EVANSTON DEPARTMENT OF HEALTH AND HUMAN SERVICES
APPLICATION FOR LONG TERM CARE FACILITY LICENSURE

____

FACILITY NAME AS RECORDED WITH IDPH

____

PREFERRED CONTACT NAME / TITLE / PHONE / EMAIL

APPLICATION ATTACHMENTS
Place an X next to those returned. Write "N/A" if not applicable to your facility.

_____	Attachment A	Firm, Partnership or Association Members' Names and Addresses
_____	Attachment B	Corporation: Board of Directors, Officers, Stockholders' Names and Addresses
_____	Attachment C	Statement of Ownership: Site and Building Names and Addresses
_____	Attachment D	Personnel Information: Administrative & Consultative Staff
_____	Attachment E	Other Facilities, Services, Programs, Activities of Applicant
_____	Attachment F	Annual Operating Budget Report
_____	Attachment G	Continuing Education Requirements if twenty percent (20%) or more of Facility's residents are cognitively impaired, mentally ill or developmentally disabled

TO BE RETURNED WITH APPLICATION, IF REQUIRED
Place an X next to those returned. Write "N/A" if not applicable to your facility.

_____	Document 1	Copy of Management Agreement(s) for Facility
_____	Document 2	Certified Copies of Medicare and/or Medicaid Certification Statements
_____	Document 3	Preliminary Plans/Specifications if New Construction or Conversion of Existing Structure

RETURN THE COMPLETED APPLICATION WITH APPROPRIATE FEES TO:
EVANSTON DEPARTMENT OF HEALTH AND HUMAN SERVICES
ATTN: ELLYN GOLDEN, ENVIRONMENTAL HEALTH LICENSING COORDINATOR
2100 RIDGE AVENUE, EVANSTON, ILLINOIS 60201

FOR HEALTH DEPT USE ONLY

Date current license expires: _____________ DATE APPLICATION RECEIVED:__________

EVANSTON DEPARTMENT OF HEALTH AND HUMAN SERVICES
APPLICATION FOR LONG TERM CARE FACILITY LICENSURE
(PLEASE TYPE OR PRINT)

1. ____
Complete Name of Facility as Recorded with IDPH IDPH Facility ID IDPH Licensee ID

____
Complete Street Address City, State, Zip Code

____
Telephone Number

2. Is the name and address of the facility as listed on the existing license? _____Yes _____ No

If no, provide correct name and address:____

3. Indicate level(s) of service, capacity for each and type of resident to be served (MI, DD, GER, PED).

SERVICE LEVEL	CAPACITY	TYPE OF RESIDENT SERVED (MI, DD, GER, PED)	LICENSED BED (Per bed fee required)
Independent Living Unit			NO
Sheltered Care			YES
Intermediate Care			YES
Intermediate Care/DD			YES
Intermediate Care/DD 15 Beds Or Less			YES
Intermediate Care/MI			YES
Skilled Care			YES

4. Type of legal entity designated as Applicant:
If applicant is a firm, partnership or association, complete ATTACHMENT A and return.
If applicant is a corporation, complete ATTACHMENT B and return.

_____ Hospital Operated
_____ Church Operated
_____ For-Profit Corporation
_____ Individual
_____ Not-for-Profit Corporation
_____ Other Not-for-Profit
_____ Trust
_____ Partnership
_____ Other (explain)

5. Name and Address of Applicant:

____
Applicant's Name

____
Complete Street Address City, State, Zip Code Telephone Number

6. Name and Address of Registered Agent for Service:

Registered Agent's Name

Complete Street Address   City, State, Zip Code   Telephone Number

7. Name and Address of Beneficial Owner of Facility:

Beneficial Owner's Name

Complete Street Address   City, State, Zip Code   Telephone Number

8. Does legal entity identified as Applicant own the site and building in which the facility is located?

_____ Yes _____ No (If NO, please complete ATTACHMENT C and return.)

9. Is the legal entity identified as Applicant the management of the operation of the facility?

_____ Yes _____ No (If NO, please complete ATTACHMENT C and provide DOCUMENT 1 and return.)

10. List the names and addresses of other Long Term Care facilities where the applicant holds or has held a financial interest within the last five (5) years. In **ATTACHMENT E**, list those operations that are non-LTC facility related and return.

