New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
P.O. Box 358
Trenton, NJ 08625-0358

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR A LONG TERM CARE FACILITY LICENSE

General Licensure Requirements:

Licensure by the New Jersey Department of Health, Office of Certificate of Need and Healthcare Facility Licensure is mandatory **PRIOR TO** commencement of new or expanded services. To be licensed as an operator of a health care service in New Jersey, all of the applicable licensing requirements for that service must be met. This includes both physical plant and operational requirements.

To obtain the licensing standards for the proposed service and/or additional information regarding the licensure process, please call:

609-292-6552 Team A: for facilities located in Bergen, Hudson, Mercer, Morris, Passaic, Somerset, Sussex and Warren Counties
609-633-9042 Team B: for facilities located in Burlington, Gloucester, Hunterdon, Middlesex, Monmouth and Ocean Counties
609-292-7228 Team C: for facilities located in Atlantic, Camden, Cape May, Cumberland, Essex, Salem and Union Counties

Forward completed applications to:

Mailing Address:
New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
P. O. Box 358
Trenton, NJ 08625-0358

Overnight Services (DHL, FedEx, UPS):
New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
120 South Stockton Street, 3rd Floor
Trenton, NJ 08608-1832

Checks should be made payable to *"Treasurer, State of New Jersey."*

New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
PO Box 358
Trenton, NJ 08625-0358

APPLICATION FOR A LONG TERM CARE FACILITY LICENSE

Type of Application:	**Date of Application:**	**Date of Check/Money Order:**
☐ New – CN#: ______ ☐ New – No CN Required, ID#: ______ ☐ Transfer of Ownership #: ______ ☐ Other: ______	**Check/Money Order No.:**	**Amount of Check/MO:** **$**

Official Name of Facility (Provider Name):				**EIN Number:**
Site Address:				
City:		State:	Zip:	County:
Telephone Number:	Fax Number:			Official Facility Email Address:
Name of Administrator:				License Number (LNHA/CALA if applicable):
Emergency Contact:				
Emergency Telephone:	Emergency Fax Number:			Emergency Email Address:
Mailing Address (if different from above):				
City:		State:	Zip:	County:
Owner/Corporate Name *(LICENSED OPERATOR)*:				**EIN Number:**
Doing Business As (if applicable):				
Address:				
City:		State:	Zip:	County:
Telephone Number:	Fax Number:			Email Address:
Management Company (if applicable):				
Address:				
City:		State:	Zip:	County:
Telephone Number:	Fax Number:			Email Address:
Contact:		Title:		

APPLICATION FOR A LONG TERM CARE FACILITY LICENSE, Continued

Official Name of Facility (Provider Name):	**EIN Number:**

Primary Type of Facility *(check one)*

- ☐ Adult Day Health Services
- ☐ Alternate Family Care
- ☐ Assisted Living Program
- ☐ Assisted Living Residence
- ☐ Comprehensive Personal Care Home
- ☐ Hospital Based Subacute
- ☐ Pediatric Day Health Services
- ☐ Residential Health Care Facility
- ☐ Other: ______________________
- ☐ Long-Term Care T18 only
- ☐ Long-Term Care T19 only
- ☐ Long-Term Care T18/19
- ☐ Long-Term Care Private

Enter the Quantity of all Beds/Slots at this Location

Adult Day Health Service Slots .... __________

Assisted Living Beds .... __________

Comprehensive Personal Care Beds........... __________

Hospital Based Subacute............................ __________

Long-Term Care Beds .... __________

Pediatric Day Health Slots .... __________

Residential Health Care Beds .... __________

Other/Type: ____________________ . __________

Type of Ownership *(check one)*

For-Profit ☐ Yes ☐ No

Non-Profit ☐ Yes ☐ No

Facility is Hospital Based ☐ Yes ☐ No

Government Owned ☐ Yes ☐ No

- ☐ *Corporation
- ☐ Partnership
- ☐ Other(specify): ____
- ☐ Proprietorship
- ☐ Limited Partnership
- ☐ Limited Liability Corp.
- ☐ Religious Affiliation
- ☐ Federal
- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District

