

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.
4. A change in the ownership of a license has an associated fee which must be submitted with the application. The Change of Ownership fee is shown on 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 MHL#:** Enter Facility Mental Health License number.
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 7).
 - *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 Service Category:* New letter of support needed from the LME
 - *Change of Facility Name:* Complete this application.
 - *Change of Licensee/Ownership:* Complete this application. Signatures necessary in both #4 & #5. All signatures are required of owners of partnerships or equal shareholders. Add additional sheet if necessary for all signatures required approving the change. A fee is assessed for a change of ownership which must accompany application.
 - *Requested Effective Date of Change:* Enter date when you are requesting that the change be effective. This may be 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.
4. Signature of Current Licensee: Current licensee or designated authority for licensee must sign and date here. For a change in ownership request, see above italicized directions for Change of Licensee/Ownership.
5. Signature of Requested New Licensee: If a change of ownership being requested, the representative of the new licensee must sign here. *Note fee charge for a change of ownership.

Requested Changes

In pages 4-10, 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. Facility Correspondence Mailing Address: This address will be where you will receive all mail for the facility. Indicate the name to address correspondence.
4. Name of Facility Director: This will be the person who is responsible for managing the facility.
5. Name of Contact Person: This may be you or the person responsible for managing the facility. This person can answer daily process and licensure questions about the facility.
6. Management Company: Enter this information if the facility will be managed by a company other than the licensee.
7. Local Management Entity: Enter the names of LMEs with which the facility has a contract.
8. Legal Identity of Ownership/Licensee: This is the name that will be printed on the license as licensee/owner.
 - (a) Enter name and contact information of new owner.
 - (b) Federal Tax ID# - if applicable.
 - (c) Check if you are registered with the state as profit or non-profit.
 - (d) Type of entity under which the business is operated. All entities should be registered with the state except proprietorship and private partnership.
 - (e) Supply information for CEO or President.

- (f) If you lease the building, complete the data on the person from whom you lease/rent.
9. Owners, Partners, Affiliates, Shareholders (Confidential Information for Official Use Only):
 - If this is a non-profit entity, Signature and title and date needed in 1st box.
 - If the ownership has investors or shareholders in the business, fill in the information requested. If ownership is a corporation/company having only 1 person who is sole owner, please fill in as percentage interest is 100%. Social Security numbers are requested, but voluntary.
 - If proprietary ownership, complete the box as if shareholder
 10. Extensions in Ownership: Enter information about Affiliates who directly or indirectly control the owner of this facility.
 11. Service Categories: Note the change or additions to service category. If change in service category complete "from" and "to" entries. Check the category that describes the service/s your facility will provide. For residential facilities, enter the number of beds under either the Children category or Adult category. Increase of beds above 6 may require invoicing by DHSR for additional fee.
 12. Certificate of Need: Note whether or not you have a certificate of need for a required service category, and the CON # and date.
 13. Number of Clients: Note the number of clients you will serve and the disability category or categories that you will serve.
 14. Number of Others Living in the Facility: Complete only if requesting service category *.5600F* or *.5100-Private Home Respite*. Include the number and ages of anyone that lives in the facility that is not a client.

Construction: Physical Plant

Complete this section if a change in location.

1. Inspection Department information
2. Building Information.

Change of Ownership Fees

The Operations and Capital Improvements Appropriations Act of 2006 instituted a fee for all residential and non-residential facilities.

Following is a list of types of facilities that require a change of ownership fee, including the base fee and the per bed fee.

Type of Facility	Number of Beds	Base Fee	Per Bed Fee
Non-residential Facilities	0	\$215.00	N/A
Residential Facilities (Non-ICF/MR)	6 beds or less	\$305.00	\$0
Residential Facilities (Non-ICF/MR)	7 beds or more	\$475.00	\$17.50
ICF/MR* Facilities	6 beds or less	\$845.00	\$0
ICF/MR* Facilities	7 beds or more	\$800.00	\$17.50

N.C. Department of Health and Human Services

Division of Health Service Regulation

Mental Health Licensure and Certification Section

2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

CHANGE LICENSURE APPLICATION FOR MH/DD/SAS FACILITIES

TYPE OF LICENSURE APPLICATION

FACILITY MHL#- _____ - _____

Change of Facility Name Change of Capacity Service Category
 Change of Licensee/Ownership* Change of Location Other (specify): _____
 Requested Effective Date of Change: _____

Note: Change in Ownership requires a license fee to accompany this application. Change of Location & Change of Capacity require a Construction Fee. You will be invoiced for these fees. Do not send money for Construction Section when submitting this application.

CURRENT LICENSE INFORMATION (complete requested change/s on following pages)

1. CURRENT FACILITY NAME: _____

2. CURRENT FACILITY SITE ADDRESS: (NO P.O. BOXES)

Street: _____

City _____ Zip Code _____ County _____

*Facility Telephone Number (_____) Fax Number (_____)

*must be installed and operable prior to licensing-no cell phones.

