

ASSISTED LIVING

APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

Initial
 Change of Ownership
 (specify effective date)
 Other Change (specify type)

LICENSE NUMBER (if applicable)			WEBSITE (if applicable)		
LEGAL AGENCY NAME			TRADING NAME (DBA)		
E-MAIL ADDRESS			PHONE NUMBER	FAX NUMBER	
BUSINESS ADDRESS (physical location)			MAILING ADDRESS (if different)		
NUMBER, STREET			NUMBER, STREET		
CITY	STATE	ZIP	CITY	STATE	ZIP

Does the owner, corporation, or partnership operate and manage the assisted living program? Yes No
 (identify the management structure and its relationship to the business owner)

NUMBER OF BEDS REQUESTED	LEVEL OF CARE REQUESTED 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
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Are all areas of the assisted living facility fully constructed? Yes No (identify any areas not fully constructed and the extent of construction progress)

NAME OF MANAGER	PHONE NUMBER	CELL NUMBER	
HOME ADDRESS (number, street)	CITY	STATE	ZIP
NAME OF ALTERNATE MANAGER	PHONE NUMBER	CELL NUMBER	
HOME ADDRESS (number, street)	CITY	STATE	ZIP
NAME OF DELEGATING NURSE (DN)	PHONE NUMBER	CELL NUMBER	
HOME ADDRESS (number, street)	CITY	STATE	ZIP
DN'S LICENSE NUMBER	EXPIRATION DATE OF DN'S LICENSE		

Is your facility planning to operate, or currently operating, an "Alzheimer's Special Care Unit or Program?"
 No Yes (refer to the instruction guide for details on submitting your program description)

3. OWNERSHIP (Type of business organization of disclosing entity) SOLE PROPRIETORSHIP PARTNERSHIP CORPORATION

NAME

ADDRESS

IF PARTNERSHIP OR CORPORATION,
PARTNER, OFFICER, DIRECTOR, OR STOCKHOLDER INFORMATION AND PERCENTAGE OWNED IF 25% OR MORE

NAME AND TITLE	E-MAIL	PHONE NUMBER	ADDRESS	% OWNED

IF CORPORATION:

DATE OF CHARTER

DATE OF INCORPORATION

FEIN NUMBER

NAME OF PRESIDENT

PHONE NUMBER

CELL NUMBER

ADDRESS (number, street)

CITY

STATE

ZIP

4. BACKGROUND

1. Has the applicant, owner, or managerial staff ever had a license, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked? No Yes (explain)
2. Does the applicant currently hold, or has the applicant previously held, any license or certification for the operation of a health care facility or similar health care program? No Yes (explain)
3. Does the owner, applicant, manager, alternate manager, other staff, or any household member have a criminal conviction or other criminal history? No Yes (explain)

5. WORKERS' COMPENSATIONDo you have any employees? Yes No

If you answered YES, provide your workers' compensation insurance information:

POLICY NUMBER

BINDER NUMBER

INSURANCE COMPANY

EFFECTIVE DATE

EXPIRATION DATE

If you answered NO, additional documentation from the Workers' Compensation Commission must accompany this application (refer to the instruction guide for details).

6. AFFIDAVIT

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing application are true. I understand that the falsification of an application for a license may subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by the MDH. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in denial of a request to become licensed.

I certify that this agency is in compliance with administrative and procedural requirements pertaining to the Assisted Living Programs Code of Maryland Regulations (COMAR 10.07.14).

I further certify that I will notify the OHCQ if there are any future substantive changes in agency and operation, and that written notice will be given before the effective date of the change.

I hereby swear and affirm that I am over the age of 21 and I am otherwise competent to sign this Affidavit.

If the program is going to be in more than one applicant's name, each applicant's signature is required.

SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE