

License Application for Residential Care and Assisted Living Facilities

Applications must be received by Seniors and People with Disabilities (SPD):

- 60 days prior to initial licensing
- 60 days prior to change of ownership
- 45 days prior to license renewal date

Part 1: Facility information

1. **Type of license:** Indicate type of license being requested. *(One application per license)*

2. **Licensing fee:**

A licensing fee is required for each change of license, including initial licensing, change of ownership, change of management, new facility name, increase or decrease in capacity.

Licensing fees are determined by the number of licensed beds at the facility: 1 to 15 beds - \$360; 16 - 49 beds - \$520; 50 – 99 beds - \$1,040; 100 – 150 beds - \$1,340; 151 or more beds - \$1,500.

Alzheimer's care unit fees: Fewer than 16 beds - \$50.00; 17 - 50 beds - \$75.00; 51 or more beds - \$100.00.

Make all checks payable to the Department of Human Services (DHS).

3. **Type of action:** check appropriate box.

4. **Facility information:**

Identify *name of facility*. Facility name must be registered with Secretary of State Corporation Division.

Web site: <http://filinginoregon.com>

Name of administrator – If *Administrator Reference Summary* has not been previously submitted, please submit form *SDS 0566*, which can be obtained at <http://www.dhs.state.or.us/admin/forms>.

Authorized designee is the person who is approved to receive and process criminal history check forms.

Please state *maximum capacity* and total *number of rooms or units*.

5. **Applicant information:**

One application form must be submitted by the business owner and another form by the *operator (i.e., management)*. If owner and operator are the same, only one application is required (*check both boxes*). If business is owned by one party, but operated or managed by another entity, two application forms are required. Only one license fee (*and Alzheimer's Care Unit (ACU) fee if applicable*) must be paid.

- Federal Employer Identification Number (EIN). Enter nine-digit employer identification number (EIN) assigned by the IRS in the following format: XX-XXXXXXX. For more information about an EIN, please check <https://www.irs.gov> for "Employer Identification Numbers" or "EIN".
- Check the entity type that best describes the structure of your organization. "Government" or "Tribal" agencies or organizations: If a Federal, State, County, City or other level of government, or an Indian tribe, will be legally and financially responsible for Medicaid payments received (*including any potential overpayments*), the name of that government or Indian tribe should be reported as owner. The provider should identify as having "ownership or control interests" the key authorized officials of

the government or tribal agency or organization to the laws, regulations, and program instructions of the Medicaid program.

Part 2: Ownership and control interests *(Use the following definitions to identify the individuals you should enter in parts A, B and D of this section.)*

“Direct ownership interest” is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. See 42 CFR 455.100 to calculate ownership or control percentages.

“Indirect ownership interest” is defined as ownership interest in an entity that has direct or indirect ownership interest in the applicant. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock in the applicant, A’s interest equates to an 8 percent indirect ownership.

“Controlling interest” is defined as the operational direction or management of an applicant which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (*i.e. joint venture agreement, unincorporated business status*) of the applicant; the ability or authority to nominate or name members of the Board of Directors or Trustees of the applicant; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the applicant; the right to control any or all of the assets or other property of the applicant upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the applicant to new ownership or control. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equates to 6 percent.

“Other disclosing entity” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participating in any Title V, XVLL, or XX of the Act. This includes hospitals, skilled nursing facilities, health maintenance organizations that participate in Medicare (*Title XVLL*) and any entity that furnished or arranges for the furnishing of health related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

“Subcontractor” means an individual, agency, or organization to which a disclosing entity has contracted or delegated part of its management functions or responsibilities of providing medical care to its patients; or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

F. List each long term care facility *(include RCFs, ALFs and Nursing Facilities (NF))* in Oregon or any other state owned or managed by any person owning 10% or more of this facility.

Part 3: Status changes *(respond to all questions)*

- “**Management company**” is defined as any organization that operates and names a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operations of the facility.
- A “**chain affiliate**” is any freestanding health care facility that is owned, controlled or operated under lease or contract by an organization consisting of two or more freestanding health care facilities organized within or across state lines, which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital-based home health agencies are not considered chain affiliates.

Part 4: Board of Directors *(for organizations that are corporations, this section asks for information about each person on the Board of Directors)*

Part 5: Credit check authorization

A consent for individual credit record check to be completed by each 10% owner.
Consent for business credit record check to be completed by an authorized representative for the business owner.

