



**Government of the District of Columbia
 Department of Health
 Health Regulation and Licensing Administration
 Health Regulation Administration
 Health Care Facilities Division**

Mailing Address:
**Department of Health
 HRLA
 Health Care Facilities
 Division
 P.O.Box 37804
 Washington, DC 20013**



Application for Nursing Homes Licensure

Filing Fees

No of Bed	Annual	Late
1-50	\$390	\$195
51-100	\$520	\$260
> 101	\$650	\$325

Under the authority of DC Law 5-48, application is hereby made to operate a facility as indicated below:

1. APPLICATION IS FOR (CHECK ONE):

	Type Action	Effective Date of Action
<input type="checkbox"/>	Initial Licensure Provider Number _____	
<input type="checkbox"/>	Change of licensed operator	
<input type="checkbox"/>	License Renewal	
<input type="checkbox"/>	Change in Number of Beds	
<input type="checkbox"/>	Name Change	

2. FACILITY IDENTIFICATION

Name of Facility _____		Telephone Number _____	
Street Address _____		FA X Number _____	
City _____	State _____	ZIP _____	
Facility is (Check one) <input type="checkbox"/> Owned – Documentation Required		<input type="checkbox"/> Leased - Bond Required	

3. Type of Licensed Beds

Skilled Beds ____ (Title 18 only) Dual Beds ____ (Title 18 & 19) Nursing Facility Beds ____ (Title 19 only)
 Total Number of Beds _____

4. LICENSEE IDENTIFICATION

*Name of Licensee _____		EIN# _____	
Street Address _____		Telephone Number _____	FAX Number _____
City _____	State _____	ZIP _____	
This entity is: (Check one)			
Public: <input type="checkbox"/> State	Not for Profit: <input type="checkbox"/> Church	For Profit: <input type="checkbox"/> Individual	
<input type="checkbox"/> City	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> Hospital District }	<input type="checkbox"/> Other	<input type="checkbox"/> Corporation	
*Name the principals/officers of the licensee: (such as, CEO, President, VP, Secretary, Treasurer, Director – attach additional sheet if needed)			
Name: _____	Address: _____	Phone: _____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

8. FEDERAL CERTIFICATION

A. Does the facility participate in or intend to participate in the Medicaid program? Yes () No ()
Medicare program? Yes () No ()

If applying for initial or change of licensed operator licensure, a separate application is required to participate in the Medicare and/or Medicaid programs.

B. EXCLUSION FROM MEDICARE OR MEDICAID

1. Has the applicant, licensee, or other controlling interest ever been excluded from Medicare or Medicaid?
Yes () No ()

2. If yes, please provide the following information:

- a. Name of persons or entities excluded:
- b. Relationship of person or entity to applicant or licensee:
- c. Date(s) of exclusion:
- d. Attach documentation regarding the exclusion.

Proof of compliance with disclosure of ownership and controlling interest requirements of the Medicaid and Medicare programs shall be accepted in lieu of this submission.

C. NEW MEDICARE PROVIDER AGREEMENT

If applying for change of licensed operator licensure and the NEW OWNER requests a NEW Medicare Provider Agreement.

9. RESIDENT GRIEVANCES

If applying for renewal of an existing license, report the following information regarding the resident grievance Procedures in accordance with Title 22 DCMR.

Reporting period: _____ (12-month period ending with last calendar quarter)

Total number of grievances handled in reporting period : _____

Number of Grievances per Category:

Number of Outcomes by Category:

- ____ (#) Food and Nutrition
- ____ (#) Staffing
- ____ (#) Personal Possessions
- ____ (#) Privacy and Dignity
- ____ (#) Activities and Social Services
- ____ (#) Financial Issues
- ____ (#) Environmental
- ____ (#) Other: _____

- ____ (#) Resolved
- ____ (#) Unresolved
- ____ (#) Resolution Pending
- ____ (#) Other Outcome: _____

10. CONTINUING CARE RETIREMENT COMMUNITY

Does the facility offer continuing care agreements ? Yes () No ()

If yes, attach Certificate of Authority issued by the Department of Insurance.

11. CERTIFICATE OF NEED

If applying for initial licensure or the addition of licensed beds, attach a copy of all pertinent Certificates of Need or a statement that the facility is exempt from review.