3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Name of Owner: _____

Address: _____ City _____ State: _____ Zip Code _____

Business Phone # of Applicant/Licensee: (_____) Fax (_____)

4. SIGNATURE OF CURRENT LICENSEE: The undersigned, representing the governing authority, submits information for the above named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G. * if partnership or equal shareholders

Name: _____ Title: _____

Signature: _____ Date: _____

*Name: _____ Title: _____

Signature: _____ Date: _____

5. SIGNATURE OF REQUESTED NEW LICENSEE (if applicable): The undersigned, representing the governing authority, submits information for the above named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: _____ Title: _____

Signature: _____ Date: _____

ALL APPLICATIONS MUST BE MAILED TO ABOVE ADDRESS AND MUST HAVE AN ORIGINAL SIGNATURE

OFFICIAL USE ONLY: DHSR Form 4080

Licensure Categories: _____

Licensure Recommendation: _____ DHSR Consultant: _____

Remarks: _____

REQUESTED CHANGES

In the rest of the application pages, please complete **ONLY** those changes being requested.

1. **FACILITY NAME:** _____

2. **FACILITY SITE ADDRESS: (NO P.O. BOXES)**

Street: _____

City _____ Zip Code _____ County _____

*Facility Telephone Number (_____) Fax Number (_____)

*must be installed and operable prior to licensing-no cell phones.

3. **FACILITY CORRESPONDENCE MAILING ADDRESS:**

Name: _____

Street: _____

City _____ Zip Code _____ County _____

Email Address: _____

4. **NAME OF FACILITY DIRECTOR:** _____

5. **NAME OF CONTACT PERSON:** _____

Title: _____

Telephone Number (_____) Cell # (_____) Fax Number (_____)

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

Name of Company: _____

Name of Contact Person: _____

Address: _____

Telephone Number (_____) Fax Number (_____)

7. **LOCAL MANAGEMENT ENTITY (LME):** List name(s) of LMEs with which the facility has a contract:

8. LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Full legal name of individual, partnership, corporation or other legal entity, which owns the mental health facility business, is required. Owner/Licensee means any person/business entity (Corp., LLC, etc.) that has legal or equitable title to or a majority interest in the mental health facility. This entity is responsible for financial and contractual obligations of the business and will be **recorded as the licensee on the license**.

(a) Name of Owner/Corporation: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

(b) Federal Tax ID number of Owner/Licensee: _____

(c) Legal entity is: _____ For Profit _____ Not for Profit

(d) Legal entity is:
_____ Proprietorship
_____ Corporation _____ Limited Liability Company
_____ Partnership _____ Limited Liability Partnership
_____ Government Unit

(e) Name of CEO/President: _____ **Title:** _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

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

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

Name of Building Owner: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

9. OWNERS, PARTNERS, AFFILIATES, SHAREHOLDERS (Confidential Information for Official Use Only):

Non-Profit Companies

If no individual holds an interest of 5% or more please sign the statement below, thereby indicating this is a non-profit group.

There are **no owners, partners, affiliates of shareholders who hold an interest of 5% or more** of the entity applying for license:

Signature Title Date

Complete the information below on **all** individuals, proprietorship or entities who are owners, partners, affiliates or shareholders holding an interest of 5% or more of the applicant entity. Attach additional pages if necessary. 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. If you are the only owner, complete the information below, listing the percentage interest as 100%.

Shareholder Name: _____ Social Security Number: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone # of Shareholder: (_____) Fax (_____)
 Percentage interest in this facility: _____ Title: _____

Shareholder Name: _____ Social Security Number: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone # of Shareholder: (_____) Fax (_____)
 Percentage interest in this facility: _____ Title: _____

Shareholder Name: _____ Social Security Number: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone # of Shareholder: (_____) Fax (_____)
 Percentage interest in this facility: _____ Title: _____

Shareholder Name: _____ Social Security Number: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone # of Shareholder: (_____) Fax (_____)
 Percentage interest in this facility: _____ Title: _____

10. EXTENSIONS IN OWNERSHIP:

North Carolina General Statute 122C-23 also requires information about “affiliates” of the applicant entity.

