

Registration under the Health and Social Care Act 2008   
(as amended)

**Application to add a location to an approved regulated activity.**

Application by an existing service provider

July 2023

Applications under section 19 of the Health and Social Care Act 2008   
(as amended)

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| This form must only be used by:  **Existing service providers applying to add a location to  an approved regulated activity.**  It must not be used by:   * Service providers (‘providers’) to apply for registration. * Providers to add or remove a regulated activity. * Providers to cancel their registration. * Managers for any purpose. |

Providers are registered to carry on regulated activities. Conditions of registration apply to each regulated activity separately.

**It is an offence under the Health and Social Care Act 2008 (as amended) (the ‘Act’) for registered providers to fail to comply with any condition of registration attached to that regulated activity without reasonable cause (section 33 of the Act). If you commit such an offence you could be prosecuted, and it could lead to the cancellation of your registration.**

There is more information about registration to carry on regulated activities and guidance on how to apply to remove or vary conditions of registration on our website: www.cqc.org.uk.

**Fees**

**Before you complete Section 2 of this form, you are strongly advised to read the guidance about service types that can be found in the** *Guidance about the Regulations for Providers*

**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**.

These guidance documents are available on our website.

**Confidential personal information**

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**

All of the following must have a **registered manager** in respect of the regulated activities carried on at each location:

* Partnerships
* Organisations (excluding NHS bodies in relation to healthcare regulated activities)
* Providers who are individuals who will not be in day-to-day charge of carrying on the regulated activity in this application.

Managers can sometimes manage more than one regulated activity and/or location (see the relevant guidance on our website).

If any location added 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 (or activities) with the same conditions on their registration at the same location(s),

then the manager(s) does 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’).

If you intend any registered managers already working for you to manage the regulated activity (or activities) at the location(s) in this application, they must submit forms to add (and if necessary remove) regulated activities and/or locations, as needed.

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 complete the appropriate forms. Our website form finder pages will help them to do so. You must submit all required manager’s form(s) with this application via email.

**Sales and transfers of existing services and locations**

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 the Care Quality Commission (CQC) knows about this. There is space in this form for you to tell us when this is the case; please make sure you complete it 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.

**Completing this form**

You must provide an answer to every field marked with an asterisk (\*). Other fields are optional but if you have the information please provide it. We will return any incomplete.

If you use a computer to complete the form, you can submit it by attaching it to an email – this is the quickest and easiest way to make applications to CQC.

This form has been prepared as a ‘protected’ Word document. This 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 when the box is highlighted. If you need to make a change to your answers, use your ‘page up’ key, up arrow key, or mouse to go backwards.

You cannot use the spell check function or format text with bullet points in protected Word documents. If you want to check spelling or use bullet points, type or paste your text into a blank new document, correct any spelling errors, add any bullet points, and then copy and paste it into the appropriate 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 expand while you type, if needed.

**Additional sections**

If you are applying to add **more than one** location, you will need to download, complete and submit additional sections. There is information about this within the relevant sections in this form.

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 do not attach all the additional location sections required we will have to return your application.**

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**Section 1: Application details**

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| --- | --- |
| **1.1 Details of the service provider**  † You can find your Provider ID is found at the top right-hand side of your certificate of registration. | |
| \*CQC Provider ID† |  |
| \*Name of provider |  |
| \*Address line 1 |  |
| \*Postcode |  |

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

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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 failure to submit the required application(s) will result in the application form being returned. |

**Statement of Purpose**

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| --- |
| The law says that your Statement of Purpose must be up to date. You are changing the details of your registration, so you must send us an amended copy of the Statement of Purpose that covers the locations in this application.  **If you do not, we will return your application to you.** |

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| \*2.1 Location Readiness |
| You must not begin to provide regulated activity (or activities) at a new location until that location is included in your conditions of registration. Do not Submit this application if your location is not ready to be assessed as this will result in your application being returned. |

