

For OLP office use only

Initial & date for approval

## NURSING HOME LICENSE APPLICATION/REAPPLICATION

Date of application: \_\_\_\_\_

### I. IDENTIFYING INFORMATION

# Skilled Beds: \_\_\_ NF: \_\_\_\_\_

Name of facility: \_\_\_\_\_

Mailing address: \_\_\_\_\_

\_\_\_\_\_

Physical Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ FAX #: \_\_\_\_\_

Facility's e-mail address: \_\_\_\_\_

Administrator's e-mail (if different from facility's e-mail): \_\_\_\_\_

LICENSEE: \_\_\_\_\_

Name of Administrator: \_\_\_\_\_ License #: \_\_\_\_\_

Alternate Administrator (if applicable): \_\_\_\_\_

Name of Director of Nursing: \_\_\_\_\_ License #: \_\_\_\_\_

Name of Medical Director: \_\_\_\_\_ License #: \_\_\_\_\_

**II. CRIMINAL RECORD AND ABUSE REGISTRY CHECKS**

Please answer the following questions by circling Yes or No.

If yes, list names and addresses of individuals under each question.

- A. Has any individual or organization owning or having more than 5% or more controlling interest in the facility been convicted of a criminal offense or had a substantiation of abuse, neglect or exploitation? YES NO

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

- B. Are there any directors, officers or employees of the home who have had a substantiated complaint of abuse, neglect or exploitation? YES NO

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

- C. Have Criminal Record Checks and Adult Abuse Registry Checks been completed on all staff, including the Administrator? YES NO

**III. OWNERSHIP**

- A. List names and addresses for individuals or organizations having direct ownership or controlling interest in the business. Attach a separate page if needed.

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_

- B. Is the facility a non-profit? YES NO

- C. Type of business (check one):  
\_Partnership \_Corporation Sole Owner \_Other (describe)\_\_\_\_\_

If the corporation is checked, then list names and addresses of the Directors. Attach a separate page if needed.

\_\_\_\_\_  
\_\_\_\_\_

**IV. FOR ALL APPLICANTS - Please answer the following questions.**

- A. Does the facility currently carry Workers' Compensation Insurance? \_\_\_ YES \_\_\_ NO  
**If yes, please attach proof of current coverage. Please check the expiration date.** (The one-page document is called "***Certificate of Liability Insurance***".) **If no insurance**, please provide an explanation.

- B. Does the facility currently carry a Surety Bond? **If yes, please attach proof of current coverage of the Surety Bond.** Please check the expiration date. YES NO  
**If no coverage**, please provide an explanation.

- C. Is the facility registered with the Vermont Secretary of State's office? \_\_\_ YES \_\_\_ NO  
**If yes, under what name:** \_\_\_\_\_

**V. FOR REAPPLICATION ONLY** - Please answer the following questions Yes or No. Fill in additional information if applicable.

A. Has there been a change of ownership or control in the past year? YES NO  
If yes, give date of change \_\_\_\_\_

B. Is the facility operated by a management company, or leased in whole or part by another organization? YES NO  
If yes, name of company/organization \_\_\_\_\_

C. Has there been a change in Administrator within the past year? YES NO  
If yes, give date of change \_\_\_\_\_  
Name of new Administrator \_\_\_\_\_

D. Have you increased your bed capacity within the past year? YES NO  
If yes, give date of change: \_\_\_\_\_  
# of current beds: \_\_\_\_\_ # of prior beds: \_\_\_\_\_ Current census: \_\_\_\_\_

E. Does the facility have a **designated special care unit**? YES NO  
If yes, for what purpose: \_\_\_\_\_  
Please give number of beds/units: \_\_\_\_\_

F. Has the nature of services been expanded or any changes anticipated (such as adult day care, senior meals site, etc.)? YES NO  
If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VI. REFERENCES (FOR INITIAL APPLICATION ONLY)**

Please provide three letters of reference from unrelated persons. Acceptable references will address the applicant's ability to run the facility and the applicant's character.

**VII. PERMITS (FOR INITIAL APPLICATION OR REQUEST FOR INCREASED LICENSED CAPACITY, SUBMIT THE FOLLOWING):**

- A. Written evidence of compliance with local zoning codes or a statement signed by official representatives of the city, town, or village clerk that zoning codes have not been adopted in the community.
- B. Written evidence of compliance from Environmental Conservation in regard to water and sewage systems.

VIII. BUILDING PLANS (*FOR INITIAL APPLICATION, NEW CONSTRUCTION AND/OR REQUEST FOR INCREASED LICENSED CAPACITY*)

Building plans/blueprints must be submitted to the Department Public Safety in your district. Address and phone numbers are included with initial application packet. Floor plans must be submitted to Division of Licensing and Protection (not blueprints).

IX. ONE (1) ORIGINAL TAX FORM (*FOR INITIAL APPLICATION AND REAPPLICATION*)

The applicant and licensee shall be in good standing with the Vermont Department of Taxes, pursuant to V.S.A. Section 3113. Failure to do so shall result in denial or revocation of license. Submit with application/reapplication the enclosed *Tax Certification Form*, signed and dated.

*The undersigned agrees to comply with the applicable State of Vermont and Federal Regulations. In making this application for licensure, the undersigned agrees to submit a written notice to the Vermont Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, at least 90 days in advance of sale or change in ownership of the facility, in the event residents will be required to move.*

*I hereby certify that the above statements are made for the purpose of obtaining a license to operate a facility of the type I have indicated above. Failure to provide complete, truthful and accurate information as required shall be grounds for automatic denial or revocation of a License to Operate.*

\_\_\_\_\_  
SIGNATURE OF LICENSEE or ADMINISTRATOR

\_\_\_\_\_  
DATE

**RENEWAL APPLICATIONS ARE DUE 45 DAYS PRIOR TO THE EXPIRATION DATE OF LICENSE**

