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##### Application for registration and licensing as a new service provider

*This is a single form enabling the provider to apply at the same time for a CQC registration and an NHS provider licence issued by Monitor. The CQC and Monitor have combined their application forms for the convenience of the applicants.*

##### Application for organisations

April 2014

**Applications are required / submitted under section 11 of the Health and Social Care Act 2008 (CQC registration) and Sections 81 and 85 of the Health and Social Care Act 2012(NHS provider licence issued by Monitor).**

|  |
| --- |
| Only use this form if you are an  **organisation applying to register and applying for a licence as a new service provider.**  Do not use it if you are an:   * Organisation that is already registered as a service provider (‘provider’), for any purpose * Partnership, for any purpose * Individual, (whether provider or manager), for any purpose * Organisation that is exempt from requiring an NHS provider licence |

Registration entitles you to provide ‘regulated activity’ as defined by section 8 of the Health

and Social Care Act 2008 and by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can read continuously updated versions of the Act and regulations

on our website: www.cqc.org.uk.

**It is an offence under section 10 of the Health and Social Care Act 2008 to carry on regulated activity without being registered by the Care Quality Commission. You**

**could be prosecuted, and it could lead to your application being refused.**

Section 81(1) of the Health and Social Care Act 2012 (“the 2012 Act”) provides that any person who provides health care services for the purpose of the NHS must hold a licence unless exempt under section 83 of the 2012 Act. All such providers are required to hold a licence from 1 April 2014.

**Filling in this form**

You must complete the entire application form, including Part A for CQC registration and

Part B for a NHS provider licence issued by Monitor.

It is your responsibility to confirm whether or not you are required to hold an NHS provider licence by reading the Department Of Health exemption criteria, and the licensing application guidance on Monitor’s website ([www.monitor.gov.uk/licence](http://www.monitor.gov.uk/licence)).

If a provider does not hold a licence in breach of the requirement under Section 81 of the 2012 Act, Monitor can take formal enforcement action against that provider including levying a fine.

For CQC registration and Monitor NHS provider licence application you must fill in an answer to every field marked with an asterisk (\*). Other fields are optional, but if you have the information please provide it. We will have to reject an incomplete application and return it.

For CQC registration, you must complete the declaration of compliance section for each regulated activity at each location where it will be provided.

You can fill in and submit this form on paper or on a computer. If you fill it in on a computer

you can submit it by attaching it to an email; this is the best way to submit an application for processing. If you have any additional attachments for the licensing part of this application, you must attach them to the same email, and any attachment must clearly show the provider name and address, as well as the question number(s) the attachment relates to. If you send in your application by post, similarly, any attachments must be included with your application form and show the provider name and address, with the question number(s) each attachment relates to.

This form has been prepared as a ‘protected’ Word document. That means that if you use a computer you can easily move from answer to answer using your ‘tab’, down arrow, and page down keys. You can also click from answer to answer using a mouse. You can put an ‘X’ in checkboxes using your space bar or mouse. You can go backwards to change your answers using your page up key, up arrow key, or mouse.

Spell check and formatting text with bullets cannot be done in protected Word documents. If you want to check spelling or use bullets you can type or paste text into a blank new document, correct any spelling errors, add any bullet points and then copy and paste it into the relevant part of your application form.

You can fill in this form on a computer using ‘Microsoft Word’ or ‘Open Office’. Open Office is a free programme you can download from www.openoffice.org. The spaces for answers increase in size if this is needed while you are typing.

If you are filling in this form on paper and need more space to answer any questions please submit additional clearly numbered sheets and mark them with the question number from this form.

**Fees**

**Before you complete Part A: CQC Registration - section 2 of this application, you are strongly advised to read the CQC guidance about service types that can be found on pages 13 to 31 of the** *Guidance about compliance: Essential standards of quality and safety.*

**The service type(s) you select are used to calculate your annual fee, so it is important**

**to select only those that apply to each of the locations you are registering**.

**You should also read the CQC guidance for providers about fees before completing section 2.**

**There are currently no fees for applying for a provider licence with Monitor.**

These guidance documents are available on the CQC website.

**Confidential personal information – applies to CQC registration only**

Please make sure that your application does not include any confidential personal information about the people who will use your service or your staff. This includes any information that can identify a person. We will reject any application form that includes such information.

**Registered Managers – applies to CQC registration only**

Organisations must have a **registered manager** for each regulated activity. Managers can sometimes manage more than one regulated activity and/or location (see the relevant guidance on our website).

If any location in this application already exists, and:

* is being transferred or sold to you by an existing registered provider, and
* has an existing registered manager who you intend to employ to manage the same regulated activity(s) with the same conditions on their registration at the same location(s):

The manager(s) do not have to submit the normal full application forms. They can use a ‘fast track’ process that uses a shorter form (‘Application to continue registration as a manager under a new provider’) to both cancel their existing registration and apply for new registration with you as provider.

All other managers must submit a full new registered manager application form, even if they are registered as a manager elsewhere or have been in the past.

Managers should download and fill in the correct form. The CQC website form finder pages will help them to do so. You must submit the manager’s form(s) with this application.

**Sales and transfers of existing services and locations – applies to CQC registration only**

If this application involves buying or otherwise taking over a service or location(s) being run by an existing registered provider, it is important that CQC knows about this. There is space in this form for you to tell us when this is the case; please make sure you fill it in where relevant.

CQC must receive and process relevant applications to cancel or vary registration(s) from existing provider(s) and manager(s), as well as from the new provider and manager(s).

New applicants and existing registered persons must work with each other and CQC to ensure that all required applications are submitted. This will ensure the smooth and lawful transfer of legal responsibilities for existing services.

**Additional sections – applies to CQC registration only**

Where your application includes more than one nominated individual or location, you will need to download, fill in and submit additional sections. There is information about this within the relevant sections in this form.

If you are submitting this application by email you must attach all of the required additional sections and manager application forms, as well as this main form, to your application email. If you are submitting your application by post you must enclose all of the forms in your application envelope.

If you do not attach or enclose additional nominated individual and location forms and manager forms *where they are needed*, we will have to return your application.

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**Contents list above – Please roll your cursor over each title and press “Ctrl” on your keyboard and left “click” your mouse. You will then be taken to that section. Throughout the application form there are underlined titles in blue, please roll your cursor over these titles and follow the instructions.**

**Statement on the Data Protection Act 1998**

You must sign the statement below. If you do not we will have to return your application.

