

|                              |         |
|------------------------------|---------|
| <b>Make Payment to HHSRL</b> |         |
| Initial Fees:                |         |
| 1-50 Beds                    | \$1,550 |
| 51-100 Beds                  | \$1,750 |
| 101 or more beds             | \$1,950 |

**NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC HEALTH  
LICENSURE UNIT**

|  |
|--|
| Check one:<br><input type="radio"/> Initial License<br><input type="radio"/> Change of Location<br><input type="radio"/> Change of Ownership |
|--|

**Nursing Home Licensure Application**

Nursing Home Type: Please Check **This form may be filled out on-line and mailed to Regulation and Licensure**

- Skilled Nursing Facility
  Nursing Facility
  Intermediate Care Facility

**IDENTIFYING INFORMATION**

1. NAME OF FACILITY: \_\_\_\_\_ AREA CODE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ AREA CODE \_\_\_\_\_ FAX NUMBER \_\_\_\_\_  
 (STREET ADDRESS, CITY, ZIP)
2. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: \_\_\_\_\_  
 (IF NOT INDIVIDUAL)
3. ADMINISTRATOR: \_\_\_\_\_ DIRECTOR OF NURSING \_\_\_\_\_
4. PREFERRED MAILING ADDRESS FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:  
 \_\_\_\_\_
5. NUMBER OF BEDS TO BE LICENSED: \_\_\_\_\_
6. PLANNED OCCUPANCY DATE: \_\_\_\_\_
7. ACCREDITATION/CERTIFICATION: (check if applicable) JCAHO  AOA  CARF  Medicare or Medicaid   
 Are you requesting deemed status? Yes  No
8. SPECIFY ANY SPECIAL CARE AND TREATMENT TO BE PROVIDED: Please Check.
- Physical Therapy
  Special Care Unit
  Other Behavioral Needs  
 Pediatric
  Respiratory
  Other-please specify \_\_\_\_\_

**OWNERSHIP INFORMATION**

9. OWNERSHIP OF FACILITY: \_\_\_\_\_  
 (LEGAL NAME OF CORPORATION, PARTNERSHIP, ETC.)  
 ADDRESS: \_\_\_\_\_  
 (STREET ADDRESS, CITY, ZIP)
10. MAILING ADDRESS OF OWNERSHIP: \_\_\_\_\_  
 (IF DIFFERENT THAN ABOVE)
11. BUSINESS ORGANIZATION: (Check one)
- |  |
|--|
| (check one)<br><input type="radio"/> Profit <input type="radio"/> Non Profit |
|--|
- Sole Proprietorship  
 Partnership  
 Limited Partnership  
 Corporation  
 Limited Liability Company  
 Governmental ( State,  District,  County,  City or Municipal)  
 Other (Please Specify) \_\_\_\_\_

**CERTIFICATION**

I/we have read the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application and on the attached documents are true and correct and I/we hereby apply for a license. PLEASE NOTE: In Neb.Rev.Stat. Section 71-433 "Applications shall be signed by (1) the owner, if the applicant is an individual or partnership, (2) two of its members, if the applicant is a limited liability company, (3) two of its officers, if the applicant is a corporation, or (4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit."

Sign Here \_\_\_\_\_ AUTHORIZED REPRESENTATIVE \_\_\_\_\_ AUTHORIZED REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_

Sign Here \_\_\_\_\_ AUTHORIZED REPRESENTATIVE \_\_\_\_\_ AUTHORIZED REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_