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NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH SERVICE REGULATION NURSING HOME LICENSURE AND CERTIFICATION SECTION

2711 MAIL SERVICE CENTER

RALEIGH, NORTH CAROLINA 27699-2711

TELEPHONE: (919) 855-4520

**2024**

**NURSING HOME APPLICATION - INITIAL**

**(Including Adult Care Home Beds in Combination Facilities)**

**LEGAL IDENTITY OF APPLICANT**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 PRIMARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FACILITY MAILING ADDRESS:**

Street/P O Box: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**FACILITY SITE ADDRESS:**

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address for Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PART A OWNERSHIP AND MANAGEMENT DISCLOSURE

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

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

 NAME:

* 1. Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City: State: Zip:

Telephone: ( )

 Fax:

( )

Senior Officer:

* 1. Indicate the Percent of Ownership of the Legal Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Is legal entity: (check one)

 For Profit \_\_\_\_\_\_ Not For Profit \_\_\_\_\_\_

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

* + 1. **PROPRIETOR \_\_\_\_**

* + 1. **LIMITED LIABILITY CORPORATION \_\_\_\_\_**

* + 1. **PARTNERSHIP**

* + - 1. General \_\_\_\_ If General, where is it registered? County State \_\_\_\_\_\_\_

* + - 1. Limited If Limited, where is it registered? State \_\_\_\_\_\_\_

* + - 1. Is the limited partnership registered with the North Carolina Corporations Division in the NC Department of the Secretary of State?

 **YES**  **NO**

* + - 1. List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

 Name: Title:

 Address: Percent of Ownership:

 Name: Title:

 Address: Percent of Ownership:

 Name: Title:

 Address: Percent of Ownership:

* + 1. **CORPORATION \_\_\_**

* + - 1. Where was the corporation originally established? State \_\_\_\_\_\_\_\_

* + - 1. List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  Name:   |   |   |   |   |   |   | Title:  |   |
|  Address:  |   |   |   |   |   |   | Percent of Ownership:  |   |
|   |   |   |   |   |   |   |   |   |
|  Name:  |   |   |   |   |   |   | Title:  |   |

 Address:

Percent of Ownership:

Percent of Ownership:

 Name: Title:

 Address:

* + 1. **UNIT OF GOVERNMENT**
			1. What is the name and title of the official in charge of the above governmental unit?

 Name:

 Title:

* + - 1. Check the word which best describes the above type of governmental unit:

 CITY COUNTY STATE AUTHORITY

1. Does the licensee (legal entity: individual, partnership, corporation or unit) own the building from which services are

 offered? **YES** **NO**

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

 Name:

 Mailing Address:

 City:

 State:

 Zip:

Telephone: (

Fax: (

)

 )

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

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

 **YES** **NO**

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

* 1. Name of the Parent Company:

 b.

 d. State:

c. City:

Mailing Address:

e. Zip:

-

f. Telephone: ( )

 g. Name of Senior Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the facility operate under a management contract?

 **YES** **NO**

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

* 1. Name of Organization:

 b.

 d. State:

c. City:

Mailing Address:

e. Zip:

-

f. Telephone: ( )

 g. Name of Chief Executive Officer:

# PART B OPERATIONS

**PROVIDE NAMES FOR THE FOLLOWING:**

1. FACILITY PERSONNEL
	* 1. Full-time administrator as required in 10A NCAC 13D .2201(c).

 Name of Administrator: First name\_\_\_ Middle initial Last name Date Hired As Administrator: N. C. License No.:

* + 1. Nursing

 1. Director of Nursing: First full name Middle initial Last name

 N.C. License Number:

Date Hired as DON: \_\_\_\_\_\_\_\_\_\_

* + 1. Activity Director:

* + 1. Dietary Services Director:

* + 1. Social Services Director:

1. MEDICAL AND DENTAL STAFF FOR EMERGENCY CALL
	* 1. Medical Director’s Name Address

 First name

 Last name

Middle initial\_\_\_\_\_\_\_\_\_\_

 e-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N.C. License No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + 1. Dentist(s) Name(s) Address(es)

 1.

 2. 3.

1. CONTRACT/OTHER PERSONNEL OR CONSULTANTS

 a. Physical Therapist:

b.

Occupational Therapist:

c.

Speech Therapist:

d.

Medical Records:

e.

Pharmacy Consultant:

f.

Dietary Consultant:

g.

Other (i.e. Respiratory Therapist):

1. PHARMACY

 a. Source of Drugs:

* + - 1. Do you have a pharmacy located in your facility? **YES** **NO**

* + - 1. If "YES", please complete:

 Pharmacist Manager:

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

 Name: Street Address:

 City, State, Zip:

# PART C PATIENT SERVICES

1. Continuing Care Retirement Communities (CCRC)

* 1. Is the facility licensed by the Department of Insurance

 as a "Continuing Care Retirement Community"? a. **YES** **NO**

1. Is the facility a “Combination Facility”, thereby incorporating licensed ACH beds? 2. **YES** \_\_\_ **NO \_\_\_\_\_** If “Yes”, indicate which rules the facility chooses to apply to the operation of

 these ACH beds. Nursing Home Licensure \_\_\_\_\_ ACH Licensure\_\_\_

*(NH Licensure rules only, ACH rules only, or both NH & ACH licensure rules.\*\* Complete checklist if using both sets of rules.)*

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

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

* + 1. General Nursing Facility Beds 1.
		2. \*Alzheimer's Special Care Unit Resident Beds 2.
		3. Ventilator Dependent Resident Beds 3. \_\_\_\_\_\_\_\_\_
		4. Traumatic brain Injury Beds 4. \_\_\_\_\_\_\_\_\_

 Are you equipped to accommodate bariatric residents? Y \_\_\_ N \_\_\_\_

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

* + 1. General Adult Care Home Beds 1.

* + 1. \*Alzheimer’s Special Care Unit Resident Beds 2. \_\_\_\_\_\_\_\_\_

 Are you equipped to accommodate bariatric residents? Y \_\_\_ N \_\_\_\_

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

**PART D LICENSE FEE**

A non-refundable license fee is required and must accompany this application prior to the issuance of a nursing home license.

The payment should be in the form of check, certified check or money order and must be made payable to: “**The Division of Health Service Regulation**.” A separate check is required for each licensed entity.

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

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

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

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

Title: Date:

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or the provision of services."