CABINET FOR HEALTH AND FAMILY SERVICES
Office of the Inspector General

OIG-20:480, November 2022

Application for Licensure to Operate an Assisted Living Community

- If you have questions regarding this application, please call (502) 564–7963.
- Please answer all questions completely and accurately. Supporting documentation and payment of the applicable licensure fee must be attached. An incomplete or illegible application will be returned without being processed.
- This application, supporting documentation, and payment of any applicable fee shall be submitted:
    - At least 60 days prior to a planned opening, annual renewal, the addition of living units, or voluntary termination of operations;
    - At least 10 calendar days prior to a name change, change of ownership, or change of managing agent; and
    - Prior to a change of location.

The undersigned hereby seeks licensure to operate a social model assisted living community (ALC), assisted living community that provides basic health or health-related services (ALC-BH), or assisted living community that provides assisted living services and dementia care services in a secured dementia care unit (ALC-DC) subject to the requirements of KRS 194A.700—194A.729 and 902 KAR 20:480.

A. Type of Application

☐ Provisional, Initial Licensure
☐ Annual Re-licensure
☐ Change of Name
☐ Change of Location
☐ Change of Ownership
☐ Request for Additional Living Units

B. Licensure Category

☐ Social Model Assisted Living Community (ALC)
☐ Basic Health Care Model Assisted Living Community (ALC-BH)
☐ Assisted Living Community with Secured Dementia Unit (ALC-DC)

C. Identification

1. Assumed Name/"Doing Business As" Name ______________________________

2. Legal Name as Registered with KY Secretary of State ______________________________

3. Facility Street Address ______________________________
(P.O. Box without a street address is not acceptable.)

4. City/State/Zip ______________________________

5. Telephone Number ______________________ Email Address ______________________

6. Fax Number ______________________________

7. Name of county in which the facility is located ______________________________

8. License Number ______________________________
(Do not fill in if this is an application for a provisional, initial license.)

9. Name of Designated Manager (Director) ______________________________

10. Email of Designated Manager (Director) ______________________________

D. Ownership and Controlling Interest

For Profit	**Non Profit**
☐ Individual	☐ Church-related
☐ Partnership	☐ Individual
☐ Corporation	☐ Partnership
☐ Group	☐ Corporation
☐ Limited Liability Company	☐ Limited Liability Company
☐ Sole Proprietorship	☐ Other Nonprofit Ownership ______________
☐ Other ______________	

1. List the name of the corporation, association, person, or partners legally responsible for the operation of this ALC, ALC-BH, or ALC-DC.

   ____

2. Federal ID # ______________________ State Tax ID # ______________________

3. If a corporation, list the date and place of incorporation ______________________

   Attach a Certificate of Authority to do business in Kentucky if incorporated in another state.

4. If a corporation, attach copies of articles of incorporation and current by-laws.

5. President ______________________________

6. Agent(s) ______________________________
   (Individual(s) authorized to transact business with the Cabinet for Health and Family Services and upon whom all notices and orders shall be served. Include address if different from the above address. Please attach another sheet of paper if necessary.)

   Address ______________________ City, State, Zip ______________________

E. Managing Agent (if different from owner)

The licensee must submit a copy of the management agreement.

Managing Agent's Name ____

Email Address ____________________ City, State, Zip ____________________

Please complete the following if reporting a change of managing agents and provide a copy of the new management agreement.

Previous Managing Agent's Name ______________________________________

New Managing Agent's Name ____

New Managing Agent's Email ____

New Managing Agent's Physical Address ________________________________
(City, State, Zip)

F. Officers and Members of Governing Body

Attach names and addresses of officers and members of the governing body, if applicable.

☐ Check if not applicable.

G. Number of Living Units

Provisional licensure: Please check licensure category for which you are applying and number of living units requested.

Re-licensure: Please check licensure category to be re-licensed and number of living units currently licensed.

Addition of living units: Please check appropriate licensure category and enter the number of living units you are requesting to be added to your license.

License Category:	Number of Living Units	Number of Additional Living Units Requested
☐ ALC	____________	____________
☐ ALC-BH	____________	____________
☐ ALC-DC	____________	____________

H. Application Contact Information: Provide legal name and contact information of the individual the Office of Inspector General can contact regarding questions about this application.

Name ________________________ Title ________________________

Telephone Number ____________________ Email Address ____________________

I. Specific Information

1. If an individual(s) with a significant financial interest in the facility holds other licenses, please list all licenses below.

____

2. Has any individual with a "significant financial interest" in the prospective or existing ALC, ALC-BH, or ALC-DC had a "significant financial interest" in an out-of-state or a Kentucky-licensed health facility or health service, or other entity regulated by the Cabinet for Health and Family Services in which the facility had its licensure, certification, or registration denied, suspended, or revoked, or voluntarily relinquished as the result of an investigation or adverse action that placed residents, patients, or clients at risk of death or serious harm?

