

IDAHO DEPARTMENT OF HEALTH & WELFARE  
DIVISION OF MEDICAID  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
APPLICATION FOR SKILLED NURSING FACILITY LICENSE

The undersigned hereby makes application for a license (or renewal of license) to operate a nursing home, subject to the provisions of the Idaho State Code, Section 39-1301 to 1317, as amended, and to the rules, regulations and standards adopted thereunder by the Board of Health and Welfare.

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I. CLASSIFICATION

A. Identification

Facility \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
County \_\_\_\_\_ Phone Number \_\_\_\_\_

B. Ownership (check only ONE) Check the entity which has legal responsibility for operation of the facility.

PROFIT \_\_\_\_\_ Individual \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation \_\_\_\_\_  
NONPROFIT \_\_\_\_\_ Church Related \_\_\_\_\_ Non-Profit Corp. \_\_\_\_\_ Other Non-Profit \_\_\_\_\_  
STATE OR LOCAL GOVERNMENT \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ City/County \_\_\_\_\_ Hosp Dist \_\_\_\_\_

If "for profit", please list the names and addresses of those persons with ownership interests of ten percent or more. (Use separate sheet if necessary)

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If facility is a corporate facility, give legal corporation name.

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C. Administration

Administrator \_\_\_\_\_ NHA Number \_\_\_\_\_

OFFICERS OF THE GOVERNING BOARD:

President \_\_\_\_\_ Phone Number \_\_\_\_\_

Vice-President \_\_\_\_\_ Phone Number \_\_\_\_\_

Secretary \_\_\_\_\_ Phone Number \_\_\_\_\_

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## II. BEDS

### A. Licensed Bed Capacity Requested

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|----|------------------------|------|-------|
| 1. | Medicare/Medicaid SNF  | Beds | _____ |
| 2. | Medicare Only SNF      | Beds | _____ |
| 3. | Distinct Part Medicare | Beds | _____ |
| 4. | Licensed Only SNF      | Beds | _____ |
| 5. | Residential Care       | Beds | _____ |

## III. EFFECTIVE DATE

A. **Change of Ownership** – Indicate the date that change of ownership occurs \_\_\_\_\_

B. **New Facility** – Indicate the date the facility will begin admitting patients/residents \_\_\_\_\_

C. **Change in Licensed Bed Capacity** – Indicate the effective date \_\_\_\_\_

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I certify that the information herein submitted is true, complete and correct to the best of my knowledge and belief.

SIGNATURE \_\_\_\_\_  
Authorized Representative

TITLE \_\_\_\_\_

DATE \_\_\_\_\_