



GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATIONS AND LICENSING ADMINISTRATION
Health Care Facilities

899 North Capitol Street, NW
2nd Floor
Washington, DC 20002
Phone: 202-724-8800

FOR OFFICE USE ONLY

License Fee \$
Late Fee \$
License Duplication Fee \$

APPLICATION FOR HOSPITAL LICENSURE

TYPE OF APPLICATION

Initial Change of Ownership Renewal

Completion of this form is required by the D.C. Official Code §§ 44-502 and 44-503. Failure to complete this form may result in denial of licensure. Information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose. Collection of the applicant's Federal Provider Number (if applicable) and Licensure Number are required by District's regulations. Failure to supply the number may result in denial of the application. The number will be disclosed only to the Department of Revenue for use in collection of delinquent taxes. Questions about completion of this application may be directed to the Health Care Facilities Division at 202 442-5888

License fees for Hospitals as specified in 2013.1 of the D.C. Code are as follows:

# Beds	Annual Fee	Late Fee
1-100	\$1,040.00	\$520.00
101- 200	\$1,300.00	\$650.00
201- 300	\$1,690.00	\$845.00
301- 400	\$ 1,950.00	\$975.00
400 or more	\$ 2,650.00	\$1,300.00

I. GENERAL INFORMATION

A. HOSPITAL LOCATION

Name --Facility		Initial Begin Date (at present location)	
Previous Hospital Name (if applicable)			
Street (physical) Address			
Mailing Address			
City	County	State	Zip Code
Telephone Number		Fax Number	
E-mail Address			

B. CHANGE OF OWNERSHIP

List the previous owner's name, License number, and Medicare and Medicaid numbers.

Name -- Previous Owner		
Previous License Number	Medicare Number - Previous	Medicaid Number - Previous Owner

C. TYPE OF HOSPITAL

- | | |
|--|---|
| <input type="checkbox"/> General | <input type="checkbox"/> Critical Access Hospital (CAH) |
| <input type="checkbox"/> Special | <input type="checkbox"/> Long Term Acute Care |
| <input type="checkbox"/> Chemical Dependency / Alcohol | <input type="checkbox"/> Hospital Located Within Another Hospital |
| <input type="checkbox"/> Children's <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Maternity | |
| <input type="checkbox"/> Orthopedic <input type="checkbox"/> Surgical | |

Name - Fiscal Intermediary	Fiscal Year End Date
----------------------------	----------------------

D. TYPE OF CURRENT CERTIFICATION

- | | |
|---|---|
| <input type="checkbox"/> Medicare (Title XVIII) | <input type="checkbox"/> Medicare and Medicaid |
| <input type="checkbox"/> Medicaid (Title XIX) | <input type="checkbox"/> District Licensed Only (no TXIX / TXVIII certification) |

E. ACCREDITATION STATUS

- Non Accredited
- Applying for Accreditation With:
- The Joint Commission AOA Other _____

Complete the following for CHANGE OF OWNERSHIP applications only:

<input type="checkbox"/> Currently Accredited By: <input type="checkbox"/> The Joint Commission <input type="checkbox"/> AOA <input type="checkbox"/> Other _____	Accreditation Begin Date
	Accreditation End Date
<input type="checkbox"/> Deemed	Deemed Begin Date
	Deemed End Date

F. BED CAPACITY Indicate the total number of beds requested for those categories that apply

MED/SUR		NEONATAL ICU	
ICU/ICCU		PEDS	
OB/GYN		REHABILITATION	
NURSERY- BEDS		ALCOHOL/CHEMICAL DEPENDENCY	
PSYCHIATRIC			
TOTAL BEDS			
		NURSERY- LEVEL	
Total Number of Acute Care Beds			Are Swing Bed Services Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No

G. OFFSITE LOCATIONS Yes No

Name of Off-Site Facility	Type of Provider
Physical Address	Telephone Number
City / State / Zip Code	Number of Beds
Services Provided	

