CHANGE LICENSURE APPLICATION PACKET FOR ADULT CARE HOME (7 OR MORE BEDS)

Return the entire packet to

Mailing address of Adult Care Licensure Section:

U.S. Postal Service:
Division of Health Service Regulation
Adult Care Licensure Section
2720 Mail Service Center
Raleigh NC 27699-2720
Attn: License Materials Enclosed

Express/Overnight Courier (FED-EX, UPS):
Division of Health Service Regulation
Adult Care Licensure Section
801 Biggs Drive
Raleigh, North Carolina 27603
Attn: License Materials Enclosed

Adult Care Licensure Section: 919-855-3765

STEPS FOR A CHANGE OF OWNERSHIP
FOR ADULT CARE HOMES WITH 7 OR MORE BEDS

Please read and follow these steps to complete a change of ownership successfully.

1. The prospective licensee shall provide the Healthcare Planning and Certificate of Need Section of the Division of Health Service Regulation NC DHSR: Certificate of Need (ncdhhs.gov) with prior written notice as required by G.S. 131E-184(a)(8) prior to the purchase of the building. The applicant will need one of the following documents:
    a. A letter of exemption from review from the Healthcare Planning and Certificate of Need Section prior to the purchase of the building *(when the applicant or prospective licensee plans to purchase the building)*.
    b. A letter notifying Healthcare Planning and Certificate of Need Section of the intent to change licensee *(when licensee is changing but ownership of building is not)*.

2. The current licensee shall provide written notification of a planned change of licensee to the Division of Health Service Regulation, the county department of social services, and the residents or their responsible **persons at least 30 days prior to the date of the planned change of licensee**.

3. The prospective licensee shall submit the following license application material to the Division of Health Service Regulation:

    (a) The Change Licensure Application for Adult Care Home (7 or more Beds) that is available on the internet website, NC DHSR ACLS: Change Licensure Application Packet for Adult Care Home (ncdhhs.gov) at no cost and includes the following:

4. facility administrator and building owner information;
5. operation disclosure including new licensee information and management company, if any; and
6. ownership disclosure including new owners, principles, affiliates, shareholders, and members;

    a. (b) A fire and building safety inspection report from the local fire marshal dated within the past 12 months

    b. (c) A sanitation report from the sanitation division of the county health department dated within the past 12 months

    c. (d) A nonrefundable license fee as required by G.S. 131D-2.5.

    d. (e) Certificate of occupancy or certificate of compliance from local building officials upon completion of any construction or renovation

    e. (f) Signed letter from previous owner relinquishing ownership (this letter must specify the date of the change in ownership)

    f. (g) Copy of CON letter (Licensure applications cannot be processed without approval or exemption by CON) NC DHSR: Certificate of Need (ncdhhs.gov)
    g. (h) Non-refundable licensure fee of $360.00 plus a per-bed fee of $17.50 by check, money order or certified check and made payable to the "NC Division of Health Service Regulation".

7. **Note**: A compliance history check will be conducted on the prospective licensee. Based on the results of this review, additional information may be requested.
8. The Construction Section of the DHSR must approve any proposed structural changes of building before a license can be approved.

9. Unpaid fines for penalties imposed will result in denial of licensure. License applications will not be processed if there are outstanding/unpaid fines for penalties.

10. New and existing applicants will be required to submit Policy and Procedures for review.

11. Upon receipt of the above documents, the Adult Care Licensure Section will review and contact the prospective licensee for additional information if needed. If all documentation is complete and approved, the Adult Care Licensure Section will process the Change of Ownership and issue a new license to the prospective licensee.

Any information not included in the packet will render the application incomplete and it will not be processed.

ADDITIONAL INFORMATION REGARDING THE ADULT CARE HOME APPROVAL PROCESS

Certificate of Need (CON) Approval

If there will be an increase in the facility's licensed bed capacity, the applicant must first obtain approval from the Healthcare Planning and Certificate of Need Section. (HPCON).

To request an increase in capacity, the licensee or designee should contact the NC DHSR: Certificate of Need (ncdhhs.gov) Section of the Division of Health Service Regulation (DHSR) at 919-855-3873..

The HPCON Section will determine if the proposed increase in capacity is subject to HPCON review and approval and if applicable, a CON application.

If there is no increase in the facility capacity please continue to the submission section.

