

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES  
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION  
APPLICATION ADULT CARE HOME LICENSE

PART I

The undersigned hereby applies to the Kansas Department for Aging and Disability Services for a license to operate an adult care home subject to the provisions of Kansas law.

Applicants for adult care home licenses are reminded that K.S.A 39-938 requires compliance with applicable rules and regulations of the secretary for aging and disability services and the state fire marshal, and any other agency of government for adult care homes, their buildings, operators, staff, facilities, maintenance, operation, conduct, and the care and treatment of residents. To check for compliance with regulations and ordinances such as local building codes and zoning requirements, the owners and operators of adult care homes may wish to seek counsel from their attorney, architect, contractor, or other appropriate professional.

REASON (mark with "X")	<input type="checkbox"/> INITIAL	<input type="checkbox"/> CHANGE OF OWNERSHIP	<input type="checkbox"/> AMENDED
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A. Legal Business Name as reported to the Internal Revenue Service (not the "Doing Business As" name)

\_\_\_\_\_

Other Name: \_\_\_\_\_

Type of Other Name

Former Legal Business Name  Doing Business As Name  Other (Specify): \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip (9-digit) \_\_\_\_\_ County \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_ Federal Tax ID # \_\_\_\_\_

**B. Administration**

Administrator's Name \_\_\_\_\_ License No. \_\_\_\_\_

Administrator's Email \_\_\_\_\_

Operator's Name \_\_\_\_\_ Registration No. \_\_\_\_\_

Operator's Email \_\_\_\_\_

**C. License Category**

Nursing Facility Beds \_\_\_\_\_

Assisted Living Facility Beds \_\_\_\_\_

Residential Health Care Facility Beds \_\_\_\_\_

Nursing Facility for Mental Health Beds \_\_\_\_\_

Home Plus \_\_\_\_\_

Adult Day Care \_\_\_\_\_

Total Number of Licensed beds \_\_\_\_\_

**D. Surety Bond Information (Nursing Facilities only)**

Name of Surety Bond Insurance Co \_\_\_\_\_

Amount of Surety Bond \$ \_\_\_\_\_

**E. Professional Liability Insurance Company  
(Nursing/Assisted Living/Residential Health Care Facilities only)**

Name of Professional Liability Insurance Co _____
Amount of Professional Liability Insurance \$ _____

F. Name, address & Federal Tax ID# of Owner(s) of Building/ Premises and name and phone number of Contact Person  
(a copy of the deed must be attached when filing "initial" application or change of ownership.)

\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

G. Name, address & Federal Tax ID # of Lessee or Contract Purchaser and name and phone number of Contact Person  
**\*\*Please note that any entity defined at KSA 39-923 (a)(15) below should be included\*\***

\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

H. Name, address & Federal Tax ID # of Sublessees and name and phone number of Contact Person  
**\*\*Please note that any entity defined at KSA 39-923 (a)(15) below should be included\*\***

\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

I. Name, address & Federal Tax ID # of Management Firm who Operates Facility and name and phone number of Contact Person  
**\*\*Please note that any entity defined at KSA 39-923 (a)(15) below should be included\*\***

\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

J. Name, address & Federal Tax ID # of any other Entities involved in the operation or management of the Adult Care Home  
**\*\*Please note that any entity defined at KSA 39-923 (a)(15) below should be included\*\***

\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone No. \_\_\_\_\_

**KSA 39-923 (a)(15)** "Operate an adult care home" means to own, lease, sublease, establish, maintain, conduct the affairs of or manage an adult care home, except that for the purposes of this definition the word "own" and the word "lease" shall not include hospital districts, cities and counties that hold title to an adult care home purchased or constructed through the sale of bonds.

K. Was the building financed by an industrial revenue bond?  Yes  No

If yes, give name and address of the government agency: \_\_\_\_\_  
Expiration date of bonds: \_\_\_\_\_

L. **Attach completed Part II for each entity that appears on lines F, G, H, I or J.**

M. Submit Fee

The fee to operate an Adult Care Home is \$100.00 plus \$30.00 for each bed. Payment shall be made payable to The Kansas Department for Aging and Disability Services. Please return completed form and payment to: Kansas Department for Aging and Disability Services, Survey, Certification and Credentialing Commission, 503 S. Kansas Ave, Topeka, Kansas 66603.

The undersigned is authorized to represent all licensees:

I have read the contents of this application. My signature legally and financially binds this licensee to the laws, regulations, and program instructions of the State of Kansas. By my signature, I certify that the information contained herein and attached hereto is true, correct, and complete, and I authorize the State of Kansas to verify this information.

Signature and Title \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

License Effective Date \_\_\_\_\_ License ID Number \_\_\_\_\_

License Status \_\_\_\_\_ Annual Report Due Date \_\_\_\_\_ Approved by \_\_\_\_\_

PART II

- A. Facility Name Address City/Zip
- B. Business Entity's Name \_\_\_\_\_
- C. Type of Entity     1. Sole Proprietorship         2. Partnership         3. Joint Venture  
 4. Corporation for profit         5. Corporation not-for-profit  
 6. Limited Liability Company     7. Other (explain) \_\_\_\_\_  
 8. Government – Type \_\_\_\_\_
- D. Give the Resident Agent's name and address as filed/registered with the Secretary of State's Office for the disclosing entity listed on Line B of this form. Contact the Secretary of State's Office at (785) 296-4564 to verify this information.

Resident Agent Address

City State Zip

Complete the boxes below with the information as follows for the disclosing entity listed on Line B above.

- List the name(s) and address(es) of each person who has any direct or indirect ownership in the business entity listed above.
- List each person who is the owner (in whole or in part) of any mortgage, deed or trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- If the business entity is organized as a corporation, attach a list showing the names and addresses of each officer and director.
- If the business entity is organized as a limited partnership or limited liability company, please describe each limited liability for each owner and for all general partners.
- If the business entity is a government unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. OWNER	2. MORTGAGOR	3. DIRECTOR/OFFICER	4. LIMITED LIABILITY <i>Describe for each limited partnership and LLC the limited liability for each 5% owner and for all general partners.</i>	5. ELECTED OFFICIALS				

The following is the legal signature and title of the individual authorized to represent the governing body, corporation, partnership, joint venture, individual or organization in the operation of the facility by the business entity.

Signature and Title Print Name Date

Address Phone Number