



**Intermediate Care Facilities for Persons
with Intellectual Disability Application
Regulation 61-13**

Reason for Application

<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change Request
	License Number:	Expiration Date: <i>(Complete Part D and E)</i>

Part A. Location Information

Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Number of beds to be licensed?			

Contact Person and Correspondence Mailing Address:
(Name of person who can make licensure/operation decisions about facility and address where you want to receive ALL correspondence, including the license, from the Bureau of Health Facilities Licensing.)

Name:		Title:	
Address:		Telephone Number:	
City:	State:	Zip:	
Primary Email:			

Administrator: (MUST provide a copy of qualifications)

Name:	
Address:	
Telephone Number:	Fax:
Email Address:	

Food Service Areas

Number of Kitchens:	
Is food prepared by a caterer? <input type="checkbox"/> YES <input type="checkbox"/> NO (if yes, please attach a copy of the catering contract)	

Certified Food Protection Manager: (INITIAL APPLICATIONS MUST attach a copy of certification)

Name:	
Certificate Date:	Expiration Date:
Course Taken:	Institution:

Part B. Operation Disclosure			
Licensee Information: <i>(name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part A)</i>			
*This can be found on your current license OR your documentation from the Secretary of State.			
Licensee Name:			
Mailing Address:			
City:	State:	Zip:	
Telephone Number:		Fax Number:	
Name of Presiding Officer of the Registered Organization's Governing Body:			
Ownership Type:			
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Corporation*	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited Liability Company (LLC)*		
<input type="checkbox"/> Limited Partnership	<input type="checkbox"/> Government		
*Submit SC Secretary of State documentation, if applicable			

Licensee or Owner Documents Required

1. Secretary of State documentation, if applicable Attached N/A
2. If the licensee is a corporation or partnership, attach a list identifying all officers. Attached N/A
3. If the licensee or owner is a corporation or partnership, attach a list with the name, address and percentage of all owners that possess 5% or more ownership of the company or partnership. Attached N/A
4. If any person or other legal entity can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent and type of claim. Attached N/A

Part C: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES

<input type="checkbox"/> Change of Facility Name and/or Location (Complete Section 1)	<input type="checkbox"/> Change of Licensee/Ownership (Complete Section 2)	<input type="checkbox"/> Change of Licensed Beds (Complete Section 3)
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Section 1 (FACILITY INFORMATION)

PRIOR TO CHANGE

Current License Number:		
Current Facility Name:		
Current Facility Address:		
City:	Zip:	County:
Facility Telephone Number:	Fax Number:	

AFTER CHANGE

New Facility Name:		
New Facility Address:		
City:	Zip:	County:
New Facility Telephone Number:	Fax Number:	

Section 2 (LEGAL IDENTITY OF OWNERSHIP)

Application must be completed by new owner, as licenses are not transferable.

PRIOR TO CHANGE

Current License Number:	License Number:
Name of Current Owner:	
Address of Current Owner:	
City:	Zip: County:
Telephone Number of Current Owner:	
Signature of current owner:	Date:

AFTER CHANGE

Name of New Owner:	
Address of New Owner:	
City:	Zip: County:
Telephone Number of New Owner:	
Signature of new owner:	Date:

Section 3 (CHANGE IN LICENSED BEDS)

License Number:		
Facility Name:		
Facility Address:		
City:	Zip:	County:
Facility Telephone Number:	Fax Number:	

<input type="checkbox"/> Increase	<input type="checkbox"/> Decrease
Number of Licensed Beds:	From: To:

Part D: Verification

The application shall be signed by the following:

- If an individual, the **owner(s)**
- If a limited liability company, the **head of the limited liability company**
- If a corporation, **two** of its **officers**
- If governmental unit, the **head of the governmental department** having jurisdiction

I, the undersigned, being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with the standards set forth in South Carolina Regulation 61-13. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 61-13.

Signature:
Print Name:
Date:

Signature:
Print Name:
Date:

Subscribed and sworn to before me this _____ day of _____, _____.

(Month) (Year)

NOTARY PUBLIC _____

My commission expires _____

NOTARY SEAL