



***APPLICATION FOR LICENSING AS A SERVICE PROVIDER  
OF REGULATED ACTIVITIES UNDER  
CHAPTER 582 – SOCIAL CARE STANDARDS AUTHORITY***

**OFFICE BASED SOCIAL WELFARE SERVICES**

**THIS APPLICATION MUST BE COMPLETED IN FULL BY THE PERSON RESPONSIBLE FOR THE SERVICE PROVISION BEING APPLIED FOR.**

**(FILL IN BLOCK LETTERS AND BLUE INK)**

## SECTION 1: DETAILS OF SERVICE PROVIDER

NAME OF ORGANISATION:			
TYPE OF ORGANISATION:	GOVERNMENT DEPARTMENT GOVERNMENT AGENCY VOLUNTARY ORGANISATION PUBLIC LIMITED COMPANY PRIVATE LIMITED COMPANY LIMITED LIABILITY PARTNERSHIP JOINT VENTURE SUBSIDIARY NOT-FOR-PROFIT ORGANISATION OTHER	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
IF 'OTHER' PLEASE SPECIFY:			
ORGANISATION REGISTRATION NUMBER (WHERE APPLICABLE):			
OFFICIAL/REGISTERED ADDRESS OF ORGANISATION:			
LOCALITY:		POSTCODE:	
EMAIL ADDRESS:			
WEBSITE:			
TELEPHONE NUMBER:			
FAX:			
SOCIAL WELFARE SERVICES PROVIDED BY THE ORGANISATION (LIST ALL SOCIAL WELFARE SERVICES PROVIDED BY THE ORGANISATION, INCLUDING TYPE OF SERVICE AND GENRE):			

## SECTION 2: DETAILS OF SERVICE BEING APPLIED FOR

<b>NAME</b> OF SOCIAL WELFARE SERVICE:			
<b>CLASSIFICATION</b> OF SOCIAL WELFARE SERVICE:	<ol style="list-style-type: none"> <li>1. OLDER PERSONS</li> <li>2. PERSONS WITH DISABILITY</li> <li>3. MINORS (under 18 years of age)</li> <li>4. VICTIMS OF DOMESTIC VIOLENCE</li> <li>5. SERVICES FOR FAMILIES</li> <li>6. SOCIAL WELFARE SERVICES AT HEALTH INSTITUTIONS</li> <li>7. PERSONS WITH ADDICTIONS RELATED TO DRUGS, ALCOHOL, GAMBLING</li> <li>8. OTHER (specify below) _____</li> </ol>		<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>
<b>TYPE</b> OF SOCIAL WELFARE SERVICE: [A SEPARATE APPLICATION <b>MUST</b> BE COMPLETED FOR <b>EACH</b> TYPE OF SOCIAL WELFARE SERVICE PROVIDED]:			
<b>AGE BRACKET</b> OF SERVICE USERS			
DATE OF STARTING OF OPERATION OF SOCIAL WELFARE SERVICE:			
ADDRESS (where social welfare service is provided from):			
LOCALITY:		POSTCODE:	
EMAIL ADDRESS:			
WEBSITE:			

TELEPHONE NUMBER:	
REGISTERED COMPANY/VOLUNTARY ORGANISATION NUMBER (WHERE APPLICABLE):	
DETAILS OF THE FINANCIAL RELATIONSHIP BETWEEN THE SOCIAL WELFARE SERVICE ABOVE-MENTIONED AND THE ORGANISATION. IN PARTICULAR, STATE WHETHER THE PROVISION OF THE SOCIAL WELFARE SERVICE IS FINANCIALLY DEPENDANT ON THE ORGANISATION (WHERE APPLICABLE):	
STATEMENT OF AIMS AND OBJECTIVES [Part of Requirement No. 1 in Section 5 entitled SUPPORTING DOCUMENTATION/STATEMENTS]	
STAFFING [Requirement No. 11 in Section 5 entitled SUPPORTING DOCUMENTATION/STATEMENTS]	
EVALUATING THE SERVICE:  TELL US HOW YOU EVALUATE THE SOCIAL WELFARE SERVICE YOU PROVIDE:	

DECLARATION OF MANAGER

[Being the person entrusted to complete this Application Form on behalf of the Organisation]

I DECLARE THAT THE DETAILS IN THIS FORM ARE TO THE BEST OF HIS/HER KNOWLEDGE ACCURATE AND COMPLETE. TICK BOX TO CONFIRM

**OR**

DECLARATION OF \_\_\_\_\_ (Designation)

\_\_\_\_\_ (Name/Surname)

[Being the person entrusted to complete this application form on behalf of the Organisation]

I DECLARE THAT THE DETAILS IN THIS FORM ARE TO THE BEST OF MY KNOWLEDGE ACCURATE AND

COMPLETE. TICK BOX TO CONFIRM

### **SECTION 3: DETAILS OF LEGAL RESPONSIBLE PERSON (LRP) AND THE MANAGER**

Every Service Provider is to have a Legal Responsible Person (LRP) and a Manager, who will be responsible for the overall administration of the social welfare service (the 'service') being provided. The LRP is the person responsible for the service and for the Manager. The Manger is to ensure that the daily operations of the service abide by the laws, regulations, policies and procedures in place at any given time. The Manager is to report to the LRP about the administration and the organisation of the service.