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| **\*2.2 Purchase or transfer of existing location(s)** | | | | | |
| Is this application the result of the purchase or a transfer of a service for which a different provider is already registered under the Health and Social Care Act 2008 (as amended)? | | | | | |
| Yes | |  | No |  |  |
| If ‘Yes', please fill in the details of the existing registered provider below: | | | | | |
| \*CQC provider name |  | | | | |
| \*CQC Provider ID (if known) |  | | | | |
| \*Business telephone number |  | | | | |
| \*Business email address |  | | | | |
| **CQC may need to contact the existing provider regarding this application.  Please check/tick if you do not wish CQC to contact the existing provider regarding this application. Check/Ticking this box may result in delays to processing your application.** | | | |  |  |

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| **\*2.3 Details for Location number:** | | **1** | **of:** |  | **locations** |
| CQC Location ID (if known) |  | | | | |
| \*Name of location |  | | | | |
| \*Address line 1 |  | | | | |
| \*Town/city |  | | | | |
| \*Postcode |  | | | | |
| \*Business/mobile telephone number |  | | | | |
| No of places or beds (\*if applicable) | | | | |  |
| \*Business Email address |  | | | | |

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| **\*2.4 Planning consent** | | | | | | | | |
| Does this location have planning consent to provide the regulated activity (or activities) you intend to carry on there? | | | | | | | | |
| Yes | |  | No |  | Not applicable | |  |  |
| T | | | | | | | | |
| Local authority |  | | Date of consent received (dd/mm/yyyy) | | |  | |  |
|  | | | | | | | | |
| Where you have indicated **no** or **not applicable** and you do not have planning consent, please explain why it is not needed or why it is not yet received. | | | | | | | | |
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| **\*2.5 Food safety** | | | | | | |
| 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 |  |  |
| Where you have not registered with the Environmental Health Department or if you have indicated this is not applicable please explain why. | | | | | | |
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| **\*2.6 Building Regulations** | | | | | | |
| Is there Building Regulations approval for any applicable building works undertaken at this location? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
|  | | | | | | |
| Where you have indicated **no** or **not applicable** and the relevant Building Regulations Certificates have yet to be issued, please tell us when you expect to receive them. | | | | | | |
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| **\*2.7 Safety of equipment, plant and utilities** | | | | | | |
| 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 |  | Not applicable |  |  |
| 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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| **\*2.8 Landlord/Mortgage lender permission** | | | | | | |
| Where you do not own this location, do you have your landlord’s written permission to use it to carry on the regulated activity (or activities) you intend to provide there?  Where you do not own this location and you have a mortgage, do you have the mortgage lender’s written permission to use it to carry on the regulated activity (or activities) you intend to provide there? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
|  | | | | | | |
| Where you do not have the landlord’s or mortgage lender’s permission, please explain why it is not needed or not yet received. | | | | | | |
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| **\*2.9 The regulated activities you will carry on at this location** | | |
| Please check/tick the regulated activities you want to carry on at this location. These are defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended), Regulation 3 and Schedule 1.  **Note: You cannot apply to carry on regulated activities that you are not already registered to provide with this application. If you wish to add a regulated activity, a different form is available for this.** | | |
| Personal care – (RA1) |  |  |
| Accommodation for persons who require nursing or personal care – (RA2) |  |  |
| Accommodation for persons who require treatment for substance misuse – (RA3) |  |  |
| Treatment of disease, disorder or injury – (RA5) |  |  |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 – (RA6) |  |  |
| Surgical procedures – (RA7) |  |  |
| Diagnostic and screening procedures – (RA8) |  |  |
| Management of supply of blood and blood derived products – (RA9) |  |  |
| Transport services, triage and medical advice provided remotely - (RA10) |  |  |
| Maternity and midwifery services – (RA11) |  |  |
| Termination of pregnancies – (RA12) |  |  |
| Services in slimming clinics – (RA13) |  |  |
| Nursing care – (RA14) |  |  |
| Family planning service - (RA15) |  |  |