I/we understand that the Care Quality Commission and Monitor will use the information provided on this form (including personal data), and other relevant information that CQC or Monitor obtain or receive, for the purposes of performing their regulatory functions.

In particular, this information will be used to make regulatory judgements in relation to the licensing and the registration of individuals and providers and in relation to monitoring compliance with relevant licence conditions and/or regulations.

This includes publication of:

* A register of providers
* Conditions of registration
* Reports relating to compliance with regulations
* Other information that we may publish to assist the public in understanding the quality of services and the regulatory actions of the Commission or Monitor

Information (including personal data) may also be shared with other regulators and public bodies where necessary or expedient to assist in the exercise of public functions.

Application forms are processed on behalf of CQC and Monitor. Personal data is processed in accordance with the Data Protection Act 1998.

The person who signs below must be duly authorised to do so on behalf of the organisation.

If you are submitting this form electronically we will accept a typed-in name as your signature.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \*Applicant’s signature |  | | | |
| \*Applicant’s job title |  | | | |
| \*Applicant’s name | Title | First | Middle | Last |
| \*Date of signing (dd/mm/yyyy) |  | | | |

**Section One: Application details**

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| --- | --- | --- | --- | --- |
| **\*1.1 Provider organisation’s name and contact details** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp1) | | | | |
| \*Organisation’s name |  | | | |
| Name you trade under if different to the above |  | | | |
| The registered office of the organisation (if applicable) or its principal office: | | | | |
| \*Address line 1 |  | | | |
| \*Address line 2 |  | | | |
| \*Town/city |  | | | |
| \*County |  | | \*Postcode |  |
| \*Email address |  | | | |
| Website |  | | | |
| \*Business telephone |  | | | |
| \*Legal status of the provider organisation (public limited company/limited company/charity/ partnership/joint venture/ other)  If ‘other’ has been selected as the legal status above, please give particulars |  | | | |
| \*Registered company number (if applicable) | |  | | |
| \*Registered charity number (if applicable) | |  | | |
| \*Any other number (if applicable) | |  | | |

For the purpose of CQC registration requirements alone, the postal address details supplied at 1.1 above must be an English/UK address and must not be a PO Box number. This is the postal address we will use for service of documents in accordance with Sections 93 and 94 of the Health and Social Care Act 2008 and Section 149 of the Health and Social Care Act 2012, if you do not agree to service by email. It must be the same as the address for service of documents that you have included in your Statement of Purpose (see Section 2 below). Should you not be able to provide an English/UK address please contact us.

We will publish this address as the organisation’s contact details on our websites and on your certificates of registration and licence. We will also use this address for sending other correspondence by post, including draft and final inspection reports, if you do not agree to receive it by email.

By submitting this application you are confirming the organisation’s willingness for CQC and Monitor to use the email address **you entered in Section 1.1** for service of documents and for sending all other correspondence to you. Email ensures fast and efficient delivery of important information. If you do not want to receive documents by email please check or tick the box below. We will not share this email address with anyone else.

|  |  |  |
| --- | --- | --- |
| We do **NOT** wish to receive notices and other documents from CQC/Monitor by email |  |  |

It is vital that the postal and email addresses you supply are valid, clear and accurate, and that you keep us up to date with any changes.

For CQC registration, you can supply alternative temporary contact details at 1.2 below if this would be helpful. We will **only** use these details while processing this application.

For an NHS provider licence, the email address provided in 1.1 will be used for all notifications, unless you have ticked the box above.

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| **1.2 Alternative temporary correspondence address** | | | | | | |
| Key Contact name | Title | First | Middle | | Last | |
| Address line 1 |  | | | | | |
| Address line 2 |  | | | | | |
| Town/city |  | | | | | |
| County |  | | | Postcode | |  |
| Telephone |  | | | | | |
| Email address |  | | | | | |

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| **\*1.3 Invoice and financial contact details (for CQC registration only)** | | | | | | |
| \* Name | Title | First | Middle | | Last | |
| \* Role / job title |  | | | | | |
| \*Business address line 1 |  | | | | | |
| \*Business address line 2 |  | | | | | |
| \*Town/city |  | | | | | |
| \*County |  | | | \*Postcode | |  |
| \*Business telephone |  | | | | | |
| Mobile telephone |  | | | | | |
| \*Email address |  | | | | | |

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| **\*1.4 Financial interests in registered services (for CQC registration only)** | | | | |
| **Organisation;** Does your organisation have any current financial or business interests in a registered provider? Or does another registered provider have any financial or business interests in your organisation?  Please answer “yes” or “no” if either of the statements above applies to you. | | | | |
| Yes |  | No |  |  |
| If ‘Yes’, please provide details of the other service(s). | | | | |
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| **\*1.5 Essential business relationships with other service providers (for CQC registration only)** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp2) | | | | |
| Will your carrying on of the regulated activities proposed in this application depend upon formal contractual relationships with any other service provider? | | | | |
| Yes |  | No |  |  |
|  | | | | |
| If ‘Yes’, please provide details of the other provider(s) and the nature of the dependence. | | | | |
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| **1.6 Financial Year End information (for both CQC registration and an NHS provider licence)** | | | | |
|  | | | | |
| What was the date of the provider organisation’s last financial year end? (dd/mm/yyyy) | | |  |  |
|  | | | | |
| What is the date of the provider organisation’s establishment/ date of incorporation? (dd/mm/yyyy) | | |  |  |
|  | | | | |
| If the provider organisation’s last financial year was not 12 months please indicate the period it covered (dd/mm/yyyy) |  | to |  |  |
|  | | | | |
| What is the date of the provider organisation’s next financial year end? (dd/mm/yyyy) | | |  |  |
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| **\*1.7 Administration and receivership (for CQC registration only)** | | | | |
| Has either the company at 1.1 or any holding or parent company ever been in administration or receivership? | | | | |
| Yes |  | No |  |  |
|  | | | | |
| If yes, please give details: | | | | |
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**Part A: CQC registration**

