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 applicant or prospective licensee must contact the Certificate of Need with the Division of Health Service Regulation (DHSR):

    i. To obtain a letter of exemption from review from the Certificate of Need (CON) prior to the obligation to purchase the building *(when the applicant or prospective licensee plans to purchase the building).* Or

    ii. Notifying CON of the intent to change licensee *(when licensee is changing but ownership of building is not)*;

2. The current licensee informs the Adult Care Licensure Section (ACLS) central office, the local county department of social services and the residents or their responsible persons in writing of the proposed change of business ownership and the anticipated date of the change. **This notice should be made at least 30 days in advance of the proposed change.**
3. The Construction Section of the DHSR must approve any proposed structural changes of building before a license can be approved. (See page 4 for review form)
4. 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.
5. The applicant/prospective licensee compiles the following information and submits it to the Adult Care Licensure Section.

    a. Adult Care Home Licensure Change Application to facilitate compliance history check
    b. 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"
    c. Assisted Living Administrator Certificate
    d. Approved fire and building safety inspection reports completed within past 12 months
    e. Approved sanitation inspection report for facility completed within past 12 months
    f. Certificate of occupancy or certificate of compliance from local building officials upon completion of any construction or renovation
    g. Signed letter from previous owner relinquishing ownership (this letter must specify the date of the change in ownership)
    h. Copy of CON letter (Licensure applications cannot be processed without approval or exemption by CON)

6. **Note**: A compliance history will be conducted on the prospective licensee. Based on the results of this compliance additional information may be requested.
7. New providers will be required to submit Policy and Procedures for review. Existing providers must submit policy and procedures upon request.
8. Upon receipt of the above information or packet, 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 issue a new license to the applicant.

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 CON Section.

To request an increase in capacity, the licensee or designee should contact the CON Section of the Division of Health Service Regulation (DHSR) at 919/855-3873.

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

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

Request for Increase in Special Care Unit Capacity

A request for an increase in the number of currently licensed special care unit beds will be subject to the MORATORIUM ON SPECIAL CARE UNIT LICENSES in accordance with Session Law 2015-241, Section 12G.2.

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 CON approval if applicable, to the DHSR Construction Section according to Rule 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 Special Care Unit Policies and Procedures

Facilities that advertise, market or otherwise promote themselves as having special care units shall meet the requirements in 10A NCAC 13F .1300 or .1400, depending on the type of unit, including submission of disclosure information, according to G.S. 131D-8 and Rules 13F .1302 or 13F .1402, to the Adult Care Licensure Section. Policies and Procedures must be submitted and approved prior to issuance of a special care unit license.

Submission of Special Care Unit Disclosure

Facility shall submit the required disclosure statement. 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 919/855-3778.

Issuance of License

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 and arrange for a joint visit, as necessary, to the facility to survey for 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

The adult care home special care unit disclosure statement must address the items in order as listed below. It is to be submitted with the Adult Care Home Initial License Application or the Change Licensure Application. 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) The philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by the unit which shall address, but not be limited to the following;

a) Safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medication;

b) A structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities;

c) Individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and

d) Methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance

(2) The process and criteria for admission to and discharge from the unit;

(3) A description of the special care services offered in the unit;

(4) Resident assessment and care planning, including opportunity for family involvement in care planning, and the implementation of the care plan, including responding to changes in the resident's condition;

(5) Safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior or other behavior management problems;

(6) Staffing in the unit;

(7) Staff training based on the special care needs of the residents;

(8) Physical environment and design features that address the needs of the residents;

(9) Activity plans based on personal preferences and needs of the residents;

(10) Opportunity for involvement of families in resident care and the availability of family support programs and

(11) Additional costs and fees for the special care provided.

II. Special Care Units for Residents with Mental Health or Developmental Disabilities

In addition to all of the above, disclosure must address the following;

(1) Grouping of residents that takes age, interests and behaviors into account;

(2) Ensuring client rights, choice and service coordination [(See Rule 10A NCAC 13F .1405(3)(a)(b)]; and

(3) Safeguarding confidential information and ensuring that such information is not further disclosed in accordance with G.S. 122C-55(f).

Construction Licensure Plan Review
Information For
Adult Care Licensure Section

Please complete this form only if structural changes to the building have been made

Please do not send Construction Section Fee payment for Adult Care Home projects. The Construction Section will bill you.