Part 6: Medicaid contact

Read and complete for renewal, new license, or change of owner, if requesting a Medicaid Contract. Please specify any other contracts.

Part 7: An approved criminal history check

An approved criminal history check is required for new license, change of owner and renewal applications. Fill out DHS 0301AD, “Criminal History Request”, and process the completed form through the facility authorized designee (AD). A criminal history check within the past year will be accepted.

[Click here to download form DHS 0301AD](#)

Incomplete or falsified applications may result in denial of license.

If the application is handwritten, please print and use black or blue ink.

Do not use “white-out” or correction tape.

If an error is made, draw a line through error, write in correct information, initial and date the change.

Changes must be made by the person signing the application.

Mail applications and fees to:

Seniors and People with Disabilities

Attn: Carolyn Ramus, Licensing Specialist

500 Summer St. NE E13

Salem, OR 97301-1074

If you need this application in an alternate format contact:

Phone: 503-945-5853 Fax: 503-947-5046

License Application for Residential Care and Assisted Living Facilities

License number	Begin date	Expire date
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SPD use only	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Date: / /	Date: / /

Current license expiration date: _____

Part 1: Facility information

- 1. Type of license:** Residential care Assisted living Alzheimer's endorsed
- 2. Licensing fee:** RCF/ALF fee paid Alzheimer's fee paid
- 3. Type of action:** Biennial renewal Change of owner New facility Projected date _____
- Facility name change Change of operator/management
- Increase/decrease in licensed units/capacity

4. Facility information:

Name of facility: _____
Doing business as; (DBA) name registered with Oregon Secretary of State.

Phone: _____ FAX: _____

Street address: _____

City, State, ZIP: _____ County: _____

Mailing address (If different than street address): _____

Mailing City, State, ZIP: _____

Administrator: _____ E-mail: _____ Start date: _____

Authorized designee: _____ E-mail: _____ Start date: _____

Maximum capacity: _____ Current census: _____

Number of units: _____ Alzheimer's endorsed number of beds: _____

Is property owned by applicant? Yes No If "No," provide owner contact information below.

Name: _____ Address: _____ Phone: _____

5. Applicant information: Owner Management

Name of legal owning entity: *(exactly as registered with the Oregon Secretary of State Corporation Division)* _____
EIN or tax identification number: _____

Street address: _____

City, State, ZIP: _____ Contact name: _____

Phone: _____ Fax: _____ E-mail: _____

Type of business: For profit corporation LLC Partnership Sole proprietorship LLP

Tribal Not for profit corporation Government owned Other: _____

Workers' Compensation carrier: _____

Is applicant current on payment? Yes No Policy number: _____

Part 2: Ownership or control interests

- A. List the name and address for individuals and the EINs for organizations having **direct or indirect ownership** or controlling interest in the provider entity (*see instructions for definition of ownership and controlling interest*). Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

Name	Title	Address	EIN	Entity type*

*Entity type: In the "entity type" field, enter one of the codes listed below for each individual listed.

1. Sole proprietorship 2. Partnership 3. Unincorporated associations
 4. Corporation 5. Government or tribal 6. Other (*specify*):

- B. List the name, address and employer identification number of each person or entity with an ownership or controlling interest **in any subcontractor** in which the disclosing entity has direct or indirect ownership of 5 percent or more.

Name	Title	Address	TIN	Percentage

- C. List those persons named in A or B that are related to each other (*spouse, parent, child, sibling or other family members by marriage or otherwise*).

Name	Relationship	Address

- D. List the name, address, EIN and DHS provider number of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or control interest of at least 5% or more.

For example, are any owners of the disclosing entity also owners of Medicare or Medicaid facilities? (*Example, sole proprietor, partnership or members of Board of Directors.*)

Name	Address	EIN	DHS provider number

- E. List the name, title and address of any individual or entity with an ownership or controlling interest in the disclosing entity that has been suspended or debarred from participation in Medicare, Medicaid or Title XX program.

Name	Title	Address

F. List each long term care facility (include RCFs, ALFs and Nursing Facilities (NF)) in Oregon or any other state owned or managed by any person owning 10% or more of this facility.

