



## Arkansas Department of Human Services Division of Medical Services

Office of Long Term Care -Mail Slot S409

P.O. Box 8059

Little Rock, Arkansas 72203-8059

Telephone (501) 682-8487 TDD (501) 682-6789 Fax (501) 682-1197

<https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/index.aspx>

### MEMORANDUM

LTC-A-2011-03

**TO:**  Nursing Facilities;  ICFs/MR 16 Bed & Over;  HDCs;  
 ICFs/MR Under 16 Beds;  ALF Level I;  ALF Level II;  
 RCFs;  Adult Day Cares;  Adult Day Health Cares;  
 Post-Acute Head Injury Facilities;  Interested Parties;  
 DHS County Offices

**FROM:** Carol Shockley, Director, Office of Long Term Care

**DATE:** January 10, 2011

**RE:** Advisory Memo - Notice of Long Term Care Facility License Renewal

Each long term care nursing facility is required by State law to submit a yearly license renewal application to the Office of Long Term Care in accordance with Act 1238 of 1993 (Ark. Code Ann. 20-§ 20-10-224). Enclosed are the DMS-726 nursing home license application, IRS W-9 and revised DMS-736. Additionally, the DMS-726 (R. 1/11), instructions, checklist, and Director of Nurses form are available for download on the OLTC website:

<https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/forms/forms.aspx>

Once on the website, scroll down to Nursing Homes, then click on DMS-726.

The required **Form W-9 (Rev. 10-2007)** is enclosed; it is also available for download at:

<http://www.irs.gov>.

**Please note the following changes on the DMS-726 application:**

**Act 216 of 2009 made changes to amend the requirements for sale and licensure of Long Term Care Facilities. Please note the due date changed from June 1 to March 1.**

**On page 1 of 6 please note if your facility has HomeStyle beds.**

**A 10 percent (10%) penalty on the amount due will be assessed for each nursing facility if the renewal application is not delivered before March 1, 2011 or if mailed, is not**

**postmarked on or before March 1, 2011.** The fee submission is \$10.00 per licensed bed.

A check made payable to Arkansas Department of Human Services must be attached to each application. The **facility name** and **city** must be included on the check.

**CRIMINAL RECORD CHECK**

As stated in the instructions and the Rules and Regulations for Conducting Criminal Record Checks for Employees of Long Term Care Facilities effective October 1, 1997 (and as revised), **all operators** (the person signing this renewal application) **must fulfill the requirements as set forth in Section 202 (1) and Section 400 respectively.**

If you are signing the license application as Operator, you must complete the State criminal record check process and the National Fingerprint Card process. If the criminal record check (CRC) has not been completed on the Operator, or is more than five (5) years old, you must resubmit the CRC. If you have completed **only** the State CRC process, you must resubmit another State CRC and complete the National Fingerprint Card process. The check should be payable to the Arkansas State Police for \$25.00 for the State Record if you do not utilize the on-line system and a check for \$19.25 check made payable the Arkansas State Police for the National check. The DMS-736 form is enclosed. Please contact (501) 682-6173 or (501) 682-8424 if you need a National Fingerprint Card.

The completed, notarized license renewal application, including all attachments and a separate fee submission for each application must be sent by the following procedures:

If mailed, mail to:

If sent Federal Express, send to:

*(Postmarked on or before March 1 for each situation)*

DEPARTEMENT OF HUMAN SERVICES  
OFFICE OF FINANCE AND ADMINISTRATION  
LONG TERM CARE-SLOT WG2  
PO BOX 8181  
LITTLE ROCK, AR 72203-8181

DHS-CASH RECEIPTS  
112 WEST 8<sup>th</sup>  
DONAGHEY PLAZA SOUTH  
LITTLE ROCK, AR 72201

If HAND DELIVERED by March 1: You must come to 700 Main to the new Donaghey Plaza South Building, show identification, and surrender your driver's license to obtain a visitor's pass.

