MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Office of Inspector General - Licensure Bureau

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

APPLICATION FOR MONTANA STATE RESIDENTIAL CARE FACILITY LICENSE ASSISTED LIVING FACILITY

☐ **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 _____

Floor Plan is: ☐ **New Construction** ☐ **Existing Structure** ☐ **Remodel** ☐ **Addition**

Facility Name: _____

Facility Address: _____ PO Box _____

City: _____ State/Zip: _____

Facility Telephone Number: _____ FAX: _____

Name of Applicant: _____

Applicant (or contact) e-mail: _____

Name of Administrator: _____

Administrator Address: _____ City _____ State/Zip _____

Administrator e-mail: _____

Please include a copy of either the administrator's Nursing Home Administrator license or Senior Living University Level 1 Certificate (other certificate programs will be reviewed on an individualized basis by the Department).

If administrator does not have the above credentials, please include the date of which the administrator was hired for position and anticipated completion of the SLU Level 1 certificate program

Date of Hire: _____

Anticipated program completion date: _____

Name and Address of Management Company if different from owner:

_____

_____

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 names and address thereof and the names of its officers.**
- **State Affiliated Organization**

NAME ADDRESS

_____

_____

_____

_____

(attach additional list if necessary)_____

I certify that all information I have submitted to DPHHS is true and correct. This Application for licenure 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 50-5-227.

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.