The LRP and the Manager will be served with notices and/or any other documentation including communication in relation to inspection visits and reports.

The LRP confirms that the Manager has been appointed following robust and thorough selection and recruitment procedures and practices. The LRP confirms that the Manager is a fit and suitable person to act as a Manager of the social welfare service in question.

**PART A: DETAILS OF LEGAL RESPONSIBLE PERSON (LRP)**

NAME AND SURNAME:	
I.D. CARD NO:	
DATE OF APPOINTMENT AS LRP:	
MOBILE NUMBER:	
EMAIL ADDRESS:	
FAX:	
OFFICE ADDRESS:	

**REGISTRATION WITH PROFESSIONAL BODIES (where applicable):**

PROFESSIONAL BODY	DATE OF REGISTRATION	ROLE IN PROFESSIONAL BODY	EXPIRY DATE

I hereby declare that I do not and will not act as a medical practitioner for any service user of the proposed care service. Tick box to confirm.

**Tick the below and submit a Police Conduct Certificate as required in Section 5.**

1) I have NO convictions recorded against me whether in Malta or elsewhere

**If YES, give details and mark the below:**

2) I have the following prosecutions ongoing or pending whether in Malta or elsewhere

\_\_\_\_\_

3) I have the following convictions recorded against me

\_\_\_\_\_

**PART B:            DETAILS OF MANAGER**

NAME AND SURNAME:

I.D. CARD NO:

DATE OF APPOINTMENT:

MOBILE NUMBER:

EMAIL ADDRESS:

FAX:

OFFICE ADDRESS:

DETAILS OF THE MANAGER'S SKILLS, KNOWLEDGE, QUALIFICATIONS AND EXPERIENCE

REGISTRATION WITH PROFESSIONAL BODIES (where applicable):

PROFESSIONAL BODY	DATE OF REGISTRATION	DATE OF REGISTRATION	EXPIRY DATE

I hereby declare that I do not and will not act as a medical practitioner for any user of the proposed care service. Tick box to confirm.

**Tick the below and Submit a Police Conduct Certificate as required under Section 5.**

1) I have NO convictions recorded against me whether in Malta or elsewhere

**If YES, tick the below and include details:**

2) I have the following prosecutions ongoing or pending whether in Malta or elsewhere

\_\_\_\_\_

3) I have the following convictions recorded against me

\_\_\_\_\_



## SECTION 4: DECLARATIONS BY LRP & MANAGER OF SERVICE

- I agree to co-operate with the Authority regarding this Application Form;
- I authorise the Authority to release information for the purpose of verification of information forwarded to the Authority;
- I confirm that with regard to the service provision involving minors, clearance in terms of the Protection of Minors (Registration) Act, Chapter 518 of the Laws of Malta, was sought. I confirm that evidence of this is kept in file;
- I confirm that all the staff employed by the Organisation hold the necessary and relevant qualifications;
- I confirm that the details and information in this Application Form are to the best of my knowledge true, accurate and complete;
- I agree to abide by any conditions imposed by the Authority in accordance with standing legislation;
- I agree to inform the Authority of any changes.

**LEGAL RESPONSIBLE PERSON:**  I declare further that I act in the capacity of a Legal Responsible Person authorised by the Social Welfare Service Provider to submit this Application Form

NAME IN FULL OF LEGAL RESPONSIBLE PERSON \_\_\_\_\_

SIGNATURE OF LEGAL RESPONSIBLE PERSON \_\_\_\_\_

DATE OF SIGNING (DD/MM/YYYY): \_\_\_\_\_

**MANAGER:**  I declare further that I act in the capacity of a Manager authorised by the Social Welfare Service Provider to submit this Application Form

MANAGER'S FULL NAME: \_\_\_\_\_

SIGNATURE OF MANAGER \_\_\_\_\_

DATE OF SIGNING (DD/MM/YYYY) \_\_\_\_\_

## SECTION 5: SUPPORTING DOCUMENTATION / STATEMENTS

**BEFORE SUBMITTING THE COMPLETED APPLICATION FORM, CHECK THAT YOU HAVE INCLUDED ALL THE DOCUMENTS ASKED FOR HEREUNDER:**

Below please find a list of documentation that is required to be submitted together with this Application Form:

**1. Statement Purpose (detailed description about the Social Welfare Service being provided)**

Amongst other, this should include:

- The aims and objectives of the Social Welfare Service provided
- The service group, including the age of the client group, to whom the said Social Welfare Service is being provided to
- The maximum number of service users
- The current number of service users

**2. Management/Organisational Structure**

Amongst other, this should include:

- Details of the size of the Organisation
- Details of any Associated Entities within the Organisation (where applicable)
- The number of officers, partners or individuals concerned in the management or control of the Organisation
- A diagram or description showing the management structure of the Organisation

**3. History of the Organisation**

Describe briefly the history of the Organisation, including:

- The Date of incorporation/association
- Any change/s in name
- Details of any previous involvement in the delivery of care
- Any association with other organisations or individuals involved in the provision of care

**4. Copy of the Certificate of Registration / Voluntary Organisation Certificate**

**5. Manual of Policies and Procedures of the Organisation**

Your policies, procedures and statement should detail how the service intends to meet the needs of the service users and should have regard to the size of the service, the statement of aims and objectives and the number and needs of service users.

