Ohio Department of Health

Division of Quality Assurance
Nursing Home / Residential Care Facility
Licensure Application

ODH USE ONLY for New App
App #
OHL #

Submit Application to: Ohio Department of Health
Revenue Processing #3212
PO Box 15278
Columbus, Ohio 43215

1. **Application Type** ○ Initial ○ Change of Operator	2. Projected opening date or effective date of change of operator	3. Ohio Building Use Group ○ I-1 ○ I-2 ○ R-4
4. Licensure type ○ Nursing Home ○ Residential Care Facility	5. Capacity (# of Beds)	6. Operator Type ○ For Profit ○ Not for profit
7. Building Information ○ New Construction ○ Existing Construction Converted		8. **Nursing Home Only** CON File Number(s)

9. Facility Information

Facility Name (DBA)		
Previous facility name, if applicable		
Address		
City	Zip	County
Facility phone #	Fax #	
Facility e-mail address		
Administrator name		NHA license #
Administrator's business address, if different from operator ☐ Same as operator		
City	State	Zip

10. Individual Operator

Operator's Name		
Address		
City	State	Zip

Ohio Department of Health

11. Business Operator – Association, Corporation, Limited Liability Company, Partnership

Operator's Business Name			
Address			
City	State	Zip	Phone #
Business activity type	Charter/Registration #		Date incorporated

12. Business Operator officers/members/partners

President	Member	Partner
Vice President	Member	Partner
Secretary	Member	Partner
Treasurer	Member	Partner

13. Name of each person who has ownership interest of 5 percent or more in the Operator's business entity

Name	Name
Name	Name
Name	Name
Name	Name

14. Statutory agent of the operator (As Registered with the Secretary of State)

Name of Statutory Agent of Operator			
Address			
City	State	Zip	Phone #

15. If the Operator does not own the legal rights associated with the ownership and operation of the nursing home beds, enter the name of each person who has an ownership interest of 5 percent or more in the nursing home beds

☐ Not applicable

Name	Name
Name	Name
Name	Name
Name	Name

Ohio Department of Health

16. Statutory Agent of the owner of the legal rights associated with the ownership and operation of the nursing home beds
☐ Not applicable

Name of Statutory Agent of Owner of the Nursing Home Beds			
Address			
City	State	Zip	Phone #

17. Does the operator own the building housing this long-term care facility? ◯ **Yes** ◯ **No**
If no, name of business entity that owns building and each person who has an ownership interest of 5 percent or more in the building and an address for building owner.

Business Entity Name			
Address	City	State	Zip
Name	Name		
Name	Name		
Name	Name		

18. Loan Information

Does Operator or Building Owner have a loan with the United States Housing and Urban Development (HUD) for this home?
◯ Yes, Name of entity with HUD Loan ◯ No

19. Management firm or business employed to manage this long-term care facility. ☐ **Not applicable**

Management firm/business name			
Address			
City	State	Zip	Phone #

20. Name and address of any nursing home or any facility described in 3721.01(A)(1)(a) or (A)(1)(c) of the Revised Code in which the operator or administrator, or both, have an ownership interest of 5 percent or more or with which the operator (including owners of 5 percent or more in the Operator entity) or administrator have been affiliated with through ownership or employment in the five years prior to the date of the application.

Name	Address
Name	Address
Name	Address
Name	Address

Ohio Department of Health

21. Additional Questions

	Yes	No
Have you or any partner, member or officer listed in this application been convicted of a felony or a crime of moral turpitude?	○	○
Are you or any member, partner or officer listed of this facility engaged in practices that could be construed as immoral?	○	○
Is there any reason why this facility will not be able to operate for the next 12 months?	○	○

If you or any partner or officer has answered "**YES**" to the questions above, please attach a separate document explaining.

22. **SPECIALIZED CARE PROGRAM** - Check what specialized care or services your facility provides: ☐ N/A

	Coma treatment		Respirator or ventilator care		Specialized Alzheimer's Disease
	Neurological injury program for young adults		Traumatic brain injury program		Deaf or hearing impaired
	Pediatric care		Amyotrophic lateral sclerosis		Adult day care program
	Dialysis services		Hospice services		Other:

ATTESTATION

I, the undersigned, attest that:

- Operator has sufficient capital or financial reserve to cover not less than four months' operation and is financially able to operate the home in accordance with Chapter 3721. of the Revised Code and the applicable rules of the Ohio Administrative Code;
- Home is staffed, equipped and furnished to provide humane, kind and adequate treatment and care; and
- Home is in compliance with applicable zoning ordinances and rules.

By affixing my signature immediately below, I acknowledge awareness:

- Of the provisions of the Revised Code that provide that any person who knowingly makes a false statement or knowingly swears or affirms the truth of a false statement previously made when the statement is made with purpose to secure the issuance by a government agency of a license is guilty of falsification, a misdemeanor of the first degree (section 2921.13(A)(5) and (D)) of the Revised Code. A misdemeanor of the first degree is punishable by fine and/or imprisonment as provided in section 2929.21 of the Revised Code.
- That failure to timely provide all of the required information to the Ohio Department of Health will delay the on-site licensing inspection and issuance of my license, or void my application as being incomplete.
- That I cannot operate the home or admit more than two residents until I have been determined to be in compliance with the applicable licensing law and rules and have received my license.

I swear or affirm that the undersigned is:

The operator, if the operator is an individual, or

A duly authorized agent of the operator, if the operator is an association, partnership, limited liability company or corporation.

I further swear or affirm that the information provided herein, and any attachments hereto, have been prepared, or carefully reviewed, by me and constitute a truthful and correct disclosure of all information therein.

Name of undersigned: _____ Title: _____

Signature: _____

Date: _____