

## Caregiver Registry Application Form

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

\* 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):		
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:		
Emergency Contact Email:		
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)**

**Person who filled out this application form**

Name:

Email:

Title:

Phone:

**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 333-535-0025.**

**Questions about this application?**

**Phone:** 971-673-0540

**Email:** [mailbox.hclc@state.or.us](mailto:mailbox.hclc@state.or.us)

**Make check payable to: Oregon Health Authority**

**Mail payment to: HFLC**

**PO Box 14260**

**Portland, OR 97293**

**HCRQI Office Use Only**

Effective date of initial licensure: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Renewal Licensure/Change: Approved: \_\_\_\_\_ Denied: \_\_\_\_\_ Withdrawn: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

CASH OFFICE: QC 621 initial/QC 622 renewal