

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division-Licensure Bureau

2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953
FAX: (406) 444-1742

ASSISTED LIVING FACILITY CHANGE OF OWNERSHIP LICENSE APPLICATION

Indicate the number of beds requesting to be licensed in each category below:

- Category A** **Category B (5 or less)** **Category C**
(Include Completed Category B and C applications if applying for these licenses)

Total Number of Beds _____

New Facility Name: _____

Prior Facility Name: _____

Previous owner / administrator / leaser: _____

Facility Address: _____ PO Box _____

City: _____ State/Zip: _____

County: _____

Facility Telephone Number: _____ FAX: _____

Facility E-mail/Web page Address: _____

Floor Plan is: **Existing Structure without change** **Addition** **Remodel**

Name of Applicant: _____

Applicant Address: _____ City: _____ State/Zip: _____

Applicant (or contact) e-mail address: _____

Administrator of New Facility: _____

Owner (if different from applicant): _____

Owner Address: _____ City: _____ State/Zip: _____

Owner e-mail: _____

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Quality Assurance Division-Licensure Bureau

Information on ownership, contract or lease agreement if operated by a person other than the owner:

- If a partnership, firm or association, list every member thereof.**
- If a corporation, list the name and address thereof and the names of its officers.**
- State Affiliated Organization**

NAME	ADDRESS
<hr/>	<hr/>

(Please attach additional sheets as needed.)

I certify that all information I have submitted to DPHHS is true and correct. This Application for license for an Assisted Living Facility is hereby submitted under the provision of Section 50-5-101 through 50-5-208 and 50-5-225 through 50-5-226.

SIGNED _____ **DATE** _____

TITLE _____

ADDRESS: _____ **CITY** _____ **STATE/ZIP** _____

Enclose a check, money order or draft made payable to the *Department of Public Health & Human Services* to cover the license fee. The fee is determined as follows:

- (a) facilities with 20 or less = \$20.00**
- (b) facilities with 21 beds or more = \$1.00 per bed.**

This fee will be deposited in the State Treasury and is non-refundable.