

**CHANGE LICENSURE
APPLICATION PACKET
FOR
FAMILY CARE HOME
(2 TO 6 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 FAMILY CARE HOMES (2-6 Beds)

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

1. The current licensee contacts the county adult home specialist in the social services department for the county where the facility is located and informs the adult home specialist of the proposed change of business ownership. This contact should be made **at least 60 days** in advance of the proposed change.
 - ❑ The Construction Section of the Division of Health Service Regulation (DHSR) must approve any proposed structural changes of building.
 - ❑ 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.
2. The adult home specialist communicates with the applicant to provide him/her with an orientation to adult care and to begin processing a new license application.
3. The current licensee-notifies the residents of the proposed change, giving them the opportunity to make other plans. The residents are to be informed that the county DSS is available for assistance.
4. The adult home specialist documents that the personnel requirements for all staff are met by reviewing the home's records. The adult home specialist collects information required for administrator approval which consists of the following:
 - ❑ Report of Administrator Qualifications for Family Care Homes
 - ❑ Documentation of Education (high school diploma, GED certificate, college credits or degree)
 - ❑ 3 letters of reference
 - ❑ County criminal record check
 - ❑ Resume or letter of experience for Administrator In Training (AIT) exemption
 - ❑ Rule exam certificate
5. **Note: The administrator application material is to be sent as a package to the Adult Care Licensure Section as soon as it is complete to make sure the administrator can be approved. A copy of the administrator approval from Adult Care Licensure Section is sent to the administrator. This form is to be submitted with completed licensure packet.**

6. Once the adult home specialist has obtained all needed documentation to complete the application and assessed the applicant’s readiness to be licensed, the adult home specialist submits the following information to the Adult Care Licensure Section in Raleigh:
 - ❑ Licensure Application **(DO NOT INCLUDE LICENSURE FEE)**
 - ❑ Administrator Approval Certificate
 - ❑ Letter from previous owner relinquishing ownership (this letter must specify the date of the change in ownership)
 - ❑ Approved fire and building safety inspection reports (dated within the previous 12 months)
 - ❑ Approved sanitation inspection report (dated within the previous 12 months)

7. Upon receipt of the packet and verification of no outstanding fines, the Adult Care Licensure Section notifies the prospective applicant of the receipt of packet and request of licensure fee.
 - a. The applicant must submit a non-refundable licensure fee.
 - b. Prorated payment should be submitted to the Adult Care Licensure Section in Raleigh.
 - c. Payment should be made in the form of check, money order or certified check and must be payable to the “NC Division of Health Service Regulation.”
 - d. The adult home specialist or prospective applicant is contacted for any additional information.
 - e. 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.**

8. If all documentation is complete, the Adult Care Licensure issues a new license to the applicant within 14 working days after receipt of payment fee.

9. Licenses must be renewed annually using the Annual Renewal License Application and submitting a non-refundable annual licensure renewal fee of \$315.00.

Mailing address of Raleigh Adult Care Licensure Section:

<u>Regular Mail:</u>	<u>Express/Overnight Mail:</u>
Division of Health Service Regulation	Division of Health Service Regulation
Adult Care Licensure Section	Adult Care Licensure Section
2720 Mail Service Center	805 Biggs Drive
Raleigh NC 27699-2720	Raleigh, North Carolina 27603
ATTN: License Materials Enclosed	Attn: License Materials Enclosed

**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

Return this form: Adult Care Licensure Section
2720 Mail 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#:** 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 is \$315.00
 - **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

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

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: 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, which Construction will invoice you for after they receive this application.

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 needs to be the name of your facility, as you want it to be printed on your license.

Facility Name:

(Exact name you want on your license, 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

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

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

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				
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 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 NCAC13G) 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.