LEGAL IDENTITY OF APPLICANT:
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:

PRIMAR_Y: _____________________________________________________________________________________
Other: _______________________________________________________________________________________
c. Indicate the Percent of Ownership of the Legal Identity: _____________

d. Is legal entity: (check one)
   For Profit _____  Not For Profit _____

e. Is the legal entity a: (check 1, 2, 3 or 4)
   (1) PROPRIETOR _____
   (2) LIMITED LIABILITY CORPORATION _____
   (3) PARTNERSHIP _____
      (a) General _____  If General, where is it registered? County _________ State ______
      (b) Limited _____  If Limited, where is it registered? State ______
      (c) Is the limited partnership registered with the North Carolina Corporations Division in the NC Department of the Secretary of State?
         YES _____  NO _____
      (d) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:
         Name: ___________________________  Title: ___________________________
         Address: ___________________________  Percent of Ownership: ______
         Name: ___________________________  Title: ___________________________
         Address: ___________________________  Percent of Ownership: ______
         Name: ___________________________  Title: ___________________________
         Address: ___________________________  Percent of Ownership: ______

(4) CORPORATION _____
   (a) Where was the corporation originally established?  State ______
   (b) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:
         Name: ___________________________  Title: ___________________________
         Address: ___________________________  Percent of Ownership: ______
         Name: ___________________________  Title: ___________________________
         Address: ___________________________  Percent of Ownership: ______
         Name: ___________________________  Title: ___________________________
         Address: ___________________________  Percent of Ownership: ______

(5) UNIT OF GOVERNMENT
   (a) What is the name and title of the official in charge of the above governmental unit?
      Name: ___________________________
      Title: ___________________________
(b) Check the word which best describes the above type of governmental unit:

CITY ___  COUNTY ___  STATE ___  AUTHORITY ___

2. Does the licensee (legal entity: individual, partnership, corporation or unit) own the building from which services are offered?  
   
   YES _________  NO _________

If NO, who owns the building?

   Name: __________________________________________________

   Mailing Address: ____________________________________________

   City: ______________  State: __________  Zip: __________

   Telephone: (    ) ___________________  Fax: (    ) __________

Note: If neither the building owner nor the lessee is shown as the license applicant, explain on a separate page.

3. Is this facility part of a multiple facility system within North Carolina?  (A multiple facility system is defined as two or more nursing homes or health care facilities under the same ownership.)

   YES _________  NO _________

If "YES", give the name and address of the multiple facility system (Parent Company) located within North Carolina.

   a. Name of the Parent Company:

   b. Mailing Address: _________________________________________

   c. City: ____________________

   d. State: ______________  e. Zip: __________  f. Telephone: (    ) __________

   g. Name of Senior Officer: _______________________________________

4. Does the facility operate under a management contract?

   YES _________  NO _________

If "YES", give the name, address and name of chief executive officer of the organization that manages the facility.

   a. Name of Organization: _______________________________________

   b. Mailing Address: ____________________________________________

   c. City: ____________________

   d. State: ______________  e. Zip: __________  f. Telephone: (    ) __________

   g. Name of Chief Executive Officer: _________________________________

PART B  OPERATIONS

PROVIDE NAMES FOR THE FOLLOWING:

1. FACILITY PERSONNEL
   
   a. Full-time administrator as required in 10A NCAC 13D .2201(c).

      Name of Administrator: First name ______ Middle initial ______ Last name ________

      Date Hired As Administrator: ____________________  N. C. License No.: __________
b. Nursing

1. Director of Nursing: First full name _______ Middle initial _______ Last name _______
   N.C. License Number: __________________________ Date Hired as DON: __________

c. Activity Director: _________________________________

d. Dietary Services Director: __________________________

e. Social Services Director: ___________________________

2. MEDICAL AND DENTAL STAFF FOR EMERGENCY CALL

a. Medical Director’s Name
   Address
   First name: ____________________________
   Middle initial: __________________________
   Last name: ____________________________
   e-mail address: __________________________
   N.C. License No: ________________________

b. Dentist(s) Name(s)
   Address(es)
   1. ____________________________ ____________________________
   2. ____________________________ ____________________________
   3. ____________________________ ____________________________

3. CONTRACT/OTHER PERSONNEL OR CONSULTANTS

a. Physical Therapist: ____________________________

b. Occupational Therapist: ________________________

c. Speech Therapist: _____________________________

d. Medical Records: _____________________________

e. Pharmacy Consultant: _________________________

f. Dietary Consultant: ____________________________

g. Other (i.e. Respiratory Therapist): __________________

4. PHARMACY

a. Source of Drugs:
   1. Do you have a pharmacy located in your facility? YES _______ NO ______

   2. If "YES", please complete:

      Pharmacist Manager: ____________________________

b. If a pharmacy is not located in your facility, what is the name of the pharmacy from which drugs are obtained?

