

Michigan Department of Licensing and Regulatory Affairs  
Bureau of Health Care Services  
Long Term Care Division

<b>For LARA Use Only</b>
<b>Licensing Officer Approval</b>
Date Approved

### Application for Nursing Home License

**Note:** Failure to correctly complete this application in its entirety may delay the processing of your application. Questions regarding this application can be directed to the Long Term Care Division at (517) 334-8408.

Choose one: <input type="checkbox"/> Initial License Application <input type="checkbox"/> Change of Ownership (CHOW) License															
<b>Facility Information</b>															
Facility Name/D.B.A. (Doing Business As)						State Facility Number			CMS Certification (CCN) #						
						<b>23-</b>									
Address				City			County			Zip Code					
Phone Number						Fax Number									
Primary Contact Person for Facility						Phone Number									
Emergency Contact Person						Phone Number									
MDS Assessment Contact Person						Phone Number									
NPI#(s) (National Provider Identifier) Please attach a separate sheet if necessary.															
<b>Licensed Administrator</b> (submit a copy of your current license)															
Administrator Name						E-mail Address									
License Number						License Expiration Date			Date of Hire						
4	8											Time Involvement: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contract			
If the Licensed Administrator is not full time and he/she is the licensed administrator at more than one facility indicate who will be in charge in the absence of the administrator.															
If the Licensed Administrator is part-time what is the name of the other facility he/she will be working at?															
<b>Licensed Director of Nursing</b> (submit a copy of your current license)															
Director of Nursing Name						License Number									
						4	7	0							
License Expiration Date						Date of Hire									
<b>Fiscal Intermediary</b> If applying for Licensure & Certification this section must be completed.															
Fiscal Intermediary						Intermediary/Carrier Number (This is not the Provider # or CCN)									
Address						City			State			Zip Code			

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<b>Bed Information</b> (current or requested beds)																			
	Current Beds	Requested Beds	Does the facility have any of the following beds that are <b><i>not</i></b> part of the " <i>Special Pool Beds</i> " issued by Certificate of Need?																
Medicare (SNF)	_____	_____	<input type="checkbox"/> Religious Beds <input type="checkbox"/> Ventilator Dependent <input type="checkbox"/> Dialysis <input type="checkbox"/> Alzheimer's Beds <input type="checkbox"/> Hospice																
Medicaid (NF)	_____	_____																	
Medicare/Medicaid (SNF/NF)	_____	_____																	
<b>Total Certified Beds:</b>	_____	_____																	
Licensed Only Beds*:	_____	_____																	
<b>Total Facility Beds:</b>	_____	_____																	
<i>*Fees are for the billing cycle covering the period of 8/1 through 7/31. Change of Ownership fees is equal to 1 year license fee regardless of the billing cycle. <b>DO NOT SEND FEES WITHOUT RECEIVING AN INVOICE.</b></i>																			
Does the facility have a locked Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, what special population is serving that unit?																
<b>Ownership</b> (legal entity which directly owns the facility)																			
Company/Owner Legal Name					Primary Owner														
Phone Number			Fax Number		E-mail Address														
Address				City		State		Zip Code											
Tax ID				Is the Ownership for:			Does the Owner												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">-</td> <td style="width: 20px; height: 20px;"></td> </tr> </table>						-								<input type="checkbox"/> Profit <input type="checkbox"/> Non Profit			<input type="checkbox"/> Own the building <b>or</b> <input type="checkbox"/> Is this a management company		
		-																	
Type of Entity																			
<input type="checkbox"/> Profit Individual			<input type="checkbox"/> Non Profit Religious			<input type="checkbox"/> State		<input type="checkbox"/> City/County											
<input type="checkbox"/> Profit Partnership			<input type="checkbox"/> Non Profit Corporation			<input type="checkbox"/> County		<input type="checkbox"/> Hospital District											
<input type="checkbox"/> Profit Corporation			<input type="checkbox"/> Non Profit Other			<input type="checkbox"/> City		<input type="checkbox"/> Federal											
Is the applicant part of a nursing home chain? <input type="checkbox"/> Yes <input type="checkbox"/> No					If yes, does this chain own <input type="checkbox"/> More than 30 <input type="checkbox"/> Less than 30														
Parent Organization Name					Contact Person			Phone Number											
Address					City		State		Zip Code										
Tax ID					Contact Name			E-mail address											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">-</td> <td style="width: 20px; height: 20px;"></td> </tr> </table>							-												
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<b>Officers/Directors/Trustees:</b> (attach additional pages if necessary)									
Name					Phone Number				
Address				City			State		Zip Code
Tenure From (date)		Is Primary <input type="checkbox"/> Yes <input type="checkbox"/> No		Position	<input type="checkbox"/> Director		<input type="checkbox"/> Manager		<input type="checkbox"/> President
					<input type="checkbox"/> Secretary		<input type="checkbox"/> Treasurer		<input type="checkbox"/> Vice President
					<input type="checkbox"/> Senior Officer		<input type="checkbox"/> Junior Officer		<input type="checkbox"/> Principal Officer
Tax ID					Percentage Owned				
		-							
Name					Phone Number				
Address				City			State		Zip Code
Tenure From (date)		Is Primary <input type="checkbox"/> Yes <input type="checkbox"/> No		Position	<input type="checkbox"/> Director		<input type="checkbox"/> Manager		<input type="checkbox"/> President
					<input type="checkbox"/> Secretary		<input type="checkbox"/> Treasurer		<input type="checkbox"/> Vice President
					<input type="checkbox"/> Senior Officer		<input type="checkbox"/> Junior Officer		<input type="checkbox"/> Principal Officer
Tax ID					Percentage Owned				
		-							
Name					Phone Number				
Address				City			State		Zip Code
Tenure From (date)		Is Primary <input type="checkbox"/> Yes <input type="checkbox"/> No		Position	<input type="checkbox"/> Director		<input type="checkbox"/> Manager		<input type="checkbox"/> President
					<input type="checkbox"/> Secretary		<input type="checkbox"/> Treasurer		<input type="checkbox"/> Vice President
					<input type="checkbox"/> Senior Officer		<input type="checkbox"/> Junior Officer		<input type="checkbox"/> Principal Officer
Tax ID					Percentage Owned				
		-							
Name					Phone Number				
Address				City			State		Zip Code
Tenure From (date)		Is Primary <input type="checkbox"/> Yes <input type="checkbox"/> No		Position	<input type="checkbox"/> Director		<input type="checkbox"/> Manager		<input type="checkbox"/> President
					<input type="checkbox"/> Secretary		<input type="checkbox"/> Treasurer		<input type="checkbox"/> Vice President
					<input type="checkbox"/> Senior Officer		<input type="checkbox"/> Junior Officer		<input type="checkbox"/> Principal Officer
Tax ID					Percentage Owned				
		-							
Are there any directors, officers, agents, or managing employees of the institution agency or organization who have been convicted of a criminal offense? <input type="checkbox"/> No <input type="checkbox"/> Yes → If "yes", please attach an additional sheet describing the event.									
Does anyone listed own or have an interest in other healthcare facilities (for example: sole proprietor, partner, member of a partnership, board of directors)? <input type="checkbox"/> No <input type="checkbox"/> Yes → If "yes", please attach an additional sheet indicating name, address, city, state & zip code and interest of parent corporation.									
Is the applicant facility chain affiliated? <input type="checkbox"/> No <input type="checkbox"/> Yes → If "yes", please attach an additional sheet indicating name, address, city, state & zip code.									
Are any persons who have ownership interest required to file a beneficial ownership report pursuant to the Federal Securities Exchanges Act of 1934 [15 U.S.C. 78p, Sec. 16 (a)]? <input type="checkbox"/> Yes – If yes, attach copies of such report <input type="checkbox"/> No									

