

Application for Registration- Individual/Partnership/Body Corporate

Please complete in BLOCK CAPITALS and in black ink.

This form should be completed by: -

- all applicants who wish to register as a provider of an independent care service.

This form should be completed by the intended registered person or a person with the authority to represent the registered person (see the notes to help complete 'Application for Registration form' for more information).

In addition, an application form should be completed by each person connected with the application including: -

- the manager in charge of the day to day running of a care service (to complete a 'Application for Registration Manager form')
- all individuals making up a body corporate – this includes: partners; directors; trustees; committee members.
- Partnership - additional partners other than the nominated person completing the form.

If you need any help completing this form, please contact us on (01624) 642422

Type of Application

Are you applying as (please tick one box only)

- An Individual A Partnership A Body Corporate

Description of Care Service

Please tick a box

Adult Care Home with nursing

Adult Day Care Centre

Adult Placement Agency

Child Care Agency

Child Day Care Centre

Child Day Care Centre Forest School

Children's Home

Child (secure accommodation) establishment

Domiciliary Care Agency → Are you intending to provide a service to children. Please tick box if yes?

Fostering Agency

Independent Clinic

Independent Hospital

Independent Medical Agency

Nurses Agency

Offender accommodation service

Residential Family Centre

Voluntary Adoption Agency



SECTION 1 - General information on the Service

Name of care service

Address of care service

 Postcode

Telephone number

Email address

Are you currently registered with the Registration and Inspection Unit? Yes No

If **Yes**, please give the name and address of the registered service:

Name

Address

 Postcode

Date of registration / /

If **No**, please give proposed date of opening of the service on the Isle of Man / /

Have you/the organisation ever been registered with another registration authority as a provider of care e.g. NCSC, CQC, Ofsted? Yes No

If **Yes**, please provide the following details:

Name of Registering Authority

Address of Registering Authority

 Postcode

Name of the Registered Service

Address of Registered Service

 Postcode

'Individual' or 'partnership' applicants go to SECTION 2

'Body corporate' applicants to SECTION 3

SECTION 2 - Applicant details - Individual / Partnership Application

As the Provider will you also be managing the service?

Yes No

Title (please tick one or specify)

Mr Mrs Miss Ms Other

Full Name

Any other names by which you have been known

Date of birth

/ /

Telephone number

Email address

We will communicate with you by email unless you indicate **no**

No

Do you require a work permit?

Yes

No

Current Address

Postcode

I have lived here from

/ /

Previous Address (last 5 years)

| | | | | | | |
|----------------------|-----------|---|---|---------|---|---|
| <input type="text"/> | Date from | / | / | Date to | / | / |
| <input type="text"/> | Date from | / | / | Date to | / | / |
| <input type="text"/> | Date from | / | / | Date to | / | / |
| <input type="text"/> | Date from | / | / | Date to | / | / |
| <input type="text"/> | Date from | / | / | Date to | / | / |

Partnership Application

Please list below partners, if applicable. If the service is to be run by a partnership, each partner listed is to complete a form, please request from Registration and Inspection.

| Title | First Name(s) | Surname | Date of birth | Position | Contact with Service recipients |
|----------------------|----------------------|----------------------|----------------------|----------------------|--|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Please go to Section 4

SECTION 3 - Applicant details - Body Corporate

Name of the Body Corporate

The Registered Office/Principal Office of the body corporate

Name

Address

Postcode

Telephone number

Company registered number

Email address

Do you wish Registration & Inspection to communicate with you electronically?

Yes

No

If the organisation is a subsidiary of a holding company

Please provide the details of the registered or principal office of the holding company

Name

Address

Postcode

Telephone number

Email address

Company registered number

Please provide details of any other subsidiary/ies of the holding company on a separate sheet.

Please list below all persons who are members of the body corporate making application to become the 'Registered Provider' as a body corporate including directors and trustees

| Title | First Name(s) | Surname | Date of birth | Position |
|-------|---------------|---------|---------------|----------|
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Please continue on a separate sheet if necessary.

SECTION 3 continued. Applicant details - Body Corporate

To be completed by the Nominee as the body corporate's Responsible Person

The Nominee must be an officer of the body corporate who is responsible for supervising the overall management of the service.

