Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Long Term Care Division

For LARA Use Only
Licensing Officer Approval
Date Approved

Application/ Renewal Application for Nursing Home License

Note: Failure to correctly complete this application in its entirety may delay the processing of your application. Questions regarding this application can be directed to the Long Term Care Division at (517) 241-4712.

Choose one: ☐ Initial License Application ☐ Change of Ownership (CHOW) License
☐ Renewal Application

Facility Information

Facility Name/D.B.A. (Doing Business As)	State Facility Number	CMS Certification (CCN) # **23-**

Address	City	County	Zip Code

Phone Number	Fax Number
Primary Contact Person for Facility	Phone Number
Emergency Contact Person	Phone Number
MDS Assessment Contact Person	Phone Number

NPI# (s) (National Provider Identifier) Please attach a separate sheet if necessary.

Licensed Administrator (submit a copy of your current license)

Administrator Name	E-mail Address
License Number	License Expiration Date / Date of Hire
4 8	Time Involvement: ☐ Full-time ☐ Part-time ☐ Contract

If the Licensed Administrator is not full time and he/she is the licensed administrator at more than one facility indicate who will be in charge in the absence of the administrator.

If the Licensed Administrator is part-time what is the name of the other facility he/she will be working at?

Licensed Director of Nursing (submit a copy of your current license)

Director of Nursing Name	License Number
	4 7 0
License Expiration Date	Date of Hire

Fiscal Intermediary If applying for Licensure & Certification this section must be completed.

Fiscal Intermediary	Intermediary/Carrier Number (This is not the Provider # or CCN)

Address	City	State	Zip Code

Authority: Administrative Rules 325-20201 thru 325-20215
Completion: Mandatory
BHCS-LTC-101 (Rev. 07/13)

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Bed Information (current or requested beds)

	Current Beds	Requested Beds
Medicare (SNF)		
Medicaid (NF)		
Medicare/Medicaid (SNF/NF)		
Total Certified Beds:		
Licensed Only Beds*:		
Total Facility Beds:		

Fees are for the billing cycle covering the period of 8/1 through 7/31. Change of Ownership fees is equal to 1 year license fee regardless of the billing cycle.* ***DO NOT SEND FEES WITHOUT RECEIVING AN INVOICE.*

Does the facility have any of the following beds that are ***not*** part of the "*Special Pool Beds*" issued by Certificate of Need?

- ☐ Religious Beds
- ☐ Ventilator Dependent
- ☐ Dialysis
- ☐ Alzheimer's Beds
- ☐ Hospice

Does the facility have a locked Unit? ☐ Yes ☐ No

If yes, what special population is serving that unit?

Ownership (legal entity which directly owns the facility)

Company/Owner Legal Name		Primary Owner	
Phone Number	Fax Number	E-mail Address	
Address	City	State	Zip Code

Tax ID: ☐☐-☐☐☐☐☐☐☐

Is the Ownership for: ☐ Profit ☐ Non Profit

Does the Owner ☐ Own the building **or** ☐ Is this a management company

Type of Entity

☐ Profit Individual	☐ Non Profit Religious	☐ State	☐ City/County
☐ Profit Partnership	☐ Non Profit Corporation	☐ County	☐ Hospital District
☐ Profit Corporation	☐ Non Profit Other	☐ City	☐ Federal

Is the applicant part of a nursing home chain? ☐ Yes ☐ No

If yes, does this chain own ☐ More than 30 ☐ Less than 30

Parent Organization Name	Contact Person		Phone Number
Address	City	State	Zip Code
Tax ID ☐☐-☐☐☐☐☐☐☐	Contact Name		E-mail address

Officers/Directors/Trustees: (attach additional pages if necessary)

Name			Phone Number	
Address		City	State	Zip Code
Tenure From (date)	Is Primary ☐ Yes ☐ No	Position	☐ Director ☐ Secretary ☐ Senior Officer	☐ Manager ☐ Treasurer ☐ Junior Officer ☐ President ☐ Vice President ☐ Principal Officer
Tax ID: _ _ - _ _ _ _ _ _ _			Percentage Owned	

