

## ASSISTED LIVING APPLICATION FOR LICENSURE

### 1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

Initial       Renewal       Change of Ownership (specify effective date)       Other Change (specify type)

LICENSE NUMBER (if applicable)			WEBSITE (if applicable)		
LEGAL AGENCY NAME			TRADING NAME (DBA)		
E-MAIL ADDRESS			PHONE NUMBER	FAX NUMBER	
BUSINESS ADDRESS (physical location)			MAILING ADDRESS (if different)		
NUMBER, STREET			NUMBER, STREET		
CITY	STATE	ZIP	CITY	STATE	ZIP

Does the owner, corporation, or partnership operate and manage the assisted living program?  Yes  No  
(identify the management structure and its relationship to the business owner)

NUMBER OF RESIDENTS CURRENTLY SERVED	NUMBER OF BEDS REQUESTED	LEVEL OF CARE REQUESTED <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
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Are all areas of the assisted living facility fully constructed?  Yes  No (identify any areas not fully constructed and the extent of construction progress)

NAME OF MANAGER	PHONE NUMBER	CELL NUMBER	
HOME ADDRESS (number, street)	CITY	STATE	ZIP
NAME OF ALTERNATE MANAGER	PHONE NUMBER	CELL NUMBER	
HOME ADDRESS (number, street)	CITY	STATE	ZIP
NAME OF DELEGATING NURSE (DN)	PHONE NUMBER	CELL NUMBER	
HOME ADDRESS (number, street)	CITY	STATE	ZIP
DN'S LICENSE NUMBER	EXPIRATION DATE OF DN'S LICENSE		

Is your facility planning to operate, or currently operating, an "Alzheimer's Special Care Unit or Program?"  No  
 Yes (refer to the instruction guide for details on submitting your program description)

### 2. FEES

To determine the amount of the **non-refundable** license fee and accepted methods of payment, refer to the instruction guide.

FEE ATTACHED?  Yes

**3. OWNERSHIP (Type of business organization of disclosing entity)**
 SOLE PROPRIETORSHIP     PARTNERSHIP     CORPORATION

NAME	ADDRESS
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IF PARTNERSHIP OR CORPORATION,  
PARTNER, OFFICER, DIRECTOR, OR STOCKHOLDER INFORMATION AND PERCENTAGE OWNED IF 25% OR MORE

NAME AND TITLE	E-MAIL	PHONE NUMBER	ADDRESS	% OWNED

IF CORPORATION:  

DATE OF CHARTER	DATE OF INCORPORATION	FEIN NUMBER
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NAME OF PRESIDENT	PHONE NUMBER	CELL NUMBER	
ADDRESS (number, street)	CITY	STATE	ZIP

**4. BACKGROUND**

1. Has the applicant, owner, or managerial staff ever had a license, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked?  No  Yes (explain)

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2. Does the applicant currently hold, or has the applicant previously held, any license or certification for the operation of a health care facility or similar health care program?  No  Yes (explain)

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3. Does the owner, applicant, manager, alternate manager, other staff, or any household member have a criminal conviction or other criminal history?  No  Yes (explain)

**5. WORKERS' COMPENSATION**

Do you have any employees?  Yes  No

If you answered YES, provide your workers' compensation insurance information:

POLICY NUMBER	BINDER NUMBER
INSURANCE COMPANY	EFFECTIVE DATE
	EXPIRATION DATE

If you answered NO, additional documentation from the Workers' Compensation Commission must accompany this application (refer to the instruction guide for details).

**6. AFFIDAVIT**

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing application are true. I understand that the falsification of an application for a license may subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by the DHMH. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that this agency is in compliance with administrative and procedural requirements pertaining to the Assisted Living Programs Code of Maryland Regulations (COMAR 10.07.14).

I further certify that I will notify the OHCO if there are any future substantive changes in agency and operation, and that written notice will be given before the effective date of the change.

I hereby swear and affirm that I am over the age of 21 and I am otherwise competent to sign this Affidavit.

*If the program is going to be in more than one applicant's name, each applicant's signature is required.*

SIGNATURE OF APPLICANT	TITLE	DATE	
SIGNATURE OF APPLICANT	TITLE	DATE	
SIGNATURE OF APPLICANT	TITLE	DATE	
SIGNATURE OF APPLICANT	TITLE	DATE	
<b>FOR OFFICE USE ONLY</b>			
LICENSE NUMBER	FEE \$	CHECK/MO #	CHECK/MO DATE