



CITY OF NEW BEDFORD HEALTH DEPARTMENT
1213 Purchase St. New Bedford, MA 02740
508-991-6199

ANNUAL ROOMING HOUSE LICENSE ADVISORY

Per 105CMR.410.020: Rooming House means every dwelling or part thereof which contains one or more rooming units in which a space is let or sublet for compensation by the owner or operator to four or more persons not within the second degree of kindred to the person compensated. Boarding houses, hotels, inns, lodging houses, dormitories and other similar dwelling places are included, except to the extent that they are governed by stricter standards elsewhere created; provided that the provision of 105CMR 410.000 shall not apply to any hospital, sanatorium, convalescent or nursing home, infirmary, or boarding home for the aged licensed by the Department of Public Health in accordance with the provisions of M.G.L. Ch. 111§51 or 71.

Dear License Applicant:

The Board of Health wishes to remind you that your Rooming House license will expire on December 31st. The fee(s) for the annual license is \$180.00 for the first 20 rooms and \$12.00 per additional room.

Please complete and submit the following:

- ❖ Rooming House License application.
- ❖ Commonwealth of Massachusetts, Workers' Compensation Insurance Affidavit: General Business
- ❖ Copy of Workers Compensation Insurance (if applicable)

All applications received after December 1st will incur a late filing fee of 20%.

All incomplete or incorrect applications will be returned.

Please contact us at 508-991-6199 to make an inspection appointment for license renewal.

Payment for the license must be made in the form of a check, money order or postal note payable to the City of New Bedford, cash is not accepted.

All applications must be filed at or mailed to: **City of New Bedford Health Department**
1213 Purchase Street – 1st fl
New Bedford, MA 02740

If you have any questions or require further assistance, please contact the Health Department @ (508) 991-6199. This will be your only reminder. Thank you for your cooperation.

Very truly yours,

New Bedford Board of Health

FOR BOARD OF HEALTH USE ONLY

DATE RECEIVED	DATE INSPECTED	APPROVED BY	PERMIT FEE: \$ _____	PERMIT ISSUED
			LATE FEE: \$ _____	DATE: _____
			TOTAL FEE = \$ _____	ID#: _____

CITY OF NEW BEDFORD HEALTH DEPARTMENT

1213 Purchase Street – New Bedford, MA 02740

508- 991-6199

ANNUAL APPLICATION FOR ROOMING HOUSE LICENSE**FEE: \$180.00 (plus \$12 per room in excess of 20 rooms)*****New business application must be submitted at least 30 days prior to proposed opening date.******Renewal applications received after December 1st, will be charged a 20% late filing fee.*****Payment is due with application**

Per 105CMR.410.020: Rooming House means every dwelling or part thereof which contains one or more rooming units in which a space is let or sublet for compensation by the owner or operator to four or more persons not within the second degree of kindred to the person compensated. Boarding houses, hotels, inns, lodging houses, dormitories and other similar dwelling places are included, except to the extent that they are governed by stricter standards elsewhere created; provided that the provision of 105CMR 410.000 shall not apply to any hospital, sanatorium, convalescent or nursing home, infirmary, or boarding home for the aged licensed by the Department of Public Health in accordance with the provisions of M.G.L. Ch. 111§51 or 71.

PLEASE PRINT CLEARLY**Check type of application:** ☐ **New (Initial)** ☐ **Renewal** ☐ **Amended****1) Establishment Trade Name:****2) Establishment Address:****3) Establishment Mailing Address (if different):****4) Establishment Telephone No.: ()****Fax No.: ()****5) Number of Rooming Units :****6) Applicant Name:****Applicant's Title:****7) Applicant Address: _____ TELEPHONE No.: () _____****Applicant's E-mail Address:****8) Establishment Owner's Name:****(First) _____ (Last) _____ (MI) _____****Association, Corporation, Partnership, Legal Entity Name: (if applicable)****9) Owner's Address (if different from applicant):****10) Establishment is OWNED by: (Check one)**

- ☐ Association
☐ Corporation
☐ Individual
☐ Partnership
☐ Other Legal Entity

11) If owned by a corporation or a partnership, give name, title and home address of officers or partner(s) as registered with the Secretary of State:***(Please provide an attachment if necessary)*****Officer/Partner's Name****Title****Home Address****12) Establishment is:****(Check one)**

