CHANGE LICENSURE APPLICATION PACKET FOR ADULT CARE HOME (7 OR MORE BEDS)

Return the entire packet to

Division of Health Service Regulation
Adult Care Licensure Section
2720 Mail Service Center
Raleigh NC 27699-2720
Attn: License Materials Enclosed

STEPS FOR A CHANGE OF OWNERSHIP
FOR ADULT CARE HOMES WITH 7 OR MORE BEDS

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

1. The applicant or prospective licensee must contact the Certificate of Need with the Division of Health Service Regulation (DHSR):

   i. To obtain a letter of exemption from review from the Certificate of Need (CON) *(when licensee is changing but ownership of building is not)*; OR

   ii. Prior to the obligation to purchase the building *(when the applicant or prospective licensee plans to purchase the building)*.

2. The current licensee informs the Adult Care Licensure Section (ACLS), Raleigh office, the county department of social services and the residents or their responsible persons in writing of the proposed change of business ownership and the date of the change. **This contact should be made at least 30 days in advance of the proposed change.**

3. The Construction Section of the DHSR must approve any proposed structural changes of building before a license can be approved. (See page 4 for review form)

4. Unpaid fines for penalties imposed will result in denial of licensure. License applications will not be processed if there are any outstanding/unpaid fines for penalties.

5. The applicant/prospective licensee compile the following information and submit it to the Adult Care Licensure Section, Raleigh office.

   a. Adult Care Home Licensure Change Application to facilitate compliance history check
   b. Submit payment for the non-refundable licensure fee$360.00 plus a per-bed fee of $17.50. "Non-refundable Licensure Fee" form of check, money order or certified check and must be payable to the "NC Division of Health Service Regulation."
   c. Administrator Certificate/License
   d. Approved fire and building safety inspection reports
   e. Approved sanitation inspection report
   f. Upon completion of any construction or renovation, -a certificate of occupancy or certificate of compliance from local building officials
   g. Letter from previous owner relinquishing ownership (this letter must specify the date of the change in ownership)
   h. Copy of CON letter (Licensure applications cannot be processed without approval or exemption by CON)

   i. **Note: Any information not included in the packet will render the application incomplete and it will not be processed**.

6. Within 14 working days of receipt of the above information or packet, the Adult Care Licensure Section will review and contact the prospective licensee for additional information if needed. If all documentation is complete, the Adult Care Licensure Section will issue a new license to the applicant.

7. Licenses must be renewed annually using the Annual Renewal License Application and submitting a non-refundable annual licensure renewal fee of $360.00 plus a per-bed fee of $17.50.

Mailing address of Raleigh Adult Care Licensure Section:

Regular Mail:
Division of Health Service Regulation
Adult Care Licensure Section
2720 Mail Service Center
Raleigh NC 27699-2720
Attn: License Materials Enclosed

Express/OvernightCourier(FED-EX, UPS):
Division of Health Service Regulation
Adult Care Licensure Section
805 Biggs Drive
Raleigh, North Carolina 27603
Attn: License Materials Enclosed

Adult Care Licensure Section (Raleigh Office) : 919-855-3765

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 or ____Adult 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

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Return this form: Adult Care Licensure Section
2720Mail Service Center
Raleigh, NC 27699-2720
ATTN: Karen Jones

Office Use Only

Date Received_________________

FID____________________________LICENSE NUMBER________________

Team Supervisor/Branch Manager(C A R L)______________________________

Comments____

____

____

Instructions for Completing a Change Licensure Application

Overview

1. These instructions are provided to assist you in completing a change or renewal 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 60 days prior to the anticipated change See Change of Ownership Fees chart at end of instructions. Construction related fees will be invoiced to you at a later date (change of capacity, change of location).

Type of Licensure Application

1. **Facility Type#:** Select Adult Care Home (7 or more beds) or Family Care Home(2-6 Bed).
2. 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 Location***
  - ❑ _Within the same county on license:_ Complete this application and submit zoning approval, photos, floor plan and Physical Plant sheet (page 4).
  - ❑ _To a different county than on license:_ Complete an Initial License Application.
- ***Change of Capacity**:* if change of capacity is an increase, submit photos, floor plan.
- ***Change of Facility Name**:* Complete this application.
- ***Change of Licensee/Ownership**:* Complete this application. A fee is assessed for a change of ownership, see fee chart for payment that must accompany application.
- ***Requested Effective Date of Change**:* Enter date when you are requesting that the change be effective. This maybe related to other changes that are occurring with your business.

Current Information

1. Current Facility Name: Enter name printed on your most current license.
2. Current Facility Site Address: This address is the physical site location as printed on most current license.
3. Current Legal Identity of Ownership/Licensee: This is the name printed on your license as the licensee/owner. Please complete address & phone information.

*Note fee charge for a change of ownership.

