APPLICATION FOR LICENSE TO OPERATE A BASIC CARE FACILITY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 16855 (R09-21)

ACCOUNTING/DEPARTMENT USE ONLY

Check Number	License Number
Amount	Bed Capacity
Date	Licensure Period

INSTRUCTIONS: Type or print clearly. Attach with the application a check or money order and other information as requested. Return one completed, notarized copy to: ND Department of Health, Division of Health Facilities, 1720 Burlington Dr, Suite A, Bismarck, ND 58504-7736. Keep a copy for your records.

Official Name of Basic Care Facility		NPI Number	
Street Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	Total Bed Capacity
E-Mail Contact	E-Mail Address		

TYPE OF APPLICATION

☐ Initial ☐ Renewal ☐ Change of Facility Ownership ☐ Bed Capacity Change ☐ Name Change
☐ Location Change ☐ Change in Services ☐ Change in Facility Operator ☐ Other Change:

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)				
GOVERNMENTAL	☐ State	☐ County	☐ County & City	☐ Municipal
NONPROFIT	☐ Association	☐ Corporation		
PROPRIETARY	☐ Individual	☐ Partnership	☐ Corporation	

OWNER-OPERATOR

Name of Exact Ownership of Premises			
Mailing Address	City	State	ZIP Code
Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code
Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code

Has ownership of this Basic Care Facility changed in the last twelve months? ☐ No ☐ Yes	Has the legal entity responsible for operation of this Basic Care Facility changed in the last twelve months? ☐ No ☐ Yes	Is the Basic Care Facility under a management agreement? ☐ No ☐ Yes

Name of Basic Care Facility's General Liability Insurance Company		Name of Agent	
Mailing Address of Agent	City	State	ZIP Code
Name of Administrator			
Name and Title of Emergency Contact		Emergency Contact's Cell Phone Number	

SERVICES PROVIDED

☐ Alzheimer's, Dementia, Special Memory Care – (Separate Initial Application Required)

☐ Secured Facility - Number of Beds _____ ☐ Secured Unit - Number of Beds _____

☐ Traumatic Brain Injury (TBI) – Number of Beds _____

☐ End of Life

☐ Adult Day Care

☐ Bariatrics -- Number of Beds _____

☐ Other Services (Specify)

_____

_____

Submit a current floor plan (8 ½ x 11) showing the location of all licensed beds (with room numbers identified) and services.

Applicant Agrees to the Following:

1. To the inspection of the basic care facility by a representative of the North Dakota Department of Health;
2. To the inspection by other regulatory agencies at the request of the North Dakota Department of Health;
3. To notify the North Dakota Department of Health of any change in ownership immediately or proposed change of location or increase of bed capacity or services;
4. To operate this basic care facility at all times in compliance with the standards established by the North Dakota Department of Health

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a license to operate a basic care facility subject to the provisions of North Dakota Century Code Chapter 23-09.3-09 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

Signature	Date

State	County

Signed and sworn to (or affirmed) before me on	Date

Name(s) of Individual(s) Making Statement	Affix Notary Stamp
Signature of Notary Public or Other Authorized Officer	
Commission Expiration Date (if not listed on stamp)	