State of West Virginia

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Office of Health Facility Licensure & Certification
Assisted Living Program
1 Davis Square, Suite 101
Charleston, West Virginia 25301-1799
(304) 558-0050

LICENSE RENEWAL APPLICATION

INSTRUCTIONS

Please read carefully and complete this application **in full**. Type or print legibly with permanent ink. Failure to complete the application in full may result in delay of license being issued. The application must include all the requested information and bear the applicant's notarized signature.

The application must be completed by the individual owner or administrative officer. An application on behalf of a corporation or governmental unit shall be made by any officer or its managing agent(s) who have the responsibility for maintaining regulatory standards for the center.

Applications must be submitted at least ninety days prior to the expiration date of your current license. The renewal application shall be accompanied by a check or money order in the amount of **$100.00** (non-refundable) made payable to: **OHFLAC** (Office of Health Facility Licensure and Certification)

****It is recommended the completed application, fee and attachments be submitted via certified mail**.

A balance sheet/statement of operations must be submitted with the application, setting forth all assets and liabilities, including but not limited to all capital, surplus, reserve, depreciation, lease payments, taxes, and other extraordinary credits or charges including wages/reimbursement to owner(s), and other similar accounts.
(**Can be obtained from your accountant or bookkeeper.)**

January 14, 2000, Administrative Rule Title 96, Series 1, (implementing WV Code §21A-2-6{18} required the establishment of procedures under which agencies of this State shall not grant, issue, or renew any contract, license, permit, certificate, or other authority to conduct business in this state, if that entity has an account which is in default with the WV Bureau of Employment Programs, Divisions of Workers Compensation or Unemployment Compensation. The Office of Health Facility Licensure and Certification is required to determine that the account is not in default prior to issuing the annual renewal license for any Medical Adult Day Care Center. To assure accurate account information is obtained, your Federal Employee Identification Number (FEIN), must be provided and kept on file.

Center FEIN Number: _____ Center Name: _____

Application Check List

Completed Application _____
Application fee enclosed (payable to OHFLAC) _____
Balance sheet/statement of operations _____
Application signed _____
Application notarized _____
If leased/rented, copy of lease agreement _____
Other Attachments (if applicable) _____
Copy of Director Credentials (if not on file) _____

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
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Assisted Living Program
1 Davis Square, Suite 101
Charleston, West Virginia 25301-1799
Telephone: (304) 558-0050 Fax: (304) 558-2515

LICENSE RENEWAL APPLICATION

TYPE OF FACILITY	Current Approved Capacity
Medical Adult Day Care Center	
To request and increase in licensed capacity you must notify OHFLAC in writing	

CENTER INFORMATION

Center Name		**Telephone**	
Street Address		**Fax Number**	
City, State, Zip Code		**County**	
Mailing Address (if different than street address)		**E-Mail Address:**	

CORPORATE/LICENSEE/OWNER INFORMATION

Corporate/Business/Owner Name									
Address									
City, State, Zip Code									
Corporate/Licensee/Owner Phone Number (Not center #)									
Type of Ownership	Private	Individual		Corporation		Partnership		Church/Association	
	Public	County		Municipal		City		**If other than individual applicant- Complete Attachment A**	
Is the center:		For Profit		Not for Profit					
Is building/structure leased? **If leased, copy of lease agreement must be included with application**			Property Owner Name /Address/Phone Number						

ADMINISTRATOR/EXECECUTIVE DIRECTOR

Name	

SUPERVISING or CONSULATANT REGISTERED NURSE

Name		**License No.**	
E-mail			

ANNUAL REPORT INFORMATION

Current Census		Daily, weekly, or monthly rate:	

SERVICES OFFERED

(Check all that apply-include additional costs, if any)

		Additional cost (if any)
Personal Care Services/Assistance with ADL's		
Medication Administration		
Transportation to/from the center		
Transportation to/from appointments		
Beauty shop/hair cutting services		
Assistance with making appointments		
Laundry services		
Dietary Services (specify on-site or catered)		
Recreational Activities (bingo, field trips, exercise, etc.)		
Specialty services (OT/PT/Speech Therapy)		
Special populations (Alzheimers/Dementia, PT, DD)		
Other (specify)		

PRIMARY HOURS OF OPERATION: _____

ORGANIZATIONAL PLAN

Attach an Organizational Plan or complete the information below, indicating the number of persons employed beside each position.

Full-time	Part-time	Position
		Director
		Housekeeping
		Maintenance
		Registered Nurse(s)
		Licensed Practical Nurse(s)
		Laundry
		Nursing Assistant(s)/Aide(s)
		Activity Director
		Activity Aide(s)
		RN Consultant
		Dietary
		Driver(s)

I certify that I have read and understand all state licensing requirements and that substantial compliance with licensure standards must be met for renewal of license for:

Name of Center_____

SIGNATURE

Name: _____ (please print clearly)

Signature: _____ Title_____
(Owner/ licensee/administrative officer)

Date: _____

NOTARY VERIFICATION

STATE OF WEST VIRGINIA

County of _____

_____, being by me duly sworn on his/her oath, deposes and says that he/she has read the foregoing application and knows the contents thereof, that the statements concerning the above named center, therein contained, are correct and true of his/her knowledge.

_____
(Signature of applicant)

Subscribed and sworn to before me this _____ day of _____, 20 _____

_____
(Notary Public)

My Commission Expires: _____

POLICY STATEMENT
TITLE VI, CIVIL RIGHTS ACT OF 1964

This center has agreed to comply with the provisions of the Civil Rights Act of 1964 and all requirements imposed pursuant thereto, to the end that no person shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care or service.

Specifically, the above includes (but is not limited to) the following characteristics:

1. Outpatient service will be provided on a nondiscriminatory basis; all participants will be admitted and receive care without regard to race, color, or national origin.

2. All participants will be assigned to rooms, floors, and sections without regard to race, color, or national origin.

3. Participants will not be asked if they are willing or desire to share a room or area with a person of another race.

4. Employees will be assigned to participant care and services without regard to race, color, or national origin of either the participant or employee.

5. Professionally qualified personnel will not be denied access to treat participants based on race, color, or national origin.

6. All areas of this center will be available for use without regard to race, color, or national origin.

The nondiscriminatory policy of the center applies to participants, physicians, health care consultants, and all responsible employees. Under no circumstances will the application of this policy result in the segregation or re-segregation of building, wings, floors, or rooms for reasons of race, color, or national origin.

_____
Name of Center

_____
Director Signature

_____
Date

FINANCIAL INFORMATION REQUIREMENTS
WV State Code *16-5B-2*

The licensee will submit to the secretary with the application:

A. A balance sheet and/or

B. A statement of operations

(End of year financial information for the center must be submitted