ALZHEIMER'S AND RELATED DISORDERS SPECIAL CARE UNIT
Submission of Plans and Fees

Plans for new or renovated construction or conversion of a portion of the existing building to a special care unit should be submitted by the licensee or designee, along with documentation of HPCON approval if applicable, to the NC DHSR: Construction Section (ncdhhs.gov) according to 10A NCAC 13F .0304.

Fees for review of construction projects will be invoiced to the provider by the Construction Section. The Construction Section will notify the licensee or designee when building plans are approved so that construction may begin. The contact number for the Construction Section is 919-855-3893.

Submission of For Persons with Alzheimer's and Related Disorders Special Care Unit Policies and Procedures

Facilities that advertise, market or otherwise promote itself as having a special care unit for residents with Alzheimer's disease or related disorders, shall meet the requirements in 10A NCAC 13F .1300Policies and Procedures must be submitted and approved prior to a license designating special care unit status is issued.

Submission of Special Care Unit For Persons with Alzheimer's and Related Disorders Disclosure

The facility shall submit disclosure information, in accordance with § 131D-8 (ncleg.net) and Rule 10A NCAC 13F .1302, to the Adult care Licensure Section. The Adult Care Licensure Section will notify the licensee or designee when the disclosure information has been approved. Approval of the disclosure information is required before a license designating special care unit status can be issued and residents admitted to the unit. The contact number for special care unit disclosure review is 919-855-3765.

Issuance of License for Special Care Unit For Persons with Alzheimer's and Related Disorders

The Construction Section will make on-site visits as necessary and issue approval of the completed project. DHSR Staff and an adult home specialist from the county department of social services will conduct a desk review to determine compliance with special care unit rules and statutory requirements. Once compliance is verified, a

license with special care unit designation will be issued to the facility in accordance with all other applicable rules, regulations and statutes.

FORMAT FOR SPECIAL CARE UNIT DISCLOSURE STATEMENT

Special care unit for residents with Alzheimer's disease or related disorders disclosure statement must address the items in order as listed below. It is to be submitted with the Adult Care Home Initial License Application NC DHSR ACLS: Initial License Application for Adult Care/Family Care Homes (ncdhhs.gov) or the Change Licensure Application NC DHSR ACLS: Change Licensure Application Packet for Adult Care Home (ncdhhs.gov). Any changes to the disclosure statement as submitted must be reported in writing to the Adult Care Licensure Section and written notification must be provided to the residents.

I. Special Care Units for Residents with Alzheimer's disease or Related Disorders:

(1) A statement of the overall philosophy and mission of the licensed facility and how it reflects the special needs of residents with Alzheimer's disease or other dementias, a mental health disability, or other special needs disease or condition.
(2) The process and criteria for placement, transfer, or discharge to or from the special care unit.
(3) The process used for assessment and establishment of the plan of care and its implementation, including how the plan of care is responsive to changes in the resident's condition.
(4) Staffing ratios and how they meet the resident's need for increased care and supervision.
(5) Staff training that is dementia-specific.
(6) Physical environment and design features that specifically address the needs of residents with Alzheimer's disease or other dementias.
(7) Frequency and type of programs and activities for residents of the special care unit.
(8) Involvement of families in resident care, and availability of family support programs.
(9) Additional costs and fees to the resident for special care.

For the purpose of this application the following definitions apply:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.

(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.

(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.

(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

APPLICABLE REGULATIONS:

§ 131D-2.5. License and registration fees.

(a) The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of three hundred fifteen dollars ($315.00). The Department shall charge each adult care

home with more than six beds a nonrefundable annual license fee in the amount of three hundred sixty dollars ($360.00) plus a nonrefundable annual per-bed fee of seventeen dollars and fifty cents ($17.50).

§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.

(a) Licensure. - Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of G.S. 131E-184(a)(8).

(b) Compliance History Review. - Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. - No new license shall be issued for any adult care home to an applicant for licensure under any of the following circumstances for the period of time indicated:

(1) Was the owner, principal, or affiliate of a licensable facility under this Chapter, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes and was responsible for the operation of the facility that had its license revoked until five years after the date the revocation became effective.

(1a) Was the owner, principal, or affiliate of a licensable facility under this Chapter, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes and was responsible for the operation of the facility that had its license summarily suspended until five years after the date the suspension was lifted or terminated.

