

Expiration Date:

STATE OF NEBRASKA – Department of Health and Human Services Division of Public Health – Licensure Unit P.O. Box 94669, Lincoln, NE 68509-4669

Assisted-Living Facility Licensure Renewal Application

This form may be filled out online and mailed to DHHS Licensure Unit at the address listed above.

Check one:
☐ Renew License
☐ Change of Location
☐ Change of Ownership

Renewal Licensure Fees:				
1 – 10 beds	\$950			
11 – 20 beds	\$1,450			
21 – 50 beds	\$1,650			
51 or more	\$1,950			
Make payment to DHHS				

NAME AND ADDRESS OF FACILITY: 2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACIL ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT LICENSE NUMBER: TELEPHONE NUMBER: TELEPHONE NUMBER: FAX NUMBER: ADMINISTRATOR: EMAIL ADDRESS: FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: TOTAL NUMBER OF BEDS TO BE RELICENSED: SPECIFY SPECIAL POPULATIONS (Please Check): Provides Complex Nursing Intervention ACCREDITATION: (Check if Applicable): Are you requesting deemed status for compliance with 175 NAC 4-006? Yes No Name of Accreditation Organization: OWNERSHIP INFORMATION OWNERSHIP OF FACILITY: MAILING ADDRESS OF OWNERSHIP: BUSINESS ORGANIZATION (Check One): Sole Proprietorship Partnership Corporation Limited Partnership Corporation Limited Liability Company Government (If Government, Please Select One): State District CERTIFICATION VERSHIP OF Health & Human Services and will comply with them should average the read the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should average the read the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should average the read the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should average the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should average the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should average the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should average the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should average them the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should average them the Rules and Regulations issued by the Ne	IDENTIFYII	ING INFORMATION
LICENSE NUMBER: TELEPHONE NUMBER:		ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM
LICENSE NUMBER: TELEPHONE NUMBER: FAX NUMBER: ADMINISTRATOR: EMAIL ADDRESS: FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: TOTAL NUMBER OF BEDS TO BE RELICENSED: SPECIFY SPECIAL POPULATIONS (Please Check):		
TELEPHONE NUMBER: FAX NUMBER: ADMINISTRATOR: EMAIL ADDRESS: FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: TOTAL NUMBER OF BEDS TO BE RELICENSED: SPECIFY SPECIAL POPULATIONS (Please Check):	LICENSE NUMBER:	
ADMINISTRATOR: EMAIL ADDRESS: FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: TOTAL NUMBER OF BEDS TO BE RELICENSED: SPECIFY SPECIAL POPULATIONS (Please Check): Alzheimer's/Special Care Unit Number of Beds: Provides Complex Nursing Intervention ACCREDITATION: (Check if Applicable): Are you requesting deemed status for compliance with 175 NAC 4-006? Yes No Name of Accreditation Organization: OWNERSHIP INFORMATION OWNERSHIP OF FACILITY: (Legal Name of Corporation, Partnership, Etc.) BUSINESS ORGANIZATION (Check One): Sole Proprietorship (Check One): Definited Partnership (Check One): Limited Partnership Corporation Limited Liability Company Government (If Government, Please Select One): State District County City or Municipal Other (Please Specify):	TELEPHONE NUMBER:	
EMAIL ADDRESS: FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: TOTAL NUMBER OF BEDS TO BE RELICENSED: SPECIFY SPECIAL POPULATIONS (Please Check): Alzheimer's/Special Care Unit Provides Complex Nursing Intervention ACCREDITATION: (Check if Applicable): Are you requesting deemed status for compliance with 175 NAC 4-006? Yes No Name of Accreditation Organization: OWNERSHIP INFORMATION OWNERSHIP OF FACILITY: MAILING ADDRESS OF OWNERSHIP: BUSINESS ORGANIZATION (Check One): Sole Proprietorship Partnership Corporation Limited Partnership Corporation Limited Partnership Government (If Government, Please Select One): CERTIFICATION CERTIFICATION	A DA AIAUCTO A TOD	
FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: TOTAL NUMBER OF BEDS TO BE RELICENSED: SPECIFY SPECIAL POPULATIONS (Please Check): Alzheimer's/Special Care Unit Provides Complex Nursing Intervention ACCREDITATION: (Check if Applicable): Are you requesting deemed status for compliance with 175 NAC 4-006? Yes No Name of Accreditation Organization: OWNERSHIP INFORMATION OWNERSHIP OF FACILITY: (Legal Name of Corporation, Partnership, Etc.) BUSINESS ORGANIZATION (Check One): Sole Proprietorship Partnership Partnership Corporation Limited Partnership Government (If Government, Please Select One): State Other (Please Specify): CERTIFICATION	EMAIL ADDDECC:	
TOTAL NUMBER OF BEDS TO BE RELICENSED: SPECIFY SPECIAL POPULATIONS (Please Check): Alzheimer's/Special Care Unit Provides Complex Nursing Intervention ACCREDITATION: (Check if Applicable): Are you requesting deemed status for compliance with 175 NAC 4-006? Yes No Name of Accreditation Organization: OWNERSHIP INFORMATION		
SPECIFY SPECIAL POPULATIONS (Please Check): Alzheimer's/Special Care Unit		
Name of Accreditation Organization: OWNERSHIP INFORMATION	. SPECIFY SPECIAL POPULATIONS (Please Check):	
Name of Accreditation Organization: OWNERSHIP INFORMATION	ACCREDITATION: (Check if Applicable): Are you requesting de	eemed status for compliance with 175 NAC 4-006? Yes No
OWNERSHIP INFORMATION OWNERSHIP OF FACILITY: (Legal Name of Corporation, Partnership, Etc.) MAILING ADDRESS OF OWNERSHIP: BUSINESS ORGANIZATION (Check One): Sole Proprietorship Partnership Limited Partnership Corporation Limited Liability Company Government (If Government, Please Select One): Other (Please Specify): CERTIFICATION		
OWNERSHIP OF FACILITY: (Legal Name of Corporation, Partnership, Etc.) MAILING ADDRESS OF OWNERSHIP: BUSINESS ORGANIZATION (Check One): Sole Proprietorship Partnership Imited Partnership Corporation Limited Liability Company Government (If Government, Please Select One): State District County City or Municipal Other (Please Specify):		
MAILING ADDRESS OF OWNERSHIP: BUSINESS ORGANIZATION (Check One):		HIP INFORMATION
MAILING ADDRESS OF OWNERSHIP: BUSINESS ORGANIZATION (Check One): Sole Proprietorship Partnership Limited Partnership Corporation Limited Liability Company Government (If Government, Please Select One): Other (Please Specify): CERTIFICATION	. OWNERSHIP OF FACILITY.	(Legal Name of Corporation, Partnership, Etc.)
BUSINESS ORGANIZATION (Check One): Sole Proprietorship Partnership Limited Partnership Corporation Limited Liability Company Government (If Government, Please Select One): Other (Please Specify): CERTIFICATION (Check One) Profit Non Profit Non Profit County City or Municipal	MAILING ADDRESS OF OWNERSHIP:	
□ Partnership □ Profit □ Non Profit □ Limited Partnership □ Corporation □ Limited Liability Company □ Government (If Government, Please Select One): □ State □ District □ County □ City or Municipal □ Other (Please Specify): □ Other (Please Specify):	. BUSINESS ORGANIZATION (Check One):	
□ Limited Partnership □ Corporation □ Limited Liability Company □ Government (If Government, Please Select One): □ State □ District □ County □ City or Municipal □ Other (Please Specify): CERTIFICATION	·	
 □ Corporation □ Limited Liability Company □ Government (If Government, Please Select One): □ Other (Please Specify): CERTIFICATION	•	☐ Profit ☐ Non Profit
☐ Limited Liability Company ☐ Government (If Government, Please Select One): ☐ State ☐ District ☐ County ☐ City or Municipal ☐ Other (Please Specify): CERTIFICATION		
☐ Government (If Government, Please Select One): ☐ State ☐ District ☐ County ☐ City or Municipal ☐ Other (Please Specify): ☐ CERTIFICATION	•	
CERTIFICATION	\Box Government (If Government, Please Select One): \Box	
ve have read the hales and hegalations issued by the recordska bepartment of freathfree frances and will comply with them should		
ense be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application and on the attached	- · · · · · · · · · · · · · · · · · · ·	·
cuments are true and correct and I/we hereby apply for a renewal license.		
FASE NOTE: Neb. Rev. Stat. Section 71-433 requires: Applications shall be signed by	EASE NOTE: Nob. Pay Stat. Section 71 422 requires: Application	os shall ha signad hu

- 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.

AUTHORIZED REPRESENTATIVE - SIGNATURE	AUTHORIZED REPRESENTATIVE – PRINTED NAME	DATE
AUTHORIZED REPRESENTATIVE - SIGNATURE	AUTHORIZED REPRESENTATIVE – PRINTED NAME	DATE