**Instructions for completing the license application**

**Download and save the application on your computer then proceed with the following instructions:**

* **Enter the required information in the appropriate grey boxes**
* **Use the tab key, the page up key, or page down key to move from one field (grey boxes) to another**
* **After completing the application, go to “File” on the tool bar**
* **Check “Save As”**
* **Name the file**
* **Print pages 5-14 of the application and mail to the OLC along with the appropriate fees and any additional attachments**
* **Keep a copy for your files**

**If you need any assistance, please call (804) 367-2100**

**Code of Virginia 32.1-102.2**

1. The Board shall promulgate regulations which are consistent with this article and:
2. Shall establish concise procedures for the prompt review of applications for certificates consistent with the provisions of this article which may include a structured batching process which incorporates, but is not limited to, authorization for the Commissioner to request proposals for certain projects;
3. May classify projects and may eliminate one or more of all of the procedures prescribed in §32.1-102.6 for different classifications;
4. May provide for exempting from the requirement of a certificate projects determined by the Commission, upon application for exemption, to be subject to the economic forces of a competitive market or to have no discernible impact on the cost or quality of health services;
5. Shall establish specific criteria for determining need in rural areas, giving due consideration to distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care in such areas and providing for weighted calculations of need based on the barriers to health care access in such rural areas in lieu of the determinations of need used for the particular proposed project within the relevant health systems area as a whole; and
6. May establish, on or after July 1, 1999, a schedule of fees for applications for certificates to be applied to expenses for the administration and operation of the certificate of public need program. Such fees shall not be less than $1,000 no exceed the lesser of one percent of the proposed expenditure for the project or $20,000. Until such times as the Board shall establish a schedule of fees, such fees be one percent of the proposed expenditure for the project; however, such fees shall not be less than $1,000 or more than $20,000.
7. The Board shall promulgate regulations providing for time limitations for schedules for completion and limitations on the exceeding of the maximum capital expenditure amount for all review able projects. The Commissioner shall not approve any such extension or excess unless it complies with the Board’s regulations.
8. The Board shall also promulgate regulations authorizing the Commissioner to condition approval of a certificate on the agreement of the applicant to provide a level of care at reduced rate to indigents or accept patients requiring specialized care. In addition, the Board’s licensure regulations shall direct the Commissioner to condition the issuing or renewing of any license for any applicant whose certificate was approved upon such condition on whether such applicants has complied with any agreement to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care.

**Bed Definitions**

1. **Licensed Beds** – refers to the number beds a facility is licensed to operate by State licensing authority.
2. **Staffed Beds** – beds with supporting services (such as personnel, food, laundry, and housekeeping), for patients or residents who stay in excess of 24 hours.
3. Certification of Nursing Home Beds:

a) **Certified for Medicare Only** – refers to beds, which are certified under Title 18.

b) **Certified for Medicare/Medicaid** – refers to beds which are certified under Title 18/19.

c) **Certified for Medicaid Only** – refers to beds, which are certified under Title 19.

d) **Non-Certified Beds** – refers to nursing home beds that are not certified for either Medicare or Medicaid. (Excludes any Home for Adults beds)

4**. CCRC** – Continuing Care Retirement Community. "Continuing care" means providing or

committing to provide board, lodging and nursing services to an individual, other than an individual related by blood or marriage, (i) pursuant to an agreement effective for the life of the individual or for a period in excess of one year, including mutually terminable contracts, and (ii) in consideration of the payment of an entrance fee. A contract shall be deemed to be one offering nursing services, irrespective of whether such services are provided under such contract, if nursing services are offered to the resident entering such contract either at the facility in question or pursuant to arrangements specifically offered to residents of the facility.

"Continuing care" also means providing or committing to provide lodging to an individual, other than an individual related by blood or marriage, (i)pursuant to an agreement effective for the life of the individual or for a period in excess of one year, including mutually terminable contracts, (ii)in consideration of the payment of an entrance fee, and (iii) where board and nursing services are made available to the resident by the provider, either directly or indirectly through affiliated persons, or through contractual arrangements, whether or not such services are specifically offered in the agreement for lodging. (38.2-4900.)

**NOTE: Assisted Living Facility Beds are those beds licensed by The Department of Social Services.**

**License Fees**

**This application must be accompanied by a money order, bank or teller check, or certified check payable to the Virginia Department of Health. No cash will be accepted.   
*Note: Fees are required for any changes to the current license. Bed reconfiguration does not require a fee.***

**The fee is based on the total number of licensed beds:**

**1- 50 beds $75.00**

**51 – 333 beds $1.50 {per bed}**

**334 beds and over $500.00**

**Make check or money order Payable to**:

**Virginia Department of Health**

**Office of Licensure and Certification**

**9960 Mayland Drive, Suite 401**

**Henrico, Virginia 23233**

**Virginia Department of Health Application for Nursing Home License**

**In accordance with the provisions of Chapter 5, Article 1, Title 32.1, Code of Virginia of 1950, all non-federal medical and nursing facilities desiring license as a nursing home in Virginia must submit the following information to the Virginia Department of Health.**

**Any changes during the year, which would affect the accuracy of the following information, must be reported promptly, in writing, to the Virginia Department of Health.**

|  |  |
| --- | --- |
| FOR OLC USE ONLY | |
| **Check #:** | **Check  Amt:** |
| **Rec. Date:** | **Check  Date:** |
| **Deposit  Date:** | **Ticket #:** |

**Application for: (check one)**

**Annual Renewal for Calendar Year**

**Initial License to Operate a Nursing Home**

**Changes in Licensed Bed Capacity/Bed Change**

**Changes in Ownership or Operator**

**Effective Date:**

**Name of Facility (Doing Business As name):**

**Facility Physical Address:**

**(Additional space if needed)**

**City Or Town:       State:** VA **Zip Code:**

**County:**

**Telephone Number with Area Code:       Fax Number:**

**Mailing Address:**

**Facility Web Address:**

**Name of Administrator of Record:**

**Administrator Email Address:**

**If the facility is Medicare/Medicaid certified, has the facility registered for ePOC**?  **YES NO NOT Certified**

**If “YES,” enter:**

**Date Registered:**

**Name of Registered User:**

**I hereby certify that the above named facility is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 2, Rights and Responsibilities of Patients in Nursing Homes.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Signature of Administrator/Chief Officer) (Nursing Home Administrator’s License Number)**

**Conditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 1, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need issued to it, and has determined that:**

1. Conditioned certificates for indigent or specialized care are applicable to the nursing facility.  **YES NO**

2. If conditioned certificates for indigent or specialized care are applicable to this nursing facility, does the nursing facility meet the requirements of the certificates?  **YES NO** (If “NO,” attach a letter of explanation)

I hereby certify that the information contained in the Application for License Renewal is, to the best of my knowledge, accurate and true.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Signature of Administrator/Chief Officer) (Date Completed)**

**Licensing Classification of Nursing Home Facilities and Bed Capacity by Service**

**Types of Beds by License Classification Bed Capacity**

**Licensed Beds Requested**

**FOR OFFICE USE ONLY**

Total Licensed Beds

Approved

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

Date

**Total Bed Capacity (Specify Bed Types excluding Day Care)**

Number of Beds Certified for Medicare Only

(Title 18)

Number of Beds Certified for Medicare/Medicaid

(Title 18/19)

Number of Beds Certified for Medicaid only

(Title 19)

Number of Non-certified beds

(Exclude Adult Residential beds)

**\*\*PLEASE INCLUDE FLOORPLAN OF FACILITY\*\***

**Does the facility have a specialized unit? YES NO**

**If yes, specify the type of specialized unit and number of beds (i.e. secured unit, ventilator unit, etc.)?**

**Type of Unit       Number of beds**

**Does the facility have a Nurse Aide training program on your premises? YES NO**

**If yes, is it a certified Nursing Assistant Program approved by the Board of Nursing? YES NO**

|  |  |
| --- | --- |
| **A. Name of Director of Nursing Service:** | **Start Date:** |
| **B. Name of In-Service Training Director:** | **Start Date:** |
| **C. Name of Social Services Director:** | **Start Date:** |
| **D. Name of Activities Director:** | **Start Date:** |
| **E. Name of Food Services Supervisor:** | **Start Date:** |
| **F. Name of Medical Director/Advisory Physician(s):** | **Start Date:** |
| **G. Name of Dietary Consultant:** | **Start Date:** |
| **H. Name of Pharmacy Consultant:** | **Start Date:** |
| **I. Name of Physical Therapy Consultant:** | **Start Date:** |
| **J. Name of Dental Consultant:** | **Start Date:** |

**Survey of Long-Term Care Facilities**

**Facility Name (Doing Business As name):**

(Please make sure the Facility Name is spelled the **same as on page 5**)

**Is any part of the facility licensed by another state agency? YES NO If yes, enter the number of beds:**

**If yes, specify the type of beds (i.e. Adult Residential)**

**Does the facility have Adult Day Care facilities? YES NO If yes, enter the number of accommodations:**

**Does the facility have Child Day Care facilities? YES NO If yes, enter the number of accommodations:**

**If yes, are the day care facilities required to be licensed by the Department of Social Services? YES NO**

**Does the facility share resources with an Assisted Living Facility? YES NO If yes, complete the following section:**

**Assisted Living Facility Name:**

**Number of Assisted Living Facility Beds:**

**State licensure laws and regulation do not prohibit the integration or sharing of services/areas within nursing facility/assisted living arrangements. However, providers must demonstrate compliance with all relevant licensure regulations regarding full time staffing and facility environmental requirements. Providers are obligated to assure that staffing assignments and shared services are sufficient to meet the assessed needs of all residents and the applicable regulations for each type of facility license. Please complete the questions below addressing sharing of staff, services, and areas.**

