



State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
 Office of Health Facility Licensure & Certification
 Assisted Living Program
 1 Davis Square, Suite 101
 Charleston, West Virginia 25301-1799
 (304) 558-0050

LICENSE RENEWAL APPLICATION

INSTRUCTIONS

Please read carefully and complete this application **in full**. Type or print legibly with permanent ink. Failure to complete the application in full may result in delay of license being issued. The application must include all the requested information and bear the applicants notarized signature.

The application must be completed by the individual owner or administrative officer. An application on behalf of a corporation or governmental unit shall be made by any officer or its managing agent(s) who have the responsibility for maintaining regulatory standards for the facility.

Applications must be submitted at least ninety days prior to the expiration date of your current license. The renewal application shall be accompanied by a check or money order made payable to: **OHFLAC** (Office of Health Facility Licensure and Certification)

For each bed calculate as follows:

Assisted Living Residence \$6.97 per bed x _____ (number of approved/ licensed beds) = _____
 Residential Care Community \$5.21 per bed x _____ (number of approved/ licensed beds) = _____

****It is recommended the completed application, bed fee and attachments be submitted via certified mail.**

A balance sheet/statement of operations must be submitted with the application, setting forth all assets and liabilities, including but not limited to all capital, surplus, reserve, depreciation, lease payments, taxes, and other extraordinary credits or charges including wages/reimbursement to owner(s), and other similar accounts.

(Can be obtained from your accountant or bookkeeper or attachment A may be used as a guide)

January 14, 2000, Administrative Rule Title 96, Series 1, (implementing WV Code §21A-2-6{18}) required the establishment of procedures under which agencies of this State shall not grant, issue, or renew any contract, license, permit, certificate, or other authority to conduct business in this state, if that entity has an account which is in default with the WV Bureau of Employment Programs, Divisions of Workers Compensation or Unemployment Compensation. The Office of Health Facility Licensure and Certification is required to determine that the account is not in default prior to issuing the annual renewal license for any Assisted Living Residence or Residential Care Community. To assure accurate account information is obtained, your Federal Employee Identification Number (FEIN), must be provided and kept on file.

Facility FEIN Number: _____ Facility Name: _____

Application Check List

- Application signed _____
- Application notarized _____
- Application fee enclosed (payable to OHFLAC) _____
- End of Year Financial Statement _____
- If leased/rented, copy of lease agreement _____
- Other Attachments (if applicable) _____
- Copy of Administrator Credentials (if not on file) _____
- Application Completed _____

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
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Assisted Living Program
1 Davis Square, Suite 101
Charleston, West Virginia 25301-1799
Telephone: (304) 558-0050 Fax: (304) 558-2515

LICENSE RENEWAL APPLICATION

TYPE OF FACILITY		Mark appropriate box	Current Number of Licensed Beds or Apartments
Assisted Living Residence	Small (4-16 beds)		
	Large (17+ beds)		
Residential Care Community			
To request and increase in licensed beds you must notify OHFLAC in writing			

FACILITY INFORMATION

Facility Name		Telephone	
Street Address		Fax Number	
City, State, Zip Code		County	
Mailing Address <small>(if different than street address)</small>		E-Mail Address: <small>(if different than admin)</small>	

CORPORATE/LICENSEE/OWNER INFORMATION

Corporate/Business/Owner Name							
Address							
City, State, Zip Code							
Corporate/Licensee/Owner Phone Number <small>(Not facility #)</small>							
Type of Ownership	Private	Individual		Corporation		Partnership	Church/Association
	Public	County		Municipal		City	
Is the facility:		For Profit		Not for Profit		<u>If other than individual applicant- Complete Attachment A</u>	
Is building/structure leased? If leased, copy of lease agreement must be included with application				Property Owner Name /Address/Phone Number			

ADMINISTRATOR/EXECUTIVE DIRECTOR

Name	
E-mail	

SUPERVISING or CONSULTANT REGISTERED NURSE

Name		License No.	
E-mail			

ANNUAL REPORT INFORMATION

Current Census	Total # Bedroom or Apartments	# Private <i>(Private & Semi-private beds must equal total # of licensed beds)</i>	# Semi-private <i>(Ex: 4 rooms = 8 beds) (14 rooms = 28 beds) etc.</i>	# Rooms with 3-4 Beds <i>(If grandfathered in under PCH/RBC) (3 rooms = 9 or 12 beds) (4 rooms = 12 or 16 beds)</i>
Per diem cost or monthly rate:				
Does the facility accept private pay residents only? (Yes or No)				
If no, does the facility accept residents with Supplemental Security Income (SSI)? (Yes or No) plus (per diem cost or monthly reimbursement)			Total Number Allocated to Low Income Residents	

SERVICES OFFERED

(Check all that apply-include additional costs, if any)

ADDITIONAL COSTS (if any)

Assistance with ADLs		
Medication Administration		
Limited & Intermittent Nursing Care		
Transportation to/from appointments		
Beauty shop/hair cutting services		
Assistance with making appointments		
Laundry services		
Dietary Services		
Recreational Activities (bingo, TV, field trips, etc)		
Management of personal finances		
Other		

ORGANIZATIONAL PLAN

Attach an Organizational Plan or complete the information below, indicating the number of persons employed beside each position.

