



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 _____

INITIAL LICENSE APPLICATION FOR ADULT CARE/FAMILY CARE HOMES

PLEASE READ CAREFULLY

- Steps to opening a Family Care or Adult Care Home can be found on the DHSR Website: www.ncdhhs.gov/dhsr/. Please read this information before completing this application.
- Incomplete applications or applications without a fee will delay the process
- Your annual 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.

Part A Facility Information

The name on this line is the name of your facility, as it will be printed on your license

Facility Name: _____

Facility Site Address: _____
(This address is the physical location of your facility)

County: _____

Facility Telephone: _____

Facility Fax: _____

Correspondence Mailing Address (where you want to receive your mail, including the license):

Contact Person _____ (Person who can make licensure and operational decision about the facility)

Address: _____

Part B Operation Disclosure

1. **Certified or Qualified Administrator(s):** (If the home is 6 beds or less, lists your qualified administrator. If the home is 7 beds or more, you **must** include the administrator's certificate number)

Name: _____

Address: _____ City _____

State _____ Zip _____ County _____ Telephone#: _____ (____)

Fax (____) _____

Social Security Number: _____ 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: _____

Address: _____

Telephone Number (____) _____ Fax Number (____) _____

Percentage of Ownership Interest in this Facility: _____

3. LEGAL IDENTITY OF LICENSEE

Full legal name of individual, partnership, corporation or other legal entity, which owns the Family 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 of License _____

Address: _____

City: _____ State: _____ Zip Code: _____

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
_____ Corporation _____ Limited Liability Company
_____ Partnership _____ Limited Liability Partnership
_____ Government Unit

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: _____ Phone #: (_____) _____ Fax (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

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				
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.

If Family Care Home : Ambulatory 1-3 Non-Ambulatory 4 + Non-Ambulatory

Authenticating Signature: The undersigned submits this application for licensure for the year 2007 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).