

Owner (Licensee) License Application for Residential Care and Assisted Living Facilities: Instructions



Applications must be received by Office of Licensing and Regulatory Oversight (OLRO):

- 60 days prior to initial licensing
- 60 days prior to change of ownership and change of management
- 45 days prior to license renewal date

Instructions:

Part 1 — Facility information

1. **Type of facility:** Indicate the type of facility license being requested. One application per license type.
2. **Licensing fee: A separate invoice will be sent for license renewals. Do not send renewal fees with renewal applications.** A licensing fee is required for renewal, initial licensing, change of ownership, change of management and when an increase in capacity requires an onsite inspection. Licensing fees are determined by the number of licensed beds at the facility: 1 to 15 beds, \$360; 16 to 49 beds, \$520; 50 to 99 beds, \$1,040; 100 to 150 beds, \$1,340; 151 or more beds, \$1,500. Memory Care fees: 1 to 16 beds, \$50.00; 17 to 50 beds, \$75.00; 51 or more beds, \$100.00. Contact the Office of Licensing and Regulatory Oversight (OLRO) for payment instructions. See page D for contact information.
3. **Type of action:** Check the appropriate box for an increase or decrease in capacity or units.
4. **Facility information:** Identify name of facility. The facility name must be registered with the Oregon Secretary of State Corporation Division at the following website: <http://filinginoregon.com>.

The mailing address you provide here will not be used for all mailings.

“Name of administrator” — If the Administrator Reference Summary has not been previously submitted, please submit form SDS 0566, which can be obtained at <https://apps.state.or.us/cf1/DHSforms/Forms/Served/SE0566.doc>.

“Qualified Entity Designee (QED)” is the person who is approved to receive and submit the Background Check Request form (301QED).

Please state current **licensed maximum capacity** and total current licensed number of rooms or units.

5. **Owner applicant (licensee) information:** Check the appropriate box if the applicant is owner (*licensee*) and operator. If the applicant is not operator/management, check the appropriate box and write in the name of the operator/management. One application form must be submitted by the business owner (*licensee*) (SDS 0570) and another by the management/operator (SDS 0570M) at renewal, for change of owner, change of management and initial licensing. Only one license fee and memory care fee (*if applicable*) must be paid. For change of management, please submit only the management application (SDS 0570M) and the letter of engagement. Contact the Office of Licensing and Regulatory Oversight (OLRO) for payment instructions (*see page D for contact information*).
 - **Proof of issued Federal Employer Identification Number (EIN):** Either a copy of EIN Confirmation Notice for the owner/licensee or copy of a recent letter from the IRS with your EIN circled. Individual Social Security numbers are required for 5% or more ownership if serving the Medicaid population.

- For “Government” or “Tribal” agencies or organizations: If you are a federal, state, county, city or other level of government, or an Indian tribe, you will be legally and financially responsible for Medicaid payments received (*including any potential overpayments*). The name of that government or Indian tribe should be reported as the owner. The provider should identify as having “ownership or control interests.” List the key authorized officials of your government or tribal agency or organization according to the laws, regulations, and program instruction of the Medicaid program.

Part 2 — Ownership and control interests

Use the following definitions to identify the individuals you should enter in parts A, B and D.

“**Direct ownership interest**” is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. See 42 CFR 455.100 to calculate ownership or control percentage.

“**Indirect ownership interest**” is defined as ownership interest in an entity that has direct or indirect ownership interest in the applicant (*licensee*). If a corporation is owned by one or more trusts, the beneficiaries of the trust are considered indirect owners. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level.

“**Controlling interest**” is defined as the operational direction or management of an applicant which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (*i.e., joint venture agreement, unincorporated business status*) of the applicant; the ability or authority to nominate or name members of the Board of Directors or Trustees of the applicant; the ability or authority, expressed or reserved, to amend or change the bylaws, constitution or other operating or management direction of the applicant; the right to control any or all of the assets or other property of the applicant upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the applicant to new ownership or control. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity’s assets used to secure the obligation.

“**Other disclosing entity**” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participating in any Title V, XVLL, or XX of the Act. This includes hospitals, skilled nursing facilities, health maintenance organizations that participate in Medicare (*Title XVLL*) and any entity that furnishes or arranges for the furnishing of health related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

“**Subcontractor**” means an individual, agency, or organization to which a disclosing entity has contracted or delegated part of its management functions or responsibilities of providing medical care to its patients; or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

“**List each long term care facility**”: Include Residential Care Facilities (RCF), Assisted Living Facilities (ALF) and Nursing Facilities (NF) in Oregon or any other state owned or managed by any person owning five percent (5%) or more of this facility.

Applicant compliance history. Definition of the facility, “where care is or has been provided to children, elderly, ill or persons with disabilities.” Check box to answer each question. For each “Yes” attach an explanation including specific circumstances (*who, what, where and when*) and how the situation was resolved.

Part 3 — Status changes

Respond to all questions.

“**Management company**” is defined as any organization that operates a business on behalf of the owner of that business (*licensee*), with the owner (*licensee*) retaining ultimate legal responsibility for operations of the facility.

A “**chain affiliate**” is any freestanding health care facility that is owned, controlled or operated under lease or contract by an organization consisting of two or more freestanding health care facilities organized within or across state lines, which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital-based home health agencies are not considered chain affiliates.

Part 4 — Board of Directors

For organizations that are corporations, this section asks for information about each person on the Board of Directors.

Part 5 — Business credit check authorization

Consent for business credit record check to be completed by an authorized representative for the business owner (*licensee*).

Part 6 — Medicaid

See page 6 of the application

Part 7 — Approved background check request

An approved Background Check Request is required for each ten percent (10%) owner for initial licensing, renewal, change of owner and change of management. For those who serve the Medicaid population, an approved background check request and Social Security number is required for each five percent (5%) owner. Fill out the Background Check Request (301QED) form and process the completed form through the facility Qualified Entity Designee (QED). A Background Check Request should be current and the approved 301QED will be valid for two (2) years.

Copies of the approved 301QED are required for each renewal application even if previously submitted. Find the 301QED form at: <https://apps.state.or.us/cf1/FORMS>.

Incomplete or falsified applications may result in denial of application.

If the application is handwritten, please print and use black or blue ink. Do not use “white-out” or correction tape. If an error is made, draw a line through the error, write in correct information, initial and date the change(s). Changes must be made by the person signing the application.

Send applications to:

Oregon Department of Human Services
Office of Licensing and Regulatory Oversight
Attn: Licensing Specialist
PO Box 14530
Salem, OR 97309

Email: CBC.TEAM@dhsosha.state.or.us

Fax: 503-378-8966

NOTE: Outdated versions of this application will be returned. Refer to <https://apps.state.or.us/cf1/FORMS> for the most current version of this form.

Owner (Licensee) License Application for Residential Care and Assisted Living Facilities: Application



Part 1 — Facility information

1. Current license expiration date: ____ / ____ / ____
2. Type of facility: Residential Care (RCF) Assisted Living (ALF) Memory Care Community
3. Licensing fee: RCF/ALF fee paid Memory Care fee paid
4. Type of action: Biennial renewal Change of owner New facility
 Facility name change Change of operator/management
 Increase in licensed units/capacity Decrease in licensed units/capacity
Projected date: ____ / ____ / ____

5. Facility information (**attach a screen print of the confirmed Secretary of State registration page**):

Name of facility (include "doing business as" or DBA name registered with the Oregon Secretary of State):

Phone: ____ - ____ - ____ Fax: ____ - ____ - ____

Street address: _____

City/State/ZIP: _____ County: _____

Mailing address (if different): _____

City/State/ZIP: _____

Administrator: _____ Email: _____

Start date: ____ / ____ / ____

Authorized designee: _____ Email: _____

Start date: ____ / ____ / ____

Licensed maximum capacity: _____ New capacity: _____ Current census: _____

Licensed number of units: _____ New units: _____ Memory care number of beds: _____

Is property owned by applicant (licensee)? Yes (provide owner contact information below) No

Name: _____ Phone: ____ - ____ - ____

Address: _____

6. Applicant (*licensee*) information: Applicant is owner and operator/manager
 Applicant is not owner and operator/manager

Operator/management is (attach a separate application): _____

Name of legal owning entity (*exactly as registered with the Oregon Secretary of State Corporation Division*):

EIN or tax identification number: _____

Street address: _____

City/State/ZIP: _____ Contact name: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ Email: _____

- Type of business: For-profit corporation LLC Partnership Sole proprietorship
 LLP Tribal Not-for-profit corporation Government owned
 Other (*please specify*): _____

Workers' compensation carrier: _____

Is applicant current on payment? Yes No Policy number: _____

Part 2 — Ownership or control interests

- A. List the name and address for individuals and the EINs for organizations having **direct or indirect ownership** or controlling interest in the provider entity (see instructions for definition of ownership and controlling interest). Attach additional pages as necessary to list all officers, ownership individuals and entities with ten percent (10%) or more direct or indirect ownership. If the facility serves the Medicaid population, list all those with five percent (5%) or more direct or indirect ownership and include their Social Security numbers.

Name	Address	EIN or individual SSN	Percentage of ownership	Entity type*

***Entity type:** In the "entity type" field, enter one of the codes listed below for each individual listed.
 1: Sole proprietorship 2: Partnership 3: Unincorporated associations
 4: Corporation 5: Government or tribal 6: Other (*specify*): _____

- B. List the name, address and employer identification number of each person or entity with an ownership or controlling interest **in any subcontractor** in which the disclosing entity has direct or indirect ownership of ten percent (10%) or more. If the facility serves the Medicaid population, list those with five percent (5%) or more of direct or controlling ownership.

Name	Title	Address	EIN	Percentage

- C. List those persons named in A or B that are related to each other (*spouse, parent, child, sibling or other family members by marriage or otherwise*).

Name	Relationship	Address

- D. List the name, address, EIN and DHS provider number of any other disclosing entity in which a person, with an ownership or controlling interest in the disclosing entity, also has an ownership or controlling interest of ten percent (10%) or more. If serving the Medicaid population, list those who have an ownership or controlling interest of at least five percent (5%) or more. For example, are any owners of the disclosing entity also owners of Medicare or Medicaid facilities? Examples: sole proprietor, partnership or members of board of directors.

