

Application for License to Operate a Family Care Home

OIG 007 – January 2017 Edition

I. TYPE OF APPLICATION

(Write or type an X next to all that apply.)

Provisional Licensure Change of Name
 Annual Re-licensure Change of Location
 Change in licensed capacity Change of Ownership

II. IDENTIFICATION

License Number _____
(Do not fill in License Number if this is an application for provisional licensure)

Name of Facility _____

Physical Location of Facility _____
(Street) (City)

(County) (State) (Zip Code)

Mailing Address _____
(If different from above) (Street) (City)

(County) (State) (Zip Code)

Telephone Number _____

Email Address _____
(Primary contact for correspondence)

Administrator Name _____

Date home began operating at current address _____

Number of years of education of the operator requesting licensure _____

Is/are person(s) operating this home employed outside this home: YES NO
If yes, indicate number of hours outside the home: _____

Have you been convicted of violation of any law within the past five (5) years: YES NO
If yes, explain: _____

III. LICENSED CAPACITY REQUESTED: TWO THREE

IV. PERSONS WHO RESIDE IN THIS HOME:

NAME	AGE	DETAIL RELATIONSHIP TO OPERATOR: FAMILY MEMBER, PATIENT, OR OTHER. IF OTHER, DESCRIBE.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. PERSONS WHO RESIDE IN THIS HOME (continued):

NAME	AGE	DETAIL RELATIONSHIP TO OPERATOR: FAMILY MEMBER, PATIENT, OR OTHER. IF OTHER, DESCRIBE.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

An incomplete application or failure to submit the required 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 as a condition precedent to provisional licensure, this facility shall be in compliance with all state and federal statutes and administrative regulations applicable to the license requested.

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

For Office Use Only: Check # _____ Amount _____