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| **\*1.1 Is your organisation a subsidiary of another company?**  [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp3) | | | | | | | | |
| Yes |  | No | |  | |  | | |
|  | | | | | | | | |
| If ‘No’, please go to Section 1.3  If ‘Yes’, please provide the name and address of the parent/holding company | | | | | | | | |
| \*Name of parent company | | |  | | | | | |
| \*Property name (if any) | | |  | | | | | |
| \*Business address line 1 | | |  | | | | | |
| \*Business address line 2 | | |  | | | | | |
| \*Town/city | | |  | | | | | |
| \*County | | |  | | | | \*Postcode |  |
| \*Email address | | |  | | | | | |
| Website | | |  | | | | | |
| \*Business telephone | | |  | | | | | |
| \*Registered company number (if applicable) | | | | |  | | | |
| \*Registered charity number (if applicable) | | | | |  | | | |

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| **\*1.2 More information about parent and subsidiary companies**  [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp4) | | | | | |
| What type of organisation are you? | (Please tick/check one box below) | | | | |
| Limited Company |  | | | | |
| Trust |  | | | | |
| Charity (incorporated or otherwise) |  | | | | |
|  | | | | | |
| Are you part of a franchise? | | Yes |  | No |  |
| If you have ticked/checked ‘Yes’, Please give details below of who is the franchisee? | | | | | |
|  | | | | | |
| Please detail the financial relationship between your organisation and any parent and/or subsidiaries. In particular does your organisation rely financially on any other organisations within the group? | | | | | |
|  | | | | | |
| Do you share a brand name with other organisations?  If ‘Yes’, what is the financial relationship between your organisation and other organisations within the brand, in particular does your organisation rely financially on any other organisations within the brand? | | | | | |
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| **\*1.3 Nominated individual(s)** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp6)  Provide details of the nominated individual (NI) for each regulated activity in this application.  Download additional nominated individual sections from the website page where you found this form if you intend to provide more than one regulated activity and plan to have more than one nominated individual.  **If you don’t submit a form for each nominated individual, we will return your application.** |

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| The information below is for nominated individual number: | **1** | of a total of: |  | nominated individuals |

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| **\*Details of a nominated individual for regulated activities** | | | | | | |
| \*Regulated activity(s) |  | | | | | |
| \*Name | Title | First | Middle | | | Last |
| Previous name (if applicable) |  | | | | | |
| \*Date of birth (dd/mm/yyyy) |  | | | | | |
| \*Business address line 1 |  | | | | | |
| \*Business address line 2 |  | | | | | |
| \*Town/city |  | | | | | |
| \*County |  | | | \*Postcode |  | |
| \*Email address |  | | | | | |
| \*Business telephone |  | | | | | |
| Mobile telephone |  | | | | | |

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| Please confirm that the Nominated Individual is: -   * Of good character. * Physically and mentally fit to supervise the management of the carrying on of the regulated activity. * Has the necessary qualifications, skills and experience to do so; and   Has supplied the registered person, or arranged for the availability of, the information specified in Schedule 3.( Health and Social Care Act 2008 (Regulated Activities) Regulations 2010) | | | | | | | | | | | |
| Yes |  | | No | | |  | |  | | | |
| Have you applied for and received an enhanced DBS disclosure for the person shown (if you have not done so we will return your application). | | | | | | | | | | | |
| Yes | |  | | No | | |  | |  | | |
|  | | | | | | | | | | | |
| DBS disclosure number | | | | |  | | | | | Date of disclosure (dd/mm/yyyy) |  |
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| **\*1.4 Professional body disciplinary proceedings, other investigations, and action by the Disclosure and Barring Service (DBS) [(See Guidance)](http://www.cqc.org.uk/jointlicencehelp7)**  Are or have any Nominated Individuals proposed at section(s) 1.3 been subject to any safeguarding investigation, criminal investigation or any investigation by a previous employer? Please either check or tick ‘yes’ or ‘no’. Please provide details below | | | | |
| Are any Nominated Individuals proposed in section(s) 1.3 subject to any professional disciplinary action, current proceedings, investigations or restrictions or bars on activity by a health or care professional regulator or the Disclosure and Barring Service? | | | | |
| Yes |  | No |  |  |
|  | | | | |
| If ‘Yes’, please provide details below. | | | | |
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| **\*1.5 Previous registration history** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp8) | | | |
| Has your organisation, any parent organisation or subsidiary, or any of the directors or equivalent ever been registered or licensed for, or been the owner of any service registered or licensed under any of the following Acts of Parliament? Was the registration of the organisation ever cancelled?  (check / tick for ‘Yes’, leave blank for ‘No’) | | | |
|  | The Registered Homes Act 1984 |  |  |
|  | The Registered Homes (Amendment) Act 1991 |  |  |
|  | The Children Act 1989 (including childminding and day care for children) |  |  |
|  | The Nurses Agencies Act 1957 |  |  |
|  | The Care Standards Act 2000 |  |  |
|  | Health and Social Care Act 2008 |  |  |
| If ‘Yes’, please provide details below. | | | |
|  | | | |

**You will need to submit a registered manager application.**

**Section 2: Locations, regulated activities and service types.**

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| Please provide details about the regulated activities and service types at your location.  If you are applying to provide regulated activities at more than one location you can download additional location sections from the CQC website page where you found this form.  If you are filling in this form on paper and need extra space, please add extra numbered sheets as needed, mark them with the question number from this form.  Please give each location a number so that we know you have sent us information about all of your locations.  You must check or tick the boxes for the services you will provide at **each** location you are registering. The service types you declare should match the description of your service in your Statement of Purpose.  **If you don’t give us information about all of your locations we will have to return your application.** |

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| **Statement of purpose** |
| You must draft and send us a Statement of Purpose with this application form. **If you do not, we will have to return your application.**  The guidance to filling in this form contains a summary about what the law says must be included in your Statement. There is also separate detailed guidance on statements of purpose on our [website](http://www.cqc.org.uk/ldregistration). |

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| **Day-to-day management of regulated activities at this location** |
| Where required, applications for registration from managers in respect of this location, including from *existing* managers to continue their registration to manage it under your registration, must be submitted **with this application**. |