NAME	ADDRESS

11. Please complete **ATTACHMENT F - Annual Operating Budget Report** and return.

12. Please enclose the annual license fee of $600.00, plus $60.00 per licensed bed; make check/money order payable to “City of Evanston”

    Amount Enclosed: $____

    I declare that I have examined this application and all attachments, and to the best of my knowledge and belief, the information is true, correct and complete. I understand any omissions or misstatements may jeopardize this facility qualifying for a long term care license. I understand that pursuant to section 3-103 of the State Act, the submission of false or misleading information shall be a Class A misdemeanor, in addition to a violation of this Chapter.

    Further, I attest to the moral character of all employees of said facility, as per Section 8-15-2-3(A)5) of this Chapter, and have conducted reference checks to this effect.

____
Applicant’s Signature

____
Applicant’s Name (printed) Date

____
Notary Signature Notary Date Notary Seal

ADMINISTRATOR INFORMATION

Name of Administrator | Social Security Number

Facility Name | IDPH Facility ID #

Complete Street Address | City, State, Zip Code | Telephone Number

EFFECTIVE DATE YOU ASSUMED ADMINISTRATORSHIP OF THIS FACILITY: ______________________________________

1. Are you an Illinois Licensed Nursing Home Administrator? _____ Yes _____ No

   If answer is YES, give your license number and expiration date:

   ____

2. Are you licensed as a Nursing Home Administrator in another State? _____ Yes _____ No

   If so, which State?____

3. Have you applied for an Illinois license? _____ Yes _____ No

   If so, submit a copy of application for Illinois Nursing Home Administrator's license.

   If you have not applied, please state reason: ____

   What plan do you have to become licensed? ____

   (Unless an acceptable plan is submitted to the Department of Registration and Education of the Illinois Department of Public Health, you may not be permitted to continue to serve as administrator of your facility.)

4. If you have applied, on what date do you plan to take the Illinois Nursing Home Administrator's exam? ....

   Where?_________________________ .... (Chicago/Springfield) Type?______________________ (Permanent/Temporary)

5. Your place of birth: ____
   NOTE: (1) Administrator of a facility, licensed totally as Sheltered care, is not required to be licensed at this time.

6. Are you associated in any manner in the ownership of this facility? _____ Yes _____ No

   If yes, explain extent of ownership: ____

7. Are you a high school graduate or equivalent? _____ Yes _____ No

   If yes, year graduated: ____

   List name and address of high school:_______________________________________

   Additional formal education:____

8. Have you ever been convicted of any criminal offense(s), other than traffic violations? _____ Yes _____ No

   If yes, give the following information on each conviction. (List other convictions in same manner on separate sheet and attach.)

   ____
   Place Charge Sentence

   Place where sentence was served:_______________________________________

   If requested, would you permit state or local officials to fingerprint you to further our investigation?

   _____ Yes _____ No

9. Employment record for past five (5) years (please account for entire time): (If additional space is required, use separate sheet of paper and attach.)

   1)..
   Employer's Name Address, City, State, Zip Code Full/Part Time

   ....
   Title Reason for Leaving

   ....
   Brief Work Description

   2)..
   Employer's Name Address, City, State, Zip Code Full/Part Time

   ....
   Title Reason for Leaving

   ....
   Brief Work Description

3)..

Employer's Name Address, City, State, Zip Code Full/Part Time

....

Title Reason for Leaving

....

Brief Work Description

4)..

Employer's Name Address, City, State, Zip Code Full/Part Time

....

Title Reason for Leaving

....

Brief Work Description

I declare that I have examined this completed form including attachments, accompanying documents and statements and to the best of my knowledge and belief, this information is true, correct and complete. I understand any omissions or misstatements of material facts may jeopardize this facility qualifying for a long term care license.

....

Signature Date

ASSISTANT ADMINISTRATOR INFORMATION

....
Name of Assistant Administrator Social Security Number

....
Facility Name IDPH Facility ID

....
Complete Street Address City, State, Zip Code

....
Telephone Number

1. Effective date you were delegated in writing to be assistant administrator for this facility:

2. Your place of birth: ....

3. Are you associated in any manner in the ownership of this facility? _____ Yes _____ No

   If yes, explain extent of ownership: ....

