NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
NURSING HOME LICENSURE AND CERTIFICATION SECTION
2711 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2711
TELEPHONE: (919) 855-4520

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2024
NURSING HOME APPLICATION - INITIAL
(Including Adult Care Home Beds in Combination Facilities)

LEGAL IDENTITY OF APPLICANT:

_____

_____
{Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.}

DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:

PRIMARY: _____
Other: _____

FACILITY MAILING ADDRESS:

Street/P O Box: _____

City: _____ State: _____ Zip: _____-_____

FACILITY SITE ADDRESS:

Street: _____

City: _____ County:_____

Telephone: (____)_____ Zip: _____-_____ Fax: (____)_____

E-mail Address for Administrator: _____

PART A OWNERSHIP AND MANAGEMENT DISCLOSURE

1. The following information is required by Nursing Home Licensure Rule 10A NCAC 13D .2101.

   a. What is the name of the **LEGAL ENTITY** with the ownership responsibility and liability? If it is a Corporation, please write the exact wording of the corporate office name as on file with the NC Secretary of State. If the legal entity is a Unit of Government, please write the name of the unit which has ownership responsibility and liability for the services offered.

      NAME: _____

   b. Mailing Address:

      _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Fax: (____)
Senior Officer: _____

c. Indicate the Percent of Ownership of the Legal Identity: _____

d. Is legal entity: (check one)
For Profit _____ Not For Profit _____

e. Is the legal entity a: (check 1, 2, 3 or 4)

(1) PROPRIETOR ____

(2) LIMITED LIABILITY CORPORATION _____

(3) PARTNERSHIP __

(a) General ____ If General, where is it registered? County _____
State _____

(b) Limited ____ If Limited, where is it registered? State _____

(c) Is the limited partnership registered with the North Carolina Corporations Division in the NC Department of the Secretary of State?
YES _____ NO _____

(d) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

Name: _____
Title: _____

Address: _____ Percent of Ownership: _____

Name: _____
Title: _____

Address: _____ Percent of Ownership: _____

Name: _____
Title: _____

Address: _____ Percent of Ownership: _____

(4) CORPORATION ___

(a) Where was the corporation originally established? State _____

(b) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

Name: _____
Title: _____

Address: _____ Percent of Ownership: _____

Name: _____
Title: _____

Address: _____ Percent of Ownership: _____

Name: _____
Title: _____

Address: _____ Percent of Ownership: _____

(5) UNIT OF GOVERNMENT

(a) What is the name and title of the official in charge of the above governmental unit?

Name: _____

Title: _____

(b) Check the word which best describes the above type of governmental unit:

CITY _____ COUNTY _____ STATE _____ AUTHORITY ___

2. Does the licensee (legal entity: individual, partnership, corporation or unit) own the building from which services are offered? **YES** _____ **NO** ___

If **NO**, who owns the building?

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____)_____ Fax: (_____)_____

Note: If neither the building owner nor the lessee is shown as the license applicant, explain on a separate page.

3. Is this facility part of a multiple facility system **within North Carolina**? (A multiple facility system is defined as two or more nursing homes or health care facilities under the same ownership.)

YES _____ **NO** _____

If "YES", give the name and address of the multiple facility system (**Parent Company**) located within North Carolina.

a. Name of the Parent Company: _____

b. Mailing Address: _____ c. City: _____

d. State: _____ e. Zip: _____ f. Telephone: (_____)_____

g. Name of Senior Officer: _____

4. Does the facility operate under a management contract?

YES _____ **NO** _____

If "YES", give the name, address and name of chief executive officer of the organization that manages the facility.

a. Name of Organization: _____

b. Mailing address: _____ c. City: _____

d. State: _____ e. Zip: _____ f. Telephone (_____)_____

g. Name of Chief Executive Officer: _____

PART B OPERATIONS
PROVIDE NAMES FOR THE FOLLOWING:

1. FACILITY PERSONNEL

a. Full-time administrator as required in 10A NCAC 13D .2201(c).

Name of Administrator:
First name_____ Middle initial_____Last name _____
Date Hired As Administrator: _____ N. C. License No.: _____

b. Nursing
1. Director of Nursing:
First full name _____ Middle initial_____Last name _____
Date Hired as DON : _____ N. C. License No.: _____

c. Activity Director:

d. Dietary Services Director: _____

e. Social Services Director: _____

2. MEDICAL AND DENTAL STAFF FOR EMERGENCY CALL

a. Medical Director's Name Address:
First name _____ _____
Middle Initial _____ _____
Last name _____
e-mail address: _____ N.C. License No:_____

b. Dentist(s) Name(s) Address(es)

1. _____ _____

2. _____ _____
3. _____ _____

3. CONTRACT/OTHER PERSONNEL OR CONSULTANTS

a. Physical Therapist: _____
b. Occupational Therapist: _____
c. Speech Therapist: _____
d. Medical Records: _____
e. Pharmacy Consultant: _____
f. Dietary Consultant: _____
g. Other (i.e. Respiratory Therapist): _____

4. PHARMACY

a. Source of Drugs:
1. Do you have a pharmacy located in your facility? **YES** _____ **NO** _____

2. If "YES", please complete:

Pharmacist Manager: _____

b. If a pharmacy is not located in your facility, what is the name of the pharmacy from which drugs are obtained?

Name: _____

Street Address: _____

City, State, Zip: _____

PART C PATIENT SERVICES

1. Continuing Care Retirement Communities (CCRC)

a. Is the facility licensed by the Department of Insurance as a "Continuing Care Retirement Community"? a. **YES** ___ **NO** _____

2. Is the facility a "Combination Facility", thereby incorporating licensed ACH beds? 2. **YES** ___ **NO** _____
If "Yes", indicate which rules the facility chooses to apply to the operation of these ACH beds. Nursing Home Licensure _____ ACH Licensure_____
*(NH Licensure rules only, ACH rules only, or both NH & ACH licensure rules.** Complete checklist if using both sets of rules.)*

3. **NUMBER OF BEDS BY TYPE (*Must complete required data supplement form)**

a. **Nursing Beds (NF)** **(TOTAL)** a. _____

1. General Nursing Facility Beds
1. _____
2. *Alzheimer's Special Care Unit Resident Beds
2. _____
3. Ventilator Dependent Resident Beds
3. _____

4. Traumatic brain Injury Beds
   4. _____

Are you equipped to accommodate bariatric residents? Y ___ N ____

b. **Adult Care Home (ACH)** **(TOTAL)** b. _____

1. General Adult Care Home Beds 1. _____
2. *Alzheimer's Special Care Unit Resident Beds
   2. _____

Are you equipped to accommodate bariatric residents? Y ___ N ____

c. **TOTAL LICENSED BEDS** **(TOTAL a & b)** c. _____

PART D LICENSE FEE

A non-refundable license fee is required and must accompany this application prior to the issuance of a nursing home license. The payment should be in the form of check, certified check or money order and must be made payable to: "**The Division of Health Service Regulation**." A separate check is required for each licensed entity.

Pursuant to §131E-272, effective August 14, 2009 initial license fees will be $470.00 (base fee) plus $19.00 per bed. Fees for initial licensure effective during the months of October – December will be credited to the license renewal fee.

This application must be completed and submitted to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a nursing home license. The legislation (SB 622, Session Law 2005-276) prohibits a license from being issued if the fee has not been paid.

The undersigned submits this application for licensure for the year 2024 {subject to the provisions of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission} and certifies the accuracy of this information.

_____ _____

Typed Name of Chief Administrative Officer
(Written Signature) or Authorized Official

Title: _____

Date: _____

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