Facilities operated by the State must send the completed, notarized application and attachments to:

Office of Long Term Care - Slot S404  
Nursing Facility Licensure Section  
P. O. Box 8059  
Little Rock, AR 72203-8059

If you have questions, please contact Audrey Nelson at (501) 682-6173 or Sophie Fraser at (501) 682-8424.

If you need this material in alternative format such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8307 (voice) or 501-682-6789 (TDD).

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Enclosure

Arkansas Department of Human Services  
 Division of Medical Services  
 Office of Long Term Care

Application for License to Conduct a Long Term Care Facility – Arkansas Code Annotated § 20-10-224  
 Annual Disclosure Statements of Long Term Care Facilities – Upon Application or Renewal for Licensure  
 Arkansas Code Annotated § 20-10-229 and 20-10-230

**NOTE: Before beginning this Application, please read the attached instructions.**

<b>I. NAME AND LOCATION</b>	<b>DEPARTMENT USE:</b>
Entity Name: _____	_____, 20__
Doing business as: _____	License Number: _____
Name of Facility: _____	Type License: _____
County of Facility: _____	Total Beds: _____
Physical Location: _____ (Street, City, Zip Code)	Annual Fee: _____
Facility Telephone Number: (479) _____	MMIS Number: _____
Facility Fax Number: (479) _____	Vendor Number: _____
Mailing Address: _____	Granted: _____
AR	Denied: _____
City State Zip Code	By: _____ Date: _____

Department Use: _____
Check Number: _____ Check Date: _____ Check Amount: \$ _____
Check One: Renewal: <input type="checkbox"/> Change of Ownership: <input type="checkbox"/> Bed Increase: <input type="checkbox"/> Increased from: _____ to _____

**II. CLASSIFICATION OF LICENSE**

Renewal:  Initial Licensure:  Replacement:  Increase in Bed Capacity:

Initial, Replacement, or Bed Increase Permit of Approval Number: \_\_\_\_\_ Date of Issue: \_\_\_\_\_

Type of License Requested: NF  ICF/MR  ICF/MR 15 Beds or Less

Change of Operational Control Effective Date: \_\_\_\_\_ Stock Purchase Effective Date: \_\_\_\_\_  
 (Each situation requires a 30-Day Prior Notice from the Buyer and the Seller.)

Total number of Licensed Beds Requested: \_\_\_\_\_ (Fee is \$10.00 per licensed bed).

\*\*\*\*\* Number of Licensed Beds that are HomeStyle beds: \_\_\_\_\_

\*\*\*\*\* Number of Licensed Beds that are NOT HomeStyle beds: \_\_\_\_\_

(If this is for an increase, the fee is for the increase only) Increase by: From \_\_\_\_\_ beds to \_\_\_\_\_ total beds.  
 If the licensed beds requested are different than last year, please explain: \_\_\_\_\_

**III. PERSONNEL - Name of Administrator and License Number:** \_\_\_\_\_

Name of Director of Nurses and the current RN License Number: \_\_\_\_\_

Number of Full Time RNs: \_\_\_\_\_ Number of Full Time LPNs: \_\_\_\_\_

**IV. OWNERSHIP OF BUSINESS**

**A. Please check all that applies for your individual facility:**

State:  County:  City:  Sole Proprietorship:  Partnership:   
 Limited Liability Company:  Corporation - C:  Corporation - S:  Non-Profit Corporation:   
 Non-Profit Association:  Name of Association: \_\_\_\_\_  
 Church Affiliated:  Name of Church Affiliation: \_\_\_\_\_

**B.**

Name of Entity: \_\_\_\_\_ Entity IRS Number: \_\_\_\_\_  
 Name of Nursing Facility: \_\_\_\_\_ Facility IRS Number: \_\_\_\_\_

Entity Contact Person	Title of Contact Person	Area Code/Telephone		
Entity Address	City	State	Zip Code	

FACILITY EMAIL ADDRESS

FACILITY WEBSITE ADDRESS

**C. List all percentages of ownership in the Entity: (AC = Area Code)**

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**D. List all individuals who serve as officers/members of the Entity with position held and percentage of ownership, if applicable. (AC = Area Code)**