Title (please tick one or specify) Mr Mrs Miss Ms Other

Name

Any other names by which you have been known

Date of birth /

Telephone number

Do you require a work permit? Yes No

Email address

Do you wish Registration & Inspection to communicate with you electronically? Yes No

Current Home Address

I have lived here from /

| | | | | | | | |
|---------------------------------|----------------------|-----------|---|---|---------|---|---|
| Previous Address (last 5 years) | <input type="text"/> | Date from | / | / | Date to | / | / |
| | <input type="text"/> | Date from | / | / | Date to | / | / |
| | <input type="text"/> | Date from | / | / | Date to | / | / |
| | <input type="text"/> | Date from | / | / | Date to | / | / |
| | <input type="text"/> | Date from | / | / | Date to | / | / |

Please go to SECTION 4

SECTION 4 - All applicants - details continued

The registered person and the manager may be the same person; if you are not the manager of the service the manager must complete an Application for Registration Manager application.

Current employment details

| | | | |
|------------------|----------|------------------------------------|------------------------------------|
| Name of employer | | | |
| Employer address | | | |
| | | | |
| | Postcode | | |
| Telephone number | | | |
| Job Title | | | |
| Responsibilities | | | |
| Date commenced | / / | Full Time <input type="checkbox"/> | Part Time <input type="checkbox"/> |

Previous employment - Please enclose a comprehensive Curriculum Vitae including all past employment history since leaving full time education. Please explain any gaps and provide reasons for leaving each job.

Have you ever been employed by a person registered under any Act on the Isle of Man or related jurisdictions registered for looking after adults or children? Yes No

If **Yes**, please provide details:

Have you ever been subject to disciplinary action, formal hearing, suspension and/or dismissal from a place of employment? Yes No

If **Yes**, please provide details:

Have you ever been subject to refusal or cancellation of registration in health and social care regulation for children or adults in any jurisdiction? Yes No

If **Yes**, please provide details:

SECTION 4 - continued

Do you have or have you ever had a business interest in any other care service?

Yes

No

If **Yes**, please provide details:

Name of care service

Address of care service

Telephone number

Email address

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|----------|
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| |
| Postcode |
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| |

Please detail your professional, or care qualifications that are relevant to the services that are to be provided at the establishment or agency

| Date | Name of examining body | Qualification obtained |
|------|------------------------|------------------------|
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Original certificates or other suitable evidence relating to qualifications are to be provided in person by the applicant.

Registration with professional bodies

Please provide the following information if registered with a professional body

| Professional body | Date of Registration | Level of Registration | PI Number (if applicable) | Expiry Date |
|-------------------|----------------------|-----------------------|---------------------------|-------------|
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Examples of professional bodies would include, the General Medical Council, the General Social Care Council or the Nursing and Midwifery Council

SECTION 4 - continued

Relevant work experience

Please complete if you are either the Responsible Person **or** the Provider who is also managing the service. Please give details of the relevant experience and ability you have which will enable you to manage the establishment:

Management of this specific type of service

Experience of work with service recipient group proposed

Staff management and support

Day to Day administration

SECTION 4 - continued

Referees

Please give the name and address of two referees:

- they must not be related to you;
- our reference request will ask for details of your competence to provide the service for which you are applying for;
- one of the referees must be your current or last employer.

Referee 1: Name

Job title

Address

Telephone number

Capacity in which you are known to referee

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|----------|
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| |
| Postcode |
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Referee 2: Name

Job title

Address

Telephone number

Capacity in which you are known to referee

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| |
| Postcode |
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Please go to Section 5

SECTION 5 - The Service

Proposed use:

Please indicate the days and times the provision is to be operated.

Will this be:

All year round

School term times only

School holidays only

Other

Occasional

If other or occasional, please provide details:

An indication of the size of the proposed service, (for example number of users including age group)

Please state:

The total number of service recipients who will be on the premises at any one time

| Age Range | Proposed maximum number |
|-----------|-------------------------|
| | |
| | |
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| | |

Will you have sole use of the premises?

Yes

No

If **No**, please provide details:

Is the premises currently used for the proposed provision?