   Name: ____________________________
   Street Address: ____________________________
   City, State, Zip: ____________________________

PART C PATIENT SERVICES

1. Continuing Care Retirement Communities (CCRC)

a. Is the facility licensed by the Department of Insurance as a “Continuing Care Retirement Community”? YES _______ NO ______

2. Is the facility a “Combination Facility”, thereby incorporating licensed ACH beds? YES _______ NO ______
   If “Yes”, indicate which rules the facility chooses to apply to the operation of these ACH beds.

   Nursing Home Licensure _______ ACH Licensure _______

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3. **NUMBER OF BEDS BY TYPE** (*Must complete required data supplement form)

   a. **Nursing Beds (NF)**
      (TOTAL) a. _______
      1. General Nursing Facility Beds
      2. *Alzheimer's Special Care Unit Resident Beds
      3. Ventilator Dependent Resident Beds
      4. Traumatic brain Injury Beds
      Are you equipped to accommodate bariatric residents?
      Y ___ N ____

   b. **Adult Care Home (ACH)**
      (TOTAL) b. _______
      1. General Adult Care Home Beds
      2. *Alzheimer’s Special Care Unit Resident Beds
      Are you equipped to accommodate bariatric residents?
      Y ___ N ____

   c. **TOTAL LICENSED BEDS**
      (TOTAL a & b) c. _______

**PART D  TOTAL CURRENT STAFF**

   Do not include the following: courtesy or attending staff, private duty nurses, volunteer workers or the same employee in more than one category. These employees were or will be on payroll as of ______________ month / day / year.*

* New facilities should complete according to the facility staffing level on date of Licensure.

<table>
<thead>
<tr>
<th>Routine Services</th>
<th>Total Facility FTE’s</th>
<th>Annual Consultant Hours</th>
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<tbody>
<tr>
<td>Registered Nurses</td>
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<tr>
<td>LPNs</td>
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<td>Nurse Aides</td>
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<td>Medical Director</td>
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<td>Director of Nurses</td>
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<td>Staff Devel. Coordinator</td>
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<td>Ward Secretary</td>
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<td>Medical Records</td>
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<tr>
<td>Pharmacy Consultant</td>
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<td>Administration &amp; General</td>
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<td>Activity Consultant</td>
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</tbody>
</table>

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### HOUSEKEEPING/LAUNDRY
- Housekeeping Supervisor
- Laundry Supervisor
- Housekeeping Aides
- Laundry Aides

### MAINTENANCE
- Maintenance Supervisor
- Janitors

### ANCILLARY SERVICES
- Physical Therapist
- PT/Rehabilitation Aide
- Occupational Therapy
- Speech/Hearing Therapy
- Respiratory Therapist
- Other (Specify)

### Total Positions/Total Consultant Hours

---

**PART E LICENSE FEE**

A non-refundable license fee is required and must accompany this application prior to the issuance of a nursing home license. The payment should be in the form of check, certified check or money order and must be made payable to: “The Division of Health Service Regulation.” A separate check is required for each licensed entity.

Pursuant to §131E-272, effective August 14, 2009 initial license fees will be $470.00 (base fee) plus $19.00 per bed. Fees for initial licensure effective during the months of October – December will be credited to the license renewal fee.

This application must be completed and submitted to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a nursing home license. The legislation (SB 622, Session Law 2005-276) prohibits a license from being issued if the fee has not been paid.

The undersigned submits this application for licensure for the year 2016 {subject to the provisions of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission} and certifies the accuracy of this information.

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Typed Name of Chief Administrative Officer or Authorized Official (Written Signature)

Title: __________________________ Date: __________________________

“The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or the provision of services.”