Requested Changes

<u>In pages 9-13, please complete ***only*** those changes you are requesting.</u>

1. Facility Name: Enter the name of the facility that will be printed on your license.
2. Facility Site Address: Enter the new physical location of your facility.
3. Name of Contact Person:. This person can answer daily process and licensure questions about the facility.
4. Facility Correspondence Mailing Address: This address will be where you will receive all mail for the facility. Indicate the name to address correspondence.
5. Identify the legal entity of the licensee Legal Identity of Ownership/Licensee: This is the name that will be printed on the license as licensee/owner.
6. Check if you are registered with the state as profit or non-profit
7. Type of entity under which the business is operated. All entities should be registered with the state except proprietorship and private partnership.
8. Identify the administrator for this facility.
9. Management Company: Enter this information if a company other than the licensee will manage the facility.
10. Supply information for Executive Officer if applicable.
11. If you lease the building, complete the data on the person from whom you lease/rent.
12. Owners, Partners, Affiliates, Shareholders
13. If this is a proprietorship (private) business with no shareholders or a non- profit entity, Signature and title and date needed in 1st box.
14. The application must be signed to be processed.

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: **Adult Care Home** ☐ (7 or more beds) **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 Location & Change of Capacity requires a Construction review and fee.

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 (_______)____________________

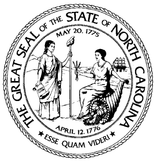
3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Name of Owner: ____

Address: ____

City: ______________________________State:____________________Zip Code:______________________

Business Phone # of Applicant/Licensee: (_____)________________Fax (_____)______________________



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

For Office Use Only
License#______________
FID__________________
Reviewed_________Date________
Compliance Check Completed:
Date________By________
Data Entry_______________

CHANGE LICENSE APPLICATION FOR ADULT CARE/FAMILY CARE HOMES 2007

PLEASE READ CAREFULLY

- **A license 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.

REQUESTED CHANGES

FOR THIS OF THE APPLICATION, PAGES 10-13, PLEASE COMPLETE **ONLY** THOSE CHANGES REQUESTED.
For Change of Ownership, complete the entire application

Part A Facility Information

The name on this line is the name of your facility, as you want it to be printed on your license.

Facility Name:
(Exact name which the facility is advertised or presented to the public.):

Facility Site Address: ____________________
(physical location of facility) ____________________
County: ____________________
Facility Telephone: ____________________
Facility Fax: ____________________

Correspondence Mailing Address: (where you want to receive mail including the license from DHSR):
Addressee: ____________________
____

Part B Operation Disclosure New Ownership

1. **Certified or Qualified Administrator**: You **must** include the administrator's certificate number.

Name: ____________________

Address: ____________________City ____________________

State ____ Zip____________County__________________Telephone#: __(___)___________

Fax (__)_________

Administrator Certificate No. (**if 7 beds or more**)_______________

Percentage Interest in this Facility: _______

2. MANAGEMENT COMPANY: If facility is managed by a company ***other than the licensee***, provide the following information about the Management Company:

Name ____________________
Street/Box: ____________________
City ____________________ State: ____________________ Zip: ____________________
Telephone: ____________________ Fax: ____________________
Percentage of Ownership Interest in this Facility: _______

3. **LEGAL IDENTITY OF LICENSEE APPLICANT**
Full legal name of individual, partnership, corporation or other legal entity, which owns the adult care home business or the legal designee of that entity. Owner means any person who has legal or equitable title to or a majority interest in an adult care home. This entity is responsible for financial and contractual obligations of the business and will be recorded as the licensee on the license

Licensee ____________________
Street/Box: ____________________
City ____________ State: ____________ Zip: ____________
Business Phone: ____________ Fax: ____________

Federal Tax ID number of Owner/Licensee**:** ____________________

Percentage of Ownership Interest in this Facility: _______

Legal entity is: ___ For Profit __ Not For Profit

Legal entity is: ____ Proprietorship ____ Partnership ____ Limited Liability Company
____ Corporation ____Government Unit ____ Limited Liability Partnership

4. *If the "licensee" is a corporation or partnership list the name of the Executive Officer or General Partner.*

Executive Officer:____________________
Address: ____________________
City: ____________State:____________Zip Code:____________
Business Phone #: (______) ____________Fax (______) ____________
Percentage of Ownership Interest in this Facility: _______

5. **Building Owner:** If the above entity (partnership, corporation, etc.) ***does not*** own the building from which services are offered, provide the following information:

Name: ____________________
Street/Box: ____________________
City ____________ State: ____________ Zip: ____________
Business Phone: ( ) ____________ Fax: ( ) ____________
Percentage of Ownership Interest in this Business not the building: _______

Part C Ownership Disclosure

1. OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS

Complete the information below on **all** individuals or entities who are owners, principles, affiliates or shareholders holding an interest of **5% or more** of the applicant entity. Attach additional pages if necessary.

