****

**PART C – APPLICATION FOR REGISTRATION IN RESPECT OF A SERVICE CARRYING OUT ANY REGULATED ACTIVITY**

**A regulated activity is one that is related to health and social care services, for example care homes, home care, day care, fostering & adoption services**

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 note that this is a standard form to be used by all providers seeking to register a service. Not all aspects of the form will be applicable to every service.

If there is a need for clarification in relation to which parts of the form need to be completed, please contact the Jersey Care Commission for advice.

*Please use continuation sheets if necessary.*

**INFORMATION ABOUT THE SERVICE**

**Section 1**

* 1. **Establishment or main office address used for administering of the service 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** |  |

**1.2 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/organisation is proposed to be established or is intended to become registered *(dd/mm/yyyy)*

|  |
| --- |
|  |

**Section 2**

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

* 1. **Description of the service carrying out regulated activity/activities. Please note a separate application form and registration may be required if more than one type of service is to be incorporated by the same provider.**

|  |  |  |
| --- | --- | --- |
| **Care Home**    **Please ensure you fully complete section 5** |  | |
| **Day Care**  **Please ensure you fully complete section 5** |  | |
| **Home Care**  **Please ensure you fully complete section 6** |  | |
| **Social Work** |  | |
| **Fostering** |  | |
| **Adoption** |  | |
| **Child Contact Centres** |  | |
| **Child & Adolescent Mental Health Service** |  | |
| **Care arrangements in special schools** |  | |
| **Independent Reviewing Officer** |  | |
| **Residential Family Centres**  **Please ensure you fully complete section 5** |  | |
| **Children and Family Community Nursing** |  | |
| **Manageable/maximum number of care receivers listed on service caseloads** | |  |
| **Maximum number of care receivers to reside in registered accommodations** | |  |
| **Number in receipt of nursing care Excluding home care services, see section 6.** | |  |
| **Number in receipt of personal care**  **Excluding home care services, see section 6.** | |  |
| **Number in receipt of personal support**  **Excluding home care services, see section 6.** | |  |
| **Age range of care receivers** | |  |

**2.2**

|  |  |  |  |
| --- | --- | --- | --- |
| **Category of care** | | | |
| ***Children and young people (0-18)*** |  | ***Young adults (19 to 25)*** |  |
| ***Mental Health*** |  | ***Dementia Care*** |  |
| ***Homelessness*** |  | ***Adult 60 +*** |  |
| ***Substance Misuse (drug and/or Alcohol)*** |  | **Learning Disability** |  |
| ***Domestic Violence*** |  | ***Autism*** |  |
| ***Physical Disability and/or Sensory Impairment*** | | |  |

**Section 3**

**3.1 Staff list**

Please fill in details of all staff including where applicable administration and ancillary/domestic staff i.e. care home or day centre. Please continue on a separate sheet if necessary, or provide a separate staffing list showing the information requested below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Position held | Full or part time | Intended no. of hours per week | Qualification | Date commenced |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**3.2 Staff Rotas** for care home and day centres registrations only

Please attach a staffing rota covering a fortnight. Show the numbers of senior carers, carers, domestic and administrative staff on duty, times of staff changeovers and handover periods. Indicate which person is in charge on each shift and where ‘sleeping in’ or ‘on call’ member of staff, their location. Clearly identify any agency staff that might be used.

**Section 4**

**Fees**

**4.1 Charges**

Please set out below the scale of charges that may be applied to people using the service specifying any top up fees over and above the Long Term Care benefit rate and additional charges that are not covered by the scale.

|  |
| --- |
|  |

**4.2 Other income**

Other than Long Term Care Benefit, does the service have a contract for services with, or receive any form of grant or aid from, any administration of the Government of Jersey?

Yes  No

If Yes, please give details

|  |
| --- |
|  |

**Section 5** **please only complete this section if applicable such as for a care home, day centre and/or premises in which regulated activities are provided. The details for any offices used only for administering regulated activity that is carried out in the wider community are not required for purpose of registration of those services**

**Premises**

* 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

|  |
| --- |
|  |

Please attach proof of ownership or copy of the tenancy/lease agreement only for a care home, day centre and/or premises in which regulated activities are provided

Attached:

