



Application for New Facility Residential Care Facility

Enclosed are the application forms and required documentation for application for license to operate a residential care facility. For additional information on the rules and regulations regarding this action please refer to:

<http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm>. An application should include the following forms and/or documentation:

1. State Form 8200, Application For License To Operate A Health Facility, to include required attachments (State Form 8200 enclosed)
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed)
3. Documentation of the applicant entity's registration with the Indiana Secretary of State
4. Internal Revenue Services (IRS) documentation: Submit a SS-4 or comparable document from the IRS that reflects direct owner's corporation, limited liability company partnership, etc name, d/b/a if applicable and EIN number. **The document must be from the IRS sent to the provider** not a form/document the provider completed and sent to the IRS.
5. State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments (enclosed)
6. Licensure fee; \$200 for the first fifty (50) beds and \$10 for each additional beds
7. State Form 4332, Bed Inventory (enclosed)
8. Facility floor plan on 8 1/2" x 11" paper to show room numbers and number of beds per room;
9. A staffing plan that should include the number, educational level and personal health of employees
10. Facilities with contracts for services which require a licensed and/or certified professional should include copies of the licenses and/or certification for the individuals who will be providing the services, agreements/contracts between the applicant entities with various providers of services for residents within the facility should include: Dietician, Emergency Shelter, Emergency Water Supply, Hospital Transfer Agreement(s) (if applicable), Pharmacy Services, and Pharmacy Consultant Services (if applicable)

The following is a general outline of the application process (in approximate chronological order):

1. Submit plans and specifications for new construction or an existing building to the Indiana State Department of Health, Division of Sanitary Engineering for review and approval
2. Once plans and specifications have been approved, and new construction or remodeling of an existing building is substantially complete, please submit a copy of the architect's Statement of Substantial Completion Request for Inspection, State Form 13025 (or A1A G407) to the Program Director-Provider Services, Division of Long Term Care
3. Submit the above documents in order for the Division of Long Term Care to grant authorization to occupy the facility:
4. Request for the applicable fire safety inspections (Life Safety Code, Sanitarian and/or State Fire Code) to the Program Director-Provider Services, Division of Long Term Care
5. Once the applicable fire safety inspections have been conducted and released, the Division of Long Term Care will issue an Authorization to Occupy letter to the applicant (residents may be admitted upon receipt of this authorization)
6. Once these requirements are satisfied, and the facility has provided residential care to at least two (2) residents, the facility may submit a written request to the Program Director-Provider Services for the initial licensure survey
7. Upon completion of the initial licensure survey, the Division of Long Term Care will forward the survey results

If you have questions regarding the application process please contact Provider Services at 317/233-7794 or 317/233-7613.



**APPLICATION FOR LICENSE
TO OPERATE A HEALTH FACILITY**

(Pursuant to IC 16-28 and 410 IAC 16.2)

State Form 8200 (R3/8-00)

Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received _____
Date Approved _____
Approved by _____

Please Print or Type

SECTION I - TYPE OF APPLICATION

Application *(check appropriate item)*

Change of Ownership *(Anticipated date of Sale/Purchase/Lease) _____* New Facility Other _____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility _____

Street Address _____

P.O. Box: _____

City _____

County _____

Zip Code +4 _____

Telephone Number _____

Fax Number _____

Facility's Cost Reporting Year

() ()

() ()

From (mm/dd):

To (mm/dd):

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address _____

P.O. Box _____

City _____

State _____

Zip Code+4 _____

Telephone Number _____

Fax Number _____

EIN Number _____

() ()

() ()

Fiscal Year End Date
(mm/dd)

C. Building Information

1. Status of building to be used *(check appropriate item)*

Proposed New Construction Alteration of Existing Building Existing Licensed Health Facility Other _____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

D. Type of Services to be Provided			
1. Level of Care <input type="checkbox"/> Residential <input type="checkbox"/> Comprehensive (Certified) <input type="checkbox"/> Comprehensive (Non-certified) <input type="checkbox"/> Children's Facility <input type="checkbox"/> Developmentally Disabled Total Number of Licensed Beds	Number of Beds in Each Category (to be licensed) _____ _____ _____ _____ _____ _____	2. Certification Designation <input type="checkbox"/> SNF (Title 18 – Medicare) <input type="checkbox"/> SNF/NF (Title 18 – Medicare/Title 19 – Medicaid) <input type="checkbox"/> NF (Title 19 – Medicaid) <input type="checkbox"/> ICF/MR Total Certified Beds	Number of Beds in Each Category (to be licensed) _____ _____ _____ _____ _____

