LOUISIANA DEPARTMENT OF HEALTH

Health Standards Section
License Application
ADULT BRAIN INJURY FACILITY

☐ *INITIAL* ☐ *RENEWAL* ☐ *CHANGE OF OWNERSHIP* ☐ *CHANGE OF LOCATION* ☐ *KEY PERSONNEL CHANGE*

☐ *OTHER* (Specify) _____ *LICENSE NUMBER* _____ *EXPIRATION DATE* _____

**Check & Payment Transmittal Form must be submitted to LDH at LDH Licensing Fee, PO Box 734350, Dallas, TX 75373-4550*
TOTAL FEE AMOUNT INCLUDED _____ *CHECK / MONEY ORDER #* _____

☐ **check if any change has occurred since last application** **STATE ID #BR**

I. *FACILITY (DBA) NAME* _____

GEOGRAPHICAL ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (____) _____ *FAX NUMBER* (____) _____ *EMAIL ADDRESS*_____

II. **MAILING ADDRESS** *(IF DIFFERENT FROM ABOVE)* _____

CITY / STATE / ZIP _____

III. Program Director: _____ **Director of Nursing:** _____

IV. **POPULATION SERVED** ☐ *MALE* ☐ *FEMALE* ☐ *BOTH* *ADMISSION AGE RANGE:* _____ *YRS. TO* _____ *YRS.*

V. **TYPE OF BRAIN INJURY PROVIDER**

☐ a. Residential - A facility publicly or privately owned providing a rehabilitative treatment environment which serves four or more adults who suffer from brain injury and at least one of whom is not related to the operator. Services include personal assistance or supervision for a period of **twenty-four hours** continuously per day preparing them for community integration.

☐ b. Community Living - A home or apartment publicly or privately owned providing a rehabilitative treatment environment which serves one to six adults who suffer from brain injury and at least one of whom is not related to the operator, in a home or apartment setting preparing them for community integration.

☐ c. Outpatient - A facility publicly or privately owned providing an outpatient rehabilitative treatment environment which serves adults who suffer from brain injury and at least one of whom is not related to the operator, in an outpatient day treatment setting in order to advance the individual's independence for higher level of community or transition to a greater level of independence in community or vocational function.

DAYS OPEN DURING WEEK *(Circle) MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY SUNDAY*
HOURS OF OPERATION _____ *a.m.* _____ *p.m. TO* _____ *a.m.* _____ *p.m.*

VI. **TYPE OF OWNERSHIP:**

NON- PROFIT	FOR – PROFIT	GOVERNMENT
☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *FEDERAL*
☐ *CORPORATION*	☐ *CORPORATION*	☐ *STATE*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*	☐ *PARISH*
☐ *RELIGIOUS AFFILIATION*	☐ *GROUP PRACTICE*	☐ *CITY/PARISH*
☐ *UNINCORPORATED ASSOCIATION*	☐ *OTHER (Specify):* _____	☐ *CITY*
☐ *OTHER (Specify):* _____		☐ *COMBINATION GOV-N-PROFIT*
		☐ *OTHER (Specify):* _____

VII. *ENTITY / CORPORATION NAME* _____

MAILING ADDRESS (IF DIFFERENT) _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (_____) _____ *FAX NUMBER* (_____) _____ *EIN#*_____

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-0157 • www.ldh.la.gov/hss

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VIII. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

OWNER	ADDRESS	TELEPHONE #

IX. *If the disclosing entity is a corporation, list name, address and telephone number of the President.*

NAME	*ADDRESS*	*TELEPHONE NUMBER*

X. *Are any owners of the disclosing entity also owners of other licensed health care facilities?* ☐ *Yes* ☐ *No*
(Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other provider numbers.

NAME	*ADDRESS*	*PROVIDER NUMBER*

XI. *Has there been a change of ownership or control within the last year?* ☐ *Yes* ☐ *No* *If yes, give date:* _____

XII. BRANCHES (OFFSITES)

Type Provider: R=Residential, O=Outpatient; Capacity required for Residential only

Type Provider: R or O	Capacity	License #	Branch DBA Name	Address	City	Zip	Parish	Phone	Fax

XIII. *Total LICENSED CAPACITY (Residential only, main location & branches)* _____ ☐ *N/A*

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ATTESTATION:

- ***I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Louisiana Department of Health, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Louisiana Department of Health.***
- ***Emergency Preparedness Attestation: I certify that I am in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules and regulations concerning emergency preparedness.***

_____

AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

_____ _____

