APPLICATION FOR LICENSE TO OPERATE A NURSING FACILITY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
Telephone 701.328.2352
SFN 14230 (R11-17)

ACCOUNTING/DEPARTMENT USE ONLY

Check Number	License Number
Amount	Bed Capacity
Date	Licensure Period

INSTRUCTIONS: Type or print clearly. Attach with the application a check or money order and other information as requested. Include the completed request for waiver, if applicable. Return one completed, notarized copy to: ND Department of Health, Division of Accounting, 600 E Boulevard Ave. Dept. 301, Bismarck, ND 58505-0200. Keep a copy for your records.

Official Name of Nursing Facility		NPI Number	
Street Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	Bed Capacity
E-Mail Contact	E-Mail Address		

TYPE OF APPLICATION

☐ Initial ☐ Renewal ☐ Change of Facility Ownership ☐ Bed Capacity Change ☐ Name Change
☐ Location Change ☐ Change in Services ☐ Change in Facility Operator ☐ Other Change:

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)

GOVERNMENTAL	☐ State	☐ County	☐ County & City	☐ Municipal
NONPROFIT	☐ Association	☐ Corporation	☐ Limited Liability Company	
PROPRIETARY	☐ Individual	☐ Partnership	☐ Corporation	

Name of Exact Ownership of Premises			
Mailing Address	City	State	ZIP Code
Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code

Has ownership of this nursing facility changed in the last twelve months? ☐ No ☐ Yes	Has the legal entity responsible for operation of this nursing facility changed in the last twelve months? ☐ No ☐ Yes	Is the nursing facility operating under a management agreement? ☐ No ☐ Yes

Name of Nursing Facility's General Liability Insurance Company	Name of Agent		
Mailing Address of Agent	City	State	ZIP Code

Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code
Name of Administrator	Title	License Number	
Name of Director of Nursing Services		License Number	
Name of Medical Director		License Number	
Name and Title of Emergency Contact:	Emergency Contact's Cell Phone Number:		

Does your facility offer the following department approved services:

☐ Memory Care in Secured Unit -- Number of Beds _____ ☐ Bariatrics -- Number of Beds _____

☐ Adult Day Care ☐ Ventilator -- Number of Beds _____

☐ Paid Feeding Assistant Training Program (Date Last Class Completed _____)

☐ Nurse Aide Training Program (Date Last Surveyed _____)

☐ Other Services (Specify)_____

Submit a current floor plan (8 ½ x 11) showing the location of all licensed beds (<u>with room numbers identified</u>) and services.

SIGNATURES AND AFFIDAVIT

NOTE: The person signing the application cannot be less than 18 years of age. The administrator of the nursing facility shall not sign the application unless he/she is also a board member. The application must be signed by official(s) of the entity responsible for the operation of the nursing facility. (If sole proprietorship, the owner shall sign the application; if a corporation, two of its officers shall sign; if a state, county, or municipal unit, the application is to be signed by the head of the department having jurisdiction over the nursing facility.)

The undersigned hereby makes application for a license to operate a nursing facility subject to the provisions of North Dakota Century Code Chapter 23-16 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

_____ _____
Signature Date

_____ _____
Signature Date

State of _____)

) SS.
County of _____)

On this _____day of _____, 20_____, before me personally

appeared_____ _____who having been sworn states that to the best of

his/her knowledge and beliefs the statements in the foregoing application are true.

_____
Notary Public

(Seal)

My commission expires_____