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

ASSISTED LIVING FACILITY CHANGE OF OWNERSHIP LICENSE APPLICATION

☐ **Category A** ☐ **Category B (5 or less)** ☐ **Category C**

(Include Completed Category B and C applications if applying for these licenses)

Floor Plan is: ☐ **Existing structure** ☐ **Addition** ☐ **Remodel**

Total Number of Beds ________________

Prior Facility Name: ____

Previous owner: ____

New Facility Name: ____

New Owner: ____

Facility Address: ______________________________ PO Box: ________________

City: _____________________________________ State/Zip: ________________

Facility Telephone Number: ____________________ FAX Number: ________________

Name of Applicant: ____

Applicant (or contact) e-mail: ____

Administrator of New Facility: ____

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:

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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

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(attach additional list if necessary)____

I certify that all information I have submitted to DPHHS is true and correct. This Application for licensure 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.