

IV. OWNERSHIP Name and address of direct owner

NOTE: Provide the following supporting documentation as an attachment to this application:

- The name, mailing address, email address and phone number of each person having at least a twenty-five (25) percent ownership interest in the facility;
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation;
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

V. LICENSURE TYPE

Initial licensure applications: Please check all license types for which you are applying and the number of beds requested.

Re-licensure applications: Please check all license types for which you are re-licensing and the number of beds currently licensed.

Addition of beds: Please check all license types for which you are licensed, enter the number of beds as specified on your facility's current license, and enter the number of beds you are requesting to add to a particular license.

LICENSE TYPE	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
<input type="checkbox"/> Nursing Facility (NF)	_____	_____
<input type="checkbox"/> Alzheimer's Nursing Home (ALZ)	_____	_____
<input type="checkbox"/> Nursing Home (NH)	_____	_____
<input type="checkbox"/> Intermediate Care Facility (ICF)	_____	_____
<input type="checkbox"/> Personal Care Home	_____	_____
<input type="checkbox"/> Intermediate Care Facility for Individuals with an Intellectual or Developmental Disability (ICF/IID)	_____	_____

An incomplete application or failure to submit the applicable licensure fee may result in return of the application to the applicant. A completed application should not be submitted to the Office of Inspector General until the facility is ready for an inspection.

I understand that **any change** in the information provided in within this application affecting the licensure status of this facility or service will be reported to the Office of Inspector General and **a new application** will be completed at that time. I agree that this facility/service and all aspects of its operation shall allow all state agency licensure 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 may result in denial or revocation of licensure.

Signature of Authorized Representative

Title

Date

Submit the application, fee and supportive documentation to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621