


DCOP Partnership	Health Information and Quality Authority (HIQA) Application to renew registration of a designated centre for older people (DCOP)	
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Designated centre name (Max. 100 Characters)	
Registered provider name (Partnership name)	
Centre ID (OSV)	
Current registration number	
Registration expiry date	

Please check this registration pack applies to you.

You should make sure:

- ☐ You are applying to **renew** your current registration.
- ☐ The **partnership** is currently registered as the registered provider carrying on the business of the designated centre. ☐
- ☐ You are providing a residential service for **older people** (DCOP).

Your registration pack to renew registration is made up of three sections.


We will process your application on receipt of:

- **Section 1.** Application Form (including statement of purpose and floor plans), and
- **Section 2.** Application Fee.

Your application should also be accompanied by:

- **Section 3.** Prescribed Information.

Please read our guidance when completing each section. Our guidance is available to download from our website www.hiqa.ie.

DCOP Section 1	Health Information and Quality Authority Application form	 Health Information and Quality Authority <small>An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte</small>
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Section 1.1 Designated centre details

Centre address	
Eircode	
Centre phone number	
Fax number (if applicable)	N/A
Website (if applicable)	N/A <input type="checkbox"/>
Date the centre was established (if applicable)	N/A <input type="checkbox"/>
What is the number of beds at the designated centre you are applying to renew ?	
Are you applying to register new beds with this application?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes , please state the number of additional beds you wish to register.	

Section 1.2 Facilities and Services

Please state if the designated centre comprises one or more **buildings**? Please tick **one** box and complete either subsection 1.2.1 **or** subsection 1.2.2

Subsection 1.2.1 Designated centre is comprised of **one** building. ☐

Subsection 1.2.2 Designated centre is comprised of **more** than one building. ☐

Subsection 1.2.1 Designated centre is comprised of **one** building

Is the applicant owner or tenant?	Owner <input type="checkbox"/>	Tenant <input type="checkbox"/>
If you ticked tenant , please state the owner's name and address (including Eircode).		
Please state the start and end date of the lease agreement	Start date	End date
Will the applicant or any staff member reside at the designated centre?	Applicant	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Staff member	Yes <input type="checkbox"/> No <input type="checkbox"/>

Subsection 1.2.2 Designated centre is comprised of **more** than one building.

How **many** buildings does the designated centre comprise?

Please complete '**subsection 1.2.3 building details**' for each building where the designated centre is comprised of more than one building.

Subsection 1.2.3 Building details

Building 1.

Building address			
Eircode			
Number of beds in this building you are applying to register			
Is the applicant owner or tenant?	Owner <input type="checkbox"/>	Tenant <input type="checkbox"/>	
If you ticked tenant , please state the owner's name and address			
Eircode			
Please state the start and end dates of the lease agreement	Start date	End date	
Will the applicant or any staff member reside at the building?	Applicant	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Staff member	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Subsection 1.2.3 Building details (cont.)

Building 2.

Building address		
Eircode		
Number of beds in this building you are applying to register		
Is the applicant owner or tenant?	Owner <input type="checkbox"/>	Tenant <input type="checkbox"/>
If you ticked tenant , please state the owner's name and address		
Eircode		
Please state the start and end dates of the lease agreement	Start date	End date
Will the applicant or any staff member reside at the building?	Applicant	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Staff member	Yes <input type="checkbox"/> No <input type="checkbox"/>

Subsection 1.2.3 Building details (cont.)

Building 3.

Building address		
Eircode		
Number of beds in this building you are applying to register		
Is the applicant owner or tenant?	Owner <input type="checkbox"/>	Tenant <input type="checkbox"/>
If you ticked tenant , please state the owner's name and address		
Eircode		
Please state the start and end dates of the lease agreement	Start date	End date
Will the applicant or any staff member reside at the building?	Applicant	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Staff member	Yes <input type="checkbox"/> No <input type="checkbox"/>

If your designated centre comprises of more than three buildings, please continue on a separate photocopy of section 1.2.3.

Section 1.3 Registered provider (Partnership)

Partnership **name**

Email (for billing purposes)¹

Please tick **one box** and go to the relevant section.

There has been no change to the partnership information submitted with your previous application to register or renew.

☐

Please go to subsection 1.4.1 (page 8), subsection 1.4.2 (page 9) and subsection 1.4.3 (page 10).

There has been a change to the partnership information submitted with your previous application to register or renew.

