



APPLICATION FOR LICENSE TO OPERATE A NURSING FACILITY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
Telephone 701.328.2352
SFN 14230 (R08-20)

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. Include the completed request for waiver, if applicable. Return one completed, notarized copy to: ND Department of Health, Division of Health Facilities, 1720 Burlington Dr, Bismarck, ND 58504-7736. Keep a copy for your records.

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

TYPE OF APPLICATION

<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change of Facility Ownership	<input type="checkbox"/> Bed Capacity Change	<input type="checkbox"/> Name Change
<input type="checkbox"/> Location Change	<input type="checkbox"/> Change in Services	<input type="checkbox"/> Change in Facility Operator	<input type="checkbox"/> Other Change:	

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)				
GOVERNMENTAL	<input type="checkbox"/> State	<input type="checkbox"/> County	<input type="checkbox"/> County & City	<input type="checkbox"/> Municipal
NONPROFIT	<input type="checkbox"/> Association	<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company	
PROPRIETARY	<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	

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	
Has ownership of this nursing facility changed in the last twelve months? <input type="checkbox"/> No <input type="checkbox"/> Yes	Has the legal entity responsible for operation of this nursing facility changed in the last twelve months? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is the nursing facility operating under a management agreement? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Name of Nursing Facility's General Liability Insurance Company		Name of Agent		
Mailing Address of Agent	City	State	ZIP Code	

Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code
Name of Administrator	Title	License Number	
Name of Director of Nursing Services		License Number	
Name of Medical Director		License Number	
Name and Title of Emergency Contact:		Emergency Contact's Cell Phone Number:	

Does your facility offer the following department approved services:

- Memory Care in Secured Unit -- Number of Beds _____
 Bariatrics -- Number of Beds _____
 Adult Day Care
 Ventilator -- Number of Beds _____
 Paid Feeding Assistant Training Program (Date Last Class Completed _____)
 Nurse Aide Training Program (Date Last Surveyed _____)
 Other Services (Specify) _____

Submit a current floor plan (8 1/2 x 11) showing the location of all licensed beds (with room numbers identified) and services.

SIGNATURES AND AFFIDAVIT

NOTE: The person signing the application cannot be less than 18 years of age. The administrator of the nursing facility shall not sign the application unless he/she is also a board member. The application must be signed by official(s) of the entity responsible for the operation of the nursing facility. (If sole proprietorship, the owner shall sign the application; if a corporation, two of its officers shall sign; if a state, county, or municipal unit, the application is to be signed by the head of the department having jurisdiction over the nursing facility.)

The undersigned hereby makes application for a license to operate a nursing facility subject to the provisions of North Dakota Century Code Chapter 23-16 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
Signature	Date

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