APPLICATION FOR RENEWAL OF HEALTH FACILITY LICENSE

State Form 1714 (R5/5-03)
Approved by State Board of Accounts - 2003
Indiana State Department of Health-Division of Long Term Care

If there will be a change in the licensee (applicant entity), a change of ownership application should be requested from The Division of Long Term Care.

NOTE: Any person, in order to lawfully operate a health facility, as defined in IC 16-18-2-167, shall first obtain an authorization to occupy the facility or a license from the Director. The applicant shall notify the Director, in writing, before the applicant begins to operate a facility that is being purchased or leased from another licensee. Failure to notify the Director precludes the issuance of a full license.

INSTRUCTIONS: If the current license is to be renewed (same licensee/applicant entity) complete and return this form within ten (10) days, along with the correct licensure fee, made payable to the Indiana State Department of Health. Payment shall be made in the form of a check or money order *(Do not send currency in the mail)*.

NOTE:
$200 for the first 50 beds
$10.00 for each additional bed

_____ Total number of licensed beds

(Please Print or Type)

1. **LICENSEE (APPLICANT/OWNING ENTITY)** _____
(List exactly as recorded on the facility's current license)

2. **LICENSEE EMPLOYER IDENTIFICATION NUMBER (EIN)** _____

3. **ENTITY TYPE**

☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Unincorporated Association ☐ Other (Specify)_____ ☐ Limited Liability Corporation

4. **FACILITY NAME (dba)** _____
(List exactly as recorded on the facility's current license)

5. **ADMINISTRATOR**	6. **DIRECTOR OF NURSING**

7. 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	MAILING ADDRESS	EIN NUMBER

8. If the licensee (disclosing entity) is a corporation, list names, titles, and addresses of the officers and directors. If a partnership, list partners and addresses. If anything other than a corporation or partnership, list name, title and address of the person or persons having directing authority. (Use additional sheets if necessary.)

A. OFFICERS OR PARTNERS:

NAME	TITLE	MAILING ADDRESS

B. DIRECTORS:

NAME	TITLE	MAILING ADDRESS

I hereby certify that operational policies of this 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 I will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in item 8 of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (E.G., THE ADMINISTRATOR) OTHER THAN INDICATED IN ITEM 8 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
Signature	Date

PLEASE RETURN TO:
INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
2 NORTH MERIDIAN STREET SECTION 2-C
INDIANAPOLIS, INDIANA 46204-3006