NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
NURSING HOME LICENSURE AND CERTIFICATION SECTION
2711 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2711
TELEPHONE: (919) 855-4520

FOR OFFICIAL USE ONLY
Computer Number
Bed Change_____
Effective Date _____
Fee Received _____
Check No: _____
Amount: _____

2025

NURSING HOME APPLICATION – BED CHANGES
(Including Adult Care Home Beds in Combination Facilities)

LEGAL IDENTITY OF APPLICANT:

_____

{Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.}

DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:

PRIMARY: _____
Other: _____

If the above names are **NOT IDENTICAL** to the names on the current license, please check reason for the change:

___ Change of Ownership/Licensee ____ Facility Name Change
___ Other (Specify): _____

NORTH CAROLINA LICENSE NUMBER: _____

Cost Reporting Year in format mm/dd: _____

FACILITY MAILING ADDRESS:

Street/P O Box: _____

City: _____ State: _____ Zip: _____-_____
(Ex. 27626 - 0530)

FACILITY SITE:

Street: _____

City: _____ County:_____

Telephone: (____)_____

Fax: (____)_____

PATIENT SERVICES

1. Is the facility now to be a "Combination Facility", thereby incorporating licensed ACH beds? 1. **YES** ___ **NO** ___
   If "Yes", indicate which rules the facility chooses to apply to the operation of
   these ACH beds. Nursing Home Licensure _____ ACH Licensure___
   (***Complete checklist if using both sets of rules.)***

APPLICATION TO INCREASE LICENSED NURSING HOME BEDS

2. **NUMBER OF BEDS BY TYPE (*Must complete required data supplement form)**

a. **Nursing Beds (NF)** **(TOTAL)** a. _____

1. General Nursing Facility Beds 1. _____
2. *Alzheimer's Special Care Unit Resident Beds 2. _____
3. Ventilator Dependent Resident Beds 3. _____
4. Traumatic Brain Injury Beds 4. _____

Are you equipped to accommodate bariatric residents? Y ___ N ____

b. **Adult Care Home (ACH)** **(TOTAL)** b. _____

1. General Adult Care Home Beds 1. _____
2. *Alzheimer's Special Care Unit Beds 2. _____

Are you equipped to accommodate bariatric residents? Y ___ N ____

c. **TOTAL LICENSED BEDS** **(TOTAL a & b)** c. _____

LICENSE FEE

A non-refundable per bed license fee is required for the number of beds added to the facility's licensed capacity and must accompany this application prior to the issuance of a nursing home license. Payment for the license fee should be in the form of check, certified check or money order and must be made payable to: "**The Division of Health Service Regulation**." Payment should include the facility's license number and be submitted with this license application.

License Fee Calculation:

a. Total number of additional Licensed beds. (must match number of additional beds approved by CON)	
b. Multiply by per bed fee	x $17.50
c. Total per bed fee (1a "x, multiply by" 1b)	$

This application must be completed and submitted to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a nursing home license. The license fee is non-refundable. The legislation (SB-622, Session Law 2005-276) prohibits a license from being issued if the annual fee has not been paid.

The undersigned submits this application for licensure for the year 2025 {subject to the provisions of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission} and certifies the accuracy of this information.

_____ _____

Name of Chief Administrative Officer or Authorized Official (Written Signature)

Title: _____ Date: _____

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or the provision of services."