

Department of Health and Welfare
MEDICAID - ADMINISTRATION OF LICENSING AND CERTIFICATION
Residential Community Care Program
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-6626
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**2007 ANNUAL REPORT AND APPLICATION FOR RENEWAL OF
 RESIDENTIAL CARE/ASSISTED LIVING FACILITY LICENSE**

I. FACILITY INFORMATION

a. Facility Name:		b. License Number:
c. Facility Physical Address:	d. Facility Mailing Address:	
e. Facility Telephone Number:	f. Facility Fax Number:	
g. E-mail address	h. Licensed Bed Capacity:	i. Accepting Medicaid Clients <input type="checkbox"/> YES <input type="checkbox"/> NO

II. ADMINISTRATOR INFORMATION

a. Administrator's Name:	b. Residential Care Administrator License Number:
c. Other Residential Care/Assisted Living Facilities for which the administrator has responsibility:	

III. RESIDENT SERVICES

Types of Service. Check all service types offered by the facility.

<input type="checkbox"/> DEMENTIA	<input type="checkbox"/> DEVELOPMENTAL DISABILITY	<input type="checkbox"/> ELDERLY
<input type="checkbox"/> MENTAL ILLNESS	<input type="checkbox"/> TRAUMATIC BRAIN INJURY	<input type="checkbox"/> PHYSICALLY DISABLED

IV. RESIDENT CENSUS AS OF SEPTEMBER 30, 2007

SERVICE TYPE (PRIMARY DIAGNOSIS)	# OF RESIDENTS	PAYOR SOURCE	# OF RESIDENTS
Dementia	a.	Private Pay	h.
Developmental Disability	b.	Medicaid	i.
Elderly	c.	Other	j.
Mental Illness	d.	TOTAL	k.
Traumatic Brain Injury	e.		
Physically Disabled	f.		
TOTAL	g.		

NOTE: Please place each resident into ONLY one (1) category for Service Type (use the current diagnosis--that is, the most significant reason for the individual needing services) and ONLY one (1) category for Payor Source. The totals in fields "g" and "k" should match.

V. FACILITY STAFFING INFORMATION FOR THE WEEK OF SEPTEMBER 25, 2007

JOB DESCRIPTION	Total Weekly Payroll Hours
Administration	a.
Direct Care	b.
Other	c.
TOTAL	d.

DESCRIPTIONS

- a. Administrator hours;
- b. Licensed nurse hours, certified nurse aide hours, caregiver hours, etc.;
- c. Laundry personnel hours, housekeeping personnel hours, food service personnel hours, etc.

VI. OWNERSHIP INFORMATION

a. Name of Individual, Partnership, or Corporation:	b. E-mail address:
c. Owner Mailing Address:	d. Owner Telephone Number:
	e. Owner Fax Number:
f. Contact Name:	
g. Disclosure of Ownership. Identify each shareholder or investor holding ten percent (10%) or more interest in the business. If the owner is a business, please give the full legal name of the entity:	
NAME	%
_____	_____
_____	_____
_____	_____
_____	_____

Please attach a separate sheet if this space is not adequate.

VII. REPORT/APPLICATION VERIFICATION

BY SIGNING BELOW, I ACCEPT AND ACKNOWLEDGE THE FOLLOWING:

- 1) I am authorized to represent the facility.
- 2) I have named all owners having an interest in the licensed entity of 10% or more, and I represent their interests on behalf of the licensed entity.
- 3) I understand that the license is non-transferable, nor can it be assigned to another.
- 4) I am responsible for maintaining the facility's compliance with the applicable laws and rules.
- 5) I certify that the statements made in this report are true, complete, and correct to the best of my knowledge.

Printed or Typed Name

Title

Signature

Date