Name of Off-Site Facility	Type of Provider
Physical Address	Telephone Number
City / State / Zip Code	Number of Beds
Services Provided	

Name of Off-Site Facility	Type of Provider
Physical Address	Telephone Number
City / State / Zip Code	Number of Beds
Services Provided	

If a change of ownership or more offsite locations are being applied for, or have been approved by the Health Care Facilities Division CHECK HERE and attach a separate listing. The listing should include all required information for each component, not located on the hospital's premises, that will be billed under the hospital's Medicare provider number and that will operate under the hospital's certificate of approval number. Also, describe the services that will be provided and the number of beds if overnight inpatient services will be provided. Provide a copy of the approval letter for each offsite location.

H. SERVICES PROVIDED BY THE HOSPITAL

Check the type of services that will be provided. Attach additional pages if necessary. Place a "1" if service will be provided directly by hospital staff and a "2" if the service will be provided by contracting with another provider of service. If services will be provided both directly and by contract, insert a "3."

Check if Provided	Enter 1, 2 or 3	Service
<input type="checkbox"/>		Acute renal dialysis
<input type="checkbox"/>		Alcohol and/or drug services
<input type="checkbox"/>		Anesthesia services
<input type="checkbox"/>		Blood bank
<input type="checkbox"/>		Burn care unit
<input type="checkbox"/>		Chiropractic services
<input type="checkbox"/>		Coronary care unit
<input type="checkbox"/>		Dental services
<input type="checkbox"/>		Dietetic services
<input type="checkbox"/>		Emergency services (organized)
<input type="checkbox"/>		Home care program
<input type="checkbox"/>		Hospice
<input type="checkbox"/>		Inpatient surgical services
<input type="checkbox"/>		Intensive care unit
<input type="checkbox"/>		Laboratory services (clinical)
<input type="checkbox"/>		Laboratory services (anatomical)
<input type="checkbox"/>		Long term care unit
<input type="checkbox"/>		Neonatal nursery
<input type="checkbox"/>		Nuclear medicine services
<input type="checkbox"/>		Obstetrics
<input type="checkbox"/>		Occupational therapy services

Check if Provided	Enter 1, 2 or 3	Service
<input type="checkbox"/>		Open heart surgery facilities
<input type="checkbox"/>		Operating rooms
<input type="checkbox"/>		Optometric services
<input type="checkbox"/>		Organ bank
<input type="checkbox"/>		Organ transplant services
<input type="checkbox"/>		Outpatient services
<input type="checkbox"/>		Outpatient surgery unit
<input type="checkbox"/>		Pediatric services
<input type="checkbox"/>		Pharmacy
<input type="checkbox"/>		Physical therapy services
<input type="checkbox"/>		Post-operative recovery rooms
<input type="checkbox"/>		Psychiatric services
<input type="checkbox"/>		Radiology services (diagnostic)
<input type="checkbox"/>		Radiology services (therapeutic)
<input type="checkbox"/>		Rehabilitation services
<input type="checkbox"/>		Respiratory care services
<input type="checkbox"/>		Self care unit
<input type="checkbox"/>		Shock trauma
<input type="checkbox"/>		Trauma level
<input type="checkbox"/>		Social services
<input type="checkbox"/>		Speech pathology services
<input type="checkbox"/>		Other (specify):

I. STAFFING Number of full-time (FT) and part-time (PT) employees.

	FT	PT		FT	PT
1. Chief Executive Officer			8. Pharmacy		
*2. Nurse Administrator, RN			9. Dietary		
*3. Nurse Supervisor			10. Laboratory		
*4. Registered Staff Nurses			11. Housekeeping		
*5. LPN Staff Nurses			12. Maintenance Personnel		
6. Nurse Aides			13. Laundry Personnel		
7. Medical Records			14. Other (Specify) _____		
(Attach additional pages if necessary.)					