SECTION III – STAFFING

A. Administrator		
Name (enter full name)		
Indiana License Number (please include a copy of license with application)	Date of Birth	Date employed in this position
1. List post secondary education and health related experience _____ _____ _____		
2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.		
3. Has the administrator ever been convicted of any criminal offense related to a dependent population? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state on a separate sheet the facts of each case completely and concisely)		
4. Has the administrator's license ever lapsed, been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state on a separate sheet the facts of each case completely and concisely)		
5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain on a separate sheet)		
B. Director of Nursing		
Name (enter full name)		
Indiana License Number (please include a copy of license with application)	Date of birth	Date employed in this position
Education (Name of School of Nursing)		
School Degree	Year Graduated	
Other College Education		
Qualifications or Experience		
1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state on a separate sheet the facts of each case completely and concisely)		

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? Yes No

(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTION IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT

(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2))

A. Applicant Entity

Name of Applicant Entity (operator(s) of the facility)

D/B/A (Name of Facility)

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (use additional sheet if necessary)

Name	Business Address	EIN Number

C. Type of Change of Ownership

- Assignment of Interest
 Lease
 Merger
 New Partnership
 Sale
 Sublease
 Termination of Lease
 Other _____

D. Type of Entity

For Profit

NonProfit

Government

- | | | |
|--|--|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Church Related | <input type="checkbox"/> State |
| <input type="checkbox"/> * Partnership | <input type="checkbox"/> Individual | <input type="checkbox"/> County |
| <input type="checkbox"/> ** Corporation | <input type="checkbox"/> * Partnership | <input type="checkbox"/> City |
| <input type="checkbox"/> *** Limited Liability Company | <input type="checkbox"/> ** Corporation | <input type="checkbox"/> City/County |
| <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> *** Limited Liability Company | <input type="checkbox"/> Hospital District |
| _____ | <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Federal |
| _____ | _____ | <input type="checkbox"/> Other (specify) _____ |

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? Yes No

If "yes," list names and addresses of facilities owned by each individual. *(use additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? Yes No

If yes, explain _____

Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? Yes No

(If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

- 1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
 Yes No (If "Yes", provide name of facility, state, date(s), restrictions and type)
- 2. Had a facility's license revoked, suspended or denied. Yes No (If "Yes", provide name of facility, state, type of actions and date(s))
- 3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
 Yes No (If "Yes", provide name of facility, state, date, type of action, results of action)
- 4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy Yes No (If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)
- 5. Filed for bankruptcy, reorganization or receivership. Yes No (If "Yes", include all relevant documentation and provide a detailed summary of the events and circumstances. Include state, dates and names of facilities)

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color, creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative (Typed)	Title
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Signature	Date
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STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____ County, State of _____,
this _____ day of _____ 20_____

(SEAL) (Signature) _____
_____, Notary Public
(Type or Print Name)

My Commission expires _____



IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)

Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility

Street Address

City

State

Zip+4

SECTION A

This health facility does does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility does does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? yes no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF _____ (date)

A. Current Assets:		B. Current Liabilities:	
<i>Asset</i>	<i>Amount (rounded to nearest dollar)</i>	<i>Liability</i>	<i>Amount (rounded to nearest dollar)</i>
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		Total Current Liabilities	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: (Total Current Assets minus Total Current Liabilities) \$ _____

D. Total Liabilities: \$ _____ E. Total Owner's Equity or Fund Balance: \$ _____

F. Lines of Credit (*List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary*):

<u>Name of Institution or Lender</u>	<u>Amount of Credit Available</u>
1.	\$
2.	\$
3.	\$
4.	\$

G. Number of Facility Beds: _____
Projected Monthly Revenue: \$ _____
Projected Monthly Operating Expenses: \$ _____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (Typed)	Title/Position
Signature of Authorized Person	Date

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (Typed)	Title/Position
Signature of Certified Public Accountant representing the firm	License/Certification Number Date



BED INVENTORY

State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility															
Street Address															
City				County				Zip+4							
PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS: Each room should be listed only once and listed in numerical order under each classification column.										Room No.	No. Beds				
Title 18 SNF = Medicare ONLY beds Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) Title 19 NF = Medicaid NCC = Non-Certified Comprehensive Residential Level of Care										8	2				
										9	2				
										10	2				
										11	3				
										12	2				
20	2														
All licensed beds must be listed.															
Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential					
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds				
Total 18 SNF		Total 18/19 SNF/NF		Total 19 NF				Total NCC		Total Residential					
Current SNF Census _____				Current SNF/NF Census _____				NOTE <i>Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed and certified for.</i>							
Current NF Census _____				Current NCC Census _____											
Current Residential Census _____				TOTAL CURRENT CENSUS _____											
TOTAL LICENSED CAPACITY _____															
Completed by _____				Position _____								Date _____			