(2) Is the owner, principal, or affiliate of an adult care home and is responsible for the operation of the facility that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department.

(3) Is the owner, principal, or affiliate of an adult care home and is responsible for the operation of the facility that had its license downgraded to provisional status or had its admissions suspended as a result of violations under this Article, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes until six months from the date of restoration from provisional to full licensure, termination of the provisional license, or lifting or termination of the suspension of admissions, as applicable.

(5) Is or was the owner, principal, or affiliate of an adult care home and is responsible for the operation of the facility where outstanding fees, fines, and penalties imposed by the State against the facility have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration under this subdivision.

§ 131D-34. Penalties; remedies

(d1)The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A1 Violation.

N.C. Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
2720 Mail Service Center ■ Raleigh, North Carolina 27699-2720

CHANGE LICENSURE APPLICATION FOR ADULT CARE HOMES

TYPE OF LICENSURE APPLICATION: Adult Care Home
(7 or more beds)

CURRENT FACILITY LICENSE Number-_____-_____-_____

☐ Change of Facility Name ☐ Change of Capacity ☐ Other (specify):_____
☐ Change of Licensee/Ownership

Requested Effective Date of Change:_____
No less than 30 days from the submission of the application and fee.

Note: A Change in Ownership requires a license fee. A Change of Capacity requires a Construction Section review and fee. The Construction Section will invoice the Contact Person listed on the application.

CURRENT INFORMATION (Prior to Change)

1. CURRENT FACILITY NAME: _____

2. CURRENT FACILITY SITE ADDRESS: (NO P.O. BOXES)

Street: _____

City: _____ Zip Code: _____ County: _____

Facility Telephone Number:_____ Fax Number:_____

3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Name of Owner: _____

Address: _____

City: _____ State:_____ Zip Code:_____

Business Contact Phone Number of Applicant/Licensee: _____Fax: _____

DHSR USE ONLY	
License#:	
FID#:	
Region:	
Compliance Check Completed:	
Entry by: _____ Date:_____	Reviewed by: _____ Date: _____
License Fee: $315.00	

Instructions for Completing a Change Licensure Application

Overview

1. These instructions are provided to assist you in completing a change application.
2. Failure to provide all requested information will result in a delay processing the application. If the information does not pertain to your facility, mark N/A in the applicable area.
3. Change requests must be submitted at least 30 days prior to the anticipated change date.
4. If structural modifications are part of the change, please contact the Construction Section prior to the completion of this application.
5. Requested Effective Date of Change: Enter the date you are requesting the change to be effective. It is understood this date may be delayed depending upon other factors associated with the change.

Type of Licensure Application

Check the appropriate box/boxes for the action you are requesting. If the action is not listed, fill in the blank beside "Other".

- **Change of Facility Name**: There is no fee for a facility name change.
- **Change of Licensee/Ownership**: The fee for a change of ownership is $315.00. Payment must be made by check, money order or certified check and made payable to: Division of Health Service Regulation, Adult Care Licensure Section.
- C**hange of Capacity**: If the change of capacity is an increase, submit photos and a floor plan.

Requested Effective Date of Change

Enter the date you are requesting the change to be effective. It is understood this date may be delayed depending upon other factors associated with the change.

Current Information

- Current Facility License Number: Enter license number on the current license.
- Current Facility Name: Enter name printed on the current license.
- Current Facility Site Address: This address is the physical site location as printed on the current license.
- Current Legal Identity of Ownership/Licensee: This is the name printed on the current license as the licensee/owner. Please enter address, phone and email information.

LICENSE FEE INVOICE

Please submit your licensure fee with the enclosed application. Failure to submit a completed application with licensure fee will result in a delay of your license being issued.

Facility Name: _____ **County: _____**

Facility Type	Base Fee	Number of Beds	Per Bed Fee	Total Fee Due
Adult Care Home	**$360.00**		**$17.50**	

- **A separate check is required for each application submitted.**
- Payment **must** be made by check, money order, or certified check, made payable to: **Division of Health Service Regulation.**
- Write the proposed facility name on the check in the memo line.