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| **\*2.1 Purchase or transfer of existing location(s)** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp9) | | | | | | | |
| Does this application involve the sale or transfer of location(s) being used to provide some or all of the regulated activities you selected in Section 2.9 below by an existing provider that is already registered under the Health and Social Care Act 2008? | | | | | | | |
| Yes |  | No | |  |  | | |
|  | | | | | | | |
| If ‘Yes', please fill in the details of the existing registered provider below: | | | | | | | |
| \*CQC provider name | | |  | | | | |
| \*CQC provider ID | | |  | | | | |
| \*Business telephone | | |  | | | | |
| \*Email address | | |  | | | | |
| The CQC may need to contact the existing provider regarding this application. Please tick if you do **not** wish CQC to contact the existing provider regarding this application. | | | | | |  |  |
|  | | | | | | | |

**\*2.2 Location details** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp10)

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|  | | | | | | |
| **Details for Location number:** | | **1** | **of:** | |  | **locations** |
|  | | | | | | |
| CQC location ID (if known) |  | | | | | |
| \*Name of location |  | | | | | |
| \*Location address line 1 |  | | | | | |
| \*Location address line 2 |  | | | | | |
| \*Town/city |  | | | | | |
| \*County |  | | | \*Postcode | |  |
| \*Business telephone |  | | | | | |
| No of places or beds (\*if applicable) | | | | | |  |
| \*Email |  | | | | | |
| Website |  | | | | | |

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| **\*2.3 Planning consent** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp11) | | | | | | | | | |
| Does this location have planning consent to provide the regulated activity(s) you intend to carry on there? | | | | | | | | | |
| Yes |  | No |  | Not applicable | |  |  | | |
| T | | | | | | | | | |
| Local authority | |  | | | Date of consent | | | (dd/mm/yyyy) |  |
|  | | | | | | | | | |
| Where you do not have planning consent, please explain why it is not needed or why it is not yet received? | | | | | | | | | |
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| **\*2.4 Building regulations** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp12) | | | | | | |
| Is there Building Regulations approval for any applicable building works undertaken at this location? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
|  | | | | | | |
| Where relevant Building Regulations Certificates have yet to be issued, please tell us when you expect to receive them? | | | | | | |
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| **\*2.5 Food safety** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp13) | | | | | | |
| If you will provide food to the people who use your service at or from this location, have you registered with the relevant local council’s Environmental Health Department as a food business? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
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| **\*2.6 Safety of equipment, plant and utilities** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp14) | | | | |
| Do you have maintenance contracts in relation to all the equipment, plant and utilities you own, lease or use – or will own, lease or use – in relation to providing your service in this location? | | | | |
| Yes |  | No |  |  |
|  | | | | |
| If ‘No’, please describe the equipment, plant and utilities not covered by maintenance contracts and how you will ensure that servicing and repairs are undertaken in a timely and prompt way, as required by their manufacturer’s instructions. | | | | |
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| **\*2.7 Landlord/Mortgage lender permission** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp15) | | | | | | |
| Where you do not own this location, do you have your landlord’s written permission to use it to carry on the regulated activity(s) you intend to provide there?  Where you do not own this location and you have a mortgage, do you have the mortgage lenders written permission to use it to carry on the regulated activity(s) you intend to provide there? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
|  | | | | | | |
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| Where you do not have your landlord’s or mortgage lender’s permission, please explain why it is not needed or not yet received? | | | | | | |
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| --- | --- | --- | --- | --- |
| **\*2.8 Location readiness** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp16) | | | | |
| You cannot carry on a regulated activity at or from a location until you can meet the requirements of the Health and Social Care Act 2008 and associated regulations at or from that location.  What date will the location be ready? | | | | |
| Date |  |  |  |  |
|  | | | | |
|  | | | | |

|  |  |  |
| --- | --- | --- |
| **\*2.9 The regulated activities you propose to carry on at this location** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp17) | | |
|  | | |
| 1. Personal care |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Accommodation for persons who require nursing or personal care |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Accommodation for persons who require treatment for substance misuse |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Accommodation and nursing or personal care in the further education sector |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Treatment of disease, disorder or injury |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Assessment or medical treatment for persons detained under the Mental Health Act 1983 |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Surgical procedures |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Diagnostic and screening procedures |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Management of supply of blood and blood-derived products |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Transport services, triage and medical advice provided remotely |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Maternity and midwifery services |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Termination of pregnancies |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Services in slimming clinics |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Nursing care |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |
| 1. Family planning services |  |  |
| Please provide an explanation for choosing this regulated activity below, what service will you be providing at this location? | | |

|  |
| --- |
| **\*The services provided at this location** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp18) |
| **Before you complete this section, you are strongly advised to read the guidance about service types that can be found on pages 13 to 31 of the** *Guidance about compliance: Essential standards of quality and safety***.**    **The service type(s) you select are used to calculate your annual fee, so it is important to select only those that apply to each of the locations you are registering**.  **You should also read our guidance for providers about fees before completing this section.** These guidance documents are available on our website. |

