NEW JERSEY DEPARTMENT OF COMMUNITY AFFAIRS
DIVISION OF CODES AND STANDARDS – BRBHS
PO BOX 804
TRENTON, NEW JERSEY 08625-804
(609) 984-1706

APPLICATION FOR RESIDENTIAL HEALTH CARE FACILITY

TYPE OF APPLICATION ☐ New – CN# ____________ ☐ New – No CN Required, ID# ____________ ☐ Transfer of Ownership # ____________ ☐ Other ____________	DATE OF APPLICATION: CHECK/MONEY ORDER NO:	DATE OF CHECK/MO: AMOUNT OF CHECK/ MO:	
OFFICIAL NAME OF FACILITY (Provider Name):		EIN NUMBER	
SITE ADDRESS:			
CITY:	STATE:	ZIP	COUNTY:
TELEPHONE NUMBER:	FAX NUMBER		EMAIL ADDRESS:
NAME OF ADMINSTRATOR:			LICENSE NUMBER (LNHA/CALA IF APPLICABLE)
EMERGENCY CONTACT:			
TELEPHONE NUMBER:	FAX NUMBER		EMAIL ADDRESS:
MAILING ADDRESS (if different from above)			
CITY:	STATE:	ZIP	COUNTY:
OWNER/CORPORATION NAME (Licensed Operator)		EIN NUMBER	
Doing Business As (if Applicable)			
ADDRESS:			
CITY:	STATE:	ZIP	COUNTY:
TELEPHONE NUMBER:	FAX NUMBER		EMAIL ADDRESS:
MANAGEMENT COMPANY (If Applicable)			
Doing Business As (if Applicable)		CONTACT PERSON	
ADDRESS:			
CITY:	STATE:	ZIP	COUNTY:
TELEPHONE NUMBER:	FAX NUMBER		EMAIL ADDRESS:

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OFFICIAL NAME OF FACILITY (Provider Name):	EIN NUMBER
ENTER THE NUMBER OF RESIENTIAL HEALTH CARE BEDS AT THIS LOCATION: ______________	

TYPE OF OWNERSHIP (CHECK ONE):

☐ FOR PROFIT ☐ NON- PROFIT ☐ FACILITY IS HOSPITAL BASED
☐ CORPORATION ☐ PROPRIETORSHIP ☐ LIMITED LIABILITY CORP.
☐ PARTNERSHIP ☐ LIMITED PARTNERSHIP ☐ RELIGIOUS AFFILIATION

☐ GOVERNMENT OWNED
☐ FEDERAL ☐ STATE ☐ CITY
☐COUNTY ☐HOSPITAL DISTRICT
☐CITY/COUNTY

☐ OTHER (SPECIFY): ____

(IF THE CORPORATE ENTITY IS A WHOLLY-OWNED SUBSIDIARY, IDENTIFY THE PARENT CORPORATION BELOW)

NAME: ____

ADDRESS: ____

CITY, STATE, ZIP CODE: ____

BUILDING OWNERSHIP (CHECK ONE)

☐ WHOLLY OWNED BY LICENSED OPERATOR IDENTIFIED ON PAGE ONE
☐ LEASED (IDENTIFY OWNER OF PHYSICAL ASSETS AND SUBMIT A COPY OF SIGNED LEASE)

____

____

____

NAME AND TITLE OF INDIVIDUAL OF CURRENT REGISTERED AGENT UPON WHOM ORDERS MAY BE SERVED *(MUST BE A NJ RESIDENT)*

NAME: ____

ADDRESS: ____

CITY, STATE, ZIP CODE: ____

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OFFICAL NAME OF FACILITY (PROVIDER NAME)	EIN NUMBER

OWNERS, OFFICERS, PARTNERS, STOCKHOLDERS, OR CORPORATE OFFICERS

- IDENTIFY 100% OF THE OWNERSHIP BELOW. (ATTACH ADDITIONAL SHEETS IF NECESSARY)
- FOR A PUBLICLY-HELD CORPORATION, IDENTIFY ALL STOCKHOLDERS WITH 10% OR MORE OF THE OUTSTANDING STOCK.
- IF AN OWNER, PARTNER OR SHAREHOLDER IS AN ENTITY, RATHER THAN AN INDIVIDUAL, PROVIDE THE INDIVIDUAL OWNERSHIP OF THAT ENTITY AS WELL.
- FOR NON-PROFIT ENTITIES, LIST BOARD MEMBERS.

<table>
<tr><td>NAME: ____
TITLE: ____
ADDRESS: ____
CITY: ____
STATE: ____ ZIP CODE: ____
SSN/TAX ID: ____
% OF OWNERSHIP: ____
☐ PROPRIETOR ☐ LIMITED PARTNER ☐ PARTNER
☐ STOCKHOLDER ☐ GENERAL PARTNER
☐ LLC MEMBER ☐ CORPORATE OFFICER</td><td>NAME: ____
TITLE: ____
ADDRESS: ____
CITY: ____
STATE: ____ ZIP CODE: ____
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% OF OWNERSHIP: ____
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OFFICIAL NAME OF FACILITY (PROVIDER NAME)	EIN NUMBER:

Please answer the following questions. (Attach additional sheets if necessary.)

1. Have you or any person mentioned in this application ever had an interest, directly or indirectly, in any application for health care facility in New Jersey or any other state which was denied or revoked?

   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   ____

2. Do any of the principals have ownership, management or operational interest in any other licensed health care facility in New Jersey or any other state?

   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   ____

3. Are you related to any person who now operates or has ever operated a health care facility in New Jersey or elsewhere?

   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   ____

4. Have any principals, owner's operators or manager of the facility ever been found guilty of a criminal or administrative charge of resident fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge?

   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   ____

5. Have any principals, owners, operators or managers of the facility ever been indicted for or convicted for a felony crime?

   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   ____

CERTIFICATION

1. That all information contained in this application and attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties
2. That the application been duly authorized by the governing body of the applicant: and
3. That the facility has been and will be operated in accordance with applicable licensing requirements.

Name of Authorized Individual Completing Application (Print or Type)	Title:
Signature:	**Date:**