ATTACH THE CHECK HERE

Part A. Facility Information

Facility Name:			
Physical Address:	**City:**	**State: NC**	**Zip:**
County:			
Telephone Number:	**Fax Number:**		
If applicable - Please provide your National Provider Identifier Number (NPI) if applicant is an owner of a currently licensed Adult Care Home. *For questions regarding NPI, contact* ***1-800-465-3203 (NPI Toll-Free)***	**NPI:**		

Contact Person and Correspondence Mailing Address: *(Name of person who can make licensure/operation decisions about the facility and address where ALL Correspondence, <u>including the license, will be mailed and emailed</u> from Division of Health Service Regulation.)*		
Name:	**Title:**	
Address:	**Telephone Number:**	
City:	**State:**	**Zip:**
Primary Email:		

CERTIFIED ADMINISTRATOR:	
Name:	
Address:	
Email:	
Telephone Number:	**Fax:**
Administrator Approval Number:	**Expiration Date:**

Part B. Operation Disclosure

LEGAL IDENTITY OF LICENSEE

Licensee Information

- The Licensee is the name of the legal entity licensed to operate the business at that site as indicated in **Part A.**
- The Licensee is responsible for compliance to State rules and laws governing adult care homes.
- Please enter the complete address and phone number(s) for licensee.
- The status of the Legal entity will be verified with the NC Office of the Secretary of State.

Licensee Name:		
Address:		
City:	**State:**	**Zip code:**
Telephone Number:	**Fax Number:**	
The licensee is :	**For Profit** ☐	**Not For Profit*** ☐

The licensee is: (Check one)	
Proprietorship (individual owner) ☐ Corporation (Inc) ☐ Limited Liability Company (LLC) ☐	Partnership (Unincorporated) ☐ Limited Liability Partnership (LLP) ☐ Government Unit ☐
NC Secretary of State ID #:	Registered in Other State: Yes ☐ No ☐

Part C. Officers, Partners, Managers

COMPLETE THE FOLLOWING INFORMATION:

NOTE: The Executive Officer, General Partner, or Managing Member must be an individual, listed by name, not a business entity.

- If the licensee is **not for profit,** the name of each Officer, Director or Trustees.
- If the licensee is a **corporation**, the name and title of each corporate officer.
- If the licensee is **a limited liability company (LLC),** the names of the managing members.
- If the licensee is **a partnership or limited liability partnership (LLP)**, the name of each partner.
- If the licensee is **a governmental unit**, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Executive Officer, General Partner, Managing Member		
Name:	**Telephone Number:**	**Fax Number:**
Address:		
Email:		
City:	**State:**	**Zip:**

Executive Officer, General Partner, Managing Member		
Name:	**Telephone Number:**	**Fax Number:**
Address:		
Email:		
City:	**State:**	**Zip:**

Executive Officer, General Partner, Managing Member		
Name:	**Telephone Number:**	**Fax Number:**
Address:		
Email:		
City:	**State:**	**Zip:**

Part D. Ownership Disclosure

OWNERS, PRINCIPLES, , SHAREHOLDERS, MEMBERS

Complete the information below on **all** individuals who are owners, principles, affiliates, shareholders or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. **If you are the only owner, complete the information below, listing the percentage interest as 100%.**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which you are an owner: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which you are an owner: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which you are an owner: _____

Part E. Majority Ownership Disclosure

MAJORITY INTEREST OWNERS

Complete the information below on **all persons** who hold a **majority** interest in the licensee. A "person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation. A **majority interest** is an interest in the licensee, or in entities who have an interest in the licensee, constituting ownership of more than fifty-percent of the licensee. For the purposes of this disclosure, all persons who hold a **majority interest** in the licensee must be disclosed **regardless of whether the persons hold a direct interest in the licensee**. The disclosure must include parent, grand-parent, or other levels of ownership. **If you are the only majority owner, please move to Part F.**

For ownership that goes above the parent level, include a diagram of the ownership structure including all majority owners.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner: _____

ATTACH OWNERSHIP DIAGRAM WITH THIS APPLICATION:

Part F. Affiliate Disclosure

AFFILIATES

Complete the information below for **all affiliates** of the licensee. "Affiliate" means any person that will directly or indirectly control the facility. "Affiliate" also means any person who will be controlled by a person who will control the facility. In addition, two or more adult care homes which are under common control are affiliates. "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two. Note, an individual or entity need not have an ownership interest in the licensee to be an affiliate. **If there are no affiliates, please move to Part G.**