|  |  |
| --- | --- |
| **\*2.10 The service types provided at this location** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp19) | |
| Please check or tick **ONLY** the service types that will be provided at this location. | |
| **Healthcare Services** | |
| **Acute services (ACS)**  If you have ticked/checked this service type, but the only, or main activity provided at this location is one of those listed below, please **also** tick/check the relevant box.  If you provide other services at this location as well as Acute Services (ACS), or more than one of the activities below at this location, **Do not tick/check the boxes below.**   |  |  |  | | --- | --- | --- | | (a) Haemodialysis or peritoneal dialysis |  |  | |  | | | | (b) Dental treatment carried out under general anaesthesia |  |  | |  |  |  | | (c) The termination of pregnancies |  |  | |  |  |  | | (d) Hyperbaric therapy |  |  | |  |  |  | | (e) Refractive eye surgery |  |  | |  |  |  | | (f) Surgical procedures associated with in vitro fertilisation or assisted conception |  |  | |  |  |  | | (g) Obstetric services and, in connection with childbirth, medical services |  |  | |  |  |  | | (h) Cosmetic surgery |  |  | |  |  |  | | (i) Acute services, where the location has no overnight beds for patients |  |  | |  |  |  | |  |
| **Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)** |  |
|  |
| **Rehabilitation services (RHS)** |  |
| **Hyperbaric chamber services (HBC)** |  |
| **Hospice services (HPS)**  If you have ticked this service type, please **also** complete **one** of the following questions only: -   1. Does your hospice service provide overnight beds for patients?   (Please complete even if your service also includes community or outreach services).   1. Does your service provide hospice at home services or end of life or respite care for people in the community? |  |
| **Long-term conditions services (LTC)** |  |
| **Prison health care services (PHS)** |  |
| **Rehabilitation services (RHS)** |  |
| **Residential substance misuse treatment/ rehabilitation services (RSM)** |  |
| **Community or integrated healthcare** | |
| **Community health care services (CHC)**  **CHC: Please also tick if you are a nursing agency only** |  |
| **Doctors consultation services (DCS)** |  |
| **Doctors treatment services (DTS)** |  |
| **Dental services (DEN)**  If you are registering this location as a single location please also complete the following question: -  Please state the number of dental chairs at this location  (State ‘0’ if you are a domiciliary dental provider and have no dental chairs of your own)  **Do not complete this question if you are applying to register more than one location.** |  |
| **Diagnostic and/or screening services (DSS)**  You should **ONLY** tick this service type if diagnostic and/or screening services are the only or main activity you provide at this location. If you provide other services at this location, you should not select this service type, even if you provide the regulated activity of Diagnostic and screening procedures.  **If you have selected DSS, please also complete the following questions: -**   1. If you are registering as an organisation or a partnership and provide diagnostic and screening services as your sole or main activity, please tick/check this box. 2. If you are registering as an individual, for the regulated activity of Diagnostic and screening procedures ONLY, AND are registering for one location ONLY, please tick/check this box. |  |
| **Community-based services for people with a learning disability (LDC)** |  |
| **Mobile doctors services (MBS)** |  |
| **Community-based services for people with mental health needs (MHC)** |  |
| **Community-based services for people who misuse substances (SMC)** |  |
| **Urgent care services (UCS)** |  |
| **Residential social care** | |
| **Specialist college service (SPC)** |  |
| **Care home service with nursing (CHN)** |  |
| **Care home service without nursing (CHS)** |  |
| **Community social care** | |
| **Domiciliary care service (DCC)** |  |
| **Extra Care housing services (EXC)** |  |
| **Shared Lives (SHL)** |  |
| **Supported living service (SLS)** |  |
| **Miscellaneous healthcare** | |
| **Ambulance services (AMB)** |  |
| **Blood and transplant services (BTS)** |  |
| **Remote clinical advice services (RCA)** |  |

|  |  |  |
| --- | --- | --- |
| **2.11 Condition of registration about the number of persons accommodated to receive nursing or personal care at this location** | | |
| Only check or tick the box in this Section if you checked / ticked ‘Accommodation for persons who require nursing or personal care’ at section 2.9 above and either ‘Care home service without nursing’ or ‘Care home service with nursing’ at Section 2.10 above**. If this does not apply to you go straight to section 2.13 below.**  Please check / tick the box below to confirm that you are agreeing in writing to a condition of registration that says  ‘**The number of persons accommodated to receive nursing or personal care at this location must not exceed [number]’.**  The number in this condition will normally be the one you filled in at section 2.2 above (number of places or beds). We will contact you if we decide we cannot agree to your proposed number for this condition. | | |
|  | | |
| We agree in writing to the condition of registration shown above, using the number of places or beds we proposed in section 2.2 of this form |  |  |
|  | | |

|  |  |  |
| --- | --- | --- |
| **2.12 Condition of registration about not providing nursing care at this location** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp20) | | |
| Only check / tick the box below if you checked / ticked ‘Accommodation for persons who require nursing or personal care’ at section 2.9 above **AND** ‘Care home service without nursing (CHS)’ at section 2.10 above (If this does not apply to you please go to section 2.13 below).  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says  **‘The provider must not provide nursing care under the accommodation for persons who require nursing or personal care regulated activity at this location’.** | | |
|  | | |
| We agree in writing to the condition of registration shown above |  |  |
|  | | |

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| --- | --- | --- |
| **2.13 Condition of registration about the Regulated Activity(s) at this and other locations** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp21) | | |
| Please check / tick below to confirm that you are agreeing in writing to a condition of registration in respect of each regulated activity that says  **This Regulated Activity may only be carried on at or from the following locations:**  **<First location> <Second location> (if there is one) (and so on for any more locations)**  The locations in this condition will be those specified in each Section 2 submitted with this application. The regulated activities will be the ones you specified in each Section 2.9. | | |
|  | | |
| We agree in writing to the condition of registration shown above |  |  |
|  | | |

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| --- |
| **\*2.14 Service user bands** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp22) |
| Please check or tick **all** of the descriptions / service user bands for the people that will use this location. If you will provide a service to everyone you can check or tick ‘The whole population’. |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Age groups** | | | | | | | | |
| Whole population | Children  0 to 3 | Children  4 to 12 | | Children  13 to 17 | | Adults  18 to 65 | Adults  65 + | |
|  |  |  | |  | |  |  | |
|  | | | | | | | | |
| **Service user band** | | | | | | | | |
| Dementia | | |  | | People detained under the Mental Health Act | | |  |
| Mental health | | |  | | People who misuse drugs or alcohol | | |  |
| People with an eating disorder | | |  | | Sensory impairment | | |  |
| Learning difficulties or autistic spectrum disorder | | |  | | Physical disability | | |  |

|  |  |  |
| --- | --- | --- |
| **\*2.15 Checklist for information that must be available** | | |
| Please confirm that the following information in relation to each of the regulated activities you are intending to provide, is available if required by CQC.  (Check / tick to show that the information is available)  If any of the information below is not confirmed as available we will have to return your application. Please **do not** submit this information with your application. We will ask to see it if needed. | | |
| Evidence of insurance arrangements for the regulated activity which must include cover for employees, premises and public liability |  |  |
| Policies, procedures and protocols where required |  |  |
| Staffing details and personnel records |  |  |
| Staffing rotas (if applicable) |  |  |
| Contract arrangements for equipment and services necessary |  |  |
| Confirmation that where planning permission or buildings approval is required, it has been obtained |  |  |