**1. Are residents of the two facilities in: Same building, Separate buildings, same campus**,

**Same wing Different wing, Other**:

**2. What services/areas are commonly shared?**

**Direct care**,  **Administrative, Housekeeping, Food service/dietary,**

**Other:**

**3. What staff positions are shared and what is the frequency of duties shared?**

|  |  |  |  |  |  |  |  |
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| **Duties** | **No. of**  **Staff** | **No. of Shared Staff** | **Frequency**  **Daily or Weekly** | **Duties** | **No. of**  **Staff** | **No. of**  **Shared**  **Staff** | **Frequency**  **Daily or Weekly** |
| **Direct Care Staff** |  |  |  | **Housekeeping** |  |  |  |
| **Administrative Staff** |  |  |  | **Food/service**  **Dietary** |  |  |  |
| **Other:** | | | | | | | |

**4. How are the Administrator duties conducted? Separate for each facility? YES NO**. **If no, there must be an   
Assistant Administrator. Describe how the duties are delegated and how the Administrator is kept informed.**

**Enter duties delegated**

**Enter how Administrator is informed**

**Is the facility part of a CCRC? YES NO If yes, complete the following section:**

**A. How many beds are in the CCRC?**

**B. How many Life Care Contract holders are in NON nursing home beds?**

**Ownership and Operation of Nursing Home**

**Facility Name (Doing Business As name):**

(Please make sure the Facility Name is spelled the **same as on page 5**)

**Legal name of the Operator of the facility:**

**Operator’s physical address:**

**(Additional space if needed)**

**City or Town:       State:       , Zip Code:**

**Operator Telephone Number with Area Code:       Fax with area code:**

**Legal/Doing Business As name of the Owner of the nursing home business:**

**Owner’s physical address:**

**(Additional space if needed)**

**City or Town:       State:      , Zip Code:**

**Is the facility operated by the owner of the building? YES NO**

**Is the facility owned by the owner of the building? YES NO**

**Type of Ownership and Control**

**If the facility IS owner-operated, select ONE from Column A.**

**If the facility IS NOT operated by the owner, select ONE from Column A and ONE from Column B.**

**(A) (B)**

**OWNER OPERATOR**

**(of facility) (of facility)**

**State or Local Government:**

**State**

**County**

**City(ies)**

**Multijurisdictional**

**Hospital District/Authority**

**Non-Profit:**

**Church Related**

**Non-Profit Corporation**

**Other Non-Profit**

**Proprietary:**

**Single Proprietary**

**Partnership**

**Corporation**

**Limited Liability Corporation**

**Is there any person other than those listed on this form (owner, operator, administrator of record) who is authorized to make administrative management decisions regarding the facility? YES NO**

**If yes, please identify the person and their relationship to the facility**

**Person's name and relationship to facility**

**Information Required on the Operator/Manager of the Facility**

**Please enter the names and Physical addresses of the governing body. If the position is vacant, please put “vacant.” If more space is needed, please attach additional pages to the back of the application**

**Name of President/Chair:**

**Physical Address:**

**Name of Vice President:**

**Physical Address:**

**Name of Secretary:**

**Physical Address:**

**Name of Treasurer:**

**Physical Address:**

**If any officer, director, trustee or any member of the governing body or any other individual, partnership, association, trust, corporation, or other legal or commercial entity owns, holds or has a financial interest of five (5) percent of more in the operating/management entity, list the name and percentages of ownership below:**

**NAME OWNERSHIP PERCENTAGE**

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**Are all remaining financial interests less than 5 percent? YES NO**

**If the operator/manager has a lease or management agreement with the legal entity or individual who owns the physical plant/buildings, list the name and the address of the building owner.**

**Name of Building Owner:**

**Physical Address of Owner:**

**If the operator/manager has a lease or management agreement with a legal entity or individual who is not the owner of the physical plant/buildings, list the name and address of the lessor.**

**Name of Lessor:**

**Physical Address of Lessor:**

**If the operator/manager has a lease or management agreement with an owner or a lesser, does the owner or the lessor have a five (5) percent or more ownership interest in the legal entity that operates/manages the facility? YES NO**

**Enter Bed Listing Here**

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| **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care**  **Only** | **Medi-caid Only** | **Licensed Only** | **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care Only** | **Medi-caid Only** | **Licensed Only** |
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| **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care**  **Only** | **Medi-caid Only** | **Licensed Only** | **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care Only** | **Medi-caid Only** | **Licensed Only** |
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| **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care**  **Only** | **Medi-caid Only** | **Licensed Only** | **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care Only** | **Medi-caid Only** | **Licensed Only** |
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| **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care**  **Only** | **Medi-caid Only** | **Licensed Only** | **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care Only** | **Medi-caid Only** | **Licensed Only** |
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**Enter Bed Listing Here**

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| **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care**  **Only** | **Medi-caid Only** | **Licensed Only** | **Room No.** | **No. of beds** | **Medicare &**  **Medicaid** | **Medi-care Only** | **Medi-caid Only** | **Licensed Only** |
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