(a) Is the facility controlled by an organization that operates any other licensed mental health facility?
Yes _____ No _____

(b) Does the applicant control any other licensed mental health facilities? Yes ____ No ____

(c) Does the applicant control other organizations that control Mental Health facilities? Yes ____ No ____

(d) If the answer to (a) or (c) above is “Yes” list the name of the other organization(s)

Organization Name: _____	Federal Tax ID Number: _____
Address: _____	
City: _____	State: _____ Zip Code: _____
Organization Phone #: (_____) _____	Fax (_____) _____
Senior Officer or CEO: _____	
Chairman of the Board: _____	

Organization Name: _____	Federal Tax ID Number: _____
Address: _____	
City: _____	State: _____ Zip Code: _____
Organization Phone #: (_____) _____	Fax (_____) _____
Senior Officer of CEO: _____	
Chairman of the Board: _____	

10. SERVICE CATEGORIES:

Services subject to licensure under G.S. 122C are shown in the table below and are **found in the Rules For Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services**. All applicants (initial and renewal) must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Changing from _____ to _____ Adding _____

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
.1100 Partial hospitalization for individuals who are acutely mentally ill.				
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness				
.1300 Residential treatment facilities for children or adolescents—Level II (Max. of 12 clients)				
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances				
.1700 Residential treatment Staff Secure for Children or Adolescents—Level III				
.1800 Intensive residential treatment for children or adolescents (Level IV)				
.1900 PRTF – Psychiatric Residential Treatment Facility for minors who are emotionally disturbed or who have a mental illness.				

.2100 Specialized community residential centers for individuals with developmental disabilities. (Max. of 30 clients) (CON Required)				
.2200 Before/after school and summer developmental day services for children with or at risk for developmental delays, developmental disabilities, or atypical development				
.2300 Adult Developmental and vocational programs for individuals with developmental disabilities				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
.3100 Non-hospital medical detoxification for individuals who are substance abusers				
.3200 Social setting detoxification for substance abuse				
.3300 Outpatient detoxification for substance abuse				
.3400 Residential treatment/rehabilitation for individuals with substance abuse disorders (CON Required)				
.3600 Outpatient narcotic addiction treatment				
.3700 Day treatment facilities for individuals with substance abuse disorders				
.4100 Therapeutic homes for individuals with substance abuse disorders and their children (min. 3 clients)				
.4300 A supervised therapeutic community for individuals with substance abuse disorder				
.4400 Substance Abuse Intensive Outpatient Program				
.4500 Substance Abuse Comprehensive Outpatient Treatment Program				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
.5000 Facility based crisis service for individuals of all disability groups				
.5100 Community respite services for individuals of all disability groups				
.5200 Residential therapeutic (habilitative) camps for children and adolescents of all disability groups				
.5400 Day activity for individuals of all disability groups				
.5500 Sheltered workshops for individuals of all disability groups				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
<i>Only one of these categories can be checked</i>				
.5600 supervised living for individuals of all disability groups		(CON required for ICF/MR facility)		
5600A Group homes for <u>adults</u> whose primary diagnosis is mental illness (Max. of 6 clients)				
5600B Group homes for <u>minors</u> whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600C Group homes for <u>adults</u> whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600D Group homes for <u>minors</u> with substance abuse problems				
.5600E Half-way houses for <u>adults</u> with substance abuse problems				
.5600F Alternative family living – providing service in own private residence (Max. 3 clients)				

12. DO YOU HAVE A CERTIFICATE OF NEED? Yes No
 Required for the following service categories: .2100, .3400, & .5600 (only when ICF/MR facility)

If yes, CON Number _____ Date _____

13. NUMBER OF CLIENTS FOR WHICH THE FACILITY IS GOING TO BE LICENSED:

Type	Specify Number to be Licensed
Ambulatory*	
Non-Ambulatory, 1-3	
Non-Ambulatory, 4 or more	

*Ambulatory: a person who can evacuate the building without physical or verbal assistance during a fire or other emergency.

14. NUMBER AND AGE(S) OF PEOPLE OTHER THAN CLIENTS RESIDING WITHIN THE FACILITY:
 (applicable only in categories where private residence is allowable: .5600 F & .5100 Private Home Respite)

Are any of these non-ambulatory? Yes No

CONSTRUCTION: PHYSICAL PLANT

Please fill in EACH inspection Department information if change of location:

Zoning Department Official

Department Name: _____	Official's Name: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
County: _____	Phone :(_____)	

Local Building Official

Department Name: _____	Inspector Name*: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
County: _____	Phone :(_____)	

Local Fire Marshall

Department Name: _____	Inspector Name*: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
County: _____	Phone :(_____)	

Local Sanitation

Department Name: _____	Inspector Name*: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
County: _____	Phone :(_____)	

*Provide Inspector's name if inspection completed and copy attached.

Building Information: Complete for 24-hour residential facilities only:

Has the building housed a licensed facility previously? Yes No

If Yes: Type of licensed facility _____

Previous License # _____ Dates of Licensure: From _____ To: _____

Does this building(s) contain facilities licensed for a different use other than the one an initial license is being sought for? Yes No

If Yes, please clarify type of license _____

Is the building a site constructed home or a manufactured/mobile home? _____

(*If it is a manufactured/mobile home – contact the DHSR Construction Section for licensure limitations on this type of structure)

If it is a manufactured/mobile home, was it built after 1976? Yes No