|  |  |  |  |
| --- | --- | --- | --- |
| **Number of floors** |  | | |
| **Number and size (no. of persons) of lifts** |  | | |
| **Which floors are serviced by shaft lift** |  | | |
| **Number and description (e.g. lounge, dining room, visitor room or communal rooms** | **Number** | **Description** | |
|  |  | |
| **Number of rooms with disabled access ensuite facilities** | **WC and washbasin only** | **WC, washbasin and Shower/adapted bath** | |
|  |  | |
| **Number and location by floor of toilets *(excluding ensuite facilities)* for use by care receivers** | **Number** | **Floor** | |
|  |  | |
| **Dimensions/area and location by floor of communal rooms** | **Floor** | **Dimensions and area** | |
|  |  | |
| **Number of bedrooms if applicable to the regulated activity including list of bedroom names/numbers** *(please note this information will be used to determine mandatory conditions applied to the registration)* |  | | |
| **Are all bedrooms single occupancy? If not, how many are double occupancy?** |  | | |
| **Number of bedrooms with ensuite facilities that do not meet disabled specification** |  | | |
| **Number and location of adapted baths/disabled access showers *(excluding ensuite facilities)*** |  |  | |
| **Number and location of baths/showers *(excluding ensuite facilities)* 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, staff, administrator etc.)** | **Number** | **Description** | |
|  |  | |
| **For homes providing nursing care, details of the washer/disinfection facilities** |  | | |
| **Provide details of the type of heating system and safety specifications** |  | | |
| **Provide details of the controls that are in place to manage the risk of scalding** |  | | |
| **Are all windows on the floors above ground level fitted with tamper proof window restrictors?** |  | | |
| **Location of laundry facilities and description equipment provided** |  | | |
| **Description of how dirty and clean laundry are kept separate and risks of cross contamination minimised** |  | | |
| **Location of kitchen and description of storage facilities and equipment provided** |  | | |
| **Staff facilities (please list e.g. staff room, separate shower facilities, lockers etc)** |  | | |
| **Staff sleep-in facilities** |  | | **Yes/no** |
| **Separate bedroom** | |  |
| **Washbasin** | |  |
| **Shower/bath** | |  |
| **Lockers** | |  |
| **Do circulation areas (corridors etc.) meet disabled specifications (e.g. minimum door width 800mm minimum corridor width 1600mm) –**  **If not – please give measurement of door and corridor widths** |  | | |
| **Do you have maintenance contracts in relation to all the equipment, plant and utilities related to the premises** |  | | |
| **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)** | **Size in sqm** | **Description of areas** | |
|  |  | |
| **Describe how the perimeter of the site is secured** |  | | |
| **How many parking spaces are there for:** | **Staff** | **visitors** | |
|  |  | |
| **If any part of the premises (or grounds) is to be used for any purpose other than the regulated activity to be registered provide details, stating ALL purposes to which such parts of the premises will be put (e.g. day care, home care agency, public hairdressing salon, public café etc.)** |  | | |
| **Provide details of any other facilities within the premises or its grounds, that will be provided as part of the service (e.g. hairdressing salon, therapy pool, shop etc.)** |  | | |
| **Provide a description of the area in which the home is located and the facilities and services available around the location (e.g. near to a park, bus services etc.)** |  | | |
| **Number and location of visitor toilets (including disabled access)** |  | | |  |

For all premises where regulated activity is carried out please 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 rooms relevant to the regulated activity. In the case of a care home or day centre this should include circulation areas, communal areas, sanitary and bathing facilities, the kitchen, laundry, offices and other amenity 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:

|  |  |
| --- | --- |
| 1. Achieving the aims and objectives set out in the Statement of Purpose | Yes  No |
| 1. 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.

|  |
| --- |
|  |

Continue on separate sheets as necessary Attached are [ ] extra sheets

**5. 2 Summary of consultation with other Regulators**

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

**Section 6 please only complete this section for a home care service**

|  |  |
| --- | --- |
| **Description of the Home Care Service** | |
| **Maximum number of all care hours to be provided** |  |
| **Maximum number of nursing care hours to be provided** |  |
| **Maximum number of personal care/personal support hours to be provided** |  |
| **Age range of care receivers** |  |
| **Category of Care (to be) provided** | |
| ***Children and young people (0-18)*** |  |
| ***Young adults (19 to 25)*** |  |
| ***Adult 60+*** |  |
| ***Learning Disability*** |  |
| ***Autism*** |  |
| ***Physical Disability and /or Sensory Impairment*** |  |
| ***Mental Health*** |  |
| ***Homelessness*** |  |
| ***Dementia Care*** |  |
| ***Substance Misuse (drug and/or alcohol*** |  |
| ***Domestic Violence*** |  |

**Section 7**

**List of attached documents**

Please ensure that you have enclosed all the documents listed below with this application. 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 |  |  |
| 1. Statement of Purpose   (Template available from <https://carecommission.je/practitioner-registration/>) |  |  |
| 1. Floor plans of premises with dimensions as specified in section 5 if applicable for a registered premises |  |  |
| 1. Copy of Fire Certificate if applicable for a registered premises |  |  |
| 1. Copy of Business licence |  |  |
| 1. 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 |  |  |
| 1. Building control completion certificate (if applicable) |  |  |
| 1. Staff list |  |  |
| 1. Staff duty rota (if applicable to the regulated activity such as care home and day centre) |  |  |

**Section 8**

**Declaration and Signature**

This section must be signed by the individual provider applying for registration, in the case of an organisation, the person nominated as the ‘main contact partner’ or if a Government of Jersey Department, the accounting officer.

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 specified information in Section 1.1, 2.1, 2.2 and 5.1 can be applied as conditions to the registration.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signature** |  | | | |
| **Full name**  *(Please Print)* | ***Title*** | ***First*** | ***Middle*** | ***Last*** |
| **Date of signing**  **(dd/mm/yyyy)** |  | | | |

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

Applications Processing

Jersey Care Commission

1st Floor, Capital House

8 Church Street

St Helier

JE2 3NN

Email: [notifications@carecommission.je](mailto:notifications@carecommission.je)

Please refer to [www.carecommission.je](http://www.carecommission.je) for data handling information.

**Appendix 1 Continuation sheet**

|  |
| --- |
| **Continuation Sheet** *(please identify the section within the application to which this sheet refers)* |
|  |