**If the corporate entity is a wholly-owned subsidiary, identify the parent corporation below:*

Name: ____

Address: ____

City, State, Zip Code: ____

Building Ownership *(check one)*

- ☐ Wholly owned by licensed operator identified on page one
- ☐ Leased (Identify owner of physical assets and submit a copy of the signed lease)

____

Name and Title of Individual or Current Registered Agent Upon Whom Orders May Be Served *(Must be NJ Resident)*

Name: ____

Address: ____

City, State, Zip Code: ____

APPLICATION FOR A LONG TERM CARE FACILITY LICENSE, Continued

Official Name of Facility (Provider Name):	**EIN Number:**

OWNER, OFFICERS, PARTNERS, STOCKHOLDERS, OR CORPORATE OFFICERS

- *IDENTIFY 100% OF THE OWNERSHIP BELOW.* (Attach additional sheets if necessary.)
- *For a publicly-held corporation, identify all stockholders with 10% or more of the outstanding stock.*
- ***If an owner, partner or shareholder is an entity, rather than an individual, provide the individual ownership of that entity as well.***
- *For Non-Profit entities, list Board Members.*

Name: ______________________
Title: ______________________
Address: ______________________
City: ______________________
State: __________ Zip Code: __________
SSN/Tax ID: ______________________
% Ownership: ______________________

☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______________________
Title: ______________________
Address: ______________________
City: ______________________
State: __________ Zip Code: __________
SSN/Tax ID: ______________________
% Ownership: ______________________

☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______________________
Title: ______________________
Address: ______________________
City: ______________________
State: __________ Zip Code: __________
SSN/Tax ID: ______________________
% Ownership: ______________________

☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______________________
Title: ______________________
Address: ______________________
City: ______________________
State: __________ Zip Code: __________
SSN/Tax ID: ______________________
% Ownership: ______________________

☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______________________
Title: ______________________
Address: ______________________
City: ______________________
State: __________ Zip Code: __________
SSN/Tax ID: ______________________
% Ownership: ______________________

☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______________________
Title: ______________________
Address: ______________________
City: ______________________
State: __________ Zip Code: __________
SSN/Tax ID: ______________________
% Ownership: ______________________

☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

APPLICATION FOR A LONG TERM CARE FACILITY LICENSE, Continued

Official Name of Facility (Provider Name):	**EIN Number:**

Please indicate whether or not your facility offers the following:

	Yes	No	No. of Beds
Separate Units for Young Adults (Ages 21 through 64):	☐	☐	___________
Pediatrics:	☐	☐	___________
Ventilator:	☐	☐	___________
Behavioral Management:	☐	☐	___________
Private Long Term Care:	☐	☐	___________
Alzheimer's/Dementia:	☐	☐	___________
IV Therapy:	☐	☐	

Chronic Dialysis:	Yes	No
Performed by In-House Staff:		
-Peritoneal:	☐	☐
-Hemodialysis:	☐	☐
Performed by Outside Firm:		
-Peritoneal:	☐	☐
-Hemodialysis:	☐	☐

Assisted Living Programs and Alternate Family Care, list counties served from office site listed on page one:

____

Please answer the following questions. (Attach additional sheets if necessary.)

1. Have you or any person mentioned in this application ever had an interest, directly or indirectly, in any application for health care facility in New Jersey or any other state, which was denied or revoked?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):
   ____
2. Do any of the principals have ownership, management or operational interest in any other licensed health care facility in New Jersey, or any other state?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):
   ____
3. Are you related to any person who now operates or has ever operated a health care facility in New Jersey or elsewhere?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):
   ____
4. Have any principals, owners, operators or managers of the facility ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):
   ____
5. Have any principals, owners, operators or managers of the facility ever been indicted for or convicted of a felony crime?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):
   ____

CERTIFICATION

The applicant certifies:

1. that all information contained in this application and attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties;
2. that the application been duly authorized by the governing body of the applicant; and
3) that the facility has been and will be operated in accordance with applicable licensing requirements.

Name of Authorized Individual Completing Application (Print or Type)	Title

Signature	Date