FOR  
OFFICE  
USE  
ONLY

**6. Risk Assessment Report in accordance with the Occupational Health and Safety legislation issued by a competent person.**

The Service Provider is to ensure that the Risk Assessor carrying out the required risk assessment is a Competent Person. The Service provider shall ensure that the Assessors would be in Possession of an academic qualification - Diploma from the University of Malta (or any foreign institution duly recognised by the UOM) in Health and Safety, or an equivalent qualification certified by MQRIC to be at level 5 or higher in the subject, ii) has experience and competence in the field;

The report shall include the signature of the Risk Assessor, the date when the assessment is to be reviewed and any other information as per **ACT XXVII of 2000, the Occupational Health and Safety Authority Act.**

**A list of registered competent persons is available**

at: <http://ohsa.org.mt/Portals/0/Docs/Competent%20Person%20Reg/2019/20190821CompetentPersons.pdf>

**7. Declaration confirming evidence of Insurance Arrangements for regulated activity, which must include cover for employees, premises and service users**

**8. The official, PA PERMIT & approved floor plan of the premises from where the social welfare service is being provided:**

**9. Staffing**

Provide a list of employees employed by the social welfare service provider

Please tell us how the service will be staffed, based on the number of people using the service and their needs. Tell us the type of staff you will have (including management, care and ancillary), posts proposed and the qualifications staff require to have.

It would be ideal to include also the whole-time equivalent number of staff required to deliver and manage direct care (whole-time equivalent is considered to be 40 hours per week).

Details of staff induction and ongoing training and development provided.

Include also the procedures adopted in vetting volunteers' ability/suitability.

The list of employees employed by the social welfare service provider should include in a separate sheet the following:

Name & Surname	Designation	Name of Service Provider they are employed by	Full-time OR Part-time	Volunteer or Employed

**10. Detailed Curriculum Vitae of the Manager**

**11. Police Conduct Certificate of the Legal Responsible Person**

A new certificate shall be submitted by the Service Provider upon the lapse of 6 months from the date of issue of the Police Conduct Certificate

**12. Police Conduct Certificate of the Manager**

A new certificate shall be submitted by the Service Provider upon the lapse of 6 months from the date of issue of the Police Conduct Certificate

**13. Protection of Minors Act (POMA) Certificate (applicable if primary or secondary service users are under 18 years of age)**

# STATEMENT ON DATA PROTECTION

Failure to sign the Statement on Data Protection will automatically return the Application Form to the applicant.

The person signing the Statement on Data Protection must be the Legal Responsible Person.

A signed scanned copy of the Statement on Data Protection is to be e-mailed together with the Application Form.

**DECLARATION:**

I/WE UNDERSTAND THAT SOCIAL CARE STANDARDS AUTHORITY ('SCSA') WILL USE THE INFORMATION PROVIDED IN THIS FORM (INCLUDING PERSONAL DATA) AND OTHER RELEVANT INFORMATION THAT IT OBTAINS OR RECEIVES, FOR THE PURPOSES OF PERFORMING ITS REGULATORY FUNCTIONS IN ACCORDANCE WITH THE SOCIAL CARE STANDARDS AUTHORITY ACT (CHAPTER 582 OF THE LAWS OF MALTA.)

INFORMATION (INCLUDING CONTACT INFORMATION AND OTHER PERSONAL DATA) MAY ALSO BE SHARED WITH OTHER REGULATORS AND GOVERNMENT BODIES WHERE NECESSARY OR EXPEDIENT TO ASSIST THEM IN CARRYING OUT TASKS IN THE PUBLIC INTEREST.

SCSA WILL USE AND PROTECT PERSONAL DATA IN ACCORDANCE WITH THE NEW DATA PROTECTION ACT, 2018 (CHAPTER 586 OF THE LAWS OF MALTA).

SIGNATURE OF LEGAL RESPONSIBLE PERSON:

\_\_\_\_\_

LEGAL RESPONSIBLE PERSON'S FULL NAME:

\_\_\_\_\_

DATE OF SIGNING (DD/MM/YYYY):

\_\_\_\_\_

**THIS APPLICATION FORM DULY FILLED IN, TOGETHER WITH THE RELEVANT ATTACHMENTS, IS TO BE SUBMITTED TO THE SOCIAL CARE STANDARDS AUTHORITY, AT 469, BUGEJA INSTITUE, ST. JOSEPH HIGH ROAD, SANTA VENERA, SVR 1012. ADDITIONALLY, A SCANNED COPY/A SOFT COPY OF THE APPLICATION FORM AND ATTACHMENTS, IS TO BE FORWARDED TO THE AUTHORITY ON [info.scsa@gov.mt](mailto:info.scsa@gov.mt)**