12. MEDICAID LIABILITY

If applying for initial or change of licensed operator licensure, attach proof of compliance with Medicaid liability requirements.

13 RESIDENT TRUST SURETY BOND

Attach proof of compliance with Resident Trust Surety Bond requirements:

- A. Proof that the applicant has a current patient trust surety bond, or
- B. Proof of current membership in an approved self-insurance pool and the amount currently on deposit.

14. BUILDING CONSTRUCTION / OCCUPANCY

If applying for initial licensure for a new construction or new operation, attach:
Certificates of approval/occupancy

15. LIABILITY INSURANCE

Attach proof of current liability insurance coverage on malpractice and comprehensive general coverage in accordance with Title 22 DCMR 3205 Insurance coverage. In addition, attach a proof that the insurance carrier has a certificate of authority from the Department of Insurance to operate in the District of Columbia.

16. CIVIL VERDICT OF JUDGEMENT

If applying for initial or change of licensed operator licensure, attach:

A. Copies of any civil verdict or judgment involving the applicant within the ten years preceding the application, relating to medical negligence, violation of resident’s rights, or wrongful death.

B. Copies of any civil verdict or judgment involving the applicant, related to such matters, within 30 days after filing with the clerk of the court.

17. OUTSTANDING FINES

The agency may take action against a license or application for any facility with outstanding fines assessed by Final Order of the Health Care Regulation and Licensing Administration or of the Centers for Medicare and Medicaid Services.

A. Are there outstanding fines ? Yes () No ()

B. If yes, please complete the following for each separate fine (attach additional information if necessary):

1. Fine amount: \$_____

2. Fines assessed by: _____Agency for Health Care Regulation and Licensing
_____Centers for Medicare and Medicaid Services

3. Survey or application date for which the fine was imposed: _____

4. Due date of fine: _____

5. Is there an appeal pending of a final order? Yes () No ()

18. CONTROLLING INTEREST INFORMATION

Please complete attached Form (Appendix I) with Controlling Interest information required for all persons or entities listed in sections 4 and 6.

20. BANKRUPTCY

Is the facility or its parent corporation presently operating under bankruptcy protection? Yes () No ()

21. FINANCIAL ABILITY TO OPERATE

If applying for initial or change of licensed operator licensure, provide proof of financial ability to operate, see instructions and forms required.

22. RISK MANAGEMENT AND QUALITY ASSURANCE:

If applying for initial or change of licensed operator licensure, submit the facility plan for quality assurance and for conducting risk management.

23. COMPLIANCE WITH ADMINISTRATIVE AND PROCEDURAL REQUIREMENTS

- A. I agree that I will notify the Health Regulation and Licensing Administration if substantive changes in facility management and operation that significantly affect policies and procedures and that notice notice will be given in writing before the effective date of the change.
- B. Upon licensure, the facility will follow, implement and abide by Title 22 DCMR Chapter 32.

24. AFFIDAVIT

I, _____ hereby swear or affirm that the information provided in or with this application is true and correct and does comply with administrative and procedural requirements.

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

Notary Public

Signature of Applicant

Title

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General’s hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General’s website at oig.dc.gov.



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Mailing Address:
899 North Capitol St., NE,
2nd Floor
Washington, DC 20002
Phone: 202-724-8800

Appendix I

**CONTROLLING INTERESTS
INFORMATION FOR NURSING HOMES**

******DISCLOSURE REQUIRED FOR ISSUANCE OF NURSING HOME LICENSE**** This Controlling Interests Information Form must be copied and completed for each person and entity listed below.**

Licensee: _____

Those owning 5% or more of the licensee: _____

Each Officer of the licensee: _____

Each Board Member* of the licensee: _____

Management Company: _____

Those owning 5% or more of the management co: _____

Each Officer of the management company: _____

Each Board Member* of the management company: _____

*Only Voluntary Board Members are exempt – see Voluntary Board Member Statement attached



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NURSING HOMES LICENSING FEES

Appendix II

Attach application together with a Check or Money Order made PAYABLE TO THE D. C. TREASURER.

PAY THIS AMOUNT \$_____

License fees for nursing homes are as follows:

(a) 1-50 beds		
Annual Fee		\$390
Late Fee		\$195
(b) 51-100 beds		
Annual Fee		\$520
Late Fee		\$260
(c) 101 or more beds		
Annual Fee		\$650
Late Fee		\$325