☐

Please go to section 1.4 (page 8) and complete the section in full including updated information and also complete subsection 1.4.1 (page 8), subsection 1.4.2 (page 9) and subsection 1.4.3 (page 10).

¹ You can specify a separate email for the payment of the annual fee. If this is blank it will be sent to the registered providers email for address.

Section 1.4 Registered provider details (Partnership)

Address of the principle place of business of the partnership	
Eircode	
Phone number of the principle place of business of the partnership	
Email address of the partnership	
Number of partners in the partnership	
Subsection 1.4.1 Registered Provider Representative*	
Name of registered provider representative	(Title, Name, Surname)
Business phone number for the registered provider representative (during office hours)	
Business mobile number for the registered provider representative	
Business email address for the registered provider representative	

* For a definition of the 'Registered Provider Representative' please read our guidance available to download from our website www.hiqa.ie.

Subsection 1.4.2 Partnership authorisation

Please select from **one** of the following options.

1.	Each partner named in this section is independently authorised to act on behalf of the partnership.	<input type="checkbox"/>
2.	All partners must jointly act on behalf of the partnership.	<input type="checkbox"/>

Please state the name or names of the partner or partners that have been authorised by the partnership to act on behalf of the partnership.

Name	Surname
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please continue on a separate photocopy of this section, if necessary.

Subsection 1.4.3 Partnership authorisation declaration

All partners must sign the partnership authorisation declaration

We, the undersigned partners, authorise each partner named in subsection 1.4.1 (page 9) to act on behalf of the partnership in relation to the registration or renewal of registration of a designated centre.

Title, Name, Surname	Signature	Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please continue on a separate photocopy of this section, if necessary.

Section 1.5 Management and staff details

Name of the **person in charge**[†] of the designated centre.

Name or names of each **person participating in management**[†] at the designated centre.

Please continue on a separate photocopy of this section, if necessary.

[†] Please read our guidance for the definition of a person in charge and a person participating in management. Our guidance is available to download from our website www.hiqa.ie.

Section 1.6 Contact person

Name of the contact person [†] (for the purpose of processing the registration pack)	
Business phone number (during office hours)	
Business mobile number (optional)	
Business email address	
What is the person's role ?	

Section 1.7 Information you must submit with your application form

A complete [§] application must include the following information.	Enclosed
1. A copy of final floor plans as-built to scale, for each building that comprises the designated centre. On the plans you must: <ul style="list-style-type: none"> ▪ Outline in red all parts of the designated centre. ▪ Outline in blue all overnight accommodation (bedrooms).^{**} 	<input type="checkbox"/>
2. You must enclose a copy of the statement of purpose and function with this application.	<input type="checkbox"/>
3. You must enclose proof of payment of application fees in the form of an Electronic Funds Transfer (EFT) with this application.	<input type="checkbox"/>

[†] Please read our guidance for the definition of a contact person. Our guidance is available to download from our website www.hiqa.ie.

[§] You must submit a complete application as per the Health Act 2007 and regulations thereunder.


^{**}For more detailed guidance please refer to the Registration renewal and variation application handbook which is available on our website www.hiqa.ie

Section 1.8 Declaration by the registered provider

I, the undersigned, having been authorised to do so, declare on behalf of the partnership that the information I have provided in this application form is true to the best of my knowledge and belief.

Name (print)	
Position	Partner <input type="checkbox"/> Authorised signatory for and on behalf of the partnership** <input type="checkbox"/>
Signed	
Date	
Contact number (during office hours)	

** A letter of authorisation notifying the Chief Inspector of the appointment of an authorised signatory must be sent by post in advance of the authorised signatory exercising signing authority. This letter must contain certain information which is set out in our Regulatory Notice which is available to download from our website www.hiqa.ie

DCOP Section 2	Health Information and Quality Authority Application fee^{††}	 Health Information and Quality Authority An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte
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Section 2.1 What is the application fee?

The application fee must accompany your application.		Paid	Date paid
Application to renew	€500	<input type="checkbox"/>	


Section 2.2 How to pay the application fee?

You should:

- **Pay** via Electronic Funds Transfer (EFT).
- **Quote** the following information to the bank when making your payment.

