

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH SERVICE REGULATION  
NURSING HOME LICENSURE AND CERTIFICATION SECTION  
2711 MAIL SERVICE CENTER  
RALEIGH, NORTH CAROLINA 27699-2711  
TELEPHONE: (919) 855-4520

FOR OFFICIAL USE ONLY Computer Number _____ Bed Change _____ Effective Date _____  Fee Received _____ Check No: _____ Amount: _____
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2009

**APPLICATION FOR LICENSE TO OPERATE A NURSING HOME**

**(Including Adult Care Home Beds in Combination Facilities)**

**LEGAL IDENTITY OF APPLICANT:**

\_\_\_\_\_  
\_\_\_\_\_  
{Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.}

**DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:**

PRIMARY: \_\_\_\_\_  
Other: \_\_\_\_\_  
Other: \_\_\_\_\_

If the above names are **NOT IDENTICAL** to the names on the current license, please check reason for the change:

Change of Ownership/Licensee                       Facility Name Change  
 Other (Specify): \_\_\_\_\_

**NORTH CAROLINA LICENSE NUMBER:** \_\_\_\_\_

**FACILITY MAILING ADDRESS:**

Street/P O Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_  
(Ex. 27626 - 0530)

**FACILITY SITE:**

Street: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_  
Fax: (\_\_\_\_) \_\_\_\_\_  
E-mail Address for Administrator: \_\_\_\_\_

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or the provision of services."

**PART A PATIENT SERVICES**

1. Continuing Care Retirement Communities (CCRC)
  - a. Is the facility licensed by the Department of Insurance as a "Continuing Care Retirement Community"? a. YES \_\_\_\_ NO \_\_\_\_
  - b. If the facility has Retirement Beds, indicate total number of these beds. Do not include nursing or "Adult Care Home" beds. b. \_\_\_\_\_
  - c. If the CCRC owns or operates a licensed home care agency provide the agency license number: c. \_\_\_\_\_
  
2. Does the facility have an adult day care program? 2. YES \_\_\_\_ NO \_\_\_\_  
 If "Yes", indicate maximum number of clients that can be served on a daily basis. \_\_\_\_\_
  
3. Does the facility provide hospice care? 3. YES \_\_\_\_ NO \_\_\_\_
  
4. Does the facility have an adult respite program? 4. YES \_\_\_\_ NO \_\_\_\_
  
5. Is the facility a "Combination Facility", thereby incorporating licensed ACH beds? 5. YES \_\_\_\_ NO \_\_\_\_  
 If "Yes", indicate which rules the facility chooses to apply to the operation of these ACH beds. Nursing Home Licensure \_\_\_\_ ACH Licensure \_\_\_\_  
*(NH Licensure rules only, ACH rules only, or both NH & ACH licensure rules. \*\*Complete checklist if using both sets of rules.)*

**6. NUMBER OF BEDS BY TYPE (\*Must complete required data supplement form)**

- a. **Nursing Beds (NF)** (TOTAL) a. \_\_\_\_\_
  1. General Nursing Facility Beds 1. \_\_\_\_\_
  2. \*Alzheimer's Special Care Unit Resident Beds 2. \_\_\_\_\_
  3. HIV/AIDS Resident Beds 3. \_\_\_\_\_
  4. Traumatic Brain Injury Resident Beds 4. \_\_\_\_\_
  5. Ventilator Dependent Resident Beds 5. \_\_\_\_\_
  6. Bariatric Beds 6. \_\_\_\_\_
  7. Other: (Specify) \_\_\_\_\_ 7. \_\_\_\_\_
  
- b. **Adult Care Home (ACH)** (TOTAL) b. \_\_\_\_\_
  1. General Adult Care Home Beds 1. \_\_\_\_\_
  2. \*Alzheimer's Special Care Unit Beds 2. \_\_\_\_\_
  3. Bariatric Beds 3. \_\_\_\_\_
  
- c. **TOTAL LICENSED BEDS** (TOTAL a & b) c. \_\_\_\_\_

**PART B CURRENT OPERATING STATISTICS**

**Current Per Diem Reimbursement Rates/Charges.**

Please state the CURRENT (today's date or date the application is signed) basic daily charges/rates for patients or residents in your facility in the following categories of care.

**\* IF YOU HAVE QUESTIONS ON HOW TO COMPLETE THE FORM CALL 919-855-3873.**

<b>Private Pay (Usual Customary Charge)</b>	<b>Private Room (1 bed/room)</b>	<b>Semi-Private (2 beds/room)</b>	<b>Ward</b>
Nursing Care	\$	\$	\$
Adult Care Home	\$	\$	\$
Special Care Unit (specify) _____	\$	\$	\$
Special Care Unit (specify) _____	\$	\$	\$

<b>Medicare</b>	<b>Code</b>	<b>Rate</b>
Three most frequent RUGS codes and rates paid for them.	1.	\$
	2.	\$
	3.	\$

<b>Medicaid</b>	<b>Quarterly Rates</b>			
	<b>Oct.-Dec.</b>	<b>Jan.-Mar.</b>	<b>Apr.-June</b>	<b>July-Sept.</b>
Nursing Care	\$	\$	\$	\$

<b>Medicaid Nursing Care</b>	<b>Current Rate</b>
Special Care Unit (specify) _____	\$
Special Care Unit (specify) _____	\$

<b>State/County Special Assistance</b>	<b>Rate</b>
Adult Care Home	\$
Special Care Unit (specify) _____	\$
Special Care Unit (specify) _____	\$

Please complete only if applicable:

<b>Alzheimer's/Dementia Special Care Unit</b>	<b>Rate</b>
Additional cost or fee to resident	\$

**PART C LICENSE FEE**

A non-refundable per bed license fee is required for the number of beds added to the facility’s licensed capacity and must accompany this application prior to the issuance of a nursing home license. Payment for the license fee should be in the form of check, certified check or money order and must be made payable to: “**The Division of Health Service Regulation.**” Payment should include the facility’s license number and be submitted with this license application.

License Fee Calculation:

1.

a. Total number of <u>additional</u> Licensed beds. (must match number of additional beds approved by CON)	
b. Multiply by per bed fee	x \$12.50
c. Total per bed fee (1a “x, multiply by” 1b )	\$

**This application must be completed and submitted to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a nursing home license. The license fee is non-refundable. The legislation (SB-622, Session Law 2005-276) prohibits a license from being issued if the annual fee has not been paid.**

The undersigned submits this application for licensure for the year 2009 {subject to the provisions of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission} and certifies the accuracy of this information.

\_\_\_\_\_  
 Typed Name of Chief Administrative Officer  
 or Authorized Official

\_\_\_\_\_  
 (Written Signature)

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Please identify the contact person for questions regarding this application:

Name: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_