

LICENSING CHECKLIST – NF CHOW
Oregon Administrative rules 411-085-0005, 0010 and 0013

Facility:

Effective Date:

Review/approve the following application materials:

**Letters of Intent, current owner/licensee and applicant
owner/licensee**

Summary of proposed action that includes:

- Name and signature of the current owner/licensee
- Name and signature of the prospective owner/licensee
- The proposed date of transfer
- The type of transfer (e.g., sale, lease or rental, etc.)

**Nursing Facility License Application (s) from the prospective
owner/licensee and operator (if applicable), [0466](#)** Submit one form for the
business owner/licensee and one form for the operator. If owner and operator are
the same, only one form is required.

**Statement of ownership and control, owner/licensee and
operator (if applicable) form [0466D](#)**

Licensing Fee (PLEASE DO NOT SEND A CHECK.**) An invoice
will be generated by DHS Accounting with remittance
instructions:**

Fewer than 16 beds, \$180

16-49 beds, \$260

50-99 beds, \$520

100-150 beds, \$670

150 or more beds, \$750

ACU: 16 or fewer beds, \$50

ACU: 17-50 beds, \$75

ACU: 51 or more beds, \$100

Financial Approval – Review includes:

Proof of Fiscal Responsibility

- Auditor’s certified financial statement and other verifiable documentary
evidence of fiscal solvency, documenting that the prospective licensee has
sufficient resources to operate the facility for 60 days.

- **Proof of fiscal solvency must include liquid assets sufficient to operate the facility for 45 days. Anticipated Medicaid** income is not considered to be “liquid assets”, but may be considered “financial resources”. Liquid assets may be demonstrated by:
 - An Unencumbered line of credit; or
 - A joint escrow account with APD or
 - A performance bond; or
 - Any other method satisfactory to APD
- The Division will require for each facility, \$50,000 in:
 - Unencumbered line of credit or
 - An escrow account; or
 - A performance bond.

Pro Forms (financial review)

Revenues, expenditures and resident days, by month for first 12 months of operation of the facility and demonstrate the ability to cover any cash flow problems identified by the pro forma.

Credit Reports – Signed Approval for Credit Checks, form [0466C](#)

Signed by each owner or entity with 10% or greater ownership interest, *If Medicare or Medicaid certified, complete a signed approval for credit check for each individual or entity with 55 or greater ownership interest in the owner/licensee and operator entities.*

Facility Information form, form [0466I](#)

New Owner or Plan of Correction Compliance Agreement, form [0466P](#)

Certificate of Performance and Financial History, form [0466F](#)

Each individuals and/or entities with 5% or greater ownership interest must complete/sign this form.

Facility Floor Plan

For resident rooms, floor plan will show the room number, location of each bed and room dimensions; dining room, activity area, shower/tub room, toilet room, clean/dirty utility rooms, therapy services, laundry and dietary service areas.

Fitness Determination – Criminal History Request ([Form 301 QED](#))

Complete for each individual with 10% or greater ownership interest in the ownership entity and the operating entity.

If Medicare or Medicaid certified, complete for each individual with 5% or greater ownership interest in the owner/licensee and operator entities.

- Please complete and original form for each individual, and complete section 2 of the form completely, leaving no spaces blank.
- Fingerprint card, if applicable.
- Please send Form 301 QED to NF Licensing.

Physical Plant or Care Corrections (last survey)

- Indicate amount of funds needed for correction
- Indicate how funds will be made available
- Indicate when the corrections will be made

Legal Agreements

Purchase Sale Agreement or Business Lease

Legally binding agreement that describes the business sale or transfer from the current licensee to the prospective licensee.

Operations Transfer Agreement

Legally binding agreement that describes all aspects of business operations that will occur as result of the business sale (or transfer). The OTA will address all aspects of business function including accounts payable and receivable, provider tax, personnel, inventories, etc.

Management/Operator Agreement (if the owner/licensee is not the operator)

Legal agreement that defines specific responsibilities of the prospective nursing facility operator.

Property Lease

Legal agreement delineating land/physical plant ownership and proposed legal agreement with the prospective licensee and/or operator. Including **Verification to Legally Operate**. The applicant must demonstrate that they have the legal right to possess the nursing facility property and operate the nursing facility business.

MEDICARE/MEDICAID Certification (if applicable)

Medicare Provider/Supplier Enrollment Form (CMS 855), provider submits to Fiscal Intermediary (FI), copy to NF licensing

<http://www.cms.gov/cmsforms/downloads/cms855a1.pdf>

Long – Term Facility Application for Medicare and Medicaid (HCFA 671),

Provider submits original form plus three copies to NF licensing
http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Forms/HCFA671.PDF

Assurance of Compliance (HHS 690), provider submits four copies with original signatures to NF licensing <http://www.hhs.gov/forms/HHS690.pdf>

Health Insurance Benefit Agreement (CMS 1561), provider submits two copies with original signatures to NF licensing
<http://www.cms.gov/cmsforms/downloads/cms1561.pdf>

Medicare Certification Civil rights Information Request Form (OMB Number: 0990-0243), 2 pages Civil Rights Questionnaire, attached to form OMB Number: 0990-0243 – Include all requested materials and original signature
http://www.fdhc.state.fl.us/mchg/health_facility_regulation/hospital_outpatient/forms/MedicareCertificationCivilRightsInfoRequestForm_OMB0990_0243.pdf
New form (Exp Date 03/31/2014) is not posted on website – use attachment
Provider submits to NF licensing

CMS 1539 Approved/Signed by Region X

MEDICAID ONLY

Long – Term Facility Application for Medicare and Medicaid (HCFA 671), original plus three copies