Centre ID (OSV)	This number has been issued to you by HIQA.
Centre name	Name of the designated centre.
Account name	Health Information and Quality Authority
Bank name and address	Danske Bank, 3 Harbourmaster Place, IFSC, Dublin 1, D01 K8F1
Bank sort code	95-15-99
Account number	80006688
IBAN	IE94 DABA 9515 9980 0066 88
Swift/BIC	DABA IE 2D

^{††} Each application must be accompanied by the application fee as per the Health Act 2007 and regulations thereunder.

DCOP Section 3	Health Information and Quality Authority Prescribed information	 Health Information and Quality Authority <small>An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte</small>
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You must complete either section 3.1 (page 16) **or** section 3.2 (page 17).

Please tick **one** box and go the associated section.

Section 3.1	There has been no change in the prescribed information supplied with the previous application. <input data-bbox="1348 609 1385 645" type="checkbox"/>
Section 3.2	A statement of each change, where there has been a change to prescribe information supplied with the previous application. <input data-bbox="1348 743 1385 779" type="checkbox"/>

Section 3.1 There has been no change in the prescribed information supplied with the previous application

The following prescribed information must accompany your application to renew form.	Enclosed	Recently submitted
1. HIQA National Vetting Bureau Invitation Form completed by each partner. ^{§§}	<input type="checkbox"/>	<input type="checkbox"/>
2. Copy of a current Garda vetting disclosure for the person in charge.	<input type="checkbox"/>	<input type="checkbox"/>
3. Copy of a current Garda vetting disclosure for each person participating in management.	<input type="checkbox"/>	<input type="checkbox"/>
If you have ticked the ' recently submitted ' box above, please provide the centre name, centre ID (OSV), and date the documentation was submitted. ^{***}		

^{§§} HIQA National Vetting Bureau Invitation Form to be completed by each partner is enclosed with your registration pack.

^{***} Please read our guidance for an explanation of recently submitted and valid documentation. Our guidance is available to download from our website www.hiqa.ie.

Section 3.2 A statement of each change, where there has been a change to prescribed information supplied with the previous application

Has there been a change to the prescribed information for the registered provider ? Please tick either the 'Yes' or 'No' box:	Yes	No
1. Photo identification for each partner.	<input type="checkbox"/>	<input type="checkbox"/>
2. Details of any previous experience by the partners of carrying on the business of a designated centre or similar service.	<input type="checkbox"/>	<input type="checkbox"/>
Has there been a change to the prescribed information for the person in charge ? Please tick either the 'Yes' or 'No' box:	Yes	No
1. Information supplied in the personal information form.	<input type="checkbox"/>	<input type="checkbox"/>
2. Photo identification.	<input type="checkbox"/>	<input type="checkbox"/>
3. Relevant qualifications.	<input type="checkbox"/>	<input type="checkbox"/>
Has there been a change to the prescribed information for any person participating in management ? Please tick either the 'Yes' or 'No' box:	Yes	No
1. Information supplied in the personal information form. ^{†††}	<input type="checkbox"/>	<input type="checkbox"/>
2. Photo identification.	<input type="checkbox"/>	<input type="checkbox"/>
3. Relevant qualifications.	<input type="checkbox"/>	<input type="checkbox"/>

^{†††} Personal information form is enclosed with your registration pack.

Section 3.2 A statement of each change, where there has been a change to prescribed information supplied with the previous application

In addition to a statement of each change, the following prescribed information must accompany your application to renew form.	Enclosed	Recently submitted
1. Updated prescribed information that has been changed since the previous application.	<input type="checkbox"/>	<input type="checkbox"/>
2. HIQA National Vetting Bureau Invitation Form completed by each partner. ^{†††}	<input type="checkbox"/>	<input type="checkbox"/>
3. Copy of a current Garda vetting disclosure for the person in charge.	<input type="checkbox"/>	<input type="checkbox"/>
4. Copy of a current Garda vetting disclosure for each person participating in management.	<input type="checkbox"/>	<input type="checkbox"/>
If you have ticked the ' recently submitted ' box above, please provide the centre name, centre ID (OSV), and date the documentation was submitted. ^{§§§}		

^{†††} HIQA National Vetting Bureau Invitation Form to be completed by each partner is enclosed with your registration pack.

^{§§§} Please read our guidance for an explanation of recently submitted and valid documentation. Our guidance is available to download from our website www.hiqa.ie.

You should **post** your registration pack to:

Registration Office

Regulatory Support Services

Health Information and Quality Authority

Unit 1301, City Gate

Mahon, Cork

T12 Y2XT

Telephone no: (021) 240 9340

Email: registration@hiqa.ie