Name			Phone Number	
Address		City	State	Zip Code
Tenure From (date)	Is Primary ☐ Yes ☐ No	Position	☐ Director ☐ Secretary ☐ Senior Officer	☐ Manager ☐ Treasurer ☐ Junior Officer ☐ President ☐ Vice President ☐ Principal Officer
Tax ID: _ _ - _ _ _ _ _ _ _			Percentage Owned	

Name			Phone Number	
Address		City	State	Zip Code
Tenure From (date)	Is Primary ☐ Yes ☐ No	Position	☐ Director ☐ Secretary ☐ Senior Officer	☐ Manager ☐ Treasurer ☐ Junior Officer ☐ President ☐ Vice President ☐ Principal Officer
Tax ID: _ _ - _ _ _ _ _ _ _			Percentage Owned	

Name			Phone Number	
Address		City	State	Zip Code
Tenure From (date)	Is Primary ☐ Yes ☐ No	Position	☐ Director ☐ Secretary ☐ Senior Officer	☐ Manager ☐ Treasurer ☐ Junior Officer ☐ President ☐ Vice President ☐ Principal Officer
Tax ID: _ _ - _ _ _ _ _ _ _			Percentage Owned	

Are there any directors, officers, agents, or managing employees of the institution agency or organization who have been convicted of a criminal offense? ☐ No ☐ Yes → If “yes”, please attach an additional sheet describing the event.

Does anyone listed own or have an interest in other healthcare facilities (for example: sole proprietor, partner, member of a partnership, board of directors)? ☐ No ☐ Yes → If “yes”, please attach an additional sheet indicating name, address, city, state & zip code and interest of parent corporation.

Is the applicant facility chain affiliated?
☐ No ☐ Yes → If “yes”, please attach an additional sheet indicating name, address, city, state & zip code.

Are any persons who have ownership interest required to file a beneficial ownership report pursuant to the Federal Securities Exchanges Act of 1934 [15 U.S.C. 78p, Sec. 16 (a)]? ☐ Yes – If yes, attach copies of such report ☐ No

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Building Owner

Legal Owner of Building		Phone Number	
Address	City	State	Zip Code

Lien Holder (if different from building owner)

Lien Holder		Phone Number	
Address	City	State	Zip Code

Management Company (who is responsible for nursing home day to day operations, if different than applicant?)

Name of Company		Phone Number	
Address	City	State	Zip Code
Contact Person	E-mail address		

PLEASE ONLY COMPLETE THE ESTIMATED MONTHLY REVENUES/ EXPENDITURES AND PROVIDE THE LIST OF SUPPLIERS IF YOU ARE REQUESTING AN INITIAL LICENSE FOR THE NURSING HOME OR IF YOU HAVE A CHANGE OF OWNERSHIP. NEITHER OF THESE TWO AREAS NEED TO BE COMPLETED IF THIS IS A RENEWAL APPLICATION.

Estimated Monthly Revenues/ Expenditures:

Business experience related to nursing home operation, delivery of health care services:

Estimated monthly revenues:_____

Estimated monthly expenditures:_____

List of Suppliers

A list disclosing the names & addresses of each supplier who furnishes goods or services to the nursing home must be attached to this application. You must also include their total charges exceeding $5,000.00 in a 12 month period including a month in the nursing homes current fiscal year.

Certification of Applicant

The Assurance and processing of this form is governed by Administrative Rules 325.20201 through 325.20215. Failure to submit an accurate and complete form in a timely manner may result in denial of licensure or certification. An applicant who makes a false statement in this application is subject to criminal penalties under Section 20142(5) of the Public Health Code (P.A. 368 of 1978 as amended) including four years imprisonment and/or $30,000 fine. Each facility must be brought in full regulatory compliance at the time a CHOW is approved.

The applicant certifies that the information provided on this application is true, complete and accurate to the best of his/her knowledge.

The applicant certifies that the applicant and/or owner(s) have not had a professional, occupational or health agency license revoked within the preceding five years.

_____ _____ _____

Applicant's Signature | Applicant's Title | Date

For an Initial License or Change of Ownership request please submit the completed form to:
Michigan Department of Licensing and Regulatory Affairs/BHCS/Long Term Care Division
Ottawa Building, 1st Floor
P. O. Box 30664
Lansing, MI 48909

Authority: Administrative Rules 325-20201 thru 325-20215
Completion: Mandatory
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