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Percentage: \_\_\_\_\_ %  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**E. List Members of Governing Body or Board of Directors, as applicable, below:**

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Title: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Title: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Title: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Title: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ AC/Phone: ( ) \_\_\_\_\_ Title: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**F. Business Fiscal Year Ending Date: \_\_\_\_\_**

**Fiscal Year Ending Date Used For Medicaid Cost Reports: \_\_\_\_\_**

**Fiscal Year Ending Date Used For Medicare Cost Reports: \_\_\_\_\_**

**G. Name and Address of Hospital if Facility is Hospital-Based: \_\_\_\_\_**

**H. Provide the name of multi-facility organization if facility is owned or leased by a multi-facility organization:**

Name: \_\_\_\_\_

**I. Management Company, if Facility is Managed: \_\_\_\_\_**

\_\_\_\_\_ ( ) \_\_\_\_\_  
**Management Company Contact Person AC/Telephone Management Company IRS Number**

\_\_\_\_\_ **Address City State Zip Code**

**NOTE: A copy of the current signed Management Agreement must be attached to the license application for each nursing facility owned/operated by the same Entity.**

**J. If the facility vendor payment address is different from the mailing address or the physical location of the facility, please Provide the information below:**

**Company Name:** \_\_\_\_\_

\_\_\_\_\_  
**Address** **City** **State** **Zip Code**

**V. Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who:**

**\*YES** **NO**

- A. Have ever been convicted of Medicare or Medicaid fraud or a felony?**
- B. Have ever been convicted of fraud, embezzlement, fraudulent conversion, misappropriation of property, or a felony?**
- C. Had a final administrative judgment on any Class A or B long-term care violations within the last two (2) years?**
- D. If buyer, has buyer had a license revoked within the last three (3) years?**

**\*If yes, please attach a copy of the Adjudication.**

**VI. Each facility must provide all services and specific items defined in the Department of Human Services Medical Assistance Program Manual of Cost Reimbursement Rules for Long Term Care Facilities, or any additions thereto or subsequent manuals. Receipt of Medicaid per diem reimbursement rates is considered payment in full for services and items included in the manual.**

**A. Does your facility provide ventilators for ventilator dependent individuals? Yes:  No:**

**B. Does you facility provide an Alzheimer's wing? Yes:  No:**

**VII. A blank copy of the Resident Services Contract (a blank copy of the Facility Admission Agreement) used by the facility must be attached to this application.**

**VIII. OWNERSHIP OF BUILDING**

**A. Check One: Same as business:  Leased:  Rented:**

**List the following information for each category:**

**Name and Address of Lease Company:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Name and Address of Landlord:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**It is the nursing facility's responsibility to send a copy of this completed license renewal application to the local area County Office of the Department of Human Services.**



**X. CERTIFICATION AND VERIFICATION**

State of \_\_\_\_\_ County of \_\_\_\_\_

I hereby certify that I have read the aforementioned Application and that all statements are true to the best of my knowledge and belief. I am aware that any willful misrepresentation of any fact contained in the Application will subject me to penalties as prescribed in the State Licensing Law including, but not limited to, revocation or suspension of the License.

I understand and affirm that the long-term care facility complies with Titles VI and VII of the Civil Rights Act. I understand and affirm that this long-term care facility complies with the Americans with Disabilities Act of 1990. I further understand that this long-term care facility will be operated, managed and deliver services without regard to age, religion, disability, political affiliation, veteran status, sex, race, color, or national origin.

\_\_\_\_\_  
Typed or Printed Name of Administrator or Owner of the Facility

\_\_\_\_\_  
Signature of the Administrator or Owner of the Facility

I certify that I have complied with the Rules and Regulations for Conducting Criminal Record Checks for Employees of Long Term Care. I further certify that I have complied with both the State ID and the National ID check as required by the operator of this long term care facility.

\_\_\_\_\_  
Signature of the Administrator or Owner of the Facility

**Note: If you have previously completed only the State ID check, you must complete both the State and the National Fingerprint Card processes when signing this application as the operator.\*\***

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires:  
  
\_\_\_\_\_

The completed Application and all attachments must be delivered by March 1 if hand-delivered. If mailed, the completed Application must be postmarked on or before March 1 for renewals. See instructions for delivery address and mailing address.