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| **\*The services provided at this location** | |
| **Before you complete this section, you are strongly advised to read the ‘Guidance for providers on meeting the regulations’.**    **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** | |
| Please check or tick **ONLY** the service types that will be provided at this location. | |
| **Healthcare services** | |
| **Acute services (ACS)**  If you have checked/ticked this service type, but the only or main activity provided at this location is one of those listed below, please **also check/tick 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 check/tick 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:   |  |  | | --- | --- | | (a) Does your hospice service provide overnight beds for patients?  (Please complete even if your service also includes  community or outreach services.) |  | | (b) 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)** |  |
| **Residential substance misuse treatment/rehabilitation services (RSM)** |  |
| **Community or integrated healthcare** | |
| **Community health care services (CHC)**  Please also tick if you are a nursing agency only |  |
| **Doctors consultation services (DCS)** |  |
| **Doctors treatment services (DTS)** |  |
| **Dental services (DEN)**  If this is a single location only 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 carry on activities at or from 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:**   |  |  | | --- | --- | | (a) If you are registering as an organisation or a partnership and provide diagnostic and screening services as your sole or main activity, please check/tick this box |  | | (b) 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 check/tick 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)** |  |

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| **For Primary Medical Service providers only**  Please select what type of location this is. | |
| **NHS GP practice** |  |
| **NHS out-of-hours service** |  |
| **Urgent care centre** |  |
| **Minor injury unit** |  |
| **Walk-in centre** |  |
| **Other** |  |
| **Please check/tick the box if you are a dispensing practice** |  |

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| **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 the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 2.9 and either the service type ‘Care home service without nursing’ or ‘Care home service with nursing’ at Section 2.10**. If this does not apply to you go straight to Section 2.13.**  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 2.3 (number of places or beds). We will contact you if we decide we cannot agree to your proposed number for this condition. | | |
| I/We agree in writing to the condition of registration shown above, using the number of places or beds we proposed in Section 2.3 of this form |  |  |

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| **2.12 Condition of registration about not providing nursing care at this location** | | |
| Only check / tick the box below if you checked / ticked the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 2.9 **AND** the service type‘Care home service without nursing (CHS)’ at Section 2.10. **If this does not apply to you please go to Section 2.13.**  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.”** | | |
| I/We agree in writing to the condition of registration shown above |  |  |

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| **\*2.13 Condition of registration about the regulated activity (or activities) at this and other locations** | | |
| 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 Section 2.9.** | | |
| I/We agree in writing to the condition of registration shown above |  |  |

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| **\*2.14 Service user bands** | | | | | | | | |
| Please look at our [**guidance on service user bands**](https://www.cqc.org.uk/guidance-providers/registration/service-user-bands) before you complete this section.  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 “Whole population”.  **Who will use the services at this location?**   General public (all GPs and most primary medical services should select this)  Specific groups (e.g. only people with mental health needs or specific age groups) | | | | | | | | |
| **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 disability or autistic spectrum disorder | | |  | | Physical disability | | |  |

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| --- | --- | --- |
| \***2.15 Condition of registration about providing a specialist service to people with a learning disability or people with a learning disability and autism.** | | |
| [**(See Guidance on agreeing to routine conditions)**](http://www.cqc.org.uk/applicationhelp62)  **This section only applies if you:**   * have applied for **ANY** of the following regulated activities:   + Accommodation for persons who require nursing or personal care   + Personal care   + Assessment or medical treatment for persons detained under the Mental Health Act 1983   **AND**   * have **NOT** selected the service user band of Learning disability or autistic spectrum disorder in section 2.14 above.   **If this does not apply to you, go straight to section 4 below.**  If this location will provide community or residential adult social care services  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for care or support is as a direct result of the person’s learning disability and or autism at or from [this location].’**  If this location will provide in-patient mental health services.  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for assessment or treatment is as a direct result of the person’s learning disability and or autism at or from [this location].’**  Note: We are adding this condition because you will not be providing a specialist service to people with a learning disability or autistic people. Because of this we will not assess your ability to deliver a service in line with [**Right support, right care, right culture**](https://www.cqc.org.uk/guidance-providers/autistic-people-learning-disability/right-support-right-care-right-culture).  If want to provide a specialist service to people with a learning disability or autistic people in the future, you can apply to remove the condition. We must approve your application before you start providing the service. | | |
| We agree in writing to the condition of registration shown above |  |  |

