LICENSURE APPLICATION
for
COMMUNITY RESIDENTIAL CARE FACILITY

REGULATION 61-84

Return all documentation to:

Email address (preferred method):
CRC@dhec.sc.gov

OR

Mailing address:
Bureau of Health Facilities Licensing
2600 Bull Street
Columbia, SC 29201

For additional questions, contact us at: 803-545-4370.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

NOTICE: *Your license must be renewed **prior** to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.*

Application must be complete and legible. Any missing information may result in delays in processing this application. Any section that requires additional space or documentation shall be included as an attachment in the 8.5" x 11" format and be labeled to identify the appropriate section. Proof of payment is required for all applications submitted.

Reason for the Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department. DO NOT check this box if this is a change of ownership for an existing licensed facility.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date. The name of the facility must appear exactly as it did the prior year.
- Amended License Request: Check this box if you are applying for a change that will alter the information on the face of your license; then, ensure that you complete Part D.

Part A: Facility Information

- Facility Information: Please complete the applicant information for the facility.
- Certified Food Protection Manager: Please complete each field and submit copy of certificate.
- Contact Person and Corresponding Mailing Address: All correspondence coming from the Bureau of Health Facilities Licensing will be sent to this person and address.
- Licensed Administrator: Please complete each field and submit a copy of Administrator's license.

Part B: Operation/Ownership Disclosure

- Licensee Information: Name of the person(s) or entity to be licensed to operate thefacility at the site indicated in Part A.
- Indicate the ownership type: Choose one type per category.
- Complete the requested information:
    - For partnerships, you must provide the name of each partner;
    - For limited liability company (LLC), you must provide the names of members, attach a list with the names and address of the members of the limited liability company;
    - For a corporation, you must provide the name and title of each corporate officer.
- If this is an LLC or Corporation list all persons/entities who have ownership interest in the entity applying for licensure.

Part C: Licensure Changes

- For Facility Name or Address changes, complete Section 1.
- For Ownership changes, complete Section 2.
- For changes in Capacity, complete Section 3.

Part D: Verification

- The application shall be signed by the following:
    - If an individual partnership, ***the owner(s)***
    - If a corporation, ***two*** of its ***officers*** if a corporation
    - If governmental unit, the ***head of the governmental department*** having jurisdiction
- You must have this page notarized.

Community Residential Care Facility
Regulation 61-84

Reason for Application			
☐ Initial	☐ Renewal		☐ Change Request
	License Number:	Expiration Date:	

Part A. Facility Information			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:( )		Fax Number:( )	
Emergency Contact Number: ( )			
Number of beds to be licensed?			
In how many buildings are patient/resident rooms located?			
Name of building:		# of Resident beds:	# of Resident rooms:
Name of building:		# of Resident beds:	# of Resident rooms:
Does the facility provide Alzheimer's special care services? ☐YES ☐NO		Does this facility have a special care ***unit*** for Alzheimer patients? ☐YES ☐NO If yes, how many licensed beds?	
Is your facility part of a continuing care community? ☐YES ☐NO If yes, what other care/service components in addition to the community residential care facility are available on campus (i.e., independent living, nursing home, etc.)?			

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:		
City:	State:	Zip:
Telephone:		
Primary Email:		

Licensed Administrator: (MUST provide a copy of license)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Administrator License Number:	Expiration Date:

Food Service Areas	
Number of Kitchens:	
Is food prepared by a caterer? ☐YES ☐NO (if yes, please attach a copy of the catering contract)	
Certified Food Protection Manager: (must attach a copy of certification FOR INITIAL APPLICATIONS ONLY)	
Name:	
Certificate Date:	Expiration Date:
Course Taken:	Institution:

Part B. Operation and Ownership Disclosure		
Licensee Information: *(name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part A)* ****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		
☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership	☐ Corporation ☐ Limited Liability (LLC)* ☐ Government	☐ Other:

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		
☐Change of Facility Name and/or Location (Complete Section1)	☐Change of Licensee/Ownership (Complete Section2)	☐Change of Licensed Beds(Complete Section 3)

Section 1 (FACILITY INFORMATION)			
PRIOR TO CHANGE			
Current License Number:			
Current Facility Name:			
Current Facility Address:			
City:	State:	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			
Name of Current Owner:		License Number:	
License Number of Current Owner:			
Address of Current Owner:			
City:	State:	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 UNITS)			
License Number:			
Facility Name:			
Facility Address:			
City:	Zip:	State:	County:
Facility Telephone Number:		Fax Number:	
☐ **Increase**		☐ **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

To obtain a license to operate a community residential care facility the person, or persons, required to sign the application for licensure must undergo a state and national fingerprint-based criminal records check. (See SC Code SECTION 44-7-264 (A)).

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 61-84. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 61-84.

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**