4. Have you ever been convicted of any criminal offense(s), other than traffic violations? _____ Yes _____ No

   If yes, give the following information on each conviction. ....

   ....
   Place where sentence was served Charge Sentence

   If requested, would you permit state or local officials to fingerprint you to further our investigation?

   _____ Yes _____ No

5. Employment record for past five (5) years (please account for entire time). (If additional space is required, use separate sheet of paper and attach.)

   1)..
   Employer's Name Address, City, State, Zip Code Full/Part Time

   ....
   Title Reason for Leaving

   ....
   Brief Work Description

2)..
Employer's Name Address, City, State, Zip Code Full/Part Time

....
Title Reason for Leaving

....
Brief Work Description

3)..
Employer's Name Address, City, State, Zip Code Full/Part Time

....
Title Reason for Leaving

....
Brief Work Description

4)..
Employer's Name Address, City, State, Zip Code Full/Part Time

....
Title Reason for Leaving

....
Brief Work Description

I declare that I have examined this completed form including attachments, accompanying documents and statements and to the best of my knowledge and belief, this information is true, correct and complete. I understand any omissions or misstatements of material facts may jeopardize this facility qualifying for a long term care license.

....
Signature Date

....
Name of Assistant Administrator (Typed/Printed)

APPLICATION ATTACHMENTS

Attachment A	Firm, Partnership or Association Members' Names and Addresses
Attachment B	Corporation: Board of Directors, Officers, Stockholders' Names and Addresses
Attachment C	Statement of Ownership: Site and Building Names and Addresses
Attachment D	Personnel Information: Administrative & Consultative Staff
Attachment E	Other Facilities, Services, Programs, Activities of Applicant
Attachment F	Annual Operating Budget Report
Attachment G	Facility Responsibilities Regarding Staff Continuing Education Requirements

ATTACHMENT A (Copy as needed)
FIRM, PARTNERSHIP OR ASSOCIATION MEMBERS' NAMES AND ADDRESSES

....	....
NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

....	....
NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

....	....
NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

....	....
NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

ATTACHMENT B (Copy as needed)
CORPORATION: BOARD OF DIRECTOR, OFFICERS, STOCKHOLDERS' NAMES & ADDRESSES

NAME	TITLE
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

NAME	TITLE
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

NAME	TITLE
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

NAME	TITLE
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

ATTACHMENT C (Copy as needed)
STATEMENT OF OWNERSHIP: SITE AND BUILDING NAMES AND ADDRESSES

NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

NAME	% OWNERSHIP
OCCUPATION	S.S.N.
BUSINESS ADDRESS	PHONE NO.
HOME ADDRESS	PHONE NO.

ATTACHMENT D
PERSONNEL INFORMATION: ADMINISTRATIVE & CONSULTATIVE STAFF

TITLE	NAME	USUAL DAYS/WORK HOURS
ADMINISTRATOR		
ASST. ADMINISTRATOR		
DIRECTOR OF NURSING		
ASST. DIRECT. OF NRSNG		
SUPERVISORY NURSE(S)		
NURSE WITH REHAB COURSE		
CONSULTANTS		
DIETICIAN		
PHARMACIST		
MEDICAL RECORDS		
OCCUPATIONAL THERAPIST		
PHYSICAL THERAPIST		
SOCIAL WORKER		
OTHERS (label)		
RESIDENT CARE COORDINATOR		
FACILITY ADVISOR TO RESIDENT		
MEDICAL DIRECTOR		

ATTACHMENT E (Copy as needed)
OTHER FACILITIES, SERVICES, PROGRAMS AND ACTIVITIES OF APPLICANT: NON-LTC-RELATED FACILITIES/SERVICES/PROGRAMS IN WHICH APPLICANT HAS A FINANCIAL INTEREST

NAME	TYPE OF FACILITY/SERVICE PROGRAM	ADDRESS

ATTACHMENT F
ANNUAL OPERATING BUDGET REPORT FOR FISCAL YEAR 2010/2011

....
Complete Name of Facility

....
Complete Street Address City, State, Zip Code Telephone Number

Is Applicant a "for-profit"? _____ Yes _____ No

Is Applicant a "not for profit" (501(c)3)? _____ Yes _____ No

Applicant's TAX number for corporation: ....

