITY: The undersigned, representing the governing authority, submits information for the above-named facility and certifies the accuracy of this information in accordance with 10A NCAC 70F & 70K.

Name: _____ Title: _____

Signature: _____ Date: _____

ALL INQUIRIES MUST BE MAILED TO THE ABOVE ADDRESS AND MUST HAVE AN ORIGINAL SIGNATURE

7. What population is your agency proposing to serve? (age range of mother, pregnant mothers currently parenting? etc.): _____

_____

8. MANAGEMENT COMPANY: If facility is managed by a company ***other than the licensee***, provide the following information about the Management Company:

Name: _____

Email Address: _____

Address: _____

Telephone Number: _____ Fax Number: _____

9. LEGAL IDENTITY OF LICENSEE: Full legal name of individual, partnership, corporation, or other legal entity, which owns the facility business, is required. Owner/Licensee means any person/business entity (Corporation, LLC, etc.) that has legal or equitable title to or a majority interest in the facility. This entity is responsible for financial and contractual obligations of the business and will be recorded as the licensee on the license. ***Please be sure to write the name of the owner exactly the same on all documents.***

(a) Name of Owner (Corporation, LLC, etc.): _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

(b) Federal Tax ID Number of Owner/Licensee: _____

(c) Legal entity is: ☐ For Profit ☐ Not for Profit

(d) Legal entity is: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government Unit
☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Limited Liability Corporation
☐ Other (specify): _____

(e) Articles of Incorporation from the Secretary of State attached: ☐ Yes ☐ N/A
Certificate of Assumed Name filed with the Register of Deeds attached: ☐ Yes ☐ N/A

(f) Name of Executive Director: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

If the “licensee” is a corporation or partnership, list the name of the Executive Officer or General Partner.

10. BUILDING/PROPERTY OWNER: If the above entity (partnership, corporation, etc.) ***does not*** own the building/property from which services are offered, please provide the following information:

Name of Building/Property Owner: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

11. OWNERS, PARTNERS, AFFILIATES, SHAREHOLDERS:

Non-Profit Companies: If **no** individual holds an interest of 5% or more please sign the statement below, thereby indicating this is a **non-profit group.**

There are **no owners, partners, affiliates or shareholders who hold an interest of 5% or more** of the licensee applying for a license:

_____ _____ _____

Signature Title Date

For-Profit Individuals or Companies: Complete the information below on **all** individuals who are owners, partners or shareholders holding an interest of 5% or more of the licensee listed on page 2. Attach additional pages if necessary. If you are the only owner, complete the information below, listing the percentage interest as 100%.

Owner or Shareholder Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Social Security Number: _____

Percentage interest in this agency: _____ Title: _____

Owner or Shareholder Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Social Security Number: _____

Percentage interest in this agency: _____ Title: _____

Owner or Shareholder Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Social Security Number: _____

Percentage interest in this agency: _____ Title: _____

12. OTHER STATUS:

(a) Are any of the owners, partners or shareholders currently operating or have previously operated a Residential Child Care Facility (group home), Maternity Home, or Child Placing Agency in North Carolina or any other state?

☐ Yes ☐ No If yes, give names and addresses of the agencies and the dates of licensure. Attach additional pages if necessary.

Agency or Facility Name: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of licensure: _____

(b) If any of the owners, partners or shareholders are currently operating or previously operated a Residential Child Care Facility (group home), Maternity Home, or Child Placing Agency in another state, provide the information requested below for the licensing authority in that state:

Name of Licensing Authority: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Contact Person: _____

(c) If any of the owners, partners or shareholders are currently operating or previously operated a Residential Child Care Facility (group home), Maternity Home, or Child Placing Agency in another state, a letter from the licensing authority in that state must be submitted advising of the agency or facilities standing. Letter attached: ☐ Yes ☐ N/A

(d) Have any of the owners, partners or shareholders been affiliated in any way with a licensed agency or facility that was assessed a penalty or had its license revoked, suspended or downgraded to provisional? ☐ Yes ☐ No If yes, please explain: _____

_____

13. EXECUTIVE DIRECTOR'S EDUCATIONAL EXPERIENCE*: Attach additional pages if necessary.

Name of College/University: _____

Degree Earned: _____ Dates of Attendance: _____

Name of College/University: _____

Degree Earned: _____ Dates of Attendance: _____

Certified college transcripts for the Executive Director attached: ☐ Yes ☐ No If no, please explain: _____

_____

*Minimum Education and Experience – The executive director shall meet the requirements of a Human Services Program Manager II as defined by the North Carolina Office of State Human Resources. A copy of these requirements can be found at the following web site: (https://files.nc.gov/ncoshr/documents/class-specifications/Human-Services-Program-Manager-II.pdf). The college or university degree shall be from a college or university listed at the time of the degree in the Higher Education Directory. This information can be obtained by calling Higher Education Publications, Inc. at 1-888-349-7715 or at: http://www.hepinc.com.