**Section 3: How you will provide your service** [**(See Guidance)**](http://www.cqc.org.uk/jointlicencehelp23)

You must complete each of the five parts of this section of the application. If you do not complete each part we will return your application to you. In answering these five key questions you should demonstrate how the requirements of the Health and Social Care Act 2008, and associated regulations will be met. In particular the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

|  |
| --- |
| **3.1 Are they Safe?**  Please describe how you will: -   * Ensure that people using the service are protected from harm, neglect or abuse? * Ensure that people using the service are encouraged to report abuse and be involved in safeguarding decisions? * Ensure that people’s privacy, dignity, values, beliefs and human rights are recognised, respected and promoted. * Act in accordance with the consent of people to their care and treatment (or that of their lawful representatives). * Assess the best interests of people who do not have the mental capacity to make decisions about their care and treatment, and do not have a representative able lawfully to do so. * Ensure that all of the premises and equipment used (as far as practicable) will be safe, clean, secure, suitable and properly maintained for the purpose for which they are being used. |
|  |

|  |
| --- |
| **3.2 Are they Effective?**  Please describe the sources of advice, expertise and information you used to design the service in this application, that you will continue to use when developing it, and the systems and methods you will use to: -   * Assess, monitor and improve the quality of your service (including the quality of the experience of people using the service). * Seek and act on feedback from people using the service and other people about how the regulated activity is being carried on. How will this feedback continually improve the service. * Maintain an accurate, complete and contemporaneous record for each person using the service. * Ensure that people’s privacy, dignity, values, beliefs and human rights are recognised, respected and promoted. * Act in accordance with the consent of people to their care and treatment (or that of their lawful representatives). * Assess the best interests of people who do not have the mental capacity to make decisions about their care and treatment, and do not have a representative able lawfully to do so. |
|  |

|  |
| --- |
| **3.3 Are they Caring?**  Please describe how your service will:   * Carry out an assessment of the needs and preferences for care and treatment of the service user. * Design care or treatment with a view to ensuring service users’ welfare. * Promote the privacy and independence of service users. * Make suitable arrangements to ensure that, in so far as reasonably practicable service users are enabled to make, or participate in making decisions relating to their care or treatment to the maximum extent possible. * Where applicable, provide for making of reasonable adjustments to meet service users’ individual needs. * Have due regard to any protected characteristics (as laid down in section 4 of the Equality Act 2010 (a)) of the service user. * How will service users feel safe and comfortable, be treated with compassion, dignity and empathy and respect? |
|  |

|  |
| --- |
| **3.4 Are they well led?**  Please describe: -   * The registered manager must undertake from time to time training as is appropriate to ensure that the manager has the experience and skills necessary for managing the regulated activity(s). Please describe what training you have planned for the next twelve months. * Where responsibility for the care and treatment of service users is shared with, or transferred to other persons, steps are taken to ensure the health, safety and welfare of service users. * Your recruitment, induction, appraisal and continuous professional development procedures/plans. * How you will deal with poor or unsafe staff performance. * How suitably skilled, experienced and qualified staff will be deployed in sufficient numbers. * How you ensure adequate financing of your business (account cash, agreed overdrafts, initial funding, other available loans and likely profits) in relation to meeting the requirements of the Act and regulations and the service described in your Statement of purpose, in particular: * When launching the service in this application * When continuing to provide a service in the long to medium term * In ensuring that you have adequate insurance and indemnity arrangements in relation to claims, losses and other financial risks |
|  |

|  |
| --- |
| **3.5 Are they responsive?**  Please describe how you will: -   * Establish and effectively operate a system for identifying, receiving, recording, handling and responding to complaints, and requests for action to be taken by people using the service. * Ensure that people who make complaints do not suffer detriment or discrimination. * Identify, assess and manage risks to people’s rights, health, safety and welfare * How will you ensure that services are responsive to the needs of people in relation to their age, disability, race, religion or belief, sex, sexual orientation, gender identity |
|  |

**Part B: NHS Provider Licence Issued by Monitor****:**

All the questions in the application form refer to “you”/”your” – this is intended to refer to the licence applicant provider. Where we refer in the application to "specified" details, this is as specified in the licensing guidance on Monitor’s website.

|  |  |
| --- | --- |
| **Have you read the licence application guidance published on Monitor’s website at** [**www.monitor.gov.uk/licence**](http://www.monitor.gov.uk/licence) **before continuing with this section of the application form? (Y/N)** |  |
|  |
|  |
| **Please confirm whether you will be including additional documents to your application to help you respond to this part of the application form (Y/N)** |  |
|  |
|  |
| **If Monitor has asked you to fill in and return an additional appendix, please confirm that you have done so (Y/N)** |  |
|  |
|  |

**All questions marked with an \* in this part MUST be completed.**

**Section 1:** **Provision of health care service(s) for the purposes of the NHS**

|  |
| --- |
| **\*1.1 Do you provide health care service(s) for the purposes of the NHS? (Y/N)**  If **Yes**, go to question 1.1.1  If **No**, go to Section 2 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  | No |  |  |
|  | | | | |

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| --- |
| **\*1.1.1 Do you provide health care service(s) for the purposes of the NHS through a contract directly with a Clinical Commissioning Group and/or NHS England? (Y/N)**    If **Yes**, go to question 1.1.1.1  If **No**, go to question 1.1.2 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  | No |  |  |
|  | | | | |

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| --- |
| **\*1.1.1.1 Do you provide any health care service(s) for the purposes of the NHS through a multi-party contract with Clinical Commissioning Group(s) and/or NHS England and other provider(s)? (Y/N)**  If **Yes or No**, go to question 1.1. 2 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  | No |  |  |
|  | | | | |

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| --- |
| **\*1.1.2 Do you provide health care service(s) for the purpose of the NHS**  **through an arrangement with another provider? (Y/N)**  If **Yes or No**, go to question 2.1 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Yes |  | No |  |  |
|  | | | | |

**Section 2: Requirement for Licence: Applicable Licence Exemptions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*2.1 Do all of the health care services you provide for the purposes of the NHS fall into one or more of the categories below?**   * **Primary Medical Services** * **Primary Dental Services** * **NHS Continuing Healthcare** * **NHS funded nursing care**   If **Yes** go to question 2.1.1  If **No** go to question 2.2 |  |  |  |  |
| Yes |  | No |  |  |
|  |  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  | | | | |
| **\*2.1.1 Please indicate which of the following health care services you provide for the purposes of the NHS**   * **Primary Medical Services** * **Primary Dental Services** * **NHS Continuing Healthcare** * **NHS funded nursing care**   If **Yes or No** then go to 2.3 |  |  |  | |
| Yes |  | No |  |  |
| Yes |  | No |  |  |
| Yes |  | No |  |  |
| Yes |  | No |  |  |
|  |  | | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*2.2 Is your applicable turnover for the relevant business year £10 million or more?** |  |  |  |  |
| Yes |  | No |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*2.3 Do you provide healthcare services for the purposes of the NHS that are designated as Commissioner Requested Services?**  If **Yes** go to question 2.3.1  If **No** go to question 3.1 |  |  |  |  |
| Yes |  | No |  |  |
|  |  |  |  |  |
|  |  |  |  |