*Under 2, 3, 4, and 5, report only those registered or licensed nurses with a current registration or license number. Report all other nurses under number 6.

II. PLANT DESCRIPTION AND SPACE USE
(Not required for facilities that already have departmentally approved plans.)

A. Description of Facility

ATTACH plans or drawings for each floor of the building occupied by the existing hospital and IDENTIFY:

1. Life Safety Code Plans

- (a) Exiting
- (b) Fire barriers
- (c) Smoke barriers
- (d) Horizontal exits
- (e) Exit passage ways
- (f) Vertical shafts
- (g) Linen and trash chutes, and
- (h) Additional relevant information.

2. Building Information

- (a) Construction type
- (b) Age of existing building segments
- (c) Additional relevant information
- (d) Local zoning compliance statement

3. Existing Space Description

- (a) Current room/space use
- (b) Identification of hazardous areas protected by rated fire resistive partitions
- (c) Other relevant information.

4. Proposed Use of Rooms / Space within the Hospital

5. ADA (Americans with Disabilities Act) Accessibility Plan

- (a) Parking
- (b) Access routes
- (c) Toilet rooms for public, staff and patients indicating if ADA accessible
- (d) Additional relevant information

Yes	No	Answer each of the following questions by checking the “Yes” or “No” boxes
<input type="checkbox"/>	<input type="checkbox"/>	<p>1-a. Are building alterations and remodeling proposed?</p> <p>1-b. If YES, attach plans or drawings indicating the areas of remodeling. SEE B.2.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>2-a. Will the building have a mixed occupancy?</p> <p>2-b. If YES, identify all classifications and locations on the drawings or plans requested above.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>3-a. Has the JCAHO (Joint Commission on the Accreditation of Healthcare Organizations), or the State approved any Life Safety Code variances or waivers?</p> <p>3-b. If YES, attach a copy of the award letter and waivers that have been approved.</p>

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	4-a. Are all patients/clients/residents capable of leaving the building on their own?
<input type="checkbox"/>	<input type="checkbox"/>	4-b. If NO , are there instances when four (4) or more staff dependent patient/clients/residents are present in the building at the same time?
<input type="checkbox"/>	<input type="checkbox"/>	5. Is the building equipped with a fire alarm system?
<input type="checkbox"/>	<input type="checkbox"/>	6-a. Is there an interconnected smoke detection system? 6-b. If YES , is the smoke detection system: <input type="checkbox"/> Throughout the building, i.e., in all areas, common areas and work spaces, whether occupied or not. <input type="checkbox"/> In limited areas. Identify locations on drawings.
<input type="checkbox"/>	<input type="checkbox"/>	7-a. Is there an approved and supervised automatic sprinkler system? 7-b. If YES , is the automatic sprinkler system: <input type="checkbox"/> Throughout the building, i.e., in <u>all</u> areas throughout the building. <input type="checkbox"/> In limited areas. Identify locations on drawings.
ENTER NUMBER		8. Indicate the number of building stories:
		8-a. Above ground, including the exit level.
		8-b. Below the ground level of the exit.

B. PROPOSED USE OF IDLE SPACE

Use of idle space requires considerable study to determine how the facility can be sectioned-off for new services, renters, or types of uses, etc. The direction and scope of renovations must be in compliance with LIFE SAFETY CODES. Applicant is strongly urged to seek expert advice, e.g., an engineering consultant, to determine which space to declare idle. Renovation cost may be a factor to consider before applying for hospital licensure status.

1. Explain how you will utilize the idle space, e.g., rental to outside groups, expansion of outpatient services, integration of existing or new health care services. **(Attach narrative.)**
2. If applicable, provide a description of construction considerations and time frame for the renovations described in Table above. **(Attach only one narrative covering all proposed building changes.)**
NOTE: You must contact the Office of Quality Assurance prior to initiating all physical plant and environment renovations.