13. EXECUTIVE DIRECTOR'S WORK EXPERIENCE: Attach a resume which includes the names and addresses of employers, dates of employment, positions held and description of duties. Resume attached: ☐ Yes

14. EXECUTIVE DIRECTOR'S BACKGROUND:

(a) Has the Executive Director ever been convicted of a crime other than minor traffic citations? ☐ Yes ☐ No If yes, please explain: _____

_____

(b) Does the Executive Director have a criminal, social or medical history that would adversely affect his/her capacity to work with children and adults? ☐ Yes ☐ No If yes, please explain: _____

_____

(c) Has the Executive Director ever had child protective services involvement resulting in the substantiation of child abuse or serious neglect? ☐ Yes ☐ No If yes, please explain: _____

_____

(d) Has the Executive Director ever abused or neglected a child, been a respondent in a juvenile court proceeding that resulted in the removal of a child, or had child protective services involvement that resulted in the removal of a child? ☐ Yes ☐ No If yes, please explain: _____

_____

(e) Has the Executive Director ever abused, neglected, or exploited a disabled adult? ☐ Yes ☐ No If yes, please explain: _____

_____

(f) Has the Executive Director ever committed an act of domestic violence against another person? ☐ Yes ☐ No If yes, please explain: _____

_____

(g) Have criminal records been completed on the Executive Director in compliance with 10A NCAC 70F .0202 (c)? ☐ Yes ☐ No If no, please explain: _____

_____

(h) If the agency does not have a governing body, submit results of criminal record checks, the North Carolina Health Care Personnel Registry check, the Responsible Individuals List check, the North Carolina Sex Offender and Public Protection Registry checks on the Executive Director in compliance with 10A NCAC 70F .0202 (c). Results attached?

☐ Yes ☐ No If no, please explain: _____

_____

(i) Executive Director's Social Security Number: _____

Executive Director's Date of Birth: _____

16. NEEDS ASSESSMENT: In the space provided below, complete a needs assessment for the county or counties you plan to serve. At a minimum, describe the individuals you plan to serve, the number of individuals you anticipate needing your service, funding sources, referral sources (list agencies that will refer clients to you), and any other documentation that describes the need for your services. _____

_____

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17. BUDGET: Attach a proposed line-item budget detailing expenses and revenues. Include your fee schedule and specific sources of revenues. Following your initial license, a Maternity Home is **ineligible** for an agency specific State Maternity Fund daily rate for individual applicants. To receive the daily rate, the facility must complete a year of licensed operation, complete a fiscal closing with an audit, and meet the reporting requirements established by the DHHS Controller's Office, Rate Setting Branch. Approval would be pending submission of the complete application and service plan. Please describe your plan for meeting the facility's budgetary needs during the first year of operation:

_____

_____

_____

_____

_____

_____

Budget attached: ☐ Yes

18. REFERENCES: Complete the information below for three references of the Executive Director. Also attach a letter from each reference. **Two of the three references must be from current or former employers.**

Reference Letters attached: ☐ Yes

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Relationship: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Relationship: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Relationship: _____

19. BUILDING INFORMATION:

(a) Status of facility: ☐ New facility ☐ Existing facility (not previously licensed)

☐ Existing facility (previously licensed) Type of license: _____

(b) Number of clients: _____ Number of staff persons on duty not living in: _____

Number of staff person dependents accompanying staff person on his/her shift (not living in): _____

Ages of staff person dependents accompanying the staff person on his/her shift (not living in): _____

Number of staff persons living in: _____ Number of staff person dependents living in: _____

Ages of staff person dependents living in: _____

Number of Ambulatory* clients per age group: 5 and under: _____ 6 to 17: _____ 18 and up: _____

Number of Non-Ambulatory clients per age group: 5 and under: _____ 6 to 17: _____ 18 and up: _____

*Ambulatory: a person who can evacuate a building or area without physical or verbal assistance during a fire or other emergency.

