Reset Form

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACILITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R4 / 7-15)
Indiana State Department of Health-Division of Long Term Care

Please Print or Type.

SECTION I - TYPE OF APPLICATON

Application *(Check appropriate item.)*

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

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address *(number and street)*			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 *(number and street)*			P.O. Box
City		State	ZIP Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Management Company Information

Name		
Street Address *(number and street)*		
City	State	ZIP Code+4
Contact Name		
Contact email	Telephone	

D. 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)*

_____ _____ _____ _____

E. 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/IID	_____
☐ 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 *(mm/dd/yy)*	Date employed in this position *(mm/dd/yy)*

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 *(mm/dd/yy)*	Date employed in this position *(mm/dd/yy)*

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 *(number and street, city, state, and ZIP code)*	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

NonProfit
☐ Church Related
☐ Corporation
☐ Other *(specify)* _____
_____

Government
☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal

**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.

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 *(number and street, city, state, and ZIP code)*	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 *(number and street)*	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 <u>AFFIDAVIT MUST BE SUBMITTED</u> 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 *(mm/dd/yy)*

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_____
(mm/dd/yy)