IOWA DEPARTMENT OF INSPECTIONS, APPEALS, AND LICENSING
Health Facilities License Application

Please answer all questions completely and accurately to avoid unnecessary delays in processing. Return the completed application with the required fee to the address below 60 days prior to expiration of your current license. Note: This application is an open record and available to the public upon request. Iowa Department Inspections, Appeals, and Licensing Health Facilities Lucas State Office Building - Third Floor 321 East 12th Street Des Moines, IA 50319-0083	**FOR OFFICE USE ONLY** **Materials Received Date:** **Application Status: (circle one)** **Approved** **Denied** **Application Status Date:** **License Number:** **License Fee:** **License Type:** **Effective Date:** **Expiration Date:**

Type of Application			
☐ **New**	☐ **Renewal**	☐ **Amendment***	☐ **Change of License/Certificate Holder (Change of Ownership), Conversion**
***specify reason for amendment:**			

I. FACILITY INFORMATION		
Name of Facility		
Facility Street Address		
City	**State**	**Zip Code**

Facility Mailing Address		
City	State	Zip Code
County in which the facility is located		
Facility Telephone Number	Facility Fax Number	Facility Email Address

Intermediate, Residential, and Nursing Facility License Type and Fee Structure

☐ Nursing Facility		Intermediate, Residential, and Nursing Facilities:	
☐ CCDI Unit	_____Beds		
☐ Intermediate Care Facility for the Intellectually Disabled		☐ 10 or fewer beds	$20.00
☐ Intermediate Care Facility for the Mentally Ill		☐ 11 to 25 beds	$40.00
☐ Residential Care Facility		☐ 26 to 75 beds	$60.00
☐ ID Unit	_____Beds	☐ 76 to 150 beds	$80.00
☐ Memory Care Unit	_____Beds	☐ 151 or more beds	$100.00
☐ Residential Care Facility for the Mentally Ill		☐ 25% late fee	
☐ Specialized 3-5 Bed Facility			

Subacute Mental Health Care Facility License and Fee Structure

☐ Freestanding Subacute Mental Health Care Facility	_____Beds	☐ $25
☐ Distinct Part Subacute Mental Health Care Facility	_____Beds	

Total Licensed Bed Capacity: Current Census:	Total License Fee(s) Enclosed:

Type of Federal Certification

☐ Medicare (Title XVIII)	☐ Medicare and Medicaid (Dual Certification)
☐ Medicaid (Title XIX)	☐ No Federal Certification

II. STATE LICENSE/CERTIFICATE HOLDER

A state license or certificate is issued to the individual(s) or entity that has the authority and legal responsibility for the operation of the facility or program and authority to comply with all applicable statutes and rules. The individual(s) or entity must be the owner or lessee of the facility or program real estate.

Name

Street Address			
City		**State**	**Zip Code**
Mailing Address (if different from street address)			
City		**State**	**Zip Code**
Telephone Number		**Fax Number**	
Contact Person	**Telephone Number (if different)**	**Email Address**	
Type of Organization (e.g., corporation, LLC, LLP, etc.):			
Subsidiary Information			
Is the applicant a subsidiary company, either wholly or partially owned by another organization or business? ☐ **Yes** ☐ **No** **If Yes, please provide the following information:**			
Legal Business Name - Parent Corporation			
DBA (Doing Business As)			
Type of Ownership			
Street Address			
City		**State**	**Zip Code**
Contact Person	**Telephone Number**	**Email Address**	
Chain Organization			
Is the applicant under the control of a chain organization? ☐ **Yes** ☐ **No**			

Chain organization is defined as multiple providers, and/or suppliers owned, leased, or through any other device, controlled by a single business entity (defined as chain home office). Each entity in the chain may have a different owner but the "home office" maintains uniform procedures in each facility for handling utilization review, reimbursement, handling admissions, also maintains controls centrally, providers/suppliers cost reports, etc.

In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporation parent.

