North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
2708 Mail Service Center
Raleigh, NC 27699-2708

INITIAL LICENSE APPLICATION FOR OVERNIGHT RESPITE SERVICES

PLEASE READ CAREFULLY

- Steps to licensing Overnight Respite Services in a Certified Adult Day/Adult Day Health Program can be found on the DHSR Website: www.ncdhhs.gov/dhsr/acls. Please read this information before completing this application.
- Incomplete applications or applications without a fee will delay the process.
- Your initial licensure fee must accompany this application.
- Complete all blanks, if not applicable mark N/A.

INITIAL LICENSURE FEE

In accordance with NC GS 131D-6.1 (i) the initial licensure fee for a new overnight respite service program is:

Type	Number of Beds	Initial Licensure Fee Due
Overnight Respite Services		**$350.00**

- **A separate check is required for each application submitted.**
- Payment **must** be by check, money order, or certified check, made payable to: **Division of Health Service Regulation.**
- Remember to write the proposed program name on the check in the memo line.

Information For Construction Plan Review

Overnight Respite Service in Adult Day/Adult Day Health

Adult Care Licensure Section

Please Print

Name of Overnight Respite Service Applicant_____

Site Address_____

Site City and Zip_____

County_____

Contact Person_____

Contact Phone Number (___)_____Contact Fax Number (___)_____

Contact Address_____

Applicant Name (If Not Same As Contact)_____

Applicant Address_____

Local Fire Marshal Name_____

Local Fire Marshal Phone Number (___)_____

Local Building Inspector Name_____

Local Building Inspector Phone Number (___)_____

Additional Information_____

_____

Number of overnight respite beds requested_____

Office Use Only

Date Received_____
FID_____LICENSE NUMBER_____
Team Supervisor/Branch Manager_____
Comments_____
_____
_____

ADULT CARE LICENSURE SECTION – INITIAL APPLICATION

For Overnight Respite Services in Adult Day/Adult Day Health Program

Part A. Facility Information

Overnight Respite Program Name:			
Name of Certified Adult Day/Adult Day Health Program:			
Physical Address:	**City:**	**State: NC**	**Zip:**
County:			
Telephone Number: ( )	**Fax Number: ( )**		
If applicable - Please provide your National Provider Identifier Number (NPI)	**NPI:**		

Contact Person and Correspondence Mailing Address:
(Name of person who can make licensure/operation decisions about program and address where you want to receive ALL correspondence <u>including the license</u> from Division of Health Service Regulation.)

Name:	**Title:**	
Address:	**Telephone Number: ( )**	
City:	**State:**	**Zip:**
Primary Email:		

Qualified Administrator:

Name:	
Address:	
Telephone Number: ( )	**Fax: ( )**

DHSR USE ONLY

☐ Certified Adult Day or Adult Day Health Program

Date Verified: ____/_____/_____ By: _____

FID # _____

License Fee: $_____

Date Fee Received: ____/_____/_____

Recorded By _____

License # _____ - _____- _____

Part B. Operation and Ownership Disclosure

LEGAL IDENTITY OF LICENSEE

Licensee Information

- The Licensee is the name of the legal entity licensed to operate the business at that site as indicated in **Part A.**
- The Licensee is responsible for compliance to State rules and laws governing overnight respite.
- Please fill in the full address and phone number(s) for licensee.
- The status of the Legal entity will be verified with the NC Office of the Secretary of State.

Licensee Name:		
Address:		
City:	**State:**	**Zip code:**
Telephone Number: ( )	**Fax Number: ( )**	
The licensee is :	___ For Profit	___ Not For Profit*

The licensee is: (Check one)	
☐ Proprietorship (individual owner) ☐ Corporation (Inc) ☐ Limited Liability Company (LLC)	☐ Partnership (Unincorporated) ☐ Limited Liability Partnership (LLP) ☐ Government Unit

COMPLETE THE FOLLOWING INFORMATION:

- If the licensee is ***not for profit,** the name of each Officer, Director or Trustees.
- If the licensee is **a corporation (Inc)**, the name and title of each corporate officer.
- If the licensee is **a limited liability company (LLC),** the names of the managing members, attach a list of the names and address of the members of the limited liability company.
- If the licensee is **a partnership or limited liability partnership (LLP)**, the name of each partner.
- If the licensee is **a governmental unit**, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Executive Officer, General Partner, Managing Member		
Name:	**Telephone Number: ( )**	**Fax Number: ( )**
Address:		
City:	**State:**	**Zip:**

Name	**Title**
Name	**Title**
Name	**Title**

Management Company:			
Is the business operated under a management contract? ☐Yes ☐No If yes, provide name and address of the management company			
Company Name:			
Owner of Management Company:	**Telephone Number: ( )**		
Street/Box:			
City:	**State:**	**Zip:**	

Building Owner:			
Is the building where services are offered leased/ rented? ☐Yes ☐ No If yes, please complete the following on the building/property owner and provide a copy of the lease agreement.			
Name:			
Street/Box:			
City:	**State:**	**Zip:**	**Email:**
Telephone Number: ( )	**Fax Number: ( )**		

Part C. Capacity

Requested Licensed Capacity: (as it will appear on License) _____

Authenticating Signature: The undersigned submits this application for licensure in accordance with North Carolina General Statute 131 D-6.1 and the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13E) and certifies the accuracy of this information.

Signature: _____ Date: _____

Print Name _____ Phone Number (____) _____

Please be advised, the license fee must accompany the initial application to the Adult Care Licensure Section, Division of Health Service Regulation.