VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING, AND INDEPENDENT LIVING
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dlp.vermont.gov
Voice/TTY: (802) 241-0480
To Report Abuse: (800) 564-1612
Fax: (802) 241-0343

For DLP office use only

_____

Initial & date for approval

NURSING HOME LICENSE APPLICATION/REAPPLICATION

Date of application: _____

I. IDENTIFYING INFORMATION

SNF Beds (Medicare/Dual): _____ NF (Medicaid Only): _____

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 #: _____

Name of Director of Nursing: _____ License #: _____

Name of Medical Director: _____License #: _____

II. CRIMINAL RECORD AND ABUSE REGISTRY CHECKS

Please answer the following questions by checking 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, addresses, email addresses, and phone numbers for individuals or organizations having direct ownership or controlling interest in the business. Attach a separate page if needed.

_____

_____

_____

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

C. Type of business (check one):

☐ Partnership ☐ Corporation ☐ LLC ☐ Sole Owner

☐ Other (describe): _____

If corporation or LLC is checked, then list the names, addresses, email addresses and phone numbers 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? ☐ YES ☐ NO

- If yes, please attach proof of current coverage of the Surety Bond. Please check the expiration date.
- 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. Do you anticipate a change of ownership or control in the next year? ☐ YES ☐ NO

If yes, give date of change: _____

C. 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: _____

D. Has there been a change in Administrator within the past year? ☐ YES ☐ NO

If yes, give date of change: _____

E. Have you increased or decreased your bed capacity within the past year? ☐ YES ☐ NO

If yes, give date of change: _____

# of current beds: _____ # of prior beds: _____ Current census: _____

F. Does the facility have a designated special care unit? ☐ YES ☐ NO

If yes, for what purpose: _____

_____

Please give number of beds/units: _____

_____

G. 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 of Public Safety in your district.
- Floor plans must be submitted to the 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

Rev. 06/07/24

TAX CERTIFICATION FORM

VERMONT DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

By law (32 V.S.A. Section 3113) no agency of the state may renew a license or other authority to conduct a trade or business (including a license to practice a profession) unless the licensee first certifies, under the pains and penalties of perjury, that he/she is in good standing with the Department of Taxes. A person is in good standing if no taxes are due and payable and all returns have been filed, if the liability for any tax that may be due is on appeal, if the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or if the licensing authority determines that immediate payment of taxes due and payable would pose an unreasonable hardship.

The maximum penalty for perjury is fifteen (15) years in prison, a $10,000 fine or both.

CERTIFICATION OF COMPLIANCE WITH 32 V.S.A. SECTION 3113

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to, or in full compliance with a plan approved by the Commissioner of Taxes to pay any and all taxes due to the State of Vermont as of the date of this application.

_____ _____

DATE SIGNATURE

NAME OF FACILITY: _____

IF YOU ARE NOT IN GOOD STANDING AT THIS TIME, YOU MAY DO ONE OF THE FOLLOWING THREE THINGS:

1. Discontinue this license or license renewal application;
2. Arrange with the Vermont Department of Taxes to bring yourself into good standing through a payment plan approved by the Commissioner or otherwise;
3. Seek a determination from the Licensing Agency that immediate payment of taxes due and payable would impose an unreasonable hardship.

If you desire to continue this application you should complete the statement below:

ALTERNATE CERTIFICATION

I am not in good standing with the Department of Taxes at this time and,

a) I will arrange with the Department of Taxes to bring myself into good standing, or
b) Seek a determination that immediate payment would impose an unreasonable hardship.

_____ _____

DATE SIGNATURE

Arrangement to achieve good standing should be made by contacting the Department of Taxes at (802) 828-2518.

Submit to DLP