Name - Chain Organization:

Interested Parties			
List all names, principal business addresses, and the percentage of ownership interest of all officers, shareholders/members/partners with a 5% or greater ownership interest, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal address of all officers, directors, and board members. Attach additional pages and provide an organizational chart, if necessary.			
Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**
Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**
Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**
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Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**
Name	**Title**	**Ownership %**	

Street	**City**	**State**	**Zip Code**
Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**

III. REAL ESTATE OWNERS AND LESSEES			
Owner Information (if more than one, complete for each owner)			
Name - Owner			
Street Address (physical location)			
City	**State**	**Zip Code**	**County**
Mailing Address (if different from street address)			
City	**State**	**Zip Code**	**County**

Telephone Number	**Fax Number**	**Email Address**	
Contact Person		**Telephone Number**	
Type of Organization (e.g., corporation, LLC, LLP, etc.):			
List all names, principal business addresses, and the percentage of ownership interest of all officers, shareholders/members/partners with a 5% or greater ownership interest, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal address of all officers, directors, and board members. Attach additional pages and provide an organizational chart, if necessary.			

Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**
Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**

Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**
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Street	**City**	**State**	**Zip Code**
Name	**Title**	**Ownership %**	
Street	**City**	**State**	**Zip Code**

Lessee Information (if the lease includes sub-leases, complete for all parties)

Is the facility leased? ☐ **Yes** ☐ **No**

If "Yes," provide a copy of the lease agreement and continue to provide information regarding the lessee. If "No," skip to Section IV.

☐ **Lease agreement is provided along with this application.**

Name - Lessee			
Street Address (physical location)			
City	**State**	**Zip Code**	**County**
Mailing Address (if different from physical address)			
City	**State**	**Zip Code**	**County**

Telephone Number	**Fax Number**	**Email Address**

Contact Person	Telephone Number
Type of Organization (e.g., corporation, LLC, LLP, etc.):	

Interested Parties

List all names, principal business addresses, and the percentage of ownership interest of all officers, shareholders/members/partners with a 5% or greater ownership interest, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal address of all officers, directors, and board members. Attach additional pages and provide an organizational chart, if necessary.

Name	Title	Ownership %	
Street	City	State	Zip Code
Name	Title	Ownership %	
Street	City	State	Zip Code

IV. MANAGEMENT AGREEMENT

Is the operation of the facility under a management contract? ☐ Yes ☐ No

If "Yes," provide a copy of the management agreement and the following information regarding any management company retained to operate this facility or program. If "No," skip to Section V.

☐ Management agreement is provided along with the application

Name - Management Company		
Street Address		
City	State	Zip Code
Mailing Address (if different from street address)		
City	State	Zip Code
Telephone Number	Fax Number	

Contact Person	Telephone Number (if different)	Email Address
Type of Organization (e.g., corporation, LLC, LLP, etc.)		

Interested Parties			
List all names, principal business addresses, and the percentage of ownership interest of all officers, shareholders/members/partners with a 5% or greater ownership interest and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal address of all officers, directors, and board members. Attach additional pages if necessary.			
Name	Title	Ownership %	
Street	City	State	Zip Code
Name	Title	Ownership %	
Street	City	State	Zip Code

V. OTHER PROVIDERS		
Identify other health care providers licensed or certified by the State of Iowa, another state, or the federal government in which an entity or individual identified in Sections II and IV has a current ownership or managerial interest. If more than two, attach additional pages.		
Name - Provider		
City	State	Zip Code
Provider Type (e.g., nursing facility, home health agency, assisted living program, hospital, etc.)		
Name - Provider		
City	State	Zip Code
Provider Type (e.g., nursing facility, home health agency, assisted living program, hospital, etc.)		

