Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration
Health Regulation Administration
Health Care Facilities Division

Mailing Address:
899 North Capitol St., NE, 2nd Floor
Washington, DC 20002
Phone: 202-724-8800

Application for Nursing Homes Licensure

Fling Fees

No of Bed	Annual	Late
1-50	$390	$195
51-100	$520	$260
> 101	$650	$325

Under the authority of DC Law 5-48, application is hereby made to operate a facility as indicated below:

1. APPLICATION IS FOR (CHECK ONE):

	Type Action	Effective Date of Action
	Initial Licensure Provider Number _____	
	Change of licensed operator	
	License Renewal	
	Change in Number of Beds	
	Name Change	

2. FACILITY IDENTIFICATION

_____
Name of Facility Telephone Number

_____
Street Address FAX Number

_____
City State ZIP

Facility is (Check one) { } Owned – Documentation Required { } Leased - Bond Required

3. Type of Licensed Beds

[]Skilled Beds ____(Title 18 only) [ ] Dual Beds____ (Title 18 & 19) [] Nursing Facility Beds ____(Title 19 only)
Total Number of Beds_____

4. LICENSEE IDENTIFICATION

_____
*Name of Licensee EIN#

_____
Street Address Telephone Number FAX Number

_____
City State ZIP

This entity is: (Check one)

Public:	{ } State	Not for Profit:	{ } Church	For Profit:	{ } Individual
	{ } City		{ } Corporation		{ } Partnership
	{ Hospital District }		{ } Other		{ } Corporation

*Name the principals/officers of the licensee: (such as, CEO, President, VP, Secretary, Treasurer, Director – attach additional sheet if needed)
Name: Address: Phone:

_____
_____
_____
_____

*Name of persons or entities (corporations, organizations, etc) having at least 10% interest in the licensee – attach additional sheet if needed:
Name: Address: Phone:

Have any of these persons ever been convicted or found guilty, regardless of adjudication, in any jurisdiction, of any felony involving fraud, embezzlement, fraudulent conversion or misappropriation of property, or violence against a person or persons? Yes ( ) No ( )
If yes, attach the criminal record of the applicable individual(s) listing the court, the date of conviction, the offense and the penalty imposed for each conviction, regardless of adjudication.
Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license of the administrator or other officer of the facility ?
Yes ( ) No ( )
If yes, list applicable orders:

5. EMPLOYEE INFORMATION

Name of Administrator District of Columbia Nursing Home Administrator License Number

Has this person ever been convicted or found guilty, regardless of adjudication, in any jurisdiction, or any felony involving fraud, embezzlement, fraudulent conversion or misappropriation of property, violence against a person or persons, or moral turpitude? Yes ( ) No ( )

If yes, attach the criminal record of the applicable individual(s) listing the court, the date of conviction, the offense and the penalty imposed for each conviction, regardless of adjudication.
Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license? Currently effective with regard to the administrator of the facility?
Yes ( ) No ( )
If yes, attach applicable

Name of Facility Financial Officer

Name of Director of Nursing District of Columbia Nurse License No.

Name of Medical Director District of Columbia Physician License No.

Name of Social Service Director

Name of Activity Director

6. MANAGEMENT COMPANY INFORMATION

Is the facility managed by an entity other than the licensee? Yes ( ) No ( ). If yes, complete the following:

*Name of Management Company EIN #

Street Address Telephone Number FAX Number

City County State ZIP

Date became Management Company of this facility:_____

This entity is: (Check one)

Public: { } State Not for Profit: { } Church For Profit: { } Individual
{ } Corporation { } Partnership
{ } City { } Other { } Corporation } { } Other

*Name all principals/officers of the management company: (such as, CEO, President, VP, Secretary, Treasurer, Director– attach additional sheet if needed)

Name: Address: Phone:

*Name of all persons having at least 10% interest in the management company – attach additional sheet if needed:

Name: Address: Phone:

7. INTEREST IN ORGANIZATIONS PROVIDING GOODS, LEASES, OR SERVICES TO FACILITY

If applying for initial or change of licensed operator licensure, complete the following information.

List the name (A) of any person who owns at least a 10-percent interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, and the name (B) and address (C) of the professional service, firm, association, partnership, or corporation in which such interest is held.

Person's Name (A) Interest Organization (B) Organization Address (C)

8. FEDERAL CERTIFICATION

A. Does the facility participate in or intend to participate in the Medicaid program? Yes ( ) No ( )
Medicare program? Yes ( ) No ( )

If applying for initial or change of licensed operator licensure, a separate application is required to participate in the Medicare and/or Medicaid programs.

B. EXCLUSION FROM MEDICARE OR MEDICAID

1. Has the applicant, licensee, or other controlling interest ever been excluded from Medicare or Medicaid? Yes ( ) No ( )
2. If yes, please provide the following information:
   a. Name of persons or entities excluded: _____
   b. Relationship of person or entity to applicant or licensee: _____
   c. Date(s) of exclusion: _____
   d. Attach documentation regarding the exclusion.

Proof of compliance with disclosure of ownership and controlling interest requirements of the Medicaid and Medicare programs shall be accepted in lieu of this submission.

C. NEW MEDICARE PROVIDER AGREEMENT

If applying for change of licensed operator licensure and the NEW OWNER requests a NEW Medicare Provider Agreement.

9. RESIDENT GRIEVANCES

If applying for renewal of an existing license, report the following information regarding the resident grievance Procedures in accordance with Title 22 DCMR.

