

Nursing Home/Residential Care Facility Annual Renewal
Ohio Department of Health – Division of Quality Assurance
Section 3721.07 of the Ohio Revised Code

1.

Facility type		Home ID #	Capacity (# of Beds)
Nursing home	Residential care facility		
Facility name (Doing Business As)			
Facility address			
City	Zip	County	
Facility phone #	Fax #		
Facility e-mail address	Administrator's e-mail address		
Administrator's name		NHA license #	

2. **Business entity officers/partners/members**

President	Partner	Member
Vice president	Partner	Member
Secretary	Partner	Member
Treasurer	Partner	Member

3.

	Yes	No
Have you or any partner or officer listed in this renewal application been convicted of a felony or a crime of moral turpitude?		
Are you or any partner or officer listed for this facility engaged in practices that could be construed as immoral?		
Is there any reason why this facility will not be able to operate financially for the next 12 months?		

If you or any partner or officer has answered "YES" to the questions above, please attach a separate document explaining.

4. **SPECIALIZED CARE PROGRAM** - Check what specialized care or services your facility provides: N/A ☐

<input type="checkbox"/> Coma treatment	<input type="checkbox"/> Respirator or ventilator care	<input type="checkbox"/> Specialized Alzheimer's Disease program
<input type="checkbox"/> Neurological injury program for young adults	<input type="checkbox"/> Traumatic brain injury program	<input type="checkbox"/> Deaf or hearing impaired
<input type="checkbox"/> Pediatric care	<input type="checkbox"/> Amyotrophic lateral sclerosis	<input type="checkbox"/> Adult day care program
<input type="checkbox"/> Dialysis services	<input type="checkbox"/> Hospice services	<input type="checkbox"/> Other

5.

I swear or affirm that the information provided herein, and any attachments hereto, have been prepared or carefully reviewed by me and constitute a truthful and correct disclosure of all information herein. I certify that the undersigned is the operator (if the operator is an individual), the president or other officer (if the operator is a corporation), a partner (if the operator is a partner), or an authorized agent of the operator.

Print/type name of undersigned _____ Title _____

Signature _____ Date _____

ODH USE ONLY

Date received	Receipt number	Fee amount
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(Addendum page)

6. **Alternative Mailing Information:**

7. **Additional Operator Information:**

☐ N/A

Operator Name:

Address:

City:

State:

Phone:

8. **Additional Building Information:**

Has this home undergone any structural changes or additions during the past year?

Yes ☐ No ☐

If yes please provide details:

9. **The following information applies to this facility (including address and phone number):**

Check one of the following which applies to the facility and provide the name, address and phone number of the building owner:

- ☐ The licensed operator owns the building
- ☐ The licensed operator leases the building
- ☐ The licensed operator leases the building and the business
- ☐ The owner owns the building
- ☐ The licensed operator operates the home under management contract

Name: Address:

City/State/Zip:

Phone Number :

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10. Additional Building Ownership Information:

- | | | | |
|--|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Limited Liability | <input type="checkbox"/> Individual | <input type="checkbox"/> Partnership | <input type="checkbox"/> Corporation |
| <input type="checkbox"/> Association | <input type="checkbox"/> Other | | |

11. Additional Officers:

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12. Additional Individual Owners:

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13. Additional Corporate Owners:

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14. Additional Partners:

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15. State Fire Inspection Information:

Date of State Fire Marshal Inspection Report on file at ODH:

Is a State Fire Marshal Inspection Required:

Means of Inspection being sent to ODH:

Date Sent:

Date of Inspection:

Number of Inspection Documents Sent/Attached:

16. Additional Suitability Information:

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