

CAREGIVER REGISTRY



License Application & Change Form Health Facilities Licensing and Certification

Phone: 971-673-0540 Fax: 971-673-0556

Type of Action

New Registry* <input type="checkbox"/>	Ownership Change* <input type="checkbox"/>
License Renewal* <input type="checkbox"/>	Effective Date of Change: _____
License # _____	Other <input type="checkbox"/>
Name/Address Change <input type="checkbox"/>	(Specify) _____

* Fee Payment Required (See back of this form for amount)

Registry Information

Parent Registry <input type="checkbox"/>	Branch/Subunit <input type="checkbox"/>	Registry E-Mail:
Registry Legal Name:		
Registry DBA Name (if applicable):		
Registry Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Registry Mailing Address (if different from above):		
Fiscal Year Ending Date (MM/DD) :		
Days of Operation:	Hours of Operation:	
Describe geographic service area for this parent registry/branch/subunit :		
Name of Administrator & Phone:		
Administrator Email:		
Emergency Contact Person & Phone:		
Office Hours: Days Times		

Owner Information

*(If partnership or corporation, list each person having 5% or more interest on an additional page)

Corporation <input type="checkbox"/>	Partnership <input type="checkbox"/>	Individual <input type="checkbox"/>
Other (Specify):		
Ownership Type: For Profit <input type="checkbox"/>	Non Profit <input type="checkbox"/>	Tax ID#:
Name of Owner(s)*:		
Address, City, State & ZIP of Owner(s):		
Phone:	Fax:	County:

I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct and complete. I will notify the Health Care Regulation and Quality Improvement Section, in writing, of any changes in this information within 30-days of any such change.

Administrator's Signature

Print Name

Print Title

Date (mm/dd/year)

Fee Schedule

New Registry/Subunit	\$1500 for parent/\$750 for each Subunit
Yearly Renewal/Subunit*	\$750 for parent/\$750 for each Subunit
Change of Ownership/Subunit	\$350 for parent/\$350 for each Subunit

***If renewal is desired, the licensee shall make application at least 30 days prior to the expiration date per 33-536-0025.**

**Make check payable to Oregon Health Authority and mail to:
Health Care Regulation and Quality Improvement
P.O. Box 14260
Portland, OR 97293-0260**

<p>HCRQI Office Use Only</p> <p>Effective date of initial licensure: _____ Initials: _____ Date: _____</p> <p>Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____</p> <p>Initials: _____ Date: _____</p> <p>CASH OFFICE: QC 621 initial/QC 622 renewal 50320 50470</p>
