



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 FAMILY CARE HOMES

PLEASE READ CAREFULLY

- Steps to opening a Family Care Home can be found on the DHSR Website: <https://info.ncdhhs.gov/dhsr/acls/licenseinfo.html>. Please read this information before completing this application.
- All sections of the application must be completed. Incomplete applications or applications without a fee will delay processing.
- The initial fee must accompany this application.
- Complete all blanks, if not applicable mark N/A.
- This application must be signed by the applicant licensee or the Executive Officer, Partner, or Managing member of the licensee.

For the purpose of this application the follow definitions apply:

- (1) **"Person"** means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.
- (2) **"Owner"** means any person who has or had legal or equitable title to or a majority interest in an adult care home.
- (3) **"Affiliate"** means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.
- (4) **"Principal"** means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.
- (5) **"Indirect control"** means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

APPLICABLE REGULATIONS

§ 131D-2.5. License and registration fees.

- (a) The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of three hundred fifteen dollars (\$315.00). The Department shall charge each adult care

home with more than six beds a nonrefundable annual license fee in the amount of three hundred sixty dollars (\$360.00) plus a nonrefundable annual per-bed fee of seventeen dollars and fifty cents (\$17.50).

§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.

(a) Licensure. - Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of G.S. 131E-184(a)(8).

(b) Compliance History Review. - Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. - No new license shall be issued for any adult care home to an applicant for licensure under any of the following circumstances for the period of time indicated:

(1) Was the owner, principal, or affiliate of a licensable facility under this Chapter, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes and was responsible for the operation of the facility that had its license revoked until five years after the date the revocation became effective.

(1a) Was the owner, principal, or affiliate of a licensable facility under this Chapter, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes and was responsible for the operation of the facility that had its license summarily suspended until five years after the date the suspension was lifted or terminated.

(2) Is the owner, principal, or affiliate of an adult care home and is responsible for the operation of the facility that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department.

(3) Is the owner, principal, or affiliate of an adult care home and is responsible for the operation of the facility that had its license downgraded to provisional status or had its admissions suspended as a result of violations under this Article, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes until six months from the date of restoration from provisional to full licensure, termination of the provisional license, or lifting or termination of the suspension of admissions, as applicable.

(5) Is or was the owner, principal, or affiliate of an adult care home and is responsible for the operation of the facility where outstanding fees, fines, and penalties imposed by the State against the facility have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration under this subdivision.

§ 131D-34. Penalties; remedies

(d1)The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A1 Violation.

**ADULT CARE LICENSURE
INITIAL LICENSE FEE INVOICE**

§ 131E-272. Initial licensure fees for new facilities.

The following fees are initial licensure fees for new facilities and are applicable as follows:

Facility Type	Number of Beds	Initial Base Fee	Initial Per Bed Fee
Family Care Home	2 to 6	\$350.00	\$0.00

Facility Name: _____ **County:** _____

Facility Type	Number of Beds	Base Fee	Per Bed Fee	Total Fee Due
Family Care Home		\$350.00	\$0.00	

- 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.**
- Write the proposed facility name on the check in the memo line.

ATTACH THE CHECK HERE

ADULT CARE LICENSURE SECTION - INITIAL APPLICATION

Family Care Home License

Part A. Facility Information

Facility Name:

Physical Address:

City:

State:

NC

Zip:

County:

Telephone Number:

Fax Number:

If applicable - Please provide your National Provider Identifier Number (NPI) if applicant is an owner of a currently licensed Adult Care Home.

For questions regarding NPI, contact 1-800-465-3203 (NPI Toll-Free)

NPI:

Contact Person and Correspondence Mailing Address:

(Name of person who can make licensure/operation decisions about the facility and address where ALL Correspondence, including the license, will be mailed and emailed from Division of Health Service Regulation.)

Name:

Title:

Address:

Telephone Number:

City:

State:

Zip:

Primary Email:

APPROVED ADMINISTRATOR:

Name:

Address:

Email:

Telephone Number:

Fax:

Administrator Approval Number:

Expiration Date:

DHSR USE ONLY

License # _____ - _____ - _____

FID # _____

License Fee: \$ _____

Date Received: ____/____/____

Recorded By: _____

Part B. Licensee

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 adult care homes.
- 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 :	<input type="checkbox"/> For Profit	<input type="checkbox"/> 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
NC Secretary of State ID #:	Registered in Other State: Yes No

Part C. Officers, Partners, Managers

COMPLETE THE FOLLOWING INFORMATION:

NOTE: The Executive Officer, General Partner, or Managing Member must be an individual, listed by name, not a business entity.