Plan Approval Applications can be obtained at ...or by calling DCRA @ (202) 442-4400

III. ADMINISTRATION

A. HOSPITAL ADMINISTRATOR / CHIEF EXECUTIVE OFFICER (CEO)

Name - Administrator / CEO	<input type="checkbox"/> Male <input type="checkbox"/> Female	Begin Date
Title	Status <input type="checkbox"/> Interim <input type="checkbox"/> Acting <input type="checkbox"/> Permanent	
Is the Administrator / CEO in charge of more than one facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Name of Facility and City	Type of Provider	

EDUCATION

Name of School / College / University	Years Attended
Address	Diploma / Degree / Year
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year

WORK EXPERIENCE

Employer	Position
Address	Dates

Attach a resume and a copy of the professional license, if applicable, for the administrator, managing employee and medical director, which include their educational and work experience.

B. PERSON IN CHARGE IN ABSENCE OF ADMINISTRATOR / CEO (SUBSTITUTE ADMINISTRATOR)

Name	Begin Date
Title	
EDUCATION	
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year
WORK EXPERIENCE	
Employer	Position
Address	Dates

C. NURSE ADMINISTRATOR (DIRECTOR OF NURSING)

Name	Begin Date
------	------------

D. NAME OF PERSON IN CHARGE OF EACH DEPARTMENT

Dietary Service	Medical Records
-----------------	-----------------

IV. OWNERSHIP

A. APPLICANT (OWNER) Person(s) or business entity having the authority to direct the management or policies of the facility.

Name – Applicant (owner)	FEIN or SSN
--------------------------	-------------

Street (physical) Address

Mailing Address (if different from physical address)

City	State	Zip Code	County
------	-------	----------	--------

Fax Number	Telephone Number
------------	------------------

E-mail Address

Contact Person	Telephone Number
----------------	------------------

Title – Contact Person

Holding (i.e., what the owner owns): Operations Building Land

B. TYPE OF ORGANIZATION (Check type of ownership.)

GOVERNMENTAL	PROPRIETARY	VOLUNTARY NON-PROFIT
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City / County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church / Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust
<p>If Incorporated, Date Incorporated</p>		

C. INTERESTED PARTIES

List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, and members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors and board members. Use Appendix I for additional pages if necessary.

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

D. OTHER PROVIDERS THAT ARE LICENSED AND / OR MEDICARE CERTIFIED, LOCATED IN THE DISTRICT OF COLUMBIA, AND ARE OWNED OR OPERATED BY THE APPLICANT / OWNER UNDER THE EXACT SAME OWNER NAME.

If more than two, check here and attach additional pages.

Name – Provider			
City		State	Zip Code
Relationship Type (nursing home, home health agency, community based residential facility, hospital)			

Name – Provider			
City		State	Zip Code
Relationship Type (nursing home, home health agency, community based residential facility, hospital)			

E. SUBSIDIARY / PARENT INFORMATION

1. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

Yes No

If Yes, provide the following information:

Legal Business Name – Parent Company

DBA (Doing Business As)

Type of Ownership

Mailing Address

City

State

Zip Code

Contact Person

Telephone Number

2. Is the applicant affiliated with any subsidiaries in the health care field in the District of Columbia or any other state?

Yes No

If Yes, provide one of the following:

Names and addresses of all subsidiaries owned by the parent company, in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)

Organizational chart exhibiting the legal business names and, if applicable, the DBA name of all the subsidiaries currently owned by the parent company in the health care field in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)

Complete annual report to shareholders.

F. CHAIN ORGANIZATION

Is the applicant under the control of a chain organization? Yes No

Chain organization is defined as multiple providers, and/or suppliers owned, leased, or through any other devices, controlled by a single business entity (defined as chain home office). Each entity in the chain may have a different owner but the “home office” maintains uniform procedures in each facility for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, provider/suppliers cost reports, etc.

In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporate parent.