**Important**: Please note if you have not agreed to the condition above because you are intending to provide a specialist service to people with a learning disability and autistic people you will also need to submit an [additional form](https://www.cqc.org.uk/sites/default/files/2022-06/20220504_additional_form_for_providers_of_services_for_autistic_people_and_people_with_%20learning_disabilities.docx) to support your application process.

**Section 3: How you will provide your service**

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| **\*3.1 Please describe how you will ensure this location will be safe and that the service provided will be caring, responsive, effective and well-led** |
|  |

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| **3.2 Supporting notes** |
| Please use this space to provide any additional information needed to support your application. |
|  |

**Section 4: Application declaration**

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| **PLEASE READ THE DECLARATION CAREFULLY BEFORE SIGNING**  This is an application under [section 19(1)(a)(b)(c) of the Health and Social Care Act 2008](https://www.legislation.gov.uk/ukpga/2008/14/section/19)  By submitting this application, you confirm:   * you have informed all the relevant parties of this application (for example, directors or partners) * you are authorised to submit this application * you will meet the requirements of the 2009 and 2014 Regulations for each regulated activity that you will carry on at this location   And you understand that:   * it is an offence to make false or misleading statements in this application. If you do so, this application could be refused and you may be liable for prosecution. This is covered under [section 37 of the Act](https://www.legislation.gov.uk/ukpga/2008/14/section/37#:~:text=37False%20statements%20in%20applications&text=%282%29If%2C%20in%20an,is%20guilty%20of%20an%20offence) * it is an offence to carry out any regulated activities without an active CQC registration * you are responsible for all regulated activities until your registration ends   **Privacy**  You understand that the data you have given and other personal data that CQC may obtain, will be used as set out in our [privacy policy.](https://www.cqc.org.uk/about-us/our-policies/privacy-statement)  The person who signs below must be one of the following:  The person who signs below must be one of the following, for a/an:  **Organisation:** Any individual authorised to do so by the Organisation  **Partnership:** A registered member of the partnership  **Individual:** The individual |

|  |  |  |
| --- | --- | --- |
| I/we confirm that I/we understand and accept this declaration |  |  |

We will accept a typed-in name as a signature.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \*Authorised signatory |  | | | |
| \*Authorised signatory full name | Title | First | Middle | Last |
| \*Date of signing (dd/mm/yyyy)  (Do not enter your date of birth) |  | | | |
| \*Role / job title |  | | | |
| \*Business email address |  | | | |

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

Please submit this application via email to CQC, making sure that all required additional forms and documents are included.

**Failure to submit all required additional forms will result in your application being returned.**

The checklist below lists the documents that you need to include with your application**.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Form or document** | | | | **Done** |
| Statement of purpose | **Failure to submit an updated Statement of Purpose will result in your application be returned.** | | |  |
| Additional location sections as needed | Number of locations I/we are applying to add to my/our registration. |  |  |  |
|  |
|  |
| Number of additional location sections submitted with this application. |  |  |
|  |
|  |
| Registered manager application forms  (Where applicable) | Number of locations in this application that will have a registered manager. |  |  |  |
|  |
|  |
| Number of manager application forms of all types submitted with this application. |  |  |
|  |
|  |
| Please check or tick this box to confirm that the appropriate number of registered managers have also submitted applications for registration | | | |  |

**Where to send your application:**

You should **email** completed form(s) and all required accompanying documents to:

[**HSCA\_Applications@cqc.org.uk**](mailto:HSCA_Applications@cqc.org.uk)

You must attach all forms and documents to the same email.

If you do not submit all required forms and information your application will 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**.

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