Name	Address	EIN	DHS provider number

- E. List the name, title, and address of any individual or entity with an ownership or controlling interest in the disclosing entity that has been suspended or debarred from participation in Medicare, Medicaid or Title XX program.

Name	Title	Address

- F. List each long term care facility (*include RCFs, ALFs and Nursing Facilities (NF)*) in Oregon or any other state, owned or managed by any person owning ten percent (10%) or more of this facility. If serving the Medicaid population, list any person owning five percent (5%) or more of this facility.

Facility name	Address

- G. Check "Yes" or "No" for each question below. For each "Yes" attach an explanation including specific circumstances (*who, what, where and when*) and how each was resolved.

Has any owning individual or owning entity currently or previously:

1. Held any ownership interest in any facility (*see instructions for definitions*)? Provided services to any individuals for which license, registration or certification was either denied, or involuntarily or voluntarily terminated during a state or federal termination process during the past five years?

Yes No

2. Owned or operated any facility which had its license denied or revoked, or received a denial or revocation notice, under the laws of any state during the past five years? Yes No

Part 3 — Status changes

A. Has there been a change in ownership or control within the last year?

Yes No If yes, give date: ___ / ___ / ___

Do you anticipate any change of ownership or control within the upcoming year?

Yes No If yes, give date: ___ / ___ / ___

B. Have you filed for bankruptcy within the last two years?

Yes No If yes, when? ___ / ___ / ___

C. Do you anticipate filing for bankruptcy within a year?

Yes No If yes, when? ___ / ___ / ___

D. If this facility is operated by a management company, or leased in whole or in part by another organization, has there been a change in management within the past year? Yes No

Name of management entity if other than owner (*licensee*): _____

Give date of change in operations: ___ / ___ / ___

E. Are you the current administrator? Yes No

Will there be a change in administrator within the next year? If yes, please fill-in the following:

Name of new administrator: _____ Start date: ___ / ___ / ___

F. Is this facility chain affiliated?

Yes. List the name and address of the corporation and the EIN below.

No. Was the facility ever affiliated with a chain? Yes No If yes, list the name and address of the corporation and the EIN below.

Name	Address	EIN

Part 4 — Board of directors

If the disclosing entity is a corporation (*examples: for profit, nonprofit, limited liability or other corporate form*) with a board of directors, list the full name, and address of the current directors (*members*). For facilities that serve the Medicaid population and are managed by a Board of Directors, the Centers for Medicare and Medicaid Services (CMS) require a social security number and date of birth for each board member.

Name	D.O.B.	SSN	Address

I understand that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of the application. By signing this disclosure statement, I hereby certify and swear, under penalty of perjury, that I have knowledge concerning the information above and the information above is true and accurate. I agree to inform the Department of Human Services (DHS) or its designee, in writing, within thirty days (30) of any changes or if additional information becomes available.

Name of authorized representative

Title

I, the undersigned, or acting as the authorized representative of the applicant (*licensee*), declare to the best of my knowledge, this information is true, correct and complete. I give Office of Licensing and Regulatory Oversight (OLRO) permission to obtain payment information from the workers' compensation carrier and any entity from which the applicant leases a building, property or business.

Signature of applicant (*licensee*) or representative

/ /
Date

Owner applicant (*licensee*) signature

/ /
Date

Part 5 — Credit check authorization for licensee

Consent for business credit record check:

I, _____, an authorized representative for the business identified below, hereby consent to a release of credit history regarding this business to the Department of Human Services, Office of Licensing and Regulatory Oversight with the State of Oregon. This consent expires 24 months after the date signed.

Name of business (*licensee*): _____

Business mailing address (*include city, state and ZIP code*): _____

Other names (*DBA's*) used by this business: _____

Name of authorized representative: _____

Title of representative: _____

Signature: _____ Date signed: ____ / ____ / ____

Photocopy additional forms as needed. Credit records are kept confidential unless disclosure is court-ordered.

Part 6 — Medicaid contract

Will you be serving the Medicaid population?

Yes No

If you are currently serving the Medicaid population, do you wish to change your Medicaid contract status?

Yes No

If yes to either question, please email the following for all information regarding Medicaid participation and payment:

APD.ProviderEnrollment@state.or.us for provider enrollment agreements

Specific-Needs.Contract-Team@dhsosha.state.or.us for supplemented rate contracts (memory care)

Contact information:

In order to insure that an authorized person will receive information and obtain signatures, please complete all the requested information below.

Contact person for the licensee/owner:

Name (*print or type*): _____

Title: _____

Address: _____

City/State/ZIP: _____

Phone number: _____ - _____ - _____ Fax: _____ - _____ - _____

Email address: _____

Attach a copy of the EIN confirmation notice or a copy of a recent letter from the IRS with the EIN circled. Will the facility have a contract with other state agency departments (*i.e., Aging and People with Disabilities, Developmental Disabilities, Addictions and Mental Health*)? Yes No

If yes, please specify which agencies: _____