   "Significant financial interest" is defined as lawful ownership of an out-of-state or a Kentucky-licensed health facility or health service, or any other entity regulated by the cabinet, whether by share, contribution, or otherwise in an amount equal to or greater than twenty-five (25) percent of total ownership of the health facility, health service, or other entity regulated by the cabinet.

   ☐ No ☐ Yes, if "yes" please list name of facility, service, or entity:________________________

J. Provisional, Initial License:

If applying for a provisional, initial license as an ALC, ALC-BH, or as an ALC-DC that did not have a dementia unit in operation prior to July 14, 2022, the applicant shall provide documentation to the OIG of its compliance history for any other care facility the applicant operates, including a copy of all enforcement action issued by the regulatory agency against the facility.

Therefore, please submit a copy of all violations, fines, or negative action taken by the regulatory agency against the facility's license during the prior seven (7) year period.

ALC, ALC-BH, or ALC-DC CONTROLLING PERSON INFORMATION

Legal Entity ___________________________________ Phone ___________________________________

Name of ALC, ALC-BH, or ALC-DC ________________________ Address________________________

City ____ State _____________ Zip ___________________

Date Completed _____________ Manager/Director___________________ Email ___________________

All Applicants:

Please provide the names, titles, and addresses of all individuals with a significant financial interest in the facility and their percent of ownership.

Name of Individual	Title	Address (Street, City, Zip)	Percent of Ownership if Proprietary (For Profit)

K. Assisted Living Communities with Dementia Care (ALC-DC) Requirements

This section must be completed by:

(1) Entities applying for provisional, initial licensure as an ALC-DC upon adoption of 902 KAR 20:480; or

(2) Existing ALCs seeking licensure as an ALC-DC.

Do not complete this section if seeking licensure or renewal as an ALC that does not provide dementia care services.

Kentucky law, KRS 194A.700(10), defines "dementia" as the loss of cognitive function, including the ability to think, remember, problem solve, or reason, of sufficient severity to interfere with an individual's daily function. Dementia is caused by different diseases and conditions, including but not limited to Alzheimer's disease, vascular dementia, neurodegenerative conditions, Creutzfeldt-Jakob disease, and Huntington's disease.

Does the applicant or its principals have experience managing residents with dementia?

☐ Yes. The applicant or its principals were operating a Kentucky-certified ALC with a dementia care unit as of July 14, 2022 and have education and experience in managing residents with dementia or other dementia illnesses and disorders.

☐ No. Pursuant to KRS 194A.7061(2), the applicant shall employ or contract with a consultant for at least the first six (6) months of operation. The consultant shall make recommendations on providing dementia care services consistent with the requirements of KRS 194A.700 – 194A.729. The consultant shall:

- Possess two (2) years of work experience related to dementia, health care, gerontology, or an associated field; and
- Have completed at least the core training required by KRS 194A.7205.

L. Documentation

Documentation to be submitted with the application. *(Re-submission of these documents is not required as part of the annual re-licensure application <u>unless</u> they are different from the original documents submitted at the time of provisional, initial licensure.)*

The following documents must be received before your application is considered complete:

- Proof of approval by the State Fire Marshal's office.
- Copy of a blank lease agreement, including any documentation incorporated in the agreement.
- An organizational chart that identifies all entities and individuals with a significant financial interest in the prospective or existing licensee, including the relationship with the licensee and with each other.
- A description of any special programming that may be provided in accordance with KRS 194A.713(11).
- A copy of the floor plan that identifies living units, central dining, laundry facility, and central living room.

A non-refundable fee based on the following fee schedule must accompany this application for: (1) provisional, initial licensure; (2) annual re-licensure; or (3) a change of location.

Number of Units	Fee
<25	$500 + $40 per unit
25-49	$1,000 + $40 per unit
50-74	$1,500 + $40 per unit
75-99	$1,750 + $40 per unit
100 or more	$2,000 + $40 per unit

A non-refundable fee based on the following fee schedule must accompany this application for a change of status as follows:

Change of Status	Fee
Name Change	$25
Change of Managing Agent	$25
Change of Ownership	$500
Request for additional living units	$60 per additional living unit

Please return the application, required documents, and the non-refundable fee payable to the Kentucky State Treasurer to:

Cabinet for Health and Family Services
Office of Inspector General
Division of Health Care
275 E. Main St., 5 E-A
Frankfort, KY 40621

M. Verification

I understand that I am required to report any change in the information provided within this application to the Office of Inspector General and complete a new application at that time. I agree that this facility and all aspects of its operation shall be open at all times during regular business hours to allow state agency personnel entrance upon its premises for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application shall result in the denial or revocation of licensure.

______________________________	______________________________
Signature of Authorized Representative	Title
______________________________	______________________________
Name (please print or type)	Date