



**APPLICATION FOR LICENSE TO OPERATE
A BASIC CARE FACILITY**

ACCOUNTING/DEPARTMENT USE ONLY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
Telephone 701.328.2352
SFN 16855 (11-14)

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. 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 Basic Care 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

<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change of Facility Ownership	<input type="checkbox"/> Bed Capacity Change	<input type="checkbox"/> Name Change
<input type="checkbox"/> Location Change	<input type="checkbox"/> Change in Services	<input type="checkbox"/> Change in Facility Operator	<input type="checkbox"/> Other Change:	

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)				
GOVERNMENTAL	<input type="checkbox"/> State	<input type="checkbox"/> County	<input type="checkbox"/> County & City	<input type="checkbox"/> Municipal
NONPROFIT	<input type="checkbox"/> Association	<input type="checkbox"/> Corporation		
PROPRIETARY	<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> 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
Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code
Has ownership of this Basic Care Facility changed in the last twelve months? <input type="checkbox"/> No <input type="checkbox"/> Yes	Has the legal entity responsible for operation of this Basic Care Facility changed in the last twelve months? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is the Basic Care Facility under a management agreement? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Name of Basic Care Facility's General Liability Insurance Company		Name of Agent	
Mailing Address of Agent	City	State	ZIP Code
Name of Administrator			
Name and Title of Emergency Contact		Emergency Contact's Cell Phone Number	
Does your facility offer the following department approved services:			
<input type="checkbox"/> Memory Care in Secured Unit -- Number of Beds _____ <input type="checkbox"/> Bariatrics -- Number of Beds _____			
<input type="checkbox"/> Adult Day Care			
<input type="checkbox"/> Other Services (Specify) _____			

Submit a current floor plan (8 1/2 x 11) showing the location of all licensed beds (with room numbers identified) and services.

Applicant Agrees to the Following:

1. To the inspection of the basic care facility by a representative of the North Dakota Department of Health;
2. To the inspection by other regulatory agencies at the request of the North Dakota Department of Health;
3. To notify the North Dakota Department of Health of any change in ownership immediately or proposed change of location or increase of bed capacity or services;
4. To operate this basic care facility at all times in compliance with the standards established by the North Dakota Department of Health

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a license to operate a basic care facility subject to the provisions of North Dakota Century Code Chapter 23-09.3 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

State of _____)
County of _____) SS.

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.

(Seal)

Notary Public

My commission expires _____