NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

For Office of LTC use only	
Approval date:	
License number:	
License expiration date:	

Alzheimer's Special Care Unit Disclosure And Memory Care Endorsement Application

Please read the following instructions for assistance in completing the Alzheimer's Disclosure Form:
1. Open the attached application and complete it electronically.
2. All five sections of the application must be completed on the form. The boxes for A through J in section 5 "Disclosure Information" are expandable. All of your information will fit under each area, therefore, additional documents are not necessary.
3. Please obtain the authorized representative's signature, scan and email the form for Department review to: dhhs.healthcarefacilities@nebraska.gov
4. Please retain a copy of the form for your records.

1. License type (Select one)

☐ Alzheimer's/Special Care Unit Disclosure
☐ Alzheimer's Memory Care Endorsement (For Assisted Living Facilities Only)

2. Type of application (Select one)

☐ Initial Projected Opening Date: _____
☐ Renewal License #_____
☐ Change of ownership

3. Facility information

Name of facility: _____
(Doing Business As (DBA) name registered with Secretary of State)
Phone: _____ FAX: _____ Facility E-mail: _____
Street address: _____
City, State, ZIP: _____ County: _____
Mailing address: _____
Administrator: _____
Maximum Capacity for Alzheimer's Beds

4. Applicant information

☐ Owner (licensee) ☐ Management

Name of legal owning entity: _____
(Exactly as registered with the Secretary of State)
Contact name: _____
Phone: _____ FAX: _____ E-mail: _____
Street address: _____
City, State, ZIP:

5. Disclosure information

Please attach additional page if needed.

A) Overall philosophy and mission:

B) Criteria for placement in, transfer to:

C) Criteria for discharge:

D) Process for assessment and establishing the plan of care:

E) Staffing numbers/pattern for each shift:
Staffing (8 or 12 hour shifts?):
Position: LPN/MA/NA
Number/type of Staff present:
Shift:

F) Staff training and continuing education including four (4) hours related to dementia care and training for cultural competencies:

G) Physical environment and features, including security features:

H) Resident activities related to dementia care:

I) Family support program:

J) Cost/Fees of care:

Applicant Signature

I, the undersigned, an authorized representative of the applicant declare to the best of my knowledge this information is true, correct and complete. By knowingly and willfully failing to fully disclose the information requested may result in denial of application.

(Print Name of authorized representative)	*(Date)*
(Signature)	*(Date)*