- 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:		
Email:		
City:	State:	Zip:

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

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

Part D. Ownership Disclosure

OWNERS, PRINCIPALS, SHAREHOLDERS, MEMBERS

Complete the information below on **all** individuals who are owners, shareholders or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. **If you are the only owner, complete the information below, listing the percentage interest as 100%.**

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____
Email Address: _____
Percentage interest in this licensed Facility: _____ Title: _____
List the names of other licensed Family Care Homes and Adult Care Homes in which you are an owner: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which you are an owner: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which you are an owner: _____

Part E. Majority Ownership Disclosure

MAJORITY INTEREST OWNERS

Complete the information below on **all persons** who hold a **majority** interest in the licensee. A “person” means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation. A **majority interest** is an interest in the licensee, or in entities who have an interest in the licensee, constituting ownership of more than fifty-percent of the licensee. For the purposes of this disclosure, all persons who hold a **majority interest** in the licensee must be disclosed **regardless of whether the persons hold a direct interest in the licensee**. The disclosure must include parent, grand-parent, or other levels of ownership. **If you are the only majority owner, please move to Part F.**

For ownership that goes above the parent level, include a diagram of the ownership structure including all majority owners.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Percentage interest in this licensed Facility: _____ Title: _____

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner:

ATTACH OWNERSHIP DIAGRAM WITH THIS APPLICATION:

Part F. Affiliate Disclosure

AFFILIATES

Complete the information below for **all affiliates** of the licensee. “Affiliate” means any person that will directly or indirectly control the facility. “Affiliate” also means any person who will be controlled by a person who will control the facility. In addition, two or more adult care homes which are under common control are affiliates. “Indirect control” means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two. Note, an individual or entity need not have an ownership interest in the licensee to be an affiliate. **If there are no affiliates, please move to Part G.**

Management companies and other entities that control a facility’s operations are affiliates, including but not limited to entities that control/oversee a facility’s clinical or healthcare services, contracts and billing, provision of goods and services, and human resources. **(Attach additional pages as necessary).**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Is the affiliate a management company? Yes No

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner, principal or affiliate:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Is the affiliate a management company? Yes No

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner, principal or affiliate:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Is the affiliate a management company? Yes No

List the names of other licensed Family Care Homes and Adult Care Homes in which this person is an owner, principal or affiliate:

Part G. Ownership and Affiliate Disclosure - Confidential Information

The following information will be used to conduct compliance history checks as required by G.S. 131D-2.4. Please provide the last four digits of the social security number or tax EIN for all persons identified in this application, both individual and business entities. This information will be used only as an identification number for internal record keeping and data processing. Incomplete data will delay the application being processed. **(Attach additional pages as necessary).**

Category	Name	Last 4 digits of SSN of Individuals or EIN of Corporation	Contact Number	Percentage of interest as reported on pages 6-8 (If Applicable)
			Cell Number	
Licenses/Owner		***-**-_____ or EIN ____-_____		
Administrator		***-**-_____ or EIN ____-_____		
Officers, Partners and Managers		***-**-_____ or EIN ____-_____		

Officers, Partners and Managers		***-**-_____ or EIN ____-_____		
Officers, Partners, and Managers		***-**-_____ or EIN ____-_____		
Owners, Principals, Shareholders or Members		***-**-_____ or EIN ____-_____		
Owners, Principals, Shareholders or Members		***-**-_____ or EIN ____-_____		
Owners, Principals, Shareholders or Members		***-**-_____ or EIN ____-_____		
Majority Interest Owners		***-**-_____ or EIN ____-_____		
Majority Interest Owners		***-**-_____ or EIN ____-_____		
Majority Interest Owners		***-**-_____ or EIN ____-_____		
Affiliate (Management Company)		***-**-_____ or EIN ____-_____		
Affiliates (Management Company)		***-**-_____ or EIN ____-_____		
Affiliates (Management Company)		***-**-_____ or EIN ____-_____		
Affiliates (Management Company)		***-**-_____ or EIN ____-_____		
Affiliates (Management Company)		***-**-_____ or EIN ____-_____		

Reminder: *Failure to complete this information will delay the licensing process*

Part H. 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 I. Capacity

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

- Ambulatory**
 1-3 Non-Ambulatory
 4 + Non-Ambulatory
(non-ambulatory - unable to leave a building unassisted under emergency conditions)

Authenticating Signature: The undersigned submits this application for licensure in accordance with Article 1 Chapter 131 D of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13G) and certifies the accuracy of this information.

The undersigned must be the applicant licensee or the Executive Officer, Partner, or Managing member of the licensee.

Signature: _____ Date: _____

Print Name: _____ Phone Number: _____