

APPLICATION FOR LICENSE 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
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 Beds
B. Approvals Requested; Please check those for which application is made:
[] Medication Administration [ARSD 44:70:04:14(2)] In-service date
[] Acceptance of Cognitively Impaired Residents (ARSD 44:70:04:14(3)) In-service date
[] Acceptance of Physically Impaired Residents [ARSD 44:70:04:14(4)]
[] Acceptance of Residents Incapable of Self-preservation [ARSD 44:70:04:14(5)]
[] Acceptance of Residents Dependent on Supplemental Oxygen [ARSD 44:70:04:14(6)] In-service date
[] Acceptance of Residents Requiring Therapeutic Diets [ARSD 44:70:04:14(7)]
[] Acceptance of Residents that have Elected Hospice [ARSD 44:70:04:14(8)] In-service date
[] Acceptance of Residents who require dining assistance [ARSD 44:70:04:14(9)] In-service date
[] Acceptance of Residents who require total assistance with ADLs or two-person assist [ARSD 44:70:04:14(10)] In-service date

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 [] Non-profit If corporation, give name and address of corporation: Phone
[] 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, Vice-President, Secretary and Treasurer including their mailing address.
C. Staffing: Attach list of consultants, if applicable, including license, certification or registration and expiration date.
D. Management Group, if applicable: (Organization) (Address)
E. Administrator Attach proof of administrator qualifications.

- 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. Complete attached list of services offered
- B. Address of buildings in which residents are housed _____;
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. 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: |
|---------------|------------------------|

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.