**\*\*Note: If Form DMS-736 or the Fingerprint card is needed, please call 501-682-6173 or 501-682-8424.**

If you need this material in alternate format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8307 or 501-682-6789 (TDD).

## INSTRUCTIONS FOR DMS-726 (R.01/11)

### Application for Licensure to Conduct a Long Term Care Facility and Annual Disclosure Statements of Long Term Care Facilities Upon Initial Application, Renewal for Licensure, or *Change of Ownership*

An act to establish Long Term Care Facility Licensure Fees; and for other purposes. (ACT 1238 of 1993)

*Act 216 of the Regular Session 2009, Senate Bill 310: An Act to Amend Arkansas Law Concerning the Sale and Licensure of Long-Term Care Facilities; and for other purposes. Subtitle: An Act to Amend Arkansas Law Concerning the Sale and Licensure of Long-Term Care Facilities.*

- A. Applicants for long term care facility licensure shall file applications under oath with the Office of Long Term Care of the Division of Medical Services of the Department of Human Services upon forms prescribed by the Office of Long Term Care. Each long term care facility, except facilities operated by the State of Arkansas, shall pay an annual licensure fee determined by multiplying ten dollars (\$10.00) by the total licensed resident beds or maximum licensed client population.

All funds derived from fees collected shall be deposited into the State Treasury and credited to the Division of Medical Services Administrative Fund for maintenance and operation of the long-term care facility licensure program.

Fees are payable by or on March 1 of each year. Annual licensure fees shall be tendered with each application for a new long term care facility license and with each long term care facility license renewal application.

Failure to pay when due shall result in a notice of delinquency from the Department of Human Services and a ten percent (10%) penalty assessed on the amount due.

- B. Applications shall be signed by the administrator or the owner of the facility (original signatures only).

**Procedures for Person Signing the Application:**

**Section 100 DEFINITIONS of the Rules and Regulations for Conducting Criminal Record Checks for Employees of Long Term Care Facilities:**

**Operator** - A person responsible for signing an application for an initial or renewal license to operate as a service provider.

**Section 202 (1) of the Rules and Regulations for Conducting Criminal Record Checks for Employees of Long Term Care Facilities:**

**The requirement for a criminal record check for an operator shall apply to the first application signed by an operator and shall be required to undergo periodic criminal record checks no less than one (1) time every five (5) years. Upon the yearly licensure renewal of a long term care facility, the operator signing the renewal application shall not be subject to a criminal record check unless the operator has not had an initial criminal record check or a periodic criminal record check conducted within the previous five (5) years as required by these regulations.**

**Rules and Regulations for Conducting Criminal Record Checks for Employees of Long Term Care Facilities further states:**

**Section 400 - APPLICATION PROCESS FOR OPERATORS**

401 When an operator applies for a license to operate a long term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from the Office of Long Term Care. The forms and appropriate fees shall be submitted to the Office of Long Term Care attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the Office of Long Term Care shall forward the criminal record check request form and fee payments to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to the Office of Long Term Care for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure.

**NOTE: Submission by the Operator of both the State and the National Criminal Record Check (CRC) is a requirement for renewals, initial licensure, and changes of ownership. Whenever there is a notice of change of ownership, the necessary CRC paperwork is submitted to the buyer along with the license application.**

**402 The requirement for a criminal record check for an operator shall apply to the first application signed by an operator and the operator shall undergo periodic criminal record checks no less than one (1) time every five (5) years. Upon the yearly licensure renewal of a long term care facility, the operator signing the renewal application shall not be subject to a criminal record check unless the operator has not had an initial or a periodic criminal record check conducted within the previous five (5) years.**

403 The Office of Long Term Care shall issue a 45 calendar day provisional license to a long term care facility whose operator has been determined to be disqualified based on these provisions. A long term care facility that is issued a provisional license based on the criminal record disqualification of the operator may resubmit the application for licensure with a new operator. The new application must have evidence of submission of criminal record check for the new operator. If the facility does not resubmit the correctly completed application within 15 calendar days of the issuance of the provisional license, then the facility's license shall be immediately denied or revoked.