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| --- |
| **\*2.3.1 Please provide a list of all commissioners you provide Commissioner Requested Services for with the specified details.** [**(see Guidance)**](http://www.cqc.org.uk/jointlicencehelp24) |
|  |

**Section 3: Licensing Grant Criteria: Provider Fitness**

**Registration with the Care Quality Commission as required: this will be confirmed with the CQC on the basis of the information provided in the first part of this form.**

**\*3.1 Please provide below the required details for all directors, governors and those performing equivalent or similar functions of:-**

* **your organisation (which is applying for a licence)**
* **your corporate director(s) (if applicable)**
* **the parent body (bodies) of all your corporate director(s) (if applicable)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **First name** | **Surname** | **Date of birth** | **Function**  Please select from: - Director  Governor  Equivalent/Similar to Director or Governor | **Organisation**  Please select from:-  Applicant  organisation  Corporate Director Parent of Corporate Director | | |
|  |  |  |  |  | | |
| **\*3.2 For each category below state Yes if one or more individuals who is a director or governor of your organisation (or who performs equivalent or similar functions) falls within the category; state No if no such individual falls within the category:** | | | | | | |
| (i) That person is a person who has been adjudged bankrupt, or whose estate has been sequestrated, and (in either case) the bankruptcy or sequestration has not been discharged or the bankruptcy order has not been annulled. | | | | |  | Yes |
|  | No |
| (ii) That person is a person in relation to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986. | | | | |  | Yes |
|  | No |
| (iii) That person is a person who has made a composition or arrangement with, or granted a trust deed for, that person’s creditors and has not been discharged in respect of that composition, arrangement or deed. | | | | |  | Yes |
|  | No |
| (iv) Within the preceding 5 years ending on the date the application for a licence is made, that person has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on that person. | | | | |  | Yes |
|  | No |
| (v) That person is subject to a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986. | | | | |  | Yes |
|  | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*3.3 Do you have a corporate director?**  If **Yes** you must complete 3.3.1 and 3.3.2.  If **No** go to Section 4 |  |  |  |  |
| Yes |  | No |  |  |
|  |  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **\*3.3.1 For each category below state Yes if one or more individuals who is a director or governor of your organisation’s corporate director (or who performs equivalent or similar functions) falls within the category; state No if no such individual falls within the category:** | | |
| (i) That person is a person who has been adjudged bankrupt, or whose estate has been sequestrated, and (in either case) the bankruptcy or sequestration has not been discharged or the bankruptcy order has not been annulled. |  | Yes |
|  | No |
| (ii) That person is a person in relation to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the 1986 Act. |  | Yes |
|  | No |
| (iii) That person is a person who has made a composition or arrangement with, or granted a trust deed for, that person’s creditors and has not been discharged in respect of that composition, arrangement or deed. |  | Yes |
|  | No |
| (iv) Within the preceding 5 years ending on the date the application for a licence is made, that person has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on that person. |  | Yes |
|  | No |
| (v) That person is subject to a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986. |  | Yes |
|  | No |

|  |  |  |
| --- | --- | --- |
| **\*3.3.2 For each category below state Yes if the corporate director falls within the category; state No if the corporate director does not fall within the category** | | |
| (i) That body or its parent body (if it has a parent body) is subject to a proposal for a voluntary arrangement made in accordance with section 1(those who may propose and arrangement) of the Insolvency Act 1986. |  | Yes |
|  | No |
| (ii) A receiver, including an administrative receiver (within the meaning of Section 29(2) (definitions) of the Insolvency Act 1986) has been appointed for the whole or any material part of that body’s or its parent body’s (if it has a parent body) property or undertaking. |  | Yes |
|  | No |
| (iii) An administrator has been appointed in respect of that body or its parent body (if it has a parent body), to manage its affairs, business and property in accordance with Section 8 of, and Schedule B1 (administration) to, the Insolvency Act 1986. |  | Yes |
|  | No |
| (iv) That body or its parent body (if it has a parent body) has passed a resolution for winding up or is subject to an order of the High Court for winding up under Part IV (winding up of companies registered under the Companies Acts) of the Insolvency Act 1986. |  | Yes |
|  | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*3.4 Do you have a corporate director who has a parent body(s)?**  If **Yes** you must complete 3.4.1  If **No** go to Section 4 |  |  |  |  |
| Yes |  | No |  |  |
|  |  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **\*3.4.1 For each category below state Yes if one or more individuals who is a director or governor of your corporate directors’ parent bodies (or who performs equivalent or similar functions) falls within the category; state No if no such individual falls within the category:** | | |
| (i) That person is a person who has been adjudged bankrupt, or whose estate has been sequestrated, and (in either case) the bankruptcy or sequestration has not been discharged or the bankruptcy order has not been annulled. |  | Yes |
|  | No |
| (ii) That person is a person in relation to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986. |  | Yes |
|  | No |
| (iii) That person is a person who has made a composition or arrangement with, or granted a trust deed for, that person’s creditors and has not been discharged in respect of that composition, arrangement or deed. |  | Yes |
|  | No |
| (iv) Within the preceding 5 years ending on the date the application for a licence is made, that person has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on that person. |  | Yes |
|  | No |
| (v) That person is subject to a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986. |  | Yes |
|  | No |

**Section 4: Additional Information Request**

**Information related to provision of Commissioner Requested Services**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*4.1 Do you have an Ultimate Controller (s)?**  If **Yes** you must complete the following details  If **No** go to question 4.2 |  |  |  |  |
| Yes |  | No |  |  |
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| --- | --- |
| Name of Ultimate controller(s) |  |
| Company registration number(s) if applicable |  |
| Website address(es) |  |
| Key contact(s) at Ultimate Controller(s) |  |
| Job title |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| \*Name | Title | First | | Middle | Last | |
| \*Business address line 1 | | |  | | | |
| \*Business address line 2 | | |  | | | |
| \*Town/city | | |  | | | |
| \*County | | |  | \*Postcode | |  |
| \*Email address | | |  | | | |
| \*Business telephone | | |  | | | |

