



Office of Health Facility  
Licensure & Certification

ASSISTED LIVING RESIDENCE  
LICENSE RENEWAL APPLICATION

COMPLETE THIS APPLICATION AND RETURN TO:

Office of Health Facility Licensure & Certification  
Attention: Assisted Living Program  
408 Leon Sullivan Way  
Charleston, WV 25301-1713  
(304) 558-0050

LOG NUMBER _____
DATE _____

**OFFICIAL USE ONLY**

NOTE: This application can only be accepted if all required fields are completed and additional requested documentation is attached.

**FACILITY INFORMATION**

Operating Name: \_\_\_\_\_

Legal Name: \_\_\_\_\_

FEIN: \_\_\_\_\_

Physical Address: \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP Code*

*County*

Mailing Address: \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP Code*

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Website URL: \_\_\_\_\_

**OCCUPANCY**

Number of private rooms: \_\_\_\_\_ Private room daily rate: \$ \_\_\_\_\_

Number of semi-private rooms: \_\_\_\_\_ Semi-private room daily rate: \$ \_\_\_\_\_

Number of 3 – 4 bed wards: \_\_\_\_\_ 3 – 4 bed ward daily rate: \$ \_\_\_\_\_

Does the facility accept residents with Supplemental Security Income (SSI)?  Yes  No

If yes, what is the daily rate: \$ \_\_\_\_\_

Total number of beds in facility: \_\_\_\_\_

Total number of beds allocated to low income residents: \_\_\_\_\_

Total number of beds allocated for day care: \_\_\_\_\_



**SERVICES**

Check the provider(s) for all services offered:

Facility	Contract		Facility	Contract	
<input type="checkbox"/>	<input type="checkbox"/>	24-hour Security	<input type="checkbox"/>	<input type="checkbox"/>	24-hour Supervised Care
<input type="checkbox"/>	<input type="checkbox"/>	Activities	<input type="checkbox"/>	<input type="checkbox"/>	Activities of Daily Living
<input type="checkbox"/>	<input type="checkbox"/>	Administrative Office	<input type="checkbox"/>	<input type="checkbox"/>	All Utilities Included
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer Care	<input type="checkbox"/>	<input type="checkbox"/>	Appointment Scheduling
<input type="checkbox"/>	<input type="checkbox"/>	Appointment Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Beauty Shop
<input type="checkbox"/>	<input type="checkbox"/>	Cable Television	<input type="checkbox"/>	<input type="checkbox"/>	Church Services
<input type="checkbox"/>	<input type="checkbox"/>	Day Care Services	<input type="checkbox"/>	<input type="checkbox"/>	Dietary Services
<input type="checkbox"/>	<input type="checkbox"/>	Field Trips	<input type="checkbox"/>	<input type="checkbox"/>	Home Health Services
<input type="checkbox"/>	<input type="checkbox"/>	Hospice	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping Services
<input type="checkbox"/>	<input type="checkbox"/>	Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	Library
<input type="checkbox"/>	<input type="checkbox"/>	Management of Personal Finances	<input type="checkbox"/>	<input type="checkbox"/>	Medication Administration
<input type="checkbox"/>	<input type="checkbox"/>	Mobile X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	Nursing Services
<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Pet Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Pharmacy Services	<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Physician Services	<input type="checkbox"/>	<input type="checkbox"/>	Podiatry
<input type="checkbox"/>	<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Other

**ADMINISTRATOR**

Full Name: \_\_\_\_\_  
*Last* *First* *M.I.*

Address: \_\_\_\_\_  
*Street Address*

\_\_\_\_\_

*City* *State* *ZIP Code*

E-mail Address: \_\_\_\_\_

WV Administrator's License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**SUPERVISING/CONSULTANT REGISTERED NURSE**

Full Name: \_\_\_\_\_  
*Last* *First* *M.I.*

E-mail Address: \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_





**SHAREHOLDERS**

Director                       Officer                       Stockholder                       Trustee/Beneficiary

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

Address: \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP Code*

Principle Occupation: \_\_\_\_\_

Proprietary Interest: \_\_\_\_\_ %

**SHAREHOLDERS**

Director                       Officer                       Stockholder                       Trustee/Beneficiary

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

Address: \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP Code*

Principle Occupation: \_\_\_\_\_

Proprietary Interest: \_\_\_\_\_ %

**OTHER FACILITIES OWNED OR OPERATED BY APPLICANT**

Operating Name: \_\_\_\_\_

Address: \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP Code*

**OTHER FACILITIES OWNED OR OPERATED BY APPLICANT**

Operating Name: \_\_\_\_\_

Address: \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP Code*



**APPLICANT**

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

Title or Position: \_\_\_\_\_

Address: \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP Code*

Relationship to Facility:     Lessee or assignee of the facility     Owner

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

**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 Center/Agency, therein contained, are correct and true of his/her own knowledge.

Signature of Applicant: \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
*Notary Public*

My Commission Expires: \_\_\_\_\_