How long has the corporation been in existence? ....

Date of Incorporation: ....

Name, address, phoned number and relationship to the corporation of the person completing form:

....
Name Relationship

....
Complete Street Address City, State, Zip Code

....
Telephone Number

Applicant agrees that these forms were prepared in accordance with generally accepted accounting principles and that the projected annual services, expenses and revenues represent corporation and management's best estimate of the anticipated level(s) for the budget period.

Certified by President:

....
Name (Typed)

....
Signature Date

ANNUAL OPERATING BUDGET REPORT - Continued

1. ....
Complete Name of Facility
....
Complete Street Address City, State, Zip Code
....
Telephone Number

2. Name of current licensed administrator: ....

3. Total number of residents/census as of this date: ....

4. No. of Medicare residents: .... No. of Medicaid/Public Aid residents: ....

No. of private pay residents: ....

5. Public Aid individual rate: __________ High __________ Low

6. Has facility qualified for QUIP within the past six months? _____ Yes _____ No

If yes, additional rate per person facility is receiving or expecting to receive: ....

7. For the past fiscal year, report the rate and number of bed days for each level of care and total:

LEVELS OF CARE	RATE	NO. OF BED DAYS	TOTAL
SKILLED			
INTERMEDIATE			
SHELTERED			

8. Current daily charges:

Single Room .... Double Room ....

3 Bedroom .... 4 Bedroom ....

9. If daily charges are expected to change, report new rates:

Single Room .... Double Room ....

3 Bedroom .... 4 Bedroom ....

ANNUAL OPERATING BUDGET REPORT - Continued

10. STATEMENT OF REVENUE AND EXPENSES

REVENUES	AUDITED ACTUAL RESULTS LAST COMPLETED FY	EST. CURRENT FY	PROPOSED NEXT FY
GOVERNMENTAL			
RESIDENTS FEES			
INVESTMENTS			
OTHER INCOME			
TOTAL REVENUES			

EXPENSES	AUDITED ACTUAL RESULTS LAST COMPLETED FY	EST. CURRENT FY	PROPOSED NEXT FY
NURSING			
FOOD SERVICES			
HOUSEKEEPING			
ACTIVITIES			
PLANT OPER/ &			
MAINTENANCE			
GENERAL & ADMINISTRATIVE			
INTEREST			
REAL ESTATE TAXES			
DEPRECIATION & AMORTIZATION			
TOTAL EXPENSES			

NET DIFFERENCE BETWEEN REVENUE AND EXPENSES: ....

ATTACHMENT G
FACILITY RESPONSIBILITIES REGARDING STAFF CONTINUING EDUCATION REQUIREMENTS

1. At the time of the facility's annual licensure, to comply with Section 8-15-3-2-(N) of the Evanston LTC Ordinance, each facility in which twenty percent (20%) or more of its residents are cognitively impaired, mentally ill or developmentally disabled, shall include in its application to the Health Department the following, labeled as ATTACHMENT G, in accordance with the population(s) being served by the facility:

    a. Documentation that the administrator has completed a six hour training program in the past year which has provided information and skill development in the management and care of persons who are elderly, cognitively impaired, mentally ill, or developmentally disabled. This documentation shall also be in the employee's personnel file.

    b. Documentation that the all nurses and clinical social workers have completed at least one continuing education course in the past year which has provided information and skill development in the care of persons who are elderly, cognitively impaired, mentally ill or developmentally disabled. This documentation shall also be in the employee's personnel file.

    c. Documentation that all certified nurse's aides hired within the past year were provided six hours of orientation regarding the care and management of persons with mental illness or developmental disabilities. This documentation shall also be in each employee's personnel file.

    d. Documentation that all certified nurse's aides hired within the past year were provided six hours of orientation regarding the care and management of persons with mental illness or developmental disabilities. This documentation shall also be in each employee's personnel file.

    e. A written plan and curriculum for providing six hours of orientation to all certified nurse's aides hired in the coming year regarding the treatment, care and management of persons with mental illness or developmental disabilities.

    f. A written plan and curriculum for providing three hours of orientation to all certified nurse's aides hired in the coming year regarding the treatment, care and management of persons with cognitive impairment.