

**CHANGE LICENSURE
APPLICATION PACKET
FOR
FAMILY CARE HOME
(2 TO 6 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 FAMILY CARE HOMES (2-6 Beds)

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

1. The current licensee contacts the county adult home specialist in the local county department of social services (DSS) where the facility is located and informs the adult home specialist of the proposed change of licensee/business ownership. **This contact should be made at least 60 days in advance of the proposed change.**
 - The Construction Section of the Division of Health Service Regulation (DHSR) must approve any proposed structural changes of building.
 - 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.
2. The adult home specialist communicates with the applicant to provide him/her an orientation to adult care and to begin processing a change license application.
3. The current licensee informs the residents or their responsible persons in writing of the proposed change of business ownership and the anticipated date of the change at least 30 days in advance of the change. If needed, the facility will contact the local county DSS for assistance with discharge if desired by any resident.
4. The following information is required to be submitted for administrator approval:
 - Report of Administrator Qualifications for Family Care Homes
 - Documentation of Education (high school diploma, GED certificate, college credits or degree)
 - 3 letters of reference
 - County criminal record check
 - Resume or letter of experience for Administrator In Training (AIT) exemption
 - Rule exam certificate
5. Once the adult home specialist has obtained all needed documentation to complete the application and has assessed the applicant's readiness to be licensed, the adult home specialist will submit the following information to the Adult Care Licensure Section at least 30 days in advance of the anticipated change of ownership:
 - FCH Change Licensure Application
 - Non-refundable License Fee of \$315.00 in the form of check, money order or certified check and made payable to the "NC Division of Health Service Regulation."
 - Packet of administrator documents outlined in #4 above.
 - Letter from previous owner relinquishing ownership (this letter must specify the date of the change in ownership)
 - Approved fire and building safety inspection reports (dated within the previous 12 months)
 - Approved sanitation inspection report (dated within the previous 12 months)
 - New Providers will be required to submit Policy and Procedures for Review. Existing Providers must submit policy and procedures upon request.

6. Upon receipt of the licensing packet, including the license fee, and completion of a compliance review, the Adult Care Licensure Section will notify the prospective licensee of any outstanding documents or actions required for licensure.
7. If all requirements are met, the Adult Care Licensure Section will issue a new license to the applicant within 2 days of the effective date of the change of ownership.
8. Licenses must be renewed annually using the Annual Renewal License Application and submitting a non-refundable annual licensure renewal fee of \$315.00.

**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: Family Care Rules

Number of beds requested _____

Status of Residents:

 ___ All Ambulatory

 ___ Non-Ambulatory, 1-3

 ___ Non-Ambulatory, More than 3

Review For : ___ Initial Licensure ___ Capacity Increase ___ Remodeling ___ Other

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

Overview

1. These instructions are provided to assist you in completing a change application.
2. Failure to provide all requested information will result in delaying the processing of the application. 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. If structural modifications are part of the change please contact the construction section prior to completion of this application.

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:** Complete this application.
- Change of Licensee/Ownership:** Complete this application. The fee for a change of ownership is \$315.00
- Change of Capacity:** if change of capacity is an increase, submit photos, floor plan.

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

- 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 license as the licensee/owner. Please complete address & phone information.

Requested Changes

Please complete **only** those changes you are requesting.

- Facility Name:** Enter the name of the facility that will be printed on your license.
- Name of Contact Person:** This person will be contacted regarding all licensure matters.
- Facility Correspondence Mailing Address:** This address will be where you will receive all mail for the facility.
- Identify the Legal Identity of Ownership/Licensee:** This is the name that will be printed on the license as licensee/owner.
- Check if you are registered with the state as profit or non-profit
- Type of entity under which the business is operated.** All entities should be registered with the state except proprietorship and private partnership.
- Identify the administrator for this facility.**
- Management Company:** Enter this information if a company other than the licensee will manage the facility.
- Supply information for Executive Officer and names of other managing member as applicable.**
- If you lease or rent the building, give the name of the person/company from whom you lease/rent, their address and business phone number.**
- Enter names of Owners, Partners, Affiliates, Shareholders.**
- The application must be signed and dated to be processed.**

LICENSE FEE INVOICE

Facility Name:

County:

Facility Type	Number of Beds	Total Fee Due
Family Care Home		\$315.00

- **A separate check is required for each licensed facility.**
 - Payment **must** be by check, money order, or certified check, made payable to: **Division of Health Service Regulation.**
 - Remember to write the facility's Family Care License number on the check. (i.e. FCL-000-000)
-

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: Family Care Home

(2-6 beds)

CURRENT FACILITY LICENSE Number- _____ - _____ - _____

- Change of Facility Name, Change of Capacity, Other (specify):, Change of Licensee/Ownership, Change of Location

Requested Effective Date of Change: _____

Note: Change in Ownership requires a license fee. Change of Capacity requires a Construction review and fee, which Construction will invoice you for after they receive this 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 Phone # of Applicant/Licensee: () _____ Fax () _____

Table with 1 column and 8 rows: DHSR USE ONLY, License#, FID#, Region, Compliance Check Completed () _____, Entry by _____ Reviewed by _____, Date: _____ Date: _____, License Fee: 315.00



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

Part A. Facility Information

Facility Name:			
Physical Address:	City:	State: NC	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 Toll-Free)		NPI:	

Correspondence Mailing Address: (where you want to receive ALL correspondence including the license from Division of Health Service Regulation): *Make corrections as needed

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

ADMINISTRATOR:

Name:	
Telephone Number: ()	Fax: ()

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
- 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 a: (check one)	___ For Profit	___ Not For Profit
The licensee is a: (check one)	___ Proprietorship (Sole owner)	___ Partnership
OR licensee is registered with the NC Secretary of State as: (check one)	___ Corporation	___ Limited Liability Partnership
	___ Limited Liability Company (LLC)	___ Limited Liability Partnership (LLP)
NC Secretary of State ID #:		<input type="checkbox"/> Registered in Other State. (Attach a copy of the Certificate of Authority issued by NCSOS)

PLEASE 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**, 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.

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 and owner of the management company.

Company Name:		
Owner of Management Company	Telephone ()	Number:
Street/P. O Box:		
City:	State:	Zip:
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:		

Part C. Ownership Disclosure (*REQUIRED)

For the purpose of this application the following definitions apply throughout the 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 (*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: _____

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 Only Elderly

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 LICENSE CAPACITY _____

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	Percentage of interest as reported on page 5
			Cell Number	
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*

Please use additional paper and attach if needed.