



WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION
408 Leon Sullivan Way, Charleston, WV 25301-1713

Alzheimer's/Dementia Special Care Unit and Program

Initial Application

Facility Name: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Telephone: _____ Administrator: _____

License #: _____ Licensed Bed Capacity: _____ Facility is currently licensed as: _____

Name of Unit/Program Coordinator*: _____

**Please submit evidence of the coordinator's qualifications with this application.*

Residents to be served by the unit or program: _____ Number of Units or Programs: _____

Location of Unit (Wing or hall designation)*: _____

**Please submit architectural drawings of the unit or space to be utilized by the program.*

The facility will provide which of the following services: ***(Check only one)***

_____ A Specialized Unit for Residents with Alzheimer's/Dementia
(programming is offered 24 hours a day)

_____ A Specialized Program for Residents with Alzheimer's/Dementia
(programming is offered for a specific number of hours per day)

Applicant's Signature/Title: _____ Date: _____