Mississippi State Department of Health

APPLICATION FOR LICENSURE
INSTITUTION FOR AGED OR INFIRM
LICENSURE YEAR: APRIL 1, 2018 - MARCH 31, 2019

Read the entire application carefully before completing each applicable part. Also, refer to "Minimum Standards for Personal Care Homes", as amended, where rules are cited.

NAME OF FACILITY (see Rule 48.7.3) ______________________________

ADDRESS ______________________________
Number and Street

____
City or Town Zip Code

MAILING ADDRESS (if different from physical address)

____
Post Office Box Number City or Town Zip Code

TELEPHONE NUMBER (______) ______________________

FAX NUMBER (______) ______________________

E-MAIL ADDRESS ______________________________

COUNTY ______________________

Is facility operated by individual, partnership, corporation, limited liability company, joint stock association, church, governmental unit or other?

____

a) If operated by an individual, provide full name, address and social security number:

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____

____

b) If operated by a partnership, provide full name, address and social security number of each partner:

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(c) If operated by a corporation or limited liability company, (LLC), attach a copy of the Corporate Charter and:

1) Provide full name and address of corporation or a limited liability company:

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2) Provide full name, title and address of each Officer:

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3) If a foreign corporation, provide full name and address of registered agent in Mississippi, and enclose a copy of the certificate authorizing the corporation to do business in Mississippi:

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4) Is the corporation or LLC profit or non-profit? ____________________

d) If the facility is owned by a corporation or limited liability company (LLC), list each individual person who owns five percent (5%) or more of stock, including their current mailing and/or street address and percentage of ownership. If five percent (5%) or more of such stock is owned by another corporation, furnish the same information requested herein above:

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e) If church operated, give the names and addresses of the responsible officers:

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f) If a governmental unit, give the name and address of the unit and the names and addresses of the responsible officers:

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Name, address and social security number of licensee. The licensee's name will appear on the license.

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Give the name and social security number of the person in charge of the personal care home:

____

Has the owner or operator ever been convicted of a felony? Yes ________ No ________

Classification for which application is made. (see Rule 48.5.1 and 48.5.2)

Assisted Living ________________ **Residential Living** ________________

Maximum number of beds for which the facility is eligible (see Rule 47.7.4 and 48.7.4) _____

Does facility have a designated Alzheimer's/Dementia Unit? Yes ________No ________

If yes, how many beds are in this unit? _______

Date of construction of the building: ____________________ Number of floors: ________

Is building owned, leased or rented? ____________________

If leased or rented, please provide the name and address of the owner of the building:

____

____

____

Is facility operated through a management agreement? ______________________
If so, provide the name and address of the management entity:

____

____

____

Give the name, address, and percent of ownership of each individual, and/or corporation owning at least five percent (5%) of managing entity:

____

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____

If leased, rented or under a management agreement, enclose a copy of the agreement(s).

If a record of inspection by the Fire Department has not been submitted to this office within the last six (6) months, please enclose a copy of the report.

Is this application for INITIAL LICENSURE or for LICENSE RENEWAL? __________

If this is an initial application, please list the names and addresses of three (3) persons for references.

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Enclose a check or money order, made payable to Mississippi State Department of Health, for the licensure fee. The licensure fee is $17.25 per bed with a $115.00 minimum.

I certify that the information contained herein is accurate, and hereby request licensure as indicated. I agree not to modify the structure, location, services, or designation of license without prior consultation with an approval by the Bureau of Licensure and Certification of the Mississippi Department of Health.

APPLICANT'S SIGNATURE: ______________________________

TITLE: ______________________________

DATE: ______________________

Mail to:

Mississippi State Department of Health
Bureau of Health Facilities
Licensure and Certification
Post Office Box 1700
Jackson, Mississippi 39215-1700