Yes

No

If **Yes**, please provide details:

SECTION 5 - continued

Please state any separate facilities for use by staff:

| |
|--|
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Are meals to be provided? (this includes packed lunches):

| |
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Property ownership

Please provide:

The name and address of the person/company who owns the premises if different from the applicant:

| | |
|---------|----------|
| Name | |
| Address | |
| | |
| | Postcode |

Name and address of parties with financial interest in the premises and/or the business: (e.g. Loan company)

| | |
|---------|----------|
| Name | |
| Address | |
| | |
| | Postcode |

Name and address of professional advisers (e.g. Accountants, solicitors) from whom confirmation of ownership and financial arrangements can be sought:

| | |
|---------|----------|
| Name | |
| Address | |
| | |
| | Postcode |

Insurance

Please enclose with this Application a copy of a Certificate of Insurance to cover Employers Public Liability

Rented property

If you are renting a property for the establishment, please enclose a copy of the lease or Short Particulars with this application.

Please go to Section 6

SECTION 6 - Description of premises

Please enclose a site plan of the interior and exterior of the property

Location of premises (Please indicate distance from local amenities, for example, shops, post office, park)

Condition of premises (please ✓)

Purpose built Converted for use To be developed

Building work (if property is to be developed/under construction)

Does the premises have planning approval for the proposed provision? Yes No

If **Yes**, please enclose a copy of the approval notice.

If **No**, please give details of pending action:

What is the projected date of completion?

Use of premises

Is any other business to be carried on in the same premises as those of the service? Yes No

Does the premises have occupied accommodation **not** connected to the care service? Yes No

If **Yes**, please provide details:

For providers using domestic premises - e.g. Children's Homes, Learning Disability Homes

Purpose built House Flat

Other Please detail:

SECTION 6 - continued

For non-residential services and body corporate where files/documents not held at the service.

Please describe arrangements that exist for:

Out of hours emergency access

Out of hours telephone contact

Please provide the name and contact details of the principal keyholder:

Please go to Section 7

SECTION 7 - Security Arrangements

Please provide a statement as to the security arrangements for the purpose of:

Safeguarding access to information/records held by the service (both on and off site)

Restricting access from adjacent premises or, when the premises form part of a building, from other parts of the Building (if applicable)

Please go to Section 8

SECTION 8 - Staffing

Please fill in details of **all** staff aged sixteen or over, including maintenance and domestic staff. Please continue on a separate sheet if necessary, or provide a separate staffing list showing the information requested below.

| Title | Full name | Date of Birth | Proposed position | Qualifications |
|-------|-----------|---------------|-------------------|----------------|
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Suitability of staff

Please confirm that you have or will obtain for the following for **each member of staff**:

| | Already obtained | Will obtain | Comments |
|--|--------------------------|--------------------------|----------|
| Information relating to their relevant qualifications, skills and experience | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| A statement that they are physically and mentally fit for the work which they are to perform | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Proof of identity (i.e. A copy of a birth certificate, passport, driving licence) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| A recent photograph | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Two satisfactory references | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| A Disclosure and Barring Service (DBS) check for each member of staff | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Please state how you have satisfied or intend to satisfy yourself that the qualifications, skills and experience of all staff are suitable and authentic.

SECTION 9 - Disclosure and Declarations

Please note that further information may be required by the Registering Authority to establish the financial viability of the establishment.

Have you ever:

been involved as an owner or manager of, or had a financial interest in, a voluntary or registered service whose registration has been refused or cancelled?

Yes

No

If you have answered **YES** to the above questions, please supply below the dates, circumstances, outcomes, the name of the local authority area in which you were living and, if applicable, any social services departments from other local authorities who were involved. (Please use an additional sheet of paper if necessary)

Are you disqualified from registration as listed in the Regulation of Care Act 2013 Sections 43, 44, 45 and 46?

Yes

No

If you have answered **YES** please provide details:

Are you applying for an exemption from disqualification?
Please see the Regulation of Care Act 2013 Section 47

Yes

No

If you have answered **YES** please provide details:

Disclosure Document - Criminal Convictions & Investigations

You are required to declare any convictions, cautions, conditions/unconditional discharges and bindovers. This includes declaring all 'spent convictions' in accordance with the Rehabilitation of Offenders Act (Exemption Order) 2001 and Rehabilitation of Offenders Act (Exemption Order) 1975 (UK).

