



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Office of Inspector General
Office of Health Facility Licensure and Certification

Assisted Living Program

408 Leon Sullivan Way

Charleston, West Virginia 25301-1713

Telephone: (304) 558-0050 Fax: (304) 558-2515

Earl Ray Tomblin
Governor

Karen L. Bowling
Cabinet Secretary

INITIAL or CHANGE OF OWNERSHIP (CHOW)
LICENSE 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 approval. The application must include all the requested information and bear the applicants notarized signature.

An application for a license must be made by the individual owner or administrative officer. An application on behalf of a corporation or governmental unit shall be made by any officer or by its managing agents who have the responsibility for maintaining approved licensing standards for the facility.

Applications must be submitted at least ninety days prior to the date proposed for commencement of operation. The application shall be accompanied by a check or money order in the amount of \$65.00 (non-refundable) payable to: Office of Health Facility Licensure and Certification (OHFLAC). Prior to being licensed, a facility must comply with all applicable licensure standards. A copy of the rules can be obtained by linking to www.wvdhhr.org/ohflac/rules or sending \$10.00 to the address listed at the top of this page.

It is recommended the application, attachments, and initial licensure fee be submitted via certified mail.

A preliminary 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. (Attachment A may be used for the proposed statement of operations if completed in its entirety)

INITIAL/CHOW LICENSURE FEE: West Virginia State Code §16-5D-6-e and §16-5N-6-e, mandates that all direct costs for initial licensure of a facility will be assessed based on the average costs of the previous ten facilities and must be received prior to the facility receiving a license. This charge will apply to the Initial or CHOW only; thereafter, the annual charge for licensed number of beds will apply. This fee must be paid prior to the license being issued.

Facility Name: \_\_\_\_\_

Application Check List

- Completed Application
Application fee enclosed (payable to OHFLAC)
Preliminary statement of operations
Application signed
Application Notarized
Administrator's proof of education-enclosed
Criminal Background Check Completed (receipt attached)\*
Pictures of facility are attached
If leased/rented, copy of lease agreement

\*Criminal background checks will be conducted by Morpho Trust via electronic submission at various sites around the state. So far, there are only twelve (12) sites available. You can locate those sites once you go to the Morpho Trust's website. Prior to sending in your application, you must go to one (1) of the sites to obtain fingerprinting. You can obtain a dated/signed receipt showing the fingerprinting was completed. Also, you can obtain a tracking number to determine the status of when the background will be completed. If you hire someone or someone volunteers in your home, THE INDIVIDUAL MUST REQUEST THE RECEIPT AND TRACKING NUMBER. This will serve as documentation the criminal background check was done PRIOR to hiring anyone to work in your facility. If you have further questions, or to set up an appointment to have your criminal background check complete, you can go to www.morphotrust.com or call (855) 766-7746.

# LICENSE APPLICATION

<b>ASSISTED LIVING RESIDENCE (LARGE-17 or more beds)</b>		<b>TYPE OF APPLICATION</b>	
<b>ASSISTED LIVING RESIDENCE (SMALL - 4-16 beds)</b>		<b>INITIAL</b>	<b>CHOW</b>
<b>RESIDENTIAL CARE COMMUNITY</b>			

<b>Facility Name</b>		<b>Telephone #</b>	
<b>Street Address</b>		<b>Fax #</b>	
<b>City, State Zip Code</b>		<b>County</b>	
<b>Mailing Address (if different than street address)</b>			

West Virginia Business License Number \_\_\_\_\_

Apply online at [www.business4wv.com](http://www.business4wv.com)

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 #:** \_\_\_\_\_ (This is **not** your Facility ID Number)

## FACILITY INFORMATION

<b>Type of Construction</b>							
<b>Is the structure owned by the individual applicant, partnership or corporation?</b>				<b>If no, Is the facility leased or rented?</b>			
<b>If leased, owner's name, address and phone number:</b>				<b>If leased or rented, copy of lease agreement must be included with application</b>			
<b>Number of floors</b>		<b>Proposed # of Beds</b>		<b>Private</b>		<b>Per Diem/monthly cost</b>	
				<b>Semi-Private</b>		<b>Per Diem/monthly cost</b>	

**Specific Directions to the Facility from Charleston:**

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### CORPORATE/LICENSEE/OWNER INFORMATION

<b>Name:</b>	
<b>Address:</b>	
<b>City, State, Zip Code:</b>	
<b>Applicant Telephone Number:</b>	

#### TYPE OF APPLICATION:

(If other than individual applicant, then Attachment B must be completed)

<b>Private</b>	Individual		Partnership		Corporation		Association/Church	
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<b>Public</b>	City		County		Municipal	
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<b>For Profit</b>		<b>Not For Profit</b>	
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### ADMINISTRATOR/EXECUTIVE DIRECTOR

<b>Name</b>	
<b>Education Credentials (attach copy)</b>	
<b>E-Mail Address:</b>	

### SUPERVISING/CONSULTANT REGISTERED NURSE

<b>Name</b>		<b>License Number (attach copy of license)</b>	
<b>E-Mail Address:</b>			

### SERVICES TO BE OFFERED

(Check all that apply; include additional costs if any)

		Additional cost
Assistance with ADL's		
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

Complete the information below, indicating the number of persons employed beside each position.

*(Must enter numbers; check marks are not acceptable)*

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

The signature on this application confirms an understanding of requirements for state licensure, and that in order to be licensed this facility will comply with applicable WV State Code and state licensure standards.

### SIGNATURE OF APPLICANT/OWNER/ADMINISTRATIVE OFFICER

Name: (please print) \_\_\_\_\_

Signature: \_\_\_\_\_

Title \_\_\_\_\_

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: \_\_\_\_\_

# ATTACHMENT A

## OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION ASSISTED LIVING PROGRAM

(You must complete the projected statement of operations or attach a copy provided by your accountant/bookkeeper).

**Document must be completed in full**

<b>Name of Facility:</b>		<b>Date:</b>
<b>Address:</b>		
<b>Preliminary Statement of Operations/Balance sheet</b>		
<b>Assets</b>		
Number of beds _____ X monthly rate _____		
Equals total anticipated annual income		
Cash on hand		
Inventory/Supplies		
Land and Buildings		
Furniture/Equipment		
Other assets		
<b>TOTAL ASSETS</b>		
<b>Liabilities</b>		
Mortgage/loans payable		
Utility expenses payable		
Taxes (all applicable taxes)		
Lease payment (if applicable)		
Wages/Salaries/reimbursement to owner		
Other liabilities/expenses		
Equity		
<b>TOTAL LIABILITIES</b>		

### 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)**

# **ATTACHMENT B**

## OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION ASSISTED LIVING PROGRAM

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

### West Virginia State Code §16-5D-6, §16-5H-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. The name and address of the owner of the premises of the personal care home or proposed personal care home, if h 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 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)

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

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

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

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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:

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**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.

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**Name of Facility**

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**Administrator Signature**

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**Date**