Management companies and other entities that control a facility's operations are affiliates, including but not limited to entities that control/oversee a facility's clinical or healthcare services, contracts and billing, provision of goods and services, and human resources. **(Attach additional pages as necessary).**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Is the affiliate a management company? Yes ☐ No ☐

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner, principal or affiliate: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Is the affiliate a management company? Yes ☐ No ☐

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner, principal or affiliate: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Is the affiliate a management company? Yes ☐ No ☐

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner, principal or affiliate: _____

Part G. Ownership and Affiliate Disclosure - Confidential Information

The following information will be used to conduct compliance history checks as required by G.S. 131D-2.4. Please provide the last four digits of the social security number or tax EIN for all persons identified in this application, both individual and business entities. This information will be used only as an identification number for internal record keeping and data processing. Incomplete data will delay the application being processed. **(Attach additional pages as necessary).**

Category	Name	Last 4 digits of SSN of Individuals or EIN of Corporation	Contact Number Cell Number	Percentage of interest as reported on pages 10-12 (If Applicable)
Licensee/Owner		***-**-_____ or EIN ___-_____		
Administrator		***-**-_____ or EIN ___-_____		
Officers, Partners and Managers		***-**-_____ or EIN ___-_____		
Officers, Partners and Managers		***-**-_____ or EIN ___-_____		
Officers, Partners, and Managers		***-**-_____ or EIN ___-_____		
Owners, Principals, Shareholders or Members		***-**-_____ or EIN ___-_____		
Owners, Principals, Shareholders or Members		***-**-_____ or EIN ___-_____		

Owners, Principals, Shareholders or Members		***-**-_____ or EIN ___-_____		
Majority Interest Owners		***-**-_____ or EIN ___-_____		
Majority Interest Owners		***-**-_____ or EIN ___-_____		
Majority Interest Owners		***-**-_____ or EIN ___-_____		
Affiliate (Management Company)		***-**-_____ or EIN ___-_____		
Affiliates (Management Company)		***-**-_____ or EIN ___-_____		
Affiliates (Management Company)		***-**-_____ or EIN ___-_____		
Affiliates (Management Company)		***-**-_____ or EIN ___-_____		
Affiliates (Management Company)		***-**-_____ or EIN ___-_____		

Reminder: ***Failure to complete this information will delay the licensing process***

Part H. Building Owner:

Is the building where services are offered leased/ rented? ☐ Yes ☐ No If yes, please complete the following on the building/property owner and provide a copy of the lease agreement.

Name:			
Street/Box:			
City:	**State:**	**Zip:**	**Email:**
Telephone Number:		**Fax Number:**	

I. CAPACITY AND SPECIAL CARE UNIT

☐ **Check here if this Adult Care Home serves <u>Only</u> elderly persons.**

(In accordance with NC G.S. 131D-2.1 (5) – Elderly person means any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.)

Licensed Bed Capacity:

- **Requested Licensed Bed Capacity (as it will appear on License) _____**

Will the facility advertise, market, or promote itself as providing a special care unit for residents with Alzheimer's disease or other dementias pursuant to G.S. 131D-4.6?

§ 131D-4.6. Licensure of special care units.

(a) As used in this section, the term "special care unit" means a wing or hallway within an adult care home, or a program provided by an adult care home, that is designated especially for residents with Alzheimer's disease or other dementias, a mental health disability, or other special needs disease or condition as determined by the Medical Care Commission.

(b) An adult care home that holds itself out to the public as providing a special care unit shall be licensed as such and shall, in addition to other licensing requirements for adult care homes, meet the standards established under rules adopted by the Medical Care Commission.

YES ☐ **NO** ☐

If "YES," prepare a disclosure statement according to the required "Format for Special Care Unit Disclosure Statement" found at https://info.ncdhhs.gov/dhsr/acls/scudisclosure.html and submit it with this application unless such a statement has already been submitted. If your disclosure statement has been revised, please submit the revised statement, which must also be provided to the special care unit residents or their authorized representative.

Alzheimer's Special Care Unit in facility (Rules 13F .1300 apply) # of beds: _____

Authenticating Signature: The undersigned submits this application for licensure in accordance with Article 1 Chapter 131 D of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13F) and certifies the accuracy of this information.

The undersigned must be the applicant licensee or the Executive Officer, Partner, or Managing Member of the licensee.

Signature: Date: _____

Print Name: _____ Phone Number: _____