pennsylvania
DEPARTMENT OF HUMAN SERVICES

Attachment 1 - Request for Approved Program Capacity (APC) and Noncontiguous Clearance Form

SECTION A

Type of Request

☐ Request for *Noncontiguous Clearance* for Licensed or Unlicensed Residential Service location to provide Residential Habilitation, Life Sharing, Respite Only Homes and Licensed Community Participation Support Facilities (**proceed to section B)**

☐ Request to *Establish APC* for a new a Licensed or Unlicensed Residential Service Location to provide Residential Habilitation, Life Sharing, Respite Only Homes, or Supported Living (**proceed to section B & C**)

☐ Request to *Change APC, including Reserved Capacity,* for a Licensed or Unlicensed Residential Service Location to provide Residential Habilitation, Life Sharing, Respite Only Homes, or Supported Living (**proceed to section B & D**)

☐ Request to *Close* a Licensed or Unlicensed Residential Service Location that provided Residential Habilitation, Life Sharing, Respite Only Homes, or Supported Living or a Licensed Community Participation Support Facility (**proceed to section B**)

☐ Request for *Revalidation* for Licensed or Unlicensed Residential Service locations to provide Residential Habilitation, Life Sharing, Respite Only Home, or Supported Living (**proceed to section B)**

Please continue to the next section

SECTION B			
Legal Entity Name:			
Service Location's Street Address/City/State/Zip:			
Contact Name:	**Phone Number (include area code):**	**Email Address:**	
MPI # (9 digits):	**Service Location Code (4 digits):**		
Check the type of service location that applies to the request			
RESIDENTIAL SERVICE LOCATIONS			**COMMUNITY PARTICIPATION SUPPORT FACILITIES**
☐ Licensed 55 Pa. Code Ch. 6400 Community Living Home	☐ Licensed 55 Pa. Code Ch. 6500 Family Living Home	☐ Unlicensed Life Sharing Home	☐ Licensed 55 Pa. Code Ch. 2380 Adult Training Facility
☐ Licensed 55 Pa. Code Ch. 6400 Community Living Home (For Respite Only Homes)	☐ Licensed 55 Pa. Code Ch. 3800 Child Residential and Day Treatment	☐ Licensed 55 Pa. Code Ch. 5310 Community Residential Rehabilitation	☐ Licensed 55 Pa. Code Ch. 2390 Vocational Facility
☐ Unlicensed Residential Habilitation	☐ Supported Living		☐ Licensed 6 Pa. Code Chapter 11 Older Adult Daily Living Centers
***For a request to close a Residential Service Location or a Community Participation Support Facility** **Date of Closure:_____**			

SECTION C – REQUEST TO ESTABLISH APC (Licensed and Unlicensed Residential Service Locations)		
Effective Date of Licensing:	**Licensed Capacity:**	**Requested APC:**
Describe how the needs of the individual(s) to be served require and/or meet the level of support requested:		
☐ **Submitted a letter/email with the Administrative Entity/County approval** (When establishing APC for a one-person home)		
☐ **Submitted licensing certificate of compliance** (verifying the requested service location is licensed)		
☐ **Submitted DP 1059 form** (Verifying that provider is ODP Qualified Res Hab provider)		

SECTION D – REQUEST TO CHANGE APC	
Current APC:	**Requested Change in APC:**
End Date of Current APC:	**Effective Date of new APC:**

***THIS BOX IS TO BE FILLED OUT ONLY IF REQUESTING RESERVED CAPACITY (Medical, Hospital, or Therapeutic Leave):**

Individual's MCI (9-digits):

Date Reserved Capacity Starts (starting on the 31st day that the individual has been absent from the service location)**:**

Date Reserved Capacity Ends (this is only to be completed when the person is returning to the home and an increase in APC is required. This date must reflect the date the person returns to the home and cannot be more than 150 calendar days from the reserved capacity start date)**:**

Describe the circumstances surrounding the change in APC. (If this is a Reserved Capacity request, describe the type of leave — medical, hospital, or therapeutic — and the circumstances regarding the leave)**:**

Describe how the change will meet the need, service location size, staffing patterns, assessed needs, and outcomes for the individual(s) in the home (if requesting Reserved Capacity, this textbox does not need to be filled out)**:**

☐ **Submitted a letter/email with the Administrative Entity/County approval of increase or decrease of previous approved program capacity**

☐ **Submitted Licensing Certificate of Compliance with this form verifying the requested service location is Licensed** (If requesting Reserved Capacity, this does not need to be submitted with the form)

☐ **Provided the request to change APC to the affected individuals and persons designated by the individuals prior to submission to the Department (55 Pa. Code Chapter §6100.441(d))**

(To be filled out by the Office of Developmental Programs) **DETERMINATION FROM THE OFFICE OF DEVELOPMENTAL PROGRAMS**	
☐ **Program Capacity Approved** ☐ **Program Capacity Denied** * Once the provider has received ODP's response per this request, the determination must be provided to the affected individuals and persons designated by the individuals within 7 days following the determination (55 Pa. Code Chapter §6100.441(e))	☐ **Location has been Verified and has received Noncontiguous Clearance**
☐ **Program Capacity Approved for Revalidation**	☐ **Location is Not Verified as Noncontiguous (not eligible for waiver funding)**
☐ **Closure has been approved** *****Once closure has been approved, providers must notify licensing of the closure and remove the service location out of HCSIS and PROMISe.	
Approved Program Capacity:	
Approved Program Capacity Effective Date:	
Reason for Denial and/or Other Related Comments:	

Signature of Regional Waiver Capacity Manager

Date (mm/dd/yyyy)