Facility name	Address

Part 3: Status changes

- A. Has there been a change in ownership or control within the last year?
 No Yes If yes, give date: _____
- B. Do you anticipate any change of ownership or control within the year?
 No Yes If yes, when? _____
- C. Do you anticipate filing for bankruptcy within a year?
 No Yes If yes, when? _____
- D. Is this facility operated by a management company or leased in whole or in part by another organization, has there been a change in management within the past year?
 No Yes If yes, give date of change in operations: _____
- E. Has there been a change in administrator within the last year? (If "yes", please check box below and list date.)
 Administrator Date: _____ Name of new administrator: _____
- F. Is this facility chain-affiliated? No Yes (If yes, list name, address of corporation and EIN.)

Name	Address	EIN

If the answer to (F) is no, was the facility ever affiliated with a chain? No Yes
 If yes, list name, address of corporation and EIN.

Name	Address	EIN

- G. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last two years?
 No Yes If yes, when? _____
 Current beds: _____ Prior beds: _____

Part 4: Board of Directors

If the disclosing entity is a corporation (for example, for profit, non-profit, limited liability, or other corporate form), list the name, title and address of the directors.

Name	Title	Address

Provider signature

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of application.

By signing this Disclosure Statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the Department of Human Services (DHS) or its designee, in writing, within 30 days of any changes or if additional information becomes available.

I, the undersigned, an authorized representative of the applicant declare to the best of my knowledge this information is true, correct and complete. I give Seniors and People with Disabilities (SPD) permission to obtain payment information from the Workers' Compensation Carrier and any entity from which the applicant leases building, property or business.

Name of authorized representative

Title

Signature

Date

Part 5: Credit check authorization

Consent for individual credit record check:

I, _____, hereby consent to a release of information regarding my credit history to the Department of Human Services, Seniors and People with Disabilities, State of Oregon. This consent expires 24 months after date signed.

Name (<i>printed</i>): _____	Date of birth: _____	SSN: _____
Home mailing address: (<i>include City, State and ZIP code</i>): _____		
Maiden name (<i>if applicable</i>): _____		
Other names used: _____		
Facility name: _____		
Signature: _____		Date signed: _____

One form must be completed for each person with an ownership interest of 10% or more in the applicant.
 OAR 411-054-0013 (2b)

Consent for business credit record check:

I, _____, an authorized representative for the business identified below, hereby consent to a release of credit history regarding this business to the Department of Human Services, Seniors and People with Disabilities, State of Oregon. This consent expires 24 months after the date signed.

Name of business: _____	
Business mailing address (<i>include City, State and ZIP code</i>): _____	
Other names (<i>DBA's</i>) used by this business: _____	
Name of authorized representative: _____	
Title of representative: _____	
Signature: _____	Date signed: _____

One form must be completed for each business with an ownership interest of 10% or more in the applicant.
 OAR 411-054-0013 (2b)

Credit record check consent form is required for each individual and each organization which hold 10% or more interest in either the business or the management service (*operator*).

Photocopy additional forms as needed. Credit records kept confidential unless disclosure is court-ordered.

Part 6: Medicaid contract

- Renewal. Facility currently has a Medicaid contract. *Complete contact information section below.*
- Renewal. Facility does **not** have a contract.
- New facility Change of ownership
- No** **New owning entity chooses *not* to participate in the Medicaid program.**
- Yes** **New owning entity hereby requests a contract for provision of residential care services to Medicaid-eligible clients of the Department of Human Services, Seniors and People with Disabilities (DHS/SPD). (Complete contact information section below.)**

Please read the following information carefully.

- If the YES box has been checked, a contract for services will be mailed or faxed to you for your review and signature. The contract will not be effective until it has been signed by all parties. One of the requirements of the contract is submission of proof of three types of insurance: automobile, general liability and professional liability. DHS/SPD will sign the contract only after the contractor's insurance documentation has been received by the DHS Office of Contracts and Procurement.
- Medicaid payments will not be made to the new owner for services provided prior to the effective date of the new Medicaid contract.
- Individuals, corporations, companies and entities unable to secure any of the necessary insurances will be ineligible for the contract and will be unable to provide services to Medicaid-eligible DHS/SPD clients.
- The prior owner of the facility will not receive payment for services provided to Medicaid-eligible residents *once the change of ownership has occurred.*

Contact information

In order to insure that an authorized person will receive, obtain signatures and return the contract, please complete all the requested information below.

Contact person for the licensee/owner:

Name (*print or type*): _____

Title: _____

Address: _____

City, State, ZIP: _____

Direct phone number: _____ FAX: _____

E-mail address: _____

Will the facility have a contract with other state agencies? (*i.e. Seniors and People with Disabilities, Developmental Disabilities, Addictions and Mental Health*) No Yes

If yes please specify: _____