Continuing Care Provider Act

LICENSE APPLICATION

Initial Application _____ Renewal Application _____

Legal name of applicant ("Provider"):____

Applicant ("Provider") FEIN #: ____

Principal business location: ____

Street ____

City, State, ZIP ____

Mailing address, if different from principal business location. If there is none, enter "None"

Street ____

City, State, ZIP ____

Contact person (name, title, telephone number, fax number, email address):

Name ____

Title ____

Telephone Number ____

Email address ____

Provider's Website Address. If the company does not have one, enter "None" ______________

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Has there been any adverse regulatory action taken by any state or federal regulatory law enforcement or regulatory agency against the Continuing Care Provider, an owner, a director, an officer, or senior executive officer?

Yes ____ No ____ Comment: ____

If yes, attach an explanation and any documentation pertaining to the action.

Attachment _____

The following information must accompany this application:

1. Payment of a non-refundable Initial Application $7,550 fee, ($6,900 License fee, $600 Disclosure Statement fee and $50 E-commerce fee) or non-refundable Renewal Application $7,550 fee, ($6,900 License renewal fee, $600 Disclosure Statement fee, $50 E-commerce fee)

2. A copy of Provider's current Disclosure Statement that complies with 31A-44-301. If there have been no changes since previous application, mark "no change".

No change ____ Attachment ____ Comment: ____

3. Evidence that the provider's facility is located or will be located in a zone that a municipality or county has zoned for a Continuing Care facility. If there have been no changes since previous application, mark "no change".

No change ____ Attachment ____ Comment: ____

4. A copy of the Provider's articles of incorporation or other business organization documents. If there have been no changes since previous application, mark "no change"

No change ____ Attachment ____ Comment: ____

5. Copy of the Provider's most recent financial statement that:

a. is prepared on a GAAP basis:

b. is audited by an independent Certified Public Accountant

c. complies with Section 31A-44-307(2)

Attachment ____

6. A statement that includes the name and business address of each person that owns or controls 10% or more of the equity interests of the Provider.

No change ____ Attachment ____ Comment: ____

7. A statement that includes the name and business address of each director, president, chief executive officer, or senior executive officer of Provider's continuing care facility.

No change ____ Attachment ____ Comment: ____

Comment Section

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I hereby certify that, under penalty of perjury, all of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or other material information in connection with this application is grounds for license revocation or denial of the license and may subject me to civil or criminal penalties.

I further certify that I grant permission to the Commissioner to verify information with any federal, state, or local government agency, current or former employer, or insurance company.

______________________ ___________ ______________________ _______________

Signature Date Printed Name Title

Submitting this application and attachments thereto certifies that the statements and documentation are true.