**Licence previously held / applied for**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*4.2 Have you previously held an NHS Provider Licence?**  If **No** go to question 4.3  If **Yes** please provide details below including provider name, licence number and date granted |  |  |  |  |
| Yes |  | No |  |  |
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| **\*4.3 Have you ever made an application for an NHS Provider Licence that was refused?**  If **No** go to question 4.4  If **Yes** please provide details below including provider name(s), date(s) and reason(s) for refusal of the licence |  |  |  |  |
| Yes |  | No |  |  |
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| **\*4.4 Have you ever made an application for an NHS Provider Licence that you withdrew before Monitor made its decision as to grant or refusal?**  If **No** go to Application Declaration in Section 2  If **Yes** please provide details below including provider name(s), date(s) and reason(s) for withdrawal of the application |  |  |  |  |
| Yes |  | No |  |  |
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**Section 2: Application Declaration**

**This declaration must be signed by an individual who has been duly authorised to do so, on behalf of the provider organisation. Please read it carefully.**

We hereby declare that the information detailed in this application is true, accurate and not misleading.

We undertake that where information which has been entered on the application is no longer accurate, complete and not misleading, updated information, which is accurate, complete and not misleading, will be provided to the Care Quality Commission and Monitor promptly.

We understand that Section 37 of the Health and Social Care Act 2008 makes it an offence to knowingly make a statement which is false or misleading in a material respect in this application for a registration with the Care Quality Commission, or in any of the documents for registration submitted with this application. We understand that to knowingly make a false declaration could render us liable to prosecution and could lead to the refusal of this application.

We understand that it is our responsibility to inform the Care Quality Commission of any information that is relevant to our application for a registration and which may not have been requested, and to update this information accordingly. We have kept a copy of all the information submitted in our application for our records.

We understand that if we change our postal or email address for service of notices and delivery of other documents we must update the relevant part of our Statement of Purpose, notify CQC and Monitor about the change and supply a copy of the amended Statement of Purpose to CQC

In making this application for a registration with the Care Quality Commission we agree to comply with the Health and Social Care Act 2008 and associated regulations, and have regard to the CQC ‘Essential Standards of Quality and Safety: Guidance about Compliance for Providers.’

Once registered, we agree to inform the Care Quality Commission (as appropriate) if there are any changes to compliance with the above Acts and any regulations relative to registration. We understand that for registration non-compliance with the relevant legislation could lead to the refusal of this application or cancellation of our registration if we do not comply once registered.

By submitting this application the organisation agrees that the information contained in this form may be used as conditions of registration.

|  |  |
| --- | --- |
| Please check or tick this box to confirm that the appropriate number of registered managers have also submitted applications for registration with CQC |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \*Applicant’s signature |  | | | |
| \*Applicant’s name | Title | First | Middle | Last |
| \*Date of signing  (dd/mm/yyyy) |  | | | |
|  | | | | |
| \*Role / job title |  | | | |
| \*Email address |  | | | |

If you are submitting this form electronically we will accept a typed-in name as a signature.

**How to submit this application and accompanying documents**

Please submit this application for registration and for an NHS provider licence to the **Care Quality Commission**, making sure that all required additional forms and documents are included.

**The checklist below lists the CQC documents that you need to include with the application:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Form or document |  | | | Done |
| Statement of purpose | A template is available on our website for you to use if you prefer | | |  |
| Additional nominated individual sections as needed | Number of nominated individuals in the organisation |  |  |  |
|  |
|  |
| Number of additional nominated individual sections submitted with this application |  |  |
|  |
|  |
| Additional location sections as needed | Number of locations where we are applying to carry on regulated activities |  |  |  |
|  |
|  |
| Number of additional location sections submitted with this application |  |  |
|  |
|  |
| Registered manager application forms | Number of locations in this application that will have a registered manager |  |  |  |
| Number of manager application forms of all types submitted with this application |  |  |
|  |
|  |

## Where to send the application:

**You should wherever possible** email **your completed form(s) and accompanying documents to:** [HSCA\_Applications@cqc.org.uk](mailto:HSCA_Applications@cqc.org.uk)

You must attach all the forms and documents to the same email. If you are unable to send us your application by email you should print and sign your completed form(s) and post them with any accompanying documents in the same envelope to:

CQC HSCA Registrations

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA

Please ensure you have competed, in full, both Part A (registration) and Part B (NHS provider licence). If you do not submit all required forms and information your application will have to be returned to you.

You can read more information on our website [www.cqc.org.uk](http://www.cqc.org.uk) or call our National Customer Service Centre on **03000 616161**. For enquiries regarding the NHS provider licence, please contact Monitor’s enquiries team on **020 3747 0606**

**Next Steps**

On submission of this application you will receive an acknowledgement of receipt.

If CQC and Monitor are satisfied that the applicant meets the criteria for registration under section 11 of the Health and Social Care Act 2008 and licensing under section 86 of the Health and Social Care Act 2012, they will, as soon as reasonably practicable, grant the applications for both a CQC registration and a provider licence and advise the applicant accordingly.

**Licensing only - Additional Information Request (advance indication of request once license is granted)**

1. You must provide the following information to Monitor within one month of being granted a licence:
   1. The value of your applicable turnover and total turnover in £ for the relevant business year
2. In addition, if you provide services designated as Commissioner Requested Services, you must provide the following information to Monitor within one month of being granted a licence:
   1. The list of services designated as CRS in the specified format
   2. The value in £ of the CRS you have been contracted to deliver by commissioner at the time you submit this information
   3. If you are providing health care services to the NHS as a prime contractor, have you entered into an arrangement (such as sub-contracting) with one or more other providers for them to provide part or all of these services?
   4. If you are providing Commissioner Requested Services as a prime contractor, have you entered into an arrangement (such as sub-contracting) with one or more other providers for them to provide part or all of these services. If so, please provide the specified details
   5. Ultimate Controller declaration in accordance with the requirements of Condition CoS4 of the NHS Provider Licence
   6. Last available credit rating (if the you have one)
   7. Information relating to your transactions
   8. Information relating to your financial plans
   9. Last full set of annual report and accounts

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