North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
2708 Mail Service Center
Raleigh, NC 27699-2708

INITIAL LICENSE APPLICATION FOR ADULT CARE/FAMILY CARE HOMES

PLEASE READ CAREFULLY

- Steps to opening a Family Care or Adult Care Home can be found on the DHSR Website: www.ncdhhs.gov/dhsr/acls. Please read this information before completing this application.
- Incomplete applications or applications without a fee will delay the process.
- Your initial fee must accompany this application.
- Complete all blanks, if not applicable mark N/A.

For the purpose of this application the follow 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.

APPLICABLE RULES

"§ 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.

ADULT CARE LICENSURE
INITIAL LICENSE FEE INVOICE

§ 131E-272. Initial licensure fees for new facilities.

The following fees are initial licensure fees for new facilities and are applicable as follows:

Facility Type	Number of Beds	Initial Base Fee	Initial Per Bed Fee
Adult Care	More than 6	$400.00	$19.00
Family Care	6 or Fewer	$350.00	$ 0

Facility Name:_____ **County:** _____

Facility Type	Number of Beds	Base Fee	Per Bed Fee	Total Fee Due

- **A <u>separate check</u> is required for <u>each application</u> submitted.**
- 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 in the memo line.

ATTACH THE CHECK HERE

ADULT CARE LICENSURE SECTION - INITIAL APPLICATION

For Adult Care / Family Care Homes

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 facility and 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:**
Primary Email:		

CERTIFIED or QUALIFIED ADMINISTRATOR: (If the home is 6 beds or less, list your qualified administrator. If the home is 7 beds or more, you **<u>must</u>** include the administrator's certificate number.)	
Name:	
Address:	
Telephone Number: ( )	**Fax: ( )**
Administrator Certificate No.	**Expiration Date:**

DHSR USE ONLY

License # _____ - _____- _____

FID # _____

License Fee: $_____

Date Received: _____/_____/_____

Recorded By _____

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 fill in the full 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

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, attach a list of the names and address of the members of the limited liability company.
- 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**

Management Company:		
Is the business operated under a management contract? ☐Yes ☐No If yes, provide name and address of the management company		
Company Name:		
Owner of Management Company:	**Telephone Number: ( )**	
Street/Box:		
City:	**State:**	**Zip:**

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: ( )**		

Part C. Ownership Disclosure - REQUIRED

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: _____

_____

Part C. Ownership Disclosure (Cont.) - REQUIRED

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:__________

____

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 page 8
Licensee/Owner		***-**-_____ or EIN ___-_____		
Executive Officer/Primary Owner		***-**-_____ or EIN ___-_____		
Administrator		***-**-_____ 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 licensing process***

Part C. Ownership Disclosure (Cont.) – 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 page 8
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 ___-________		

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

Part D. Capacity and Special Care Units

Check if apply:

This Adult Care Home will serve 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.)

Capacity:

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

If Family Care Home: ☐ **Ambulatory** ☐ **1-3 Non-Ambulatory** ☐ **4 + Non-Ambulatory**

(non-ambulatory - unable to leave a building unassisted under emergency conditions**)**

If Adult Care Home:
Will facility advertise, market, or promote as providing a special care unit for residents with special needs such as Alzheimer's disease or related disorders, mental health disabilities, or developmental disabilities?
YES___ NO___

If "YES," prepare a disclosure statement according to the required "Format for Special Care Unit Disclosure Statement" 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.

Check any that apply:

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

Mental Health Disability Special Care Unit (Rules 13F .1400 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/13G) and certifies the accuracy of this information.

Signature: _____ Date: _____

Print Name _____ Phone Number (____) _____

Please be advised, the license fee must be submitted to the Adult Care Licensure Section, Division of Health Service Regulation, prior to the issuance of an Adult Care/Family Care license.