



## LICENSE APPLICATION TO OPERATE AN ASSISTED LIVING CENTER

**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 an assisted living center 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) \_\_\_\_\_  
Administrator's E-Mail Address \_\_\_\_\_

### II. CAPACITY AND CLASSIFICATION OF FACILITY

- A. \_\_\_\_\_ Number of licensed beds
- B. Care and Individualized Services provided based on the facilities ability to meet the needs of all residents, availability of written policies and procedures, and staff education. Each resident shall receive daily care by facility personnel according to ARSD 44:70:01:05 and 44:70:05:03. Additional resident care (mark all that the facility will provide) includes those who:
- Are physically impaired [ARSD 44:70:02:17(3)].
  - Are dependent on supplemental oxygen [ARSD 44:70:02:17(9)] In-service date \_\_\_\_\_.
  - Are not capable of self-preservation [ARSD 44:70:02:17(10)].
  - Require a memory care unit [ARSD 44:70:04:12]. Number of memory care beds \_\_\_\_\_. In-service date \_\_\_\_\_.
  - Require hospice services [ARSD 44:70:05:05] In-service date \_\_\_\_\_.
  - Require total ADL assistance [ARSD 44:70:05:06] In-service date \_\_\_\_\_.
  - Are cognitively impairment (ARSD 44:70:05:07) In-service date \_\_\_\_\_.
  - Require therapeutic diets [ARSD 44:70:06:06].
  - Require dining assistance [ARSD 44:70:06:18] In-service date \_\_\_\_\_.
  - Require medication administration [ARSD 44:70:07:07] and/or the resident self-administer medications [44:70:07:09]. In-service date for both requirements \_\_\_\_\_.
  - Require adult day care [ARSD 44:70:04:11].
  - Require respite care [ARSD 44:70:04:11].

**III. CONTROL OF FACILITY:**

A. Check below the one which applies:

Sole Proprietorship

If sole proprietorship, list name of owner:

Partnership

If partnership, list name of partnership and **attach** a list of names and addresses of partners: \_\_\_\_\_

Limited Liability Partnership (LLP)

Corporation:

If corporation, give name and address of corporation: Phone \_\_\_\_\_

Non-profit  Profit

\_\_\_\_\_ If corporation, give state under which laws the corporation is organized:

Limited Liability Company (LLC)

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 President/Chairman, Vice-President, Secretary, and Treasurer including their mailing address. Provide the phone number for the President/Chairman.

C. Staffing: **Attach list of consultants** according to the services provided listed in IIB. Include license, certification or registration number, and expiration date.

D. Management Group, if applicable: \_\_\_\_\_

(Organization)

(Address)

E. Administrator \_\_\_\_\_

**Attach proof of administrator qualifications and attestation statement 44:70 has been read.**

F. Owner 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, if different from B.

G. 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, List LLC members, Partners or Individual, including profession and address, if different from B.

H. **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. Attached a list of services or information within a letter that will be offered (beauty shop, spa, banking services, etc.)
- B. Address of building in which residents are housed \_\_\_\_\_;  
 Number of licensed beds \_\_\_\_\_; 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. 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;  
 Amount of monies handled \$ \_\_\_\_\_ Bond Amount \$ \_\_\_\_\_ Submit a copy of your surety bond.

**V. APPLICANT:**

I verify the information contained in this application is true and complete, and I consent to allow inspections of the assisted living center 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:
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**APPLICATIONS MUST BE COMPLETE, SIGNED AND NOTARIZED TO BE PROCESSED**

**VI. LICENSE FEE**

The license fee in the amount of \$\_\_\_\_\_, (1 to 16 Beds - \$150, 17 to 50 beds - \$300, 51 to 100 beds - \$450, or 101 + Beds – \$600) 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.