PLEASE PRINT

Current Name of Facility _____

New Name of Facility (if applicable) _____

Site Address _____

Site City, State, and Zip _____

County _____

Contact Person _____

Contact Phone Number ( )_____

Address _____

Site City, State, and Zip _____

Requested Information:

Applicable Licensure Rules: Adult Care Home Rules (10A NCAC 13F)

Number of beds requested_____

Review For : ___Initial Licensure _____ Capacity Increase ____ Remodeling ____ Other

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Return this form: Adult Care Licensure Section
2720 Mail Service Center
Raleigh, NC 27699-2720
ATTN: License Materials Enclosed

Office Use Only

Date Received_____

FID_____LICENSE NUMBER_____

Team Supervisor/Branch Manager_____

Comments_____

_____

_____

Instructions for Completing a Change Licensure Application

LICENSE APPLICATION FOR ADULT CARE HOMES

READ ALL INSTRUCTIONS BEFORE COMPLETING APPLICATION

Overview

1. These instructions are provided to assist you in completing a change application.
2. Complete all requested information. If the information does not pertain to your facility mark N/A in the area.
3. Change requests must be submitted at least 30 days prior to the anticipated change.
4. Construction related fees will be invoiced to you at a later date (change of capacity).
5. The omission of any information will delay the processing of your application. If you have any questions regarding any area of this application please contact our office 919-855-3765.

The following must be submitted to our office in order to obtain facility license:

1. Original completed application
2. Your licensure fee must accompany this application
3. Signature(s) is required on the application where specified-the application will be returned if not signed and dated
4. Copy of the administrator's current assisted living administrator certificate
5. Disclosure Statement for Special Care Unit if applicable
6. Policies and Procedures for Special Care Unit if applicable
7. Plan Review Form for Construction if structural changes are being made to the existing building.
8. New Providers will be required to submit Policy and Procedures for Review
9. Existing Providers must submit policy and procedures upon request

Type of Licensure Application

1. Check the appropriate box/boxes for the action you are requesting. If the action is not listed, fill in the blank beside “Other”.
2. Requested Effective Date of Change: Enter the date you are requesting the change to be effective. It is understood this date maybe delayed depending upon other factors associated with the change.

Current Information

1. Current Facility License Number: Enter license number on the current license.
2. Current Facility Name: Enter name printed on the current license.
3. Current Facility Site Address: This address is the physical site location as printed on the current license.
4. Current Legal Identity of Ownership/Licensee: This is the name printed on the current license as the licensee/owner. Please complete address & phone information.

Part A: Facility Information

- **Facility Information**-Please complete the applicant information for the facility.
- **Correspondence Mailing Address**-All correspondence coming from DSHR will be sent to this address.
- **Building Owner**-If you rent or have a lease agreement for the building, please give the name of the building owner, their address and business phone number.
- **Certified Administrator**- Complete each field. If more than one certified Assisted Living Administrator, provide information on separate piece of paper. Submit a copy of each certified Assisted Living Administrator's Certificate.

Part B: Operation Disclosure

- A change in licensee **requires** a change application to be submitted with the application
- For a **partnership or limited liability partnership (LLP)**, you ***must provide*** the name of each partner
- For **a limited liability company (LLC),** you ***must provide*** the names of the managing members, attach a list with the names and address of the members of the limited liability company
- For a **corporation**, you ***must provide*** the name and title of each corporate officer
- **Management Company-** Complete information if applicable

Part C: Ownership Disclosure

- Leaving this area blank will delay the process of your application
- List all persons separately who are owners of this business
- If you are the sole owner, you must enter your information as owner of this business
- Enter the name, address, etc of other Adult Care and/or Family Care facilities you own or are affiliated with in this section

Please note the following:

- **10A NCAC 13F .0202** All applications for license shall disclose the names of individuals who are co-owners, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity.
- **SECTION 10.40A.(l) G.S. 131D-34: "§ 131D-34.** Penalties; remedies
  - **(d1)** The Department shall impose a civil penalty on any applicant for licensure who provides false in 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 A Violation.

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 <u>separate check</u> is required for <u>each licensed</u> facility.**
- Payment **must** be by check, money order, or certified check, made payable to: **Division of Health Service Regulation.**
- Remember to write the proposed facility name on the check.

ATTACH THE CHECK HERE

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 FACILITIES

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

CURRENT FACILITY LICENSE Number-_____-_____-_____

☐ Change of Facility Name
☐ Change of Capacity
☐ Change of Licensee/Ownership
☐ Change to Special Care Unit (specify bed Number) _____
☐ Other (specify):_____

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

Note: Change in Ownership requires a license fee. Change of Capacity requires a Construction review and fee.

