

II. Management and Ownership (Continued)

C. If privately owned list Ownership status

- (1) Sole Proprietorship (2) Partnership (3) Corporation

Partnership: List names and addresses of partner

Name	Address
_____	_____
_____	_____
_____	_____

Corporation: List names and addresses of corporate officers and percentage of individuals owning 5% or more stock (List % of ownership by the individual's names)

Name	Address
_____	_____
_____	_____
_____	_____

Non-Profit: List names and addresses of Board of Directors of the Governing Body

Name	Address
_____	_____
_____	_____
_____	_____

D. If ownership of building is different from the person(s) or group operating the facility, explain the relationship including names and addresses of the owner(s).

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____

III. Licensure

A. Number of beds _____

B. If Above Total Is Different From That Which You Are Currently licensed, explain the difference

III. Licensure (Continued)

C. Name and address of facility manager/director if different from the ownership

Name	Address
State	Telephone #

IV. 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 material fact contained on the Application will subject me to penalties as prescribed in the State Licensing Law including, but limited to revocation and/or suspension of this license.

I further affirm that I understand that I am eligible for a license only if the facility is in compliance with the law and regulations thereunder, and that the Office of Long Term Care is empowered to deny, suspend, or revoke my license on any of the grounds listed in the State Licensing Law.

Signature of person(s) authorized to sign in
accordance with instruction II. C

Subscribed and sworn to before me on this the _____ day of _____,

Notary Public

(Notary Seal)

My Commission expires on _____

INSTRUCTIONS

- A. Enclosed are two (2) copies of Application for Licensure. Complete one copy and return to the Office of Long Term Care and retain one copy for your files.
- B. Please read these instructions carefully and complete this application in full. This application must be completed in ink or typed.
- C. This application is not valid unless it is notarized.
- D. This license application must be signed by the following person(s) dependent upon the type of management and ownership.
 - 1. If the institution is public (i.e., County, City, etc.) it must be signed by the person who is head of the governmental department having jurisdiction over it (i.e., Chairman of County Board or Chairman of Commission) or his duly authorized representative. This authorization must be in writing, notarized and submitted along with this application.
 - 2. If the institution is private, it must be signed by the following dependent upon the type of business organization.

<u>Type</u>	<u>Signer</u>
Sole Proprietorship	Owner
Partnership	One of the partner
Corporation, Church, Non-Profit Association	

If someone other than the above named is authorized to sign in his or her behalf, such authorization must be in writing, notarized and attached to this application.

- E. All licenses expire on **midnight June 30 of the calendar year** in which they are issued.
- F. Application for annual renewal **must be postmarked no later than March 1 of the current year** in order to avoid the payment of a penalty. This penalty shall be 10% of the facility's licensure fee.
- G. This application should be returned by **certified mail** to the following address:

**DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM CARE
P.O. BOX 8059 SLOT S408
LITTLE ROCK, AR 72203**

Please make certain that you use the above listed address only. All other addresses used could cause delays and may result in penalties being applied to your annual licensure renewal fees.

- H. A check or money-order for the required licensure fee made payable to ARKANSAS DEPARTMENT OF HUMAN SERVICES must accompany this submission except for those facilities operated by the State, County or City.

Licensure Fee: \$5.00 per bed