VI. ADVERSE ACTION

Has any adverse action(s) initiated by any state licensing agency resulted in the denial, suspension, or revocation of a license held by an entity or individual identified in Sections I-V or another health care provider under the control and management of an entity or individual identified in Sections I-V?	☐ **Yes** ☐ **No**
Has any entity or individual identified in Sections I-V or another health care provider under the control and management of an entity or individual identified in Sections I-V voluntarily surrendered a license or certification while under investigation in any other state or licensing jurisdiction?	☐ **Yes** ☐ **No**
Has any adverse action initiated by another state or federal agency based on non-compliance resulted in any disciplinary action, including any civil money penalties (CMPs) or denial of payments (DOP), to an entity or individual identified in Sections I-V or another health care provider under the control and management of an entity or individual identified in Sections I-V?	☐ **Yes** ☐ **No**
Has any entity or individual identified in Sections I-V, or another health care provider under the control and management of an entity or individual identified in Sections I-V, filed for bankruptcy, been operated by a court-appointed temporary manger or receiver, or been subject to a termination of provider agreement within the last 10 years?	☐ **Yes** ☐ **No**
Does any entity or individual identified in Sections I-V, or another health care provider under the control and management of an entity or individual identified in Sections I-V, owe any money to Iowa Medicaid Enterprise and/or the Centers for Medicare & Medicaid Services (including, but not limited to, outstanding quality assurance assessment fees or civil money penalties)?	☐ **Yes** ☐ **No**
Are there any complaints, allegations, or investigations pending in any other state or licensing jurisdiction against any entity or individual identified in Sections I-V, or another health care provider under the control and management of an entity or individual identified in Sections I-V?	☐ **Yes** ☐ **No**

If "Yes" to any of the above questions, complete the following table.

Entity/Individual Name	**Street Address**	**City**	**State**	**Zip Code**
Facility Name	**Street Address**	**City**	**State**	**Zip Code**

Provider Type	**Brief Explanation of Adverse Action**

☐ **Supporting documentation regarding the resolution of any disciplinary action, complaint, allegation or investigation attached.**

Entity/Individual Name	**Street Address**	**City**	**State**	**Zip Code**
Facility Name	**Street Address**	**City**	**State**	**Zip Code**

Provider Type	Brief Explanation of Adverse Action

☐ Supporting documentation regarding the resolution of any disciplinary action, complaint, allegation or investigation attached.

Entity/Individual Name	Street Address	City	State	Zip Code
Facility Name	Street Address	City	State	Zip Code

Provider Type	Brief Explanation of Adverse Action

☐ Supporting documentation regarding the resolution of any disciplinary action, complaint, allegation or investigation attached.

Entity/Individual Name	Street Address	City	State	Zip Code
Facility Name	Street Address	City	State	Zip Code

Provider Type	Brief Explanation of Adverse Action

☐ Supporting documentation regarding the resolution of any disciplinary action, complaint, allegation or investigation attached.

VII. ADMINISTRATOR	
Name - Administrator	License Number
Indicate whether the administrator is also the designee (person authorized to accept personal service and receive registered and certified mail). If "No", complete the Designee section. ☐ Yes ☐ No	
Designee	
Name - Designee	Title
Director of Nursing	

Name	☐ Permanent ☐ Temporary

Medical Director
Name

VIII. CHILD OR DEPENDENT ADULT ABUSE
Does any owner, officer, director, trustee, supervisor, lessor, manager, administrator, or other individual identified in Sections II - VII have a record of founded child or dependent adult abuse, or have they ever been convicted of a crime in the State of Iowa or any other state?
☐ Yes ☐ No

IX. FINANCIAL SUITABILITY AND ADDITIONAL DOCUMENTS
☐ Projected cash flow and balance sheet form
☐ If change of license/certification holder (change of ownership), copy of the closing statement, purchase agreement, or lease agreement between current and proposed licensee.
☐ If required, escrow account established pursuant to Iowa Code 135C.7A(3).

X. ATTESTATION AND SIGNATURE	
I certify, under penalty of perjury, that the information contained within and submitted with this document is true and correct.	
Full Signature - Applicant/Licensee	Name - Applicant/Licensee (print or type)
Title - Applicant/Licensee	Date Signed