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 ½" 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 FACLITY

(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 APPLICATON

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	Number of Beds in Each Category (to be licensed)	2. Certification Designation	Number of Beds in Each Category (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds		**Total Certified Beds**	

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? ☐ Yes ☐ 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? ☐ Yes ☐ 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?
   ☐ Yes ☐ 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? ☐ Yes ☐ 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)

SECTON 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

☐ Individual

☐ * Partnership

☐ ** Corporation

☐ *** Limited Liability Company

☐ Other *(specify)* _____

_____

_____

NonProfit

☐ Church Related

☐ Individual

☐ * Partnership

☐ ** Corporation

☐ *** Limited Liability Company

☐ Other *(specify)* _____

_____

Government

☐ State

☐ County

☐ City

☐ City/County

☐ Hospital District

☐ Federal

☐ 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
Signature	Date

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 ρ does ρ 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 E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

*Subscribed and sworn to before me, this*_____*day of* _____*,20*_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION OF ASSETS AND LIABILITIES

State Form 51996 (R1/6-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	CPA:
1. Complete sections I, II, and section III, F and G. 2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process. 3. Forward the completed materials to a Certified Public Accountant. 4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation. 2. Using agreed upon procedures; verify items in section IV, F. 3. Sign and date the certification statement as indicated in Section IV (CPA). 4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

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

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:			
Street Address			
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) Same as Licensee on Application for License to Operate a Health Facility, Section B		
Street Address		P.O. Box
City	State	Zip Code + 4

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____

(date)

A. Current Assets:		B. Current Liabilities:	
Asset	*Amount (rounded to nearest dollar)*	*Liability*	*Amount (rounded to nearest dollar)*
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)*:

Name of Institution or Lender	Amount of Credit Available
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.

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

All licensed beds must be listed.

Room No.	No. Beds
8	2
9	2
10	2
11	3
12	2
20	2

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 _____
Current NF Census _____
Current NCC Census _____
Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

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.

Completed by	Position	Date

APPLICATION FOR CONSTRUCTION PERMIT FOR LONG-TERM CARE FACILITIES

State Form 49453 (R2 / 8-06)
INDIANA STATE DEPARTMENT OF HEALTH / SANITARY ENGINEERING
Approved by State Board of Accounts, 2006

DATE RECEIVED _____

RECEIPT NUMBER _____

PROJECT NUMBER _____

INSTRUCTIONS:
1. *Send check or money order along with plans to:*
   Indiana State Department of Health
   Attention: Cashier's Office
   P O Box 7236
   Indianapolis, IN 46207-7236
2. *Direct questions to 317/233-7177*

FAXED COPIES OF APPLICATIONS WILL NOT BE ACCEPTED

1. OWNER _____
   Name _____
   Address _____
   _____
   Phone No. _____

2. OWNER'S DESIGNATED AGENT
   Name _____
   Title _____
   Address _____
   _____
   Phone No. _____

3. FACILITY (TYPE OF PROJECT)
   _____
   Name _____
   Address _____
   _____
   City _____
   County _____ Zip _____

4. ENGINEER/ARCHITECT
   Name _____
   _____
   Address _____
   _____
   _____
   Phone No. _____
   License # _____

5. The Following Documents are Attached:
   (CHECK WHERE APPLICABLE)
   A. Water Supply: ☐ Public ☐ Existing ☐ Private ☐ New
   B. Plot Plan with Site Utilities: ☐
   C. Sewage Disposal: ☐ Public ☐ Existing ☐ Private ☐ New
   D. Plans and Specifications certified by Architect or Engineer: ☐
   E. Number of Licensed Beds _____
      (1) Comprehensive Care ☐
      (2) Residential Care ☐
   F. **Fees Required** by 410 IAC 6-12-17. ☐ **(see other side)**

6. SIGNATURE
   Application is hereby made for a Permit to authorize the activities described herein. I certify that I am familiar with the information contained in this application, and to the best of my knowledge and belief such information is true, complete, and accurate.

   _____
   Printed Name of Person Signing

   _____
   Title

   _____
   Signature of Owner or Designated Agent

   _____
   Date Application Signed *(month, day, year)*

INSTRUCTIONS FOR COMPLETION OF CONSTRUCTION PERMIT FOR LONG-TERM CARE FACILITIES

1. Owner	Name and address of person, company, firm, municipality, authority, etc.,
2. Authorized Agent	Name, title, address, and phone number of person who is designated to act for owner and who is familiar with the project and can furnish additional information as required.
3. Name of Facility or Project	State its name, location, and nearest possible address.
4. Name of Engineer/Architect	Name, title, company, address and phone number of engineer or architect registered in the State of Indiana who certified and sealed the construction plans and specifications.
5. Check the squares indicating name of documents attached to Application. All documents are required except where inapplicable.	A. Specify the type of water supply serving the subject facility, and whether new or existing. B. Plot plan or plans to scale showing property lines, structures, roads, and site utilities. C. Specify the type of sewage disposal serving the subject facility, and whether new or existing. D. Plans, drawn to scale, shall be prepared, by an individual qualified under applicable laws of the State of Indiana. (See No. 4 above, if applicable). E. Specify the number of licensed beds and indicate the level of licensure below. (1) Comprehensive Care (2) Residential Care F. **Fees Required** by Rule 410 IAC 6-12-17. **Health Facility** **$150**

6. SIGNATURE
An application submitted by a corporation must be signed by a principal executive officer of at least vice president level or his duly authorized representative, if such a representative is responsible for the overall operation at the facility from which the construction described in the form will originate. In the case of a partnership or a sole proprietorship, the application must be signed by a general partner or the proprietor, respectively.