

APPLICATION FOR LICENSE TO OPERATE A NURSING FACILITY

TO: South Dakota Department of Health
Office of Health Care Facilities Licensure & Certification
615 East 4th Street
Pierre, SD 57501-1700 Telephone No. 605-773-3356 Fax No. 605-773-6667

The undersigned hereby makes application for a license to operate a nursing facility as required by SDCL 34-12

I. NAME AND LOCATION OF FACILITY

Name of Facility
Address of Facility
(Street and Number) (City)
County Zip Code (9 digit) Telephone No. Fax No.
Mailing Address (if different from above)
E-Mail Address

II. CAPACITY AND CLASSIFICATION OF FACILITY

A. Number of Beds
B. Accredited by; Date Attach current accreditation reports,
correspondence; if previously submitted, give date.

III. CONTROL OF FACILITY:

A. Check below the one which applies:
[ ] Sole Proprietorship 1. If sole proprietorship, list name of owner:
[ ] Partnership 2. If partnership, list name of partnership and attach a list of names and
[ ] Limited Liability addresses of partners:
Partnership (LLP)
[ ] Corporation [ ] Non-profit 3. If corporation, give name and address of corporation: Phone
[ ] Profit
[ ] Limited Liability Company (LLC) 5. If LLC, give name of company and attach a list of names and addresses
of members:
[ ] Political Subdivision (Specify):
[ ] Other (Specify):
B. Governing Body Organization:
Attach list of governing board members including profession, address, and board position.
C. Staffing:
Attach list of department heads, managers and consultants, if applicable, including license, certification or
registration and expiration date. Include qualifications of social worker or designee (see ARSD 44:04:12:05)
D. Do nurses delegate nursing tasks to unlicensed assistive personnel (UAPs)? [ ] Yes [ ] No;
Supervised by Title
E. Management Group, if applicable:
(Organization) (Address)
F. Affiliation Agreement
(Hospital) (Address)
G. Name of Administrator License No.
H. Name of Director of Nursing License No.
I. Name of Medical Director License No.
J. Name of Pharmacist Consultant License No.

K. Ownership of Building: \_\_\_\_\_ Address \_\_\_\_\_  
[ ] Individual; [ ] Partnership; [ ] L.L.P.; [ ] Non-profit Corporation; [ ] Profit Corporation; [ ] LLC; [ ] Political  
Subdivision. **Attach** list Board of Directors, if corporation; List LLC members, Partners or Individual, including  
profession and address.

L. Lease: [ ] Yes [ ] No; If yes \_\_\_\_\_  
(Organization) (Address)  
[ ] Individual; [ ] Partnership; [ ] LLP; [ ] Non-profit Corporation; [ ] Profit Corporation; [ ] LLC; [ ] Political  
Subdivision. **Attach** list of Board of Directors, if corporation, if different from B. List LLC members, Partners or  
Individual, including profession and address.

M. Sub-lease [ ] Yes [ ] No. If  
yes \_\_\_\_\_

**Attach** separate page, if needed. (Organization) (Address)  
N. **Attach** organization charts for all above that are applicable, plus copies of existing leases, subleases, management  
contracts or applicable supporting documentation that indicates legal sequence from ownership to actual operation  
of the facility. If the requested documents were submitted previously, give date: \_\_\_\_\_.

**IV. BUILDING AND SERVICES**

A. Complete attached list of services offered and other information.  
B. Address of buildings in which services are provided \_\_\_\_\_;  
number of licensed beds in each \_\_\_\_\_; number of unlicensed beds \_\_\_\_\_. Co-located  
Services [ ] Yes [ ] No Describe \_\_\_\_\_

C. Is facility engaged in or planning to build, remodel, or add a new service? Yes \_\_\_\_ No \_\_\_\_\_. If yes, have  
plans been submitted? [ ] Yes [ ] No. Anticipated date of completion \_\_\_\_\_ Scope of project  
\_\_\_\_\_

D. Automatic sprinkler system annual inspection \_\_\_\_\_ by \_\_\_\_\_  
(date)

E. Testing of standby power system under load monthly [ ] Yes [ ] No.

F. Does the facility handle resident monies either in excess of \$50 per month for individual residents or in excess of  
\$500 per month for all residents? [ ] Yes [ ] No; Submit a copy of your surety bond. Amount of monies handled  
\$ \_\_\_\_\_ Bond Amount \$ \_\_\_\_\_

**V. APPLICANT**

I verify the information contained in this application is true and complete, and I consent to allow inspections of the nursing  
facility by authorized department representatives upon the presentation of identification during hours of operation.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Owner, Administrator, or other individual authorized to act on behalf of facility)

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

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

|               |                        |
|---------------|------------------------|
| Notary Public | My commission expires: |
|---------------|------------------------|

**APPLICATIONS MUST BE COMPLETE, SIGNED AND NOTARIZED TO BE PROCESSED**

**VI. LICENSE FEE**

The license fee in the amount of \$ \_\_\_\_\_, (1 to 50 beds - \$600, 51 to 100 beds - \$900, 101 to 150 beds - \$1,200, or 151  
+ beds - \$1,500) is attached to this application. Make check, money order, or postal note payable to the South Dakota  
Department of Health.

Note: Please submit original and retain one copy for your files. Attach all required documentation to the original application.

**FOR HEALTH DEPARTMENT USE ONLY**

Fee received \$ \_\_\_\_\_ Receipt No. \_\_\_\_\_ License No. \_\_\_\_\_

The department will issue or renew a license only after payment of the proper fee, ascertainment that the facts set forth in the application are true and complete, and satisfactory evidence of the applicant's ability to comply with the provisions of SDCL Chapter 34-12 and the rules promulgated thereunder.

**Nursing Facility License Application**

Facility \_\_\_\_\_ Address \_\_\_\_\_  
(Name)

Check services offered as of the date of application: (If not provided directly, list name of contractor.)

- Congregate Housing \_\_\_\_\_ Units, \_\_\_\_\_ Beds
- Day Care – Adult, Number, \_\_\_\_\_
- Day Care - Child, Number, \_\_\_\_\_
- Health Professional, Training (List) \_\_\_\_\_
- Home Health
- Hospice - Acute
- Hospice – Facility Based
- Hospice - Respite
- Meals, Home Delivered Total \_\_\_\_\_
- Nurse-Aide Training
- Occupational Therapy - Inpatient
- Occupational Therapy - Outpatient
- Physical Therapy - Inpatient
- Physical Therapy - Outpatient
- Renal dialysis (Onsite)
- Respite Program
- Secure Unit \_\_\_\_\_ Beds
- Speech Therapy - Inpatient
- Speech Therapy - Outpatient
- Transportation Services
- Volunteer Services

I hereby authorize the Department of Health to make the list of services available to requesters unless prohibited as noted below:

\_\_\_\_\_  
\_\_\_\_\_

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