Name: ____

Address: ____

City: ___________________________ State: __________________ Zip Code: _____________________

Phone # of Shareholder: (________) ____________________ Fax (________) _____________________

Percentage interest in this facility: _____________ Title: _______________________________________

List the names of other Family Care/Adult Care homes in which you are the owner or affiliate________

____

Name: ____

Address: ____

City: ___________________________ State: __________________ Zip Code: _____________________

Phone # of Shareholder: (________) ____________________ Fax (________) _____________________

Percentage interest in this 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 # of Shareholder: (________) ____________________ Fax (________) _____________________

Percentage interest in this facility: _____________ Title: _______________________________________

List the names of other Family Care/Adult Care homes in which you are the owner or affiliate________

I attest that this is a true account of all owners, principles, partners, and affiliates of shareholders who hold an interest of 5% or more of the entity applying for or renewing this license:

______________________________________ ______________________________ ___________

Signature Title Date

Print Name ____________________________ Phone Number______________________

2. EXTENSIONS IN OWNERSHIP

North Carolina General Statute also requires information about "affiliates" of the applicant entity.

(a) Is the applicant entity controlled by any other organization that operates licensed adult care facility? Yes ______ No ______

(b) Does the applicant entity control any other organizations that control any other licensed adult care facilities? Yes ______ No ______

(c) Does the applicant entity control other adult care homes? Yes____ No_____

(d) If the answer to (a), (b) or (c) above is "Yes" list the name of the other organization(s) and provide the requested information on the individuals who control 5% or more of that organization. Attach additional pages if necessary.

Person/Organization Name: ____
Facility Name: ______________________________ Federal Tax ID Number: ______________
Address: ____
City: ________________________State:________________Zip Code:__________________
Organization Phone #: (________)____________________Fax (________)____________________
Percentage of ownership Interest____________________
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate__________
____

Person/Organization Name ____
Facility Name:______________________________Federal Tax ID Number: ________________
Address: ____
City: ________________________State:________________Zip Code:__________________
Organization Phone #: (________)____________________Fax (________)____________________
Percentage of ownership Interest____________________
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate_________
____

Person/Organization Name: ____
Facility Name: ______________________________ Federal Tax ID Number: ______________
Address: ____
City: ________________________State:________________Zip Code:__________________
Organization Phone #: (________)____________________Fax (________)____________________
Percentage of ownership Interest____________________
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate__________
____

The following information will be used for internal compliance history checks as required by G.S. 131D-2b(1). We ask that you voluntarily provide 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 renewal application being processed.

Category	Name	SSN	Contact Number	Percentage of interest as reported on pages 2-5
Administrator				
Licensee				
Licensee				
Building Owner				
Executive Officer				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				

Please use additional paper and attach if needed.

Reminder: failure to complete this information will delay the renewal process.

CAPACITY AND SPECIAL CARE UNITS

- **Current total monthly private pay charge (average base plus add-ons if more than one price) for:**

- **Monthly Private Room (1bed/room) $_________**
- **Monthly Semi-Private (2 beds/room) $_________**
- **Monthly 3 or more beds/room $_________**

- **Licensed Capacity (as it appears on License) _________**

Is your facility advertised, marketed, or promoted 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 attached "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 ____

Check if apply:
This Adult Care Home serves Only elderly persons.
Persons age 55 or older or who have a primary diagnosis of Alzheimer's disease or other form dementia that require assistance with activities of daily living.

Authenticating Signature: The undersigned submits this application for licensure for the year 2009 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 NCAC13F) and certifies the accuracy of this information.

Signature: ____ Date: __________________

Print Name ____ Phone Number ________________

Please be advised, the license fee must accompany the completed application and be submitted to the Adult Care Licensure Section, Division of Health Service Regulation, prior to the issuance of an Adult Care license.

FORMAT FOR SPECIAL CARE UNIT DISCLOSURE STATEMENT

The adult care home special care unit disclosure statement must address the items in order as listed below. It is to be submitted with the Adult Care Home Initial License Application or the Change Licensure Application. Any changes to the disclosure statement as submitted must be reported in writing to the Adult Care Licensure Section and written notification must be provided to the residents.

I. Special Care Units for Residents with Alzheimer's Disease or Related Disorders:

(1) The philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by the unit which shall address, but not be limited to the following;

a) Safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medication;

b) A structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities;

c) Individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and

d) Methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance

(2) The process and criteria for admission to and discharge from the unit;

(3) A description of the special care services offered in the unit;

(4) Resident assessment and care planning, including opportunity for family involvement in care planning, and the implementation of the care plan, including responding to changes in the resident's condition;

(5) Safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior or other behavior management problems;

(6) Staffing in the unit;

(7) Staff training based on the special care needs of the residents;

(8) Physical environment and design features that address the needs of the residents;

(9) Activity plans based on personal preferences and needs of the residents;

(10) Opportunity for involvement of families in resident care and the availability of family support programs and

(11) Additional costs and fees for the special care provided.

II. Special Care Units for Residents with Mental Health or Developmental Disabilities

In addition to all of the above, disclosure must address the following;

(1) Grouping of residents that takes age, interests and behaviors into account;

(2) Ensuring client rights, choice and service coordination [(See Rule 10A NCAC 13F .1405(3)(a)(b)]; and

(3) Safeguarding confidential information and ensuring that such information is not further disclosed in accordance with G.S. 122C-55(f).