Full Time	Part-Time	Position
		Administrator
		Housekeeping
		Maintenance
		Registered Nurse(s)
		Laundry
		Nursing Assistant(s)
		Licensed Practical Nurse (s)
		Activity Aide(s)
		RN Consultant
		Dietary

I certify that I have read and understand all state licensing requirements and that substantial compliance with licensure standards must be met for renewal of license for:

Name of Facility _____

SIGNATURE

Name: _____ (please print clearly)

Signature: _____ Title _____
(Owner/ licensee/administrative officer)

Date: _____

NOTARY VERIFICATION

STATE OF WEST VIRGINIA

County of _____

_____, being by me duly sworn on his/her oath, deposes and says that he/she has read the foregoing application and knows the contents thereof, that the statements concerning the above named facility, therein contained, are correct and true of his/her knowledge.

(Signature of applicant)

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

(Notary Public)

My Commission Expires: _____



**POLICY STATEMENT
TITLE VI, CIVIL RIGHTS ACT OF 1964**

This facility has agreed to comply with the provisions of the Civil Rights Act of 1964 and all requirements imposed pursuant thereto, to the end that no person shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care or service.

Specifically, the above includes (but is not limited to) the following characteristics:

1. Inpatient and outpatient service will be provided on a nondiscriminatory basis; all patients/residents will be admitted and receive care without regard to race, color, or national origin.
2. All patients/residents will be assigned to rooms, floors, and sections without regard to race, color, or national origin.
3. Patients or residents will not be asked if they are willing or desire to share a room with a person of another race.
4. Employees will be assigned to patient/resident care and services without regard to race, color, or national origin of either the patient/resident or employee.
5. Professionally qualified personnel will not be denied access to treat patients/residents based on race, color, or national origin.
6. All areas of this facility will be available for use without regard to race, color, or national origin.
7. Transfer of patients/residents from the rooms assigned will not be made for racial reasons; however, any patient/resident may request to upgrade the room assigned and/or selected at any time for any reason provided that the room requested is readily available and the patient/resident is financially able to pay for the requested room.

The nondiscriminatory policy of the facility applies to patients/residents, physicians, and all responsible employees. Under no circumstances will the application of this policy result in the segregation or re-segregation of building, wings, floors, or rooms for reasons of race, color, or national origin.

Name of Facility

Administrator Signature

Date

ATTACHMENT A

OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION ASSISTED LIVING PROGRAM

Attachment A Must be completed if the facility is owned by a CORPORATION, PARTNERSHIP or TRUST

West Virginia State Code '16-5D-6 or '16-5N-6

The application must contain the following information: The name, address, and principal occupation of **(1)** each person who as a stockholder or otherwise, has a proprietary interest of ten (10) percent or more in the applicant, **(2)** of each officer and director of a corporate applicant; **(3)** of each trustee and beneficiary of an applicant which is a trust; and **(4)** where a corporation has a proprietary interest of twenty-five (25) percent.

The name and address of the owner of the premises of the personal care home or proposed personal care home, if he or she is a different person from the applicant, and in such case, the name and address: **(1)** of each person who, a stockholder or otherwise, has a proprietary interest of ten percent or more in the owner; **(2)** of each officer and director of a corporate applicant; **(3)** of each trustee and beneficiary of the owner if it is a trust; and **(4)** where a corporation has a proprietary interest of twenty-five (25) percent or more in the owner, the name and address of each officer and director of the corporation.

A. Name of Governing Body (Board of Directors, Trustees, etc)

B. List the name and address of each officer and/or member of the governing body (with title)

C. List the name and address of each person holding a proprietary interest of 10% or more

D. List each name and address and director of a corporate applicant or each trustee and beneficiary of the owner if a trust:

E. List each corporation which has a proprietary interest of 25% or more in the owner and each Officer or director thereof including name, address and occupation:

FINANCIAL INFORMATION REQUIREMENTS
WV State Code 16-5D-6.j.g.2/3

Requires that a licensee will submit to the secretary with the application:

- A. A balance sheet and/or
- B. A statement of operations

End of year financial information for the facility must be submitted