STATE OF MICHIGAN

Michigan Department of Licensing and Regulatory Affairs (LARA)
Bureau of Community and Health Systems
HOME FOR THE AGED LICENSURE EXEMPTION REQUEST

1. Facility Name	2. Facility Telephone # ( )	3. Maximum Number of Residents	4. County
5. Facility Street Address	6. City/Village/Township	7. State	8. Zip Code

This department form is to request exemption from Home for the Aged licensure under MCL 333.21311a. By submission of this form, you are attesting that you meet the requirement to qualify for exemption from Home for the Aged licensure.

Note that "related" means any of the following personal relationships by marriage, blood, or adoption: spouse, child, parent, brother, sister, grandparent, grandchild, aunt, uncle, stepparent, stepbrother, stepsister, or cousin. Related also means an entity owns or is owned by a person that has a direct or indirect ownership interest in another entity that provides a component of operations or service as defined by MCL 333.21311a(8)(b).

Check one that applies and answer the supplemental question:

Option #1

☐ **This option can only be chosen if the facility was previously approved for an exemption and there has been a change in owner, operator and/or governing body. Provide previously approved exemption number: XH_____.**

The person (or entity) that provides board (food) is not related to the person (or entity) that provides room (landlord) or supervised care or both.

Check all that applies (must check at least one):

☐ I attest that the food provider is not related to the room provider.
or
☐ I attest that the food provider is not related to any known personal care providers at this facility.

OR

Option #2

☐ **This option can only be chosen if the facility was previously approved for an exemption and there has been a change in owner, operator and/or governing body. Provide previously approved exemption number: XH_____.**

The person (or entity) that provides supervised personal care whether or not they are related to the person (or entity) that provides room or board or both, has had a supervised personal care arrangement in effect for at least 2 consecutive years before the date of this request. Residents at this facility have the option to select any supervised personal care provider of their choice.

Personal Care has been continuously provided at this facility since _____ (mm/yyyy)

OR

Option #3

☐ The person (or entity) that provides the room and the person (or entity) that provides the supervised personal care are related and the facility is registered as a continuing care community per MCL 554.901 to 554.993, and includes a licensed nursing home as part of the continuing care community.

The continuing care community/living care disclosure act registration number: _____ (LC-5 digits)

OR

Option #4

☐ The person (or entity) that provides room and the person (or entity) that provides supervised personal care are not related. Residents at this facility have the option to select any supervised personal care provider of their choice.

Check the one box that applies:

☐ As the room provider for this facility, I attest that the room provider is not related to any personal care provider who is providing personal care at this facility.

or

☐ As the personal care provider at this facility, I attest that that the personal care provider is not related to the room provider.

APPLICANT

9. Person(s)/Entity		10. Federal Tax I.D. or Social Security #		
11. Person(s)/Entity Street Address	12. Person(s)/Entity City	13. State	14. Zip Code	15. County
16. Mailing Address (if different than #12)	17. City	18. State	19. Zip Code	20. County
21. Person(s)/Entity Telephone ( )	22. Person(s)/Entity Email Address		23. If Entity, Provide Corporation ID #	
24. Individual or company requesting exemption: ☐ Property Owner ☐ Operator ☐ Governing Body				
25. If entity, name of individual or member of the entity with authorization to submit request (Print or Type)			26. Individual/Member Phone Number ( )	
27. Individual/Member Title			28. Date of Birth	

*Required

☐ I certify that I am authorized to submit this Home for the Aged licensure exemption request. I further certify by my signature below that the information contained herein is true and accurate and that the penalty for submitting a false or inaccurate attestation is an administrative fine of $5,000.00. Submitting false or inaccurate information could result in a denial of this request and/or revocation of an exemption.

29. Individual/Member Signature	30. Date

Return this form to the following location:

LARA-BCHS
Attn: Licensing Unit
PO Box 30664
Lansing, MI 48909

For questions please contact the Licensing Unit at (866) 685-0006 or (517) 284-9738.