Application for License to Operate a Long Term Care Facility

OIG 006 – January 2017

I. TYPE OF APPLICATION

(Write or type an X next to all that apply.)

- ☐ Provisional licensure
- ☐ Annual Re-licensure
- ☐ Add Location/Satellite/Service
- ☐ Change of Name
- ☐ Change of Location
- ☐ Change of Ownership

II. IDENTIFICATION

License Number _____

(Do not fill in License Number if this is an application for provisional licensure)

Name of Facility _____

Physical Location of Facility _____

(Street) (City)

_____

(County) (State) (Zip Code)

Mailing Address _____

(If different from above) (Street) (City)

_____

(County) (State) (Zip Code)

Telephone Number _____

Email Address _____

(Primary contact for correspondence)

Administrator Name _____

Date facility began operating at current address _____

Date facility began operating under current owner _____

III. CONTROL (Check one in each column.)

- State ○
- County ○
- City ○
- Pivate ○

- Profit ○
- Nonprofit ○

- Individual ○
- Partnership ○
- Corporation ○

IV. OWNERSHIP Name and address of direct owner

A. Provide the following supporting documentation as an attachment to this application:

- The of name, mailing address, email address and phone number each person or legal entity having an ownership interest in the facility;
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation;
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

V. LICENSURE TYPE

Provisional licensure applications: Please check all license types for which you are applying and the number of beds requested.
Re-licensure applications: Please check all license types for which you are re-licensing and the number of beds currently licensed.
Addition of beds: Please check all license types for which you are licensed, enter the number of beds as specified on your facility's current license, and enter the number of beds you are requesting to add to a particular license.

LICENSE TYPE	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
☐ Nursing Facility (NF)	_____	_____
☐ Alzheimer's Nursing Home (ALZ)	_____	_____
☐ Nursing Home (NH)	_____	_____
☐ Intermediate Care Facility (ICF)	_____	_____
☐ Personal Care Home	_____	_____
☐ Intermediate Care Facility for Individuals with an Intellectual or Developmental Disability (ICF/IID)	_____	_____

An incomplete application or failure to submit the applicable licensure fee may result in return of the application to the applicant. A completed application should not be submitted to the Office of Inspector General until the facility is ready for an inspection.

I understand that as a condition precedent to provisional licensure, this facility shall be in compliance with all state and federal statutes and administrative regulations applicable to the license requested.

I understand that **any change** in the information provided in within this application affecting the licensure status of this facility or service will be reported to the Office of Inspector General and **a new application** will be completed at that time. I agree that this facility/service and all aspects of its operation shall allow all state agency licensure personnel entrance upon its premises for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application may result in denial or revocation of licensure.

_____ _____ _____
Signature of Authorized Representative Title Date

Submit the application, fee and supportive documentation to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

For Office Use Only: Check # _____ Amount _____