A criminal conviction will not necessarily lead to a refusal of your application. However, failure to disclose any convictions could lead to either your application being refused or, if your application is successful, cancellation of your registration if it is subsequently learnt that you had a criminal conviction at the time you made the application.

Have you ever:

- been convicted of a criminal offence, cautioned or bound over by any court? **Yes** **No**
- Are you currently under police investigation? **Yes** **No**

If **Yes**, please give details:

In addition, please indicate whether you have ever been:

- subject to child protection enquiry/investigation? **Yes** **No**
- subject to adult protection enquiry/investigation? **Yes** **No**
- Investigation/proceeding under any Act on the Isle of Man or any Act in other jurisdictions? **Yes** **No**

Employed by, or in any way associated with, an establishment/agency which has been the subject of:

- Police investigation **Yes** **No**
- Registration and Inspection Unit investigation **Yes** **No**
- Child Protection investigation **Yes** **No**
- Adult Protection investigation **Yes** **No**

If **Yes** to any of the above, please give details including dates:

Please complete and sign the declaration below:

I hereby declare that the information detailed above is accurate to the best of my knowledge. I understand that it is an offence knowingly to make a statement which is false or misleading in a material respect in this application or any of the documents submitted with this form as part of this application.

In making this application for registration under the Regulation of Care Act 2013. I agree to comply with the Act and all associated regulations. I agree to comply with the standards in place for the service.

I understand that the Department of Health and Social Care will undertake any background searches it feels appropriate, including criminal conviction checks, personal and financial references and social service checks to ascertain suitability.

I understand in order to carry out the background searches the Department may seek information from the following: Social Service records, Child protection registers, Health Services, Mental Health Services, International Social Services, Ministry of Defence, previous employers, the lists kept under the Disclosure and Barring Scheme.

Other organisations which may be contacted include: the NSPCC, Ofsted, other previous registering authorities, the Probation Service, the Work Permit Office, Immigration, the Electoral Roll and any other organisations the Department believes it is necessary to approach in order to reach an opinion as to the suitability of an applicant.

Signed

**Individual /
Responsible Person /
Partner**

Print Name

Date

Issued by:

Registration and Inspection Team
Department of Health and Social Care
1st Floor, Belgravia House
34-44 Circular Road
Douglas, Isle of Man
IM1 1AE

Tel: +44 1624 642422

Email: RandI@gov.im

| Checklist for new service providers | Tick |
|---|--------------------------|
| Completed application form | <input type="checkbox"/> |
| Fee | <input type="checkbox"/> |
| A business plan for the care service | <input type="checkbox"/> |
| A record of the policies and procedures for the service | <input type="checkbox"/> |
| A copy of the last two annual reports and accounts of the care service (if any) | <input type="checkbox"/> |
| An organisational chart for the staff employed by the care service | <input type="checkbox"/> |
| A site plan of the interior and exterior of the property | <input type="checkbox"/> |
| Evidence confirming compliance with the regulations on water supply and water fittings relating to safe storage and outlet temperatures to prevent legionellosis and scalding | <input type="checkbox"/> |
| An electrical inspection certificate showing the premises comply with the current Electricity at Work Regulations and Wiring Regulations | <input type="checkbox"/> |
| Certificate or report that shows compliance with current gas safety regulations | <input type="checkbox"/> |
| A report that shows compliance with current food hygiene regulations | <input type="checkbox"/> |
| A fire risk assessment and a report on any recommendations issued by the relevant fire authority if required | <input type="checkbox"/> |
| Where applicable, a copy of the lease of the premises of the care service | <input type="checkbox"/> |
| Where applicable, a certificate of lift safety | <input type="checkbox"/> |
| The statement of purpose of the care service | <input type="checkbox"/> |
| A financial reference (arranged by the R and I upon completed document by provider) | <input type="checkbox"/> |
| Appropriate Certificates of Insurance. For example:- * Building and Contents * Use of car on business * Employer Liability * Public Liability | <input type="checkbox"/> |
| Planning approval - Planning permission has been received | <input type="checkbox"/> |