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<b>Building Owner</b>			
Legal Owner of Building		Phone Number	
Address	City	State	Zip Code
<b>Lien Holder</b> (if different from building owner)			
Lien Holder		Phone Number	
Address	City	State	Zip Code
<b>Management Company</b> (who is responsible for nursing home day to day operations, if different than applicant?)			
Name of Company		Phone Number	
Address	City	State	Zip Code
Contact Person	E-mail address		
<b>Estimated Monthly Revenues/Expenditures:</b>			
Business experience related to nursing home operation, delivery of health care services:			
Estimated monthly revenues: _____			
Estimated monthly expenditures: _____			
<b>List of Suppliers</b>			
A list disclosing the names & addresses of each supplier who furnishes goods or services to the nursing home must be attached to this application. You must also include their total charges exceeding \$5,000.00 in a 12 month period including a month in the nursing homes current fiscal year.			
<b>Certification of Applicant</b>			
The Assurance and processing of this form is governed by Administrative Rules 325.20201 through 325.20215. Failure to submit an accurate and complete form in a timely manner may result in denial of licensure or certification. An applicant who makes a false statement in this application is subject to criminal penalties under Section 20142(5) of the Public Health Code (P.A. 368 of 1978 as amended) including four years imprisonment and/or \$30,000 fine. Each facility must be brought in full regulatory compliance at the time a CHOW is approved.			
The applicant certifies that the information provided on this application is true, complete and accurate to the best of his/her knowledge.			
The applicant certifies that the applicant and/or owner(s) have not had a professional, occupational or health agency license revoked within the preceding five years.			
_____ Applicant's Signature		_____ Applicant's Title	_____ Date
<b>Please submit to:</b> Michigan Department of Licensing and Regulatory Affairs Long Term Care Division P. O. Box 30664 Lansing, MI 48909			