



**DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Public Health
Office of Health Facility Licensure & Certification
Assisted Living Program
1 Davis Square, Suite 101
Charleston, West Virginia 25301-1799
(304- 558-0050)**

INITIAL or **CHANGE OF OWNERSHIP (CHOW)**
LICENSE APPLICATION FOR MEDICAL ADULT DAY CARE

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 center.

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 **\$100.00** (non-refundable) payable to: Office of Health Facility Licensure and Certification (OHFLAC). Prior to being licensed, a center 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 §16-5B-4, mandates that any application to operate an ambulatory health care facility will be assessed a reasonable fee, determined by the director, based on the number of patients to be served. This charge will apply to the initial or CHOW. **This fee must be paid prior to the license being issued.**

Center Name: _____

Application Check List

- Completed Application _____
- Application fee enclosed (payable to OHFLAC) _____
- Preliminary statement of operations _____
- Application signed _____
- Application Notarized _____
- Director's proof of education enclosed _____
- Criminal Background Card (CIB)* _____
- Fee for CIB enclosed (made payable to WVSP) _____
- Pictures of center are attached _____
- If leased/rented, copy of lease agreement _____
- Verification of compliance with *CON Review _____ (*CON=Certificate of Need)

***Criminal Investigation Background (CIB) checks must be completed and sent with the initial application to our office at the address listed above. The West Virginia State Police (WVSP) will not accept personal checks; only business checks or money orders (made payable to WVSP). Please call the telephone number listed at the top of this page to obtain cards and instructions if you are downloading this off the website.**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Health Facility Licensure & Certification
Assisted Living Program
1 Davis Square, Suite 101
Charleston, West Virginia 25301-1799
Telephone: (304) 558-0050 Fax: (304) 558-2515

LICENSE APPLICATION

MEDICAL ADULT DAY CARE	TYPE OF APPLICATION	
	INITIAL	CHOW

Center Name		Telephone #	
Street Address		Fax #	
City, State Zip Code		County	
Mailing Address (if different than street address)			

West Virginia Business License Number _____
 Apply online at 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 Medical Adult Day Care Center. To assure accurate account information is obtained, your Federal Employee Identification Number (FEIN), must be provided and kept on file.

CENTER FEIN #: _____

CENTER INFORMATION

Type of Construction				
Is the structure owned by the individual applicant, partnership or corporation?		If no, Is the center leased or rented?		
If leased, owner's name, address and phone number:		If leased or rented, copy of lease agreement must be included with application		
Number of floors		Proposed # of Participants to serve		Daily/weekly/monthly cost

Specific Directions to the Center from Charleston: _____

CORPORATE/LICENSEE/OWNER INFORMATION

Name (Corporation, licensee or owner)	
Address	
City, State, Zip Code	
Applicant Telephone Number	

**TYPE OF APPLICATION:
(If other than individual applicant-Attachment B must be completed)**

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

Name	
Education Credentials (attach copy)	
E-Mail Address	

SUPERVISING/CONSULTANT REGISTERED NURSE

Name		License Number	
E-Mail Address			

**SERVICES TO BE OFFERED
(Check all that apply-include additional costs, if any)**

	Additional cost (if any)	
Personal Care Services/Assistance with ADL's		
Medication Administration		
Transportation to/from the center		
Transportation to/from appointments		
Beauty shop/hair cutting services		
Assistance with making appointments		
Laundry services		
Dietary Services (specify on-site or catered)		
Recreational Activities (bingo, field trips, exercise, etc)		
Specialty services (OT/PT/Speech Therapy)		
Special populations (Alzheimers/Dementia, PT, DD)		
Other (specify)		

Primary Hours of Operation: _____

ORGANIZATIONAL PLAN

Attach an Organizational Chart or complete the information below, indicating the proposed number of persons employed (or to be employed) and the position.

Full-time	Part-time	Position
		Director
		Housekeeping
		Maintenance
		Registered Nurse(s)
		Licensed Practical Nurse(s)
		Laundry
		Nursing Assistant(s)/Aide(s)
		Activity Director
		Activity Aide(s)
		RN Consultant
		Dietary
		Driver(s)

The signature on this application confirms an understanding of requirements for state licensure, and that in order to be licensed this center 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 center, 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

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

FINANCIAL INFORMATION REQUIREMENTS

The 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 center must be submitted)

ATTACHMENT B

OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION ASSISTED LIVING PROGRAM

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

West Virginia State Code §16-5B-2, §16-5B-3

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 proposed medical adult day care center, if he 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)

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

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

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

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:

**POLICY STATEMENT
TITLE VI, CIVIL RIGHTS ACT OF 1964**

This center 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. Outpatient service will be provided on a nondiscriminatory basis; all participants will be admitted and receive care without regard to race, color, or national origin.
2. All participants will be assigned to rooms, floors, and sections without regard to race, color, or national origin.
3. Participants will not be asked if they are willing or desire to share a room or area with a person of another race.
4. Employees will be assigned to participant care and services without regard to race, color, or national origin of either the participant or employee.
5. Professionally qualified personnel will not be denied access to treat participants based on race, color, or national origin.
6. All areas of this center will be available for use without regard to race, color, or national origin.

The nondiscriminatory policy of the center applies to participants, physicians, health care consultants 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.

Name of Center

Director Signature

Date