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
[ ] Limited Liability Partnership (LLP)
2. If partnership, list name of partnership and **attach** a list of names and addresses of partners:_____
_____
_____

[ ] Corporation [ ] Non-profit [ ] Profit
3. If corporation, give name and address of corporation: Phone _____
_____
_____
4. If corporation, give state under which laws the corporation is organized:
_____

[ ] 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 44:73:10:04, 44:73:01:01(48) & 44:73:01:01(49)]

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_____