

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

FOR OFFICIAL USE ONLY

Computer Number \_\_\_\_\_

Bed Change \_\_\_\_\_

Effective Date \_\_\_\_\_

Fee Received \_\_\_\_\_

Check No: \_\_\_\_\_

Amount: \_\_\_\_\_

2021

**NURSING HOME APPLICATION – BED CHANGES**  
**(Including Adult Care Home Beds in Combination Facilities)**

**LEGAL IDENTITY OF APPLICANT:**

\_\_\_\_\_  
{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: \_\_\_\_\_

If the above names are **NOT IDENTICAL** to the names on the current license, please check reason for the change:

\_\_\_\_ Change of Ownership/Licensee

\_\_\_\_ Facility Name Change

\_\_\_\_ Other (Specify): \_\_\_\_\_

**NORTH CAROLINA LICENSE NUMBER:** \_\_\_\_\_

**FACILITY MAILING ADDRESS:**

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_  
(Ex. 27626 - 0530)

**FACILITY SITE:**

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

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

Telephone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

**PATIENT SERVICES**

1. Is the facility now to be a “Combination Facility”, thereby incorporating licensed ACH beds? 1. YES \_\_\_\_ NO \_\_\_\_  
If “Yes”, indicate which rules the facility chooses to apply to the operation of  
these ACH beds. Nursing Home Licensure \_\_\_\_ ACH Licensure \_\_\_\_  
(Complete checklist if using both sets of rules.)

## APPLICATION TO INCREASE LICENSED NURSING HOME BEDS

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

- a. **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 ___ |
- b. **Adult Care Home (ACH)** (TOTAL) b. \_\_\_\_\_
- |  |             |
|--|-------------|
| 1. General Adult Care Home Beds                      | 1. _____    |
| 2. *Alzheimer's Special Care Unit Beds               | 2. _____    |
| Are you equipped to accommodate bariatric residents? | Y ___ N ___ |
- c. **TOTAL LICENSED BEDS** (TOTAL a & b) c. \_\_\_\_\_

### LICENSE FEE

A non-refundable per bed license fee is required for the number of beds added to the facility's licensed capacity and must accompany this application prior to the issuance of a nursing home license. Payment for the license fee should be in the form of check, certified check or money order and must be made payable to: "**The Division of Health Service Regulation.**" Payment should include the facility's license number and be submitted with this license application.

#### License Fee Calculation:

a. Total number of <u>additional</u> Licensed beds. (must match number of additional beds approved by CON)	
b. Multiply by per bed fee	x \$17.50
c. Total per bed fee (1a "x, multiply by" 1b )	\$

**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 license fee is non-refundable. The legislation (SB-622, Session Law 2005-276) prohibits a license from being issued if the annual fee has not been paid.**

The undersigned submits this application for licensure for the year 2016 {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.

\_\_\_\_\_  
Name of Chief Administrative Officer  
or Authorized Official

\_\_\_\_\_  
(Written Signature)

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."