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

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2019

NURSING HOME APPLICATION - INITIAL
(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: _____

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.

   a. 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: _____

   b. Mailing Address: _____

      City: _____ State: _____ Zip: _____

      Telephone: (____) _____ Fax: (____) _____
      Senior Officer: _____

c. Indicate the Percent of Ownership of the Legal Identity: _____

d. Is legal entity: (check one)
For Profit _____ Not For Profit _____

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

(1) PROPRIETOR ____

(2) LIMITED LIABILITY CORPORATION _____

(3) PARTNERSHIP ____

(a) General ____ If General, where is it registered? County _____State _____

(b) Limited ____ If Limited, where is it registered? State _____

(c) Is the limited partnership registered with the North Carolina Corporations Division in the NC Department of the Secretary of State?
YES _____ NO _____

(d) 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: _____

(4) CORPORATION ___

(a) Where was the corporation originally established? State _____

(b) 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: _____

(5) UNIT OF GOVERNMENT

(a) What is the name and title of the official in charge of the above governmental unit?
Name: _____

Title: _____

(b) Check the word which best describes the above type of governmental unit:

CITY ____ COUNTY ____ STATE ____ AUTHORITY ____

2. 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.

3. 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.

a. Name of the Parent Company: _____

b. Mailing Address: _____ c. City: _____

d. State: _____ e. Zip: _____-_____ f. Telephone: (___) _____

g. Name of Senior Officer: _____

4. 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.

a. Name of Organization: _____

b. Mailing Address: _____ c. City: _____

d. State: _____ e. Zip: _____-_____ f. Telephone: (___) _____

g. Name of Chief Executive Officer: _____

PART B OPERATIONS
PROVIDE NAMES FOR THE FOLLOWING:

1. FACILITY PERSONNEL
   a. 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.: _____

b. Nursing

1. Director of Nursing: First full name_____Middle initial___Last name_____
N.C. License Number: _____ Date Hired as DON: _____

c. Activity Director: _____

d. Dietary Services Director: _____

e. Social Services Director: _____

2. MEDICAL AND DENTAL STAFF FOR EMERGENCY CALL

a. Medical Director's Name Address

First name_____ _____
Middle initial_____ _____ _____
Last name_____ _____
e-mail address: _____ N.C. License No:_____

b. Dentist(s) Name(s) Address(es)

1. _____ _____
2. _____ _____
3. _____ _____

3. 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): _____

4. PHARMACY

a. Source of Drugs:

1. Do you have a pharmacy located in your facility? **YES** _____ **NO** _

2. 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)

a. Is the facility licensed by the Department of Insurance as a "Continuing Care Retirement Community"? a. **YES** ____ **NO** ____

2. 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.)*

3. **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 Resident Beds 2. _____

Are you equipped to accommodate bariatric residents? Y ___ N ____

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

PART D TOTAL CURRENT STAFF

Do not include the following: courtesy or attending staff, private duty nurses, volunteer workers or the same employee in more than one category. These employees were or will be on payroll as of _____.*

month / day / year

*** New facilities should complete according to the facility staffing level on date of Licensure.**

	TOTAL FACILITY FTE's	**ANNUAL CONSULTANT HOURS**
ROUTINE SERVICES		
Registered Nurses		
LPNs		
Nurse Aides		
Medical Director		
Director of Nurses		
Staff Devel. Coordinator		
Ward Secretary		
Medical Records		
Pharmacy Consultant		
ADMINISTRATION & GENERAL		
Administrator		
Asst. Administrator		
Other Office Personnel		
DIETARY		
Licensed Dietitian		
Food Services Supervisor		
Cooks		
Dietary Aides		
SOCIAL WORK SERVICES		
Social Services Director		
Social Services Asst.		
ACTIVITY SERVICES		
Activity Director		
Activity Assistant(s)		
Activity Consultant		

HOUSEKEEPING/LAUNDRY		
Housekeeping Supervisor		
Laundry Supervisor		
Housekeeping Aides		
Laundry Aides		
MAINTENANCE		
Maintenance Supervisor		
Janitors		
ANCILLARY SERVICES		
Physical Therapist		
PT/Rehabilitation Aide		
Occupational Therapy		
Speech/Hearing Therapy		
Respiratory Therapist		
Other (Specify)		
Total Positions/Total Consultant Hours		

PART E 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 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.

_____ _____

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

Title: _____ Date: _____

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