**404** If an operator or long term care facility fails or refuses to cooperate in obtaining criminal record checks, such circumstances shall be grounds to deny or revoke the facility's license or operating authority, provided that the process of obtaining criminal record checks shall not delay the process of the application for a license or other operating authority.

Applications shall set forth the full name and address of the nursing facility for which licensure is sought and such additional information as the Office of Long Term Care may require, including affirmative evidence of ability to comply with such reasonable standards, rules and regulations as may be lawfully prescribed.

Applications for licensure renewal must be delivered by March 1, if hand-delivered, or if mailed must be postmarked on or before March 1. Licenses issued hereunder shall be effective on a fiscal year basis and shall expire on June 30 of each year. Licenses shall be issued only for the premises and persons named in the application and shall not be transferable. Licenses shall be posted in a conspicuous place on the licensed premises.

- C. Any person, partnership, association or corporation establishing, conducting, managing or operating any institution or facility or any combination of separate entities working in concert within the meaning of this Act without first obtaining a license as prescribed by law shall be guilty of a misdemeanor, and upon conviction thereof shall be liable for a fine of not less than one hundred dollars (\$100) nor more than five hundred dollars (\$500) for the first offense nor more than one thousand dollars (\$1,000) for each subsequent offense. Each day the institution or facility shall operate after a first conviction shall be considered a subsequent offense.
- D. This application is not valid unless it is notarized.
- E. FOR RENEWALS: A check, or money order, for the required licensure fee should be made payable to Arkansas Department of Human Services by March 1 except for those facilities operated by the state. A separate check must be attached to each license application. Each check must list the name of the nursing facility and the city. This information may be entered on the remittance stub.
- F. FOR RENEWALS: This application along with licensure fees and attachments must be delivered before March 1 or if mailed must be postmarked on or before March 1.

If sent by mail, addressed to:

DEPARTMENT OF HUMAN SERVICES  
OFFICE OF FINANCE AND ADMINISTRATION  
LONG TERM CARE - SLOT WG2  
P O BOX 8181  
LITTLE ROCK AR 72203-8181

If sent by Federal Express send to:

DHS – CASH RECEIPTS  
112 West 8<sup>th</sup> St  
DONAGHEY PLAZA SOUTH  
LITTLE ROCK, AR 72201

**If HAND DELIVERED:** You must come to 700 Main to the new Donaghey Plaza South Building, show identification, surrender your driver's license to obtain a visitor's pass, then to the second floor walkway to proceed to the Donaghey Plaza West Building – Garden Level to deliver your license fees and applications. You must then return to the new DHS building to turn in your visitor's pass and retrieve your driver's license.

**NOTE:** Facilities operated by the State must send the completed application and all attachments to: Office of Long Term Care - Slot S404, P. O. Box 8059, Little Rock, AR 72203-8059

**G. FOR CHANGE OF OWNERSHIP:**

**Arkansas Code 20-10-224(e) (6)**

**(A): Except as provided in subdivision (e) (6) (B) of this section, the buyer shall not be issued a license until the buyer provides the department with proof of payment by the buyer to the seller of a sum equal to the annual fee under subsection (i) of this section.**

**(B) The department shall process a renewal application before issuing a license to a buyer if:**

**(i) The buyer provides the department with proof of payment by the buyer to the seller of a sum equal to the annual fee under subsection (i) of this section;**

**(ii) The sale occurs between March 1 and July 1 of any year;**

**(iii) The seller applied for or received a renewal of the license; and**

**(iv) The seller paid the annual fee under subsection (i) of this section to the department.**

**H. HOMESTYLE FACILITIES**

Office of Long Term Care issued LTC-R-2010-09 dated September 20, 2010 concerning the promulgation of the HomeStyle Regulations for Nursing Facilities. Those regulations are incorporated into the Nursing Facility Licensure regulations. The HomeStyle regulations have an effective date of October 1, 2010 and can be downloaded from the OLTC web site at:

<https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/regs/allregs.aspx>

The LTC-R-2010-09 can be downloaded from:

<https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/memos/memo.aspx>

**IN ADDITION:**

1. A copy of the Director of Nursing Services current RN license must be attached to the license application before the application can be processed. The DON Form must also be completed and signed.