Describe any other programs in the building and their License's capacity: _____

_____

(c) Provide pictures of an existing facility - one picture at minimum from the following locations: Outside - front, back, left, right; Inside – one picture of each space including basements. Please label each picture as to the identity of each room within the facility, and also on the back of the picture please provide the name and address of the facility. Pictures attached: ☐ Yes

(d) Provide plan of facility showing windows, window sizes (width and height of the opening in the wall at each window), sill heights; width and location of exit doors; type of heating system (describe); any stairs (up or down) and location on plan; all spaces labeled and measured (dimensions of each space); number of toilets, lavatories, tubs, showers and location. Plan attached: ☐ Yes

20. ZONING AND INSPECTIONS:

(a) Zoning Department Official: Attach approval from local zoning authority. Zoning approval attached: ☐ Yes

Department Name: _____ Official's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ County: _____

(b) Local Building Official: *Provide inspector name if inspection has been completed and attach copy.

Department Name: _____ *Inspector Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ County: _____

(c) Local Fire Marshall: *Provide inspector name if inspection has been completed and attach copy.

Department Name: _____ *Inspector Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ County: _____

(d) Local Sanitation: *Provide inspector name if inspection has been completed and attach copy.

Department Name: _____ *Inspector Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ County: _____

21. ACCREDITATION STATUS:

Agency must be accredited for 3 years prior to licensure.

Agency is accredited by:
☐ The Council on Accreditation [COA]
☐ The Commission of Accreditation and Rehabilitation Facilities [CARF]
☐ The Council on Quality and Leadership [CQL]
☐ The Joint Commission [TJC]
☐ Other _____

Date of initial accreditation: _____
Date of current accreditation: _____

Attach proof of accreditation.

22. SUPPLEMENTAL INFORMATION:

Administrative Rules for Residential Maternity Homes are found in North Carolina Administrative Code Chapter 10A NCAC Subchapters 70F and 70K. These rules can be accessed at the following web site:
http://reports.oah.state.nc.us/ncac.asp?folderName=%5CTitle%2010A%20-%20Health%20and%20Human%20Services%5CChapter%2070%20-%20Children%27s%20Services
Please review these rules.

The Division of Health Service Regulation, Construction Section will need to approve the facility. The Construction Section will determine if the facility meets building codes and fire codes. They will also determine the capacity of the facility. Approval of the facility by DHSR is required before you can begin the next phase of the licensing process.

FUNDING OPTIONS: MATERNITY HOME CARE

For agencies electing to participate in State Maternity Home Fund Program

- Information related to Maternity Home Care is found in North Carolina Administrative Code (10A NCAC 71L). http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2071%20-%20adult%20and%20family%20support/subchapter%20l/subchapter%20l%20rules.html
- Payment to licensed maternity homes is based on the actual per diem cost of care.

For agencies electing to participate in the Residential Child-Care Fund Program

- Maternity homes that elect to participate in the residential child-care funding program (providing services to children and young adults in the custody of a county DSS) must meet the staffing requirements for residential child-care outlined in NC Administrative Code (10A NCAC 70I .0405) http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2070%20-%20children's%20services/subchapter%20i/10a%20ncac%2070i%20.0405.pdf.
- Maternity homes that elect to participate in the residential child-care funding program must comply with the audit requirements for residential child-care.

For agencies electing to participate in both the Residential Child-Care Funding Program and State Maternity Home Funding

- Maternity homes can participate in both the residential child-care funding program and the state maternity home fund. However, the agency will have to meet the requirements for residential child-care as described above.

Contact numbers, training information and forms concerning cost reporting is available from Susan Kesler, DHHS-Controller's Office, Rate Setting, 919-855-3680 and at:
https://www.ncdhhs.gov/about/administrative-offices/office-controller/foster-care-rate-setting.

OTHER HELPFUL LINKS

Pregnancy Services https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/modified-manual-1/appendix-4-pregnancy-services.pdf

22. SUBMISSION OF INQUIRY:

Mail this form, along with attachments to:

North Carolina Division of Social Services
Regulatory and Licensing Services
952 Old US Highway 70
Black Mountain, North Carolina 28711

Please note that this inquiry and all supporting documents must be fully completed before your agency can be considered for licensure.