Reporting period: _____ (12-month period ending with last calendar quarter)

Total number of grievances handled in reporting period : _____

Number of Grievances per Category:

____ (#) Food and Nutrition
____ (#) Staffing
____ (#) Personal Possessions
____ (#) Privacy and Dignity
____ (#) Activities and Social Services
____ (#) Financial Issues
____ (#) Environmental
____ (#) Other: _____

Number of Outcomes by Category:

____ (#) Resolved
____ (#) Unresolved
____ (#) Resolution Pending
____ (#) Other Outcome: _____

10. CONTINUING CARE RETIREMENT COMMUNITY

Does the facility offer continuing care agreements ? Yes ( ) No ( )

If yes, attach Certificate of Authority issued by the Department of Insurance.

11. CERTIFICATE OF NEED

If applying for initial licensure or the addition of licensed beds, attach a copy of all pertinent Certificates of Need or a statement that the facility is exempt from review.

12. MEDICAID LIABILITY

If applying for initial or change of licensed operator licensure, attach proof of compliance with Medicaid liability requirements.

13 RESIDENT TRUST SURETY BOND

Attach proof of compliance with Resident Trust Surety Bond requirements:

A. Proof that the applicant has a current patient trust surety bond, or
B. Proof of current membership in an approved self-insurance pool and the amount currently on deposit.

14. BUILDING CONSTRUCTION / OCCUPANCY

If applying for initial licensure for a new construction or new operation, attach:

Certificates of approval/occupancy

15. LIABILITY INSURANCE

Attach proof of current liability insurance coverage on malpractice and comprehensive general coverage in accordance with Title 22 DCMR 3205 Insurance coverage. In addition, attach a proof that the insurance carrier has a certificate of authority from the Department of Insurance to operate in the District of Columbia.

16. CIVIL VERDICT OF JUDGEMENT

If applying for initial or change of licensed operator licensure, attach:

A. Copies of any civil verdict or judgment involving the applicant within the ten years preceding the application, relating to medical negligence, violation of resident's rights, or wrongful death.
B. Copies of any civil verdict or judgment involving the applicant, related to such matters, within 30 days after filing with the clerk of the court.

17. OUTSTANDING FINES

The agency may take action against a license or application for any facility with outstanding fines assessed by Final Order of the Health Care Regulation and Licensing Administration or of the Centers for Medicare and Medicaid Services.

A. Are there outstanding fines ? Yes ( ) No ( )
B. If yes, please complete the following for each separate fine (attach additional information if necessary):
1. Fine amount: $_____
2. Fines assessed by: _____ Agency for Health Care Regulation and Licensing
_____ Centers for Medicare and Medicaid Services
3. Survey or application date for which the fine was imposed: _____
4. Due date of fine: _____
5. Is there an appeal pending of a final order? Yes ( ) No ( )

18. CONTROLLING INTEREST INFORMATION

Please complete attached Form (Appendix I) with Controlling Interest information required for all persons or entities listed in sections 4 and 6.

20. BANKRUPTCY

Is the facility or its parent corporation presently operating under bankruptcy protection? Yes ( ) No ( )

21. FINANCIAL ABILITY TO OPERATE

If applying for initial or change of licensed operator licensure, provide proof of financial ability to operate, see instructions and forms required.

22. RISK MANAGEMENT AND QUALITY ASSURANCE:

If applying for initial or change of licensed operator licensure, submit the facility plan for quality assurance and for conducting risk management.

23. COMPLIANCE WITH ADMINISTRATIVE AND PROCEDURAL REQUIREMENTS

A. I agree that I will notify the Health Regulation and Licensing Administration if substantive changes in facility management and operation that significantly affect policies and procedures and that notice notice will be given in writing before the effective date of the change.

B. Upon licensure, the facility will follow, implement and abide by Title 22 DCMR Chapter 32.

.

24. AFFIDAVIT

I, _____hereby swear or affirm that the information provided in or with this application is true and correct and does comply with administrative and procedural requirements.

Subscribed and sworn to before me this _____day of _____, 20_____.

_____
Notary Public

_____
Signature of Applicant

_____
Title

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration
Health Regulation Administration
Health Care Facilities Division

Phone: 202-442-5888
Fax: 202-442-9431

Mailing Address:
717 14th St. NW, Suite 700
Washington, DC 20005

Appendix I

CONTROLLING INTERESTS INFORMATION FOR NURSING HOMES

******DISCLOSURE REQUIRED FOR ISSUANCE OF NURSING HOME LICENSE**** This Controlling Interests Information Form must be copied and completed for each person and entity listed below.**

Licensee: _____

Those owning 5% or more of the licensee: _____

Each Officer of the licensee: _____

Each Board Member* of the licensee: _____

Management Company: _____

Those owning 5% or more of the management co: _____

Each Officer of the management company: _____

Each Board Member* of the management company: _____

*Only Voluntary Board Members are exempt – see Voluntary Board Member Statement attached

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration
Health Regulation Administration
Health Care Facilities Division

Mailing Address:
717 14th St. NW, Suite 700
Washington, DC 20005

NURSING HOMES LICENSING FEES

Appendix II

Attach application together with a Check or Money Order made PAYABLE TO THE D. C. TREASURER.

PAY THIS AMOUNT $_____

License fees for nursing homes are as follows:

(a) 1-50 beds
Annual Fee $390
Late Fee $195

(b) 51-100 beds
Annual Fee $520
Late Fee $260

(c) 101 or more beds
Annual Fee $650
Late Fee $325