**NOTE:** If there is a change in the Director of Nursing Services' position during the licensure year, please submit the information on the DON Form to the following address: OLTC (Slot S404), P. O. Box 8059, Little Rock, Arkansas 72203-8059. This change must include the name of the new Director of Nursing Services and must include a copy of her/his current R.N. License. This information may be faxed to (501) 682-6171.

2. A blank copy of the Resident Services Contract (blank copy of the facility admission agreement) used by the facility must be attached to the license application.
3. A signed copy of the nursing facility's (NF) current management contract/agreement must be attached to each application if another company manages the NF.

**NOTE:** If a NF changes its management company during the licensure year, a letter must be submitted to OLTC concerning the new Management Company. A signed copy of the new management contract/agreement between the entity operator and the Management Company must be included with this letter.

4. Licensure fees must accompany each NF licensure application for renewals, bed increases, and changes of ownership, as applicable. Each separate check must include the name and city of the nursing facility.
5. The W-9 Form with taxpayer I.D. number used by the NF must be attached to the application and must include the current date with original signature. When there is a Change of Ownership, a Replacement/Relocation of a facility, or a New Nursing Facility, there will be four W-9 Forms to complete.
6. A copy of the Internal Revenue Service form from the Treasury Department showing the assignment of the Employee Identification Number for the entity operator must be attached to the license application.
7. When there is a Change of Ownership, a copy of the Articles of Filing referencing the new entity operator for each nursing facility must be attached to each application, including a copy of the Certificate issued by the Arkansas Secretary of State's office.
8. If a NF changes its name during the licensure year, a letter must be submitted to OLTC stating the new name and 4 completed W-9 Forms must be attached to the letter. The W-9 Forms must include the entity name, the new facility name, current date, and original signature. A copy of the Registered Fictitious Name filing must be included.
9. All sections of the application must be completed; enter N/A if not applicable.

- 10. Each facility shall file the completed annual disclosure statement along with its annual license application by March 1 of each year and file a copy of the disclosure statement (copy of this DMS-726) with Department of Human Services County Office in the county in which the facility is located.**
- 11. Failure to provide any resident a copy of the disclosure statement upon request or to a prospective resident upon request or the failure of any facility to disclose the required information in a timely manner or failure to file the disclosure statement as required shall be grounds for a Class C violation, pursuant to Arkansas Code 20-10-205.**
- 12. The application DMS-726 (R.1/11) is not to be scanned. No photocopies, fax copies, hand-stamped signatures, or scanned copies will be accepted for the DMS-726 or the W-9 Form.**

**After completion and before delivering or mailing, please verify that all attachments are included that are particular to your facility. The completed application and all attachments must be sent as instructed in F above, or if sent Federal Express or hand delivered must be sent or delivered as instructed in F above.**

**If you need this material in an alternate format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-8307 (voice) or (501) 682-6789 (TDD).**

**CHECKLIST FOR DMS-726 APPLICATION  
AND ALL NECESSARY ATTACHMENTS BEFORE SUBMISSION**

**For Renewal:**

An individual check made payable to Arkansas Department of Human Services for each nursing facility with the name of the facility, city, and purpose of the check (e.g., bed increase, renewal, new nursing facility, or Change of Ownership) must be included on the check or on the remittance check stub.

The complete entity operator name and the complete name of the nursing facility must be listed as necessary on the application.

Application completed, signed and notarized.

DON Information Submission Form completed and signed.

Copy of DON's current RN license attached.

W-9 Form with Entity name, Doing Business As, Facility name, addresses, and facility IRS Number including an original signature and date.

A copy of the Department of Treasury Internal Revenue Service's form verifying the Assignment of the Employer Identification Number for the entity.

Blank copy of the facility's admission agreement for each nursing facility.