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 Phone # of Applicant/Licensee: (_____) _____ Fax (_____) _____

DHSR USE ONLY
License#
FID#
Region
Compliance Check Completed ( ) _____
Entry by_____ Reviewed by _____ Date:_____ Date: _____
License Fee:

PLEASE COMPLETE THE APPLICATION FOR NEW APPLICANT

Part A. Facility/Administrator Information

Facility Name:			
Physical Address:	**City:**	**State:**	**Zip:**
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:**	

Correspondence Mailing Address: (where you want to receive all correspondence <u>including the license</u> from Division of Health Service Regulation):

Name:	**Title:**
Address:	**Telephone Number:** ( )
City, State Zip Code:	
Primary Email:	

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:**
Telephone Number: ( )	**Fax Number:** ( )	
Email Address:		

CERTIFIED ADMINISTRATOR

Name:	
Telephone Number: ( )	**Fax: ( )**
Administrator Certificate No.	**Expiration Date:**
Email:	

Part B. Operation Disclosure

LEGAL IDENTITY OF LICENSEE

Licensee Information

- Print name, address and phone number(s)for the facility
- 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 NC rules and laws governing adult care homes
- The status of the Legal Entity will be verified with the NC Secretary of State

Licensee Name:		
Address:		
City:	**State:** NC	**Zip code:**
Telephone Number:	**Fax Number:**	
The licensee is a: (check one) ___ 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. (Attach a copy of the Certificate of Authority issued by NCSOS)**

COMPLETE THE FOLLOWING INFORMATION:

- If the licensee is **not for profit,** the name of each Officer, Director or Trustees.
- If the licensee is **a corporation (Inc)**, 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:		
City:	**State:**	**Zip:**

Name	**Title**
Name	**Title**
Name	**Title**
Name	**Title**

Management Company:

Is the business operated under a management contract? _____Yes _____No. If yes, provide name and address of the management company		
Company Name:		
Contact Name:	**Telephone number:** ( )	
Street/Box:		
City:	**State:**	**Zip:**
Email:		

Part C. Ownership Disclosure

For the purpose of this application the following definitions apply:

The following definitions shall apply throughout this application:

(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.

RELATED AND APPLICABLE RULES
SECTION 10.40A.(l) G.S. 131D-34:

"**§ 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 A Violation.

Part C. Ownership Disclosure

OWNERS, PRINCIPLES, AFFILIATES, 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 Family Care/Adult Care Home in which you are the owner or affiliate:__________
____

Name: ____
Address: ____
City: ______________________________State:____________________Zip Code:_____________________
Phone #: (______) ____________________Fax (_______) ______________________
Email Address:____
Percentage interest in this licensed Facility: __________Title: ____
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:__________
____

Name: ____
Address: ____
City: ______________________________State:____________________Zip Code:_____________________
Phone #: (______) ____________________Fax (_______) ______________________
Email Address:____
Percentage interest in this licensed Facility: __________Title: ____
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:__________
____

Name: ____
Address: ____
City: ______________________________State:____________________Zip Code:_____________________
Phone #: (______) ____________________Fax (_______) __________
Email Address:____
Percentage interest in this licensed Facility: __________Title: ____
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate:__________
____

LICENSED CAPACITY AND SPECIAL CARE UNIT

❑ **Check here if this Adult Care Home serves Only 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.)

☐ **Requested Capacity** _____

☐ **Requested Special Care Unit Capacity**: _____

As defined in **10A NCAC 13F. 1302 SPECIAL CARE UNIT DISCLOSURE**

a. Only those facilities with units that meet the requirements of this Section may advertise market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders.
b. The facility shall disclose information about the special care unit according to G.S. 131D-8 and which address policies and procedures listed in Rule .1305 of this Section.

Authenticating Signature: The undersigned submits this application for licensure in accordance with Article 1 Chapter 131 D-2 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.

Signature: _____ **Date:** _____

Print Name: _____ **Phone Number: (_____)** _____

Part C. Ownership Disclosure – Confidential Information

The following information will be used for internal compliance history checks as required by G.S. 131D-2.4(b). We ask that you voluntarily provide the last four digits of your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing.
Incomplete data will delay the application being processed.

Category	Name	Last 4 digits of SSN of Individuals or EIN of Corporation	Contact Number Cell Number	Percentage of interest as reported on pages 15
Licensee		***-**-________ or EIN ___-________		
Executive Officer		***-**-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		

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

Part C. Ownership Disclosure (Cont.) – Confidential Information				
Category	Name	Last 4 digits of SSN of Individuals or EIN of Corporation	Contact Number Cell Number	Percentage of interest as reported on pages 15
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		
owners, principles, affiliates, shareholders or members		***-**-________ or EIN ___-________		