Name – Chain Organization

G. FIT AND QUALIFIED

The following information will be used to determine if the applicant meets the fit and qualified requirements under D.C. Official Code §§ 44-502 and 44-503:

- Has the applicant been affiliated in the past five years with a hospice (HSP), a home health agency (HHA), a residential care facility, e.g., Community Based Residential Facility (CBRF), Adult Family Home (AFH), or a health care facility (HCF), e.g., hospital, nursing home or facility for the developmentally disabled in the District of Columbia or in any other state.

Yes No

IF THE ANSWER IS YES, complete all information in the section below. Use the facility abbreviations (in parenthesis) from above to identify the type of facility.

IF THE ANSWER IS NO, complete only questions 4 –14 of this section.

Facility Name and Address	City and State	Type of Health Care Provider	Owner / Operator / Mgr. Vendor / Provider No.	Dates of Affiliation

- Has any adverse action initiated by any state licensing agency and/or other adverse action resulted in the denial (D), suspension (S), or revocation (R) of a license or approval?

Yes No

If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to G.1. (above) for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

3. Has any adverse action initiated by a state or federal agency based on non compliance resulted in civil money penalties, termination of provider agreement, suspension of payments , or the appointment of temporary management of the facility? Any such pending case (s)?

Yes No

If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to G.1. (above) for abbreviations for type of health care provider.

Facility Name and Address	City and State	Federal or State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

4. Has the applicant ever had a denial, suspension, enjoining or revocation of a health care provider license, in the District of Columbia or any other state or any conviction for providing health care without a license?

Yes No

If Yes, explain.

5. Has the applicant ever been convicted of a crime involving neglect or abuse of patients, or involved in assaultive behavior, wanton disregard for the health and safety of others, or any act of elder abuse under the District of Columbia Laws

Yes No

If Yes, explain.

6. Has the applicant ever been convicted of a crime related to the delivery of health care services or items?

Yes No

If Yes, explain.

7. Has the applicant ever been convicted of a crime involving controlled substances?

Yes No
If Yes, explain.

8. Has the applicant had any prior financial failure that resulted in bankruptcy or in the closing of a hospice, home health agency or an inpatient health care facility, e.g., nursing home or hospital, or the relocation of its patients or residents?

Yes No
If Yes, explain.

9. Has the applicant/owner been adjudicated bankrupt?

Yes No
If Yes, explain on a separate page. Provide the dates, court and disposition of each action.

10. Are there any unsatisfied judgements against the applicant/owner?

Yes No
If Yes, explain on a separate page. Provide the names and addresses of creditors, amounts and the reasons for non-payment.

11. Does the applicant / owner owe any debts that are 90 days past due?

Yes No
If Yes, explain on a separate page. Provide the names and addresses of creditors, amounts and reasons for non-payment.

12. Does the applicant / owner plan to provide care to patients who are unable to pay for service?

Yes No

13. Attach proof of sufficient resources as may be necessary to operate the facility for at least 90 days. Proof of sufficient financial resources should include income / expense statements.

14. FINANCIAL REFERENCES

This question is to be completed by the APPLICANT. Include at least one bank. Attach additional pages if necessary.

Name		Telephone Number
Address		
City	State	Zip Code

Name	Telephone Number	
Address		
City	State	Zip Code

H. OWNER OF BUILDING / LAND

If the building, land, or building and land, is owned by an entity, i.e., corporation, partnership, individual, etc., other than the applicant / owner, complete this section. If the owner of the land is another entity, also complete Section I.

Holding: Building Land

Name	Telephone Number	
Mailing Address	County	Fax Number
City	State	Zip Code

TYPE OF ORGANIZATION (Check type of ownership)

GOVERNMENTAL	PROPRIETARY	VOLUNTARY NON-PROFIT
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City / County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church / Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust

INTERESTED PARTIES

Definition: Interested parties are (1) persons or business entities having ownership interest of 5% or more, (2) partners if the entity is a partnership, (3) officers and directors if the entity is a corporation, and (4) if the entity is either governmental or non-profit, interested parties are the officers and directors. If there is a separate listing already in existence, and that listing contains all the required information, attach a copy of that listing to this application. If a complete listing is attached, completion of this portion of the application will be considered satisfied.

Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		

Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Street			Begin Date
City	State	Zip Code	Ownership Percentage

I. OWNER OF LAND

Complete this section if the owner of the land is not the same entity as the owner of the operation or the owner of the building.

Holding: Land

Name		Telephone Number
Mailing Address	County	Fax Number
City	State	Zip Code

TYPE OF ORGANIZATION (Check type of ownership)

GOVERNMENTAL	PROPRIETARY	VOLUNTARY NON-PROFIT
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City / County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church / Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust

INTERESTED PARTIES

Definition: Interested parties are (1) persons or business entities having ownership interest of 5% or more, (2) partners if the entity is a partnership, (3) officers and directors if the entity is a corporation, and (4) if the entity is either governmental or non-profit, interested parties are the officers and directors. If there is a separate listing already in existence, and that listing contains all the required information, attach a copy of that listing to this application. If a complete listing is attached, completion of this portion of the application will be considered satisfied.

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

IV. LEASE AGREEMENT

Is there a lease agreement? Yes No If "yes," list the name and address of the lease holder.

Name			
Mailing Address			
City	State	Zip Code	Lease Agreement End Date

V. MANAGEMENT COMPANY

A. Is the operation of the facility under a management contract? Yes No
 If Yes, provide the following information regarding any management company retained to operate this facility or program.

Type of Management Company			
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Individual	<input type="checkbox"/> Government
Name – Management Company			
Name – Contact Person		Telephone Number	
Address			
City		State	Zip Code

C. Identify other facilities the management company has owned, operated or managed in the last five years. Attach additional pages if necessary.

Name

Address

City	State	Zip Code
------	-------	----------

Dates of Involvement

Name

Address

City	State	Zip Code
------	-------	----------

Dates of Involvement

Name

Address

City	State	Zip Code
------	-------	----------

Dates of Involvement

D. While managing any of the facilities identified in item C.:

1. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

Yes No

If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to IV.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

2. Has any adverse action been initiated by a state or federal agency based on noncompliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

Yes No

If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to IV.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

E. Attach a copy of the signed contract with the management company.

VI. CONTACT PERSON

Identify the person responsible for completing this application and who can be contacted if we have questions.

Name – Contact Person (print)		Title	
Telephone Number	Fax Number	Date Application Completed	

VII. DESIGNEE

Person authorized to accept personal service and receive registered and certified mail.

Is the administrator also the Designee? Yes No

If No, provide the following information:

Name – Designee	Title
-----------------	-------

V.III CONTACT PERSON

Identify the person responsible for completing this application and who can be contacted if we have questions.

Name – Contact Person (print)		Title	
Telephone Number	Fax Number	Date Application Completed	

VIII. DESIGNEE

Person authorized to accept personal service and receive registered and certified mail.

Is the administrator also the Designee? Yes No

If No, provide the following information:

Name – Designee	Title
-----------------	-------

I understand, under penalty of law that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to \$10,000 or imprisonment not to exceed six years, or both..

IX. SIGNATURE OF APPLICANT (S)

(1) _____

Title Date

(2) _____

Title Date

Sworn and subscribed to before me this _____ day of _____, year _____

My Commission expires _____

Notary Public for the District of Columbia

**RETURN THE COMPLETED APPLICATION TO:
 Government of the District of Columbia
 Department Of Health
 Health Regulations and Licensing Administration
 Health Care Facilities Division
 717 14th Street NW Suite 1000
 Washington, DC 20005
 Phone: 202-724-8800**

<p>The Management Company cannot attest to or sign on behalf of the applicant (Owner)</p>
