Department of Health & Human Services
DHHS
NEBRASKA

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

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

1. License type (Select one)

☐ Alzheimer Special Care Unit Disclosure only
☐ Alzheimer Special Care Unit Disclosure and Memory Care Endorsement

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)
Facility
Phone: _____ FAX: _____ E-mail: _____
Street address: _____
City, State, ZIP: _____ County: _____
Mailing address: _____
Administrator: _____
Maximum endorsed capacity:

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:

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)*

Send completed application to:

Office of Long Term Care Facilities
PO Box 94986
301 Centennial Mall South
Lincoln NE 68509-4986

Or to dhhs.healthcarefacilities@nebraska.gov

If you have questions, email dhhs.healthcarefacilities@nebraska.gov

Or call (402) 471-3324

Note: A Memory Care Endorsement will not be approved until all requirements for the facility's license and endorsement have been met.