Copy of a signed, current Management Contract, as necessary.

Copy of the Administrative Services Agreement, or other type Agreements, as necessary

**For Changes of Ownership and New Nursing Facilities:**

All of the items above, and, in addition:

A copy of the articles of filing to include the minutes of the meeting, by-laws, operating agreement, etc.

A copy of the certificate as filed with the Arkansas Secretary of State's Office for the entity, including a copy of the fictitious name filing certificate, if applicable.

**For Changes of Ownership:**

All of the items above, and, in addition:

A Change in Operational Control document with the effective date and signed by the buyer and the seller.

A copy of the signed sales document, stock purchase, or building lease agreement, sub-lease, or master-lease must be included, as necessary. A copy of the signed Termination of Lease Agreement between current operator and landlord, as necessary.

\*\*\*\*\*

**Criminal Records Checklist:**

If signing as an Operator, **you must complete the State and National Fingerprint Card process.**

If signing as an Operator and **you have completed only the State criminal record check process, you must resubmit another State check and complete the National Fingerprint Card process. The fees are:**

- |  |                                       |                          |
|--|---------------------------------------|--------------------------|
| \$25.00 State Record Check Mail-In   | Made Payable to Arkansas State Police | <input type="checkbox"/> |
| \$19.25 National Record Check  | Made Payable to Arkansas State Police | <input type="checkbox"/> |
| Original Ark. Code Ann. § 20-38-101 Completed Fingerprint Card of Operator.* |                                       | <input type="checkbox"/> |
| Notarized, with original signature, completed DMS-736 Form for Operator.*    |                                       | <input type="checkbox"/> |

\*Please call 501-682-6173 or 501-682-8424 and arrangements will be made to send these forms.

If you need this material in an alternate format, such as large print, please contact our American with Disabilities Act Coordinator at 501-682-8307 or 501-682-6789 (TDD).

PLEASE SUPPLY ALL INFORMATION FOR THE  
DIRECTOR OF NURSING SERVICES (DON)

Please attach an enlarged copy of the current RN License to this form  
for the current DON (even if Interim or Acting),  
and of the resigning DON (even if Interim or Acting), if applicable.

DO NOT SEND COPIES OF DRIVER LICENSES OR SOCIAL SECURITY CARDS

Name of Nursing Facility \_\_\_\_\_

Mailing Address \_\_\_\_\_

Physical Address \_\_\_\_\_

City, State, and Zip Code \_\_\_\_\_

Name of Facility's Current DON \_\_\_\_\_

Current RN License Number \_\_\_\_\_ Hire Date At Facility \_\_\_\_\_ Hire Date At Facility As DON \_\_\_\_\_

Expiration Date of RN License: \_\_\_\_\_ Permanent DON:  Interim Acting DON:

If your DON has recently resigned, please provide the information below:

Date of Resignation \_\_\_\_\_ RN License Number \_\_\_\_\_ Date of Hire as RN \_\_\_\_\_ Date of Hire as DON \_\_\_\_\_

Name of Director of Nurses who resigned: \_\_\_\_\_

Please list the information of your Acting Director of Nurses during this time and attach a copy of RN License:

RN License Number \_\_\_\_\_ Expiration Date \_\_\_\_\_ Hire Date as RN \_\_\_\_\_ Hire Date as Acting DON \_\_\_\_\_

Name of Acting Director of Nurses during this time: \_\_\_\_\_

Printed Name of Administrator and License Number \_\_\_\_\_

Signature of Administrator \_\_\_\_\_

NOTE: Send Change in Director of Nurses to:

OR FAX TO: Audrey Nelson or  
Sophie A. Fraser at 501-682-6171.

Audrey Nelson or Sophie A. Fraser  
Licensure and Certification Section - Slot S404  
Office of Long Term Care  
P.O. Box 8059  
Little Rock, AR 72203-8059

Telephone numbers for:  
Audrey Nelson: 501-682-6173  
Sophie A. Fraser: 501-682-8424

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Disabilities Act Coordinator at 501-682-8307 (voice) or 501-682-6789 (TDD).