- ☐ Part of Chain
☐ Independent

(First) (MI) (Last) Yes No

13) Person Directly Responsible for Daily Operations (Owner, Person in Charge, Supervisor, Manager etc.): Name: _____ Title: _____ Telephone No: () _____ Address: _____ Fax Number: () 24 Hour Emergency Number: ()		
14) District or Regional Supervisor (if applicable): Name: _____ Title: _____ Telephone No: () _____ Address: _____ Fax Number: () 24 Hour Emergency Number: ()		
15) Style of Rooming House: (Check only one) <input type="checkbox"/> Boarding House <input type="checkbox"/> Dormitory <input type="checkbox"/> Hotel <input type="checkbox"/> Inn <input type="checkbox"/> Lodging House <input type="checkbox"/> Motel <input type="checkbox"/> Other Similar Dwellings	16) <div style="background-color: yellow; padding: 5px;">Number of units:</div>	
16) Is your establishment currently permitted by the Board of Health for any of the following services/operations? <input type="checkbox"/> YES (If yes, check all that apply) <input type="checkbox"/> NO <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Caterer's Permit Establishment <input type="checkbox"/> Retail Food Establishment <input type="checkbox"/> Special Purpose Pool/Spa </div> <div> <input type="checkbox"/> Food Service Establishment <input type="checkbox"/> Public or Semi-Public Swimming Pool <input type="checkbox"/> Tanning Salon </div> </div>		
17) Do you have a current City of New Bedford Business Certificate registered with the City Clerk's Office? <input type="checkbox"/> Yes <input type="checkbox"/> No		
18) A Worker's Compensation Insurance Affidavit Form and if required, a copy of the Insurance Policy Declaration Page must be included unless one is already on file with the Health Department and current. Please Check One only: <input type="checkbox"/> On File and Current <input type="checkbox"/> See Attached document (s)		
19) Municipal Real Estate Property Information: Plot #: _____ Lot #: _____ Owner's Name: _____ Owner's Address: _____		
20) Water Source:	DEP Water Supply Number: (if applicable)	21) Sewage disposal:
22) Days / Hours of Operation:		23) No. of Employees:

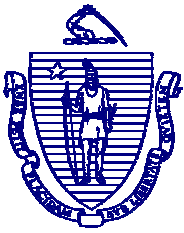
24) Establishment Owner's Tax Identification Number as reported to Massachusetts Department of Revenue:
 ✓ *If owned by an individual:* ☐ Date of Birth (D.O.B.) _____ ☐ Social Security Number: _____
 ✓ *If owned by an association, corporation, partnership, or other legal entity:*
☐ Federal Employer Identification Number: _____

Pursuant to MGL c. 62C, sec. 49A, I certify under the penalties of perjury that the owner (s) of this establishment, to the best of my knowledge and belief, have filed all applicable tax returns and paid all taxes required under law. I, the undersigned, attest to the accuracy of the information provided in this application, and affirm that this Rooming House operation will comply with 105 CMR 410.000 and all other applicable law. I acknowledge that I have been instructed by the Health Department on how to obtain copies of 105 CMR 410.000 Minimum Standards of Fitness for Human Habitation (State Sanitary Code Ch. II) by internet access at www.mass.gov/eohhs/docs/dph/regs/105cmr410.pdf.

As the license holder, I understand that I must immediately discontinue operations affected by an *imminent health hazard* and notify the Board of Health in accordance with 105 CMR 410.000. Imminent health hazards include but are not limited to: Fires, Floods, Extended interruption of Electrical or Water Service, Sewage Backup, misuse of poisonous or toxic materials, onset of an apparent food borne illness outbreak, gross unsanitary occurrences or condition, or any other circumstance that may endanger public health. (A license holder need not discontinue operations in an area of an establishment that is unaffected by the imminent health hazard).

25) Owner's / Authorized Officer's Signature – Print name, title, sign and date below:
 Print Name: _____ Title: _____
 Signature: _____ Date: _____

Reminder: Consistent with M.G.L. Ch.270, Section 22 and per order of the New Bedford Board of Health, Rooming Houses must prohibit smoking on the premises in all common areas at all times and post smoke-free notices in a clear and conspicuous manner at each entrance, restrooms, and common areas upon the premises. A designated smoking room in a hotel, motel, inn, bed and breakfast, lodging home or rooming house shall be clearly marked as a designated smoking room on the exterior of all entrances from a public hallway and public spaces; and in the interior of the room. These areas in which smoking is allowed shall be conspicuously designated as smoking areas and be adequately ventilated to prevent the migration of smoke to non-smoking areas. Signage is available at the New Bedford Health Department or online at www.makesmokinghistory.com/secondhand-smoke



The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information

Please Print Legibly

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity.
[No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name: _____

Insurer's Address: _____

City/State/Zip: _____

Policy # or Self-ins. Lic. # _____ Expiration Date: _____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to \$250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature: _____ Date: _____

Phone #: _____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ Permit/License # _____

Issuing Authority (circle one):

1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person: _____ Phone #: _____

Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an **employee** is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An **employer** is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that **"every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required."** Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111

Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE

Fax # 617-727-7749

www.mass.gov/dia