



PART C – APPLICATION FOR REGISTRATION IN RESPECT OF AN ADULT DAY CARE SERVICE

Application in accordance with Article 4 of the Regulation of Care (Jersey) Law 2014

Note that the receipt of incomplete information by the Care Commission may result in your application being refused.

Please refer to guidance document while completing this form and use continuation sheets if necessary.

INFORMATION ABOUT THE ADULT DAY CARESERVICE

Section 1

1.1 Establishment in respect of which the application is made *(please note it is a condition of registration that provider must have an address in Jersey and must supply the address from each location at which it provides a regulated service)*

Name of Service	
Name of proposed/Registered Provider	
Name of proposed/Registered Manager	
Address line 1	
Address line 2	
Parish	
Postcode	
Telephone	
Email	

2.2 Registration status

Is this service currently registered for any care purpose?

YES

NO

If you have answerer 'Yes' please describe the nature of the current registration

Please provide the date on which the establishment was or is proposed to be established (dd/mm/yyyy)

Section 2

Registration Details *(please note this information will form the basis of the mandatory conditions applied to the registration)*

2.1 Description of the Adult Day Care Service

Maximum number of care receivers who may be accommodated on the premises at any one time	
Number of care receivers accommodated on the premises at any one time who are in receipt of nursing care	
Number of care receivers accommodated on the premises at	

any one time who are in receipt of personal care or personal support		
Category of Care (to be) provided	Maximum number of care receivers	Age range of care receivers
<i>Old Age</i>		
<i>Dementia Care</i>		
<i>Physical Disability</i>		
<i>Learning Disability</i>		
<i>Autism</i>		
<i>Mental Health problem</i>		
<i>Substance misuse (drug and/or alcohol)</i>		
<i>Homelessness</i>		
<i>Domestic Violence</i>		
<i>Other (please specify)</i>		

Section 3

Premises

3.1 Information about the premises

Are these existing premises

YES NO

Has the building required conversion or extension

YES NO

Alternatively are the premises purpose built

YES NO

Will/Do you:

own the premises lease the premises rent the premises

If leasing or renting the premises how much notice to quit is required

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Please attach proof of ownership or copy of the tenancy/lease agreement

Attached:

Number of floors		
Number and size (no.of persons) of shaft lifts		
Which floors are serviced by shaft lift		
Number and description communal amenity space available	Number	Description
Dimensions/area and location by floor of communal amenity space	Floor	Dimensions and area
Number and location by floor of toilets for use by care receivers	Number	Floor

Number and location of adapted baths/disabled access showers for use by care receivers		
Number and location of baths/showers for use by care receivers that do not meet disabled specification		
Number and location of staff toilets		
Number and location of sluice facilities		
Number and location of clinic rooms		
Number and location of general storage facilities		
Number and location of facilities for cleaning/domestic equipment/products		
Number and description of offices (e.g. manager, carers, administrator etc.)	Number	Description
Provide details of the type of heating system and safety specifications		

<p>Provide details of the controls that are in place to manage the risk of scalding</p>	
<p>Are all windows on the floors above ground level fitted with tamper proof window restrictors?</p>	
<p>Location of kitchen and description of storage facilities and equipment provided</p>	
<p>Staff facilities (please list e.g. staff room, separate shower facilities, lockers etc.)</p>	
<p>Do circulation areas (corridors etc.) meet disabled specifications (e.g. minimum door width 800mm minimum corridor width 1600mm) –</p>	

<p>If not – please give measurement of door and corridor widths</p>		
<p>Do you have maintenance contracts in relation to all the equipment, plant and utilities related to the premises</p>		
<p>Garden/outside amenity areas – provide a description and where relevant the size of the external environment provided for care receivers (e.g. patio, decking, raised beds, footpaths, lawns etc.)</p>	<p>Size in sqm</p>	<p>Description of areas</p>
<p>How many parking spaces are there for:</p>	<p>Staff</p>	<p>visitors</p>
<p>If any part of the premises (or grounds) is to be used for any purpose other than a day care service provide details, stating ALL purposes to which such parts of the premises will be put (e.g. care home, home care agency, public hairdressing salon, public café etc.)</p>		

<p>Provide details of any other facilities within the premises or its grounds, that will be provided as part of the day care service (e.g. hairdressing salon, therapy pool, shop etc.)</p>	
<p>Provide a description of the area in which the premises is located and the facilities and services available around the location (e.g. near to a park, bus services etc.)</p>	

Provide a copy of plans and elevations of the premises to the scale of at least 1:100. The drawings must show dimensions [in metres] and areas [in sq metres] of all amenity areas, circulation areas, sanitary and bathing facilities, the kitchen, and storage areas. Mechanical and electrical systems, power, telephone, television, call

system points and the location of fire detection and alarm activation points must all be shown and clearly identified.

Are the premises capable of being used for the purpose of:

(a) Achieving the aims and objectives set out in the Statement of Purpose Yes No

(b) Providing the facilities described in this application Yes No

Is there a need for planning permission, building works or conversion of the premises Yes No

If yes please give details of the permission, works or conversion needed.

3.2 Summary of consultation with other Regulators
(where relevant)

Date proposals approved by Environmental Health	Documentary proof attached
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(dd/mm/yyyy)	
Date planning approval was granted (dd/mm/yyyy)	Documentary proof attached
Date proposals approved by building control (dd/mm/yyyy)	Documentary proof attached

Section 4

Staffing

4.1 Staff list

Please fill in details of all staff, including ancillary/domestic staff. Please continue on a separate sheet if necessary, or provide a separate staffing list showing the information requested below.

Name	Gender	D.O.B. (dd/m/yy)	Position held	Full or part time	Intended no. of hours per week	Qualification	Date commenced

4.2 Staff Rotas

Please attach a staffing rota covering two weeks. Show the numbers of nurses, senior carers/support workers, carers/support workers, activity support workers, domestic and administrative staff on duty, times of staff changeovers and handover periods. Clearly identify any agency staff that might be used.

Section 5

Fees

Please set out below the scale of charges that apply to people using the service including any additional charges that are not covered by the scale.

Section 6

List of attached documents

Please ensure that you have enclosed all the documents listed below with this application. Please refer to the guidance for it is your responsibility to submit the required documentation to enable the Care Commission to assess that the proposed service is fit for purpose. Should you fail to do so, the Care Commission may be required to refuse the application.

Item	Tick	Comment
1. Fully completed application form		
2. Statement of Purpose		
3. Floor plans of premises with dimensions as specified in section 3		
4. Copy of Business licence (<i>where relevant</i>)		
5. A certificate of insurance for the applicant in respect of liability that may be incurred in respect of death, injury, public liability, damage or other loss		
6. Building control completion certificate (<i>where relevant</i>)		
7. Staff list		
8. Staff duty rota		

Section 7

Declaration and Signature

This section must be signed by the individual provider applying for registration or in the case of an organisation, the person nominated as the 'main contact partner'

I certify that the information I have provided in this application form and in any attached documents is, to the best of my knowledge and belief true and complete. I understand that under Article 45 of the Law, that to knowingly make false or misleading statements is an offence that may result in prosecution and the

registration being refused. I further accept that the information in Section 1.1 and 2.1 can be applied as conditions to the registration.

Signature				
Full name <i>(Please Print)</i>	<i>Title</i>	<i>First</i>	<i>Middle</i>	<i>Last</i>
Date of signing <i>(dd/mm/yyyy)</i>				

Please return the completed application and all required documentation marked **Confidential** to:

Applications Processing
 Jersey Care Commission
 23 Hill Street
 St Helier
 JE2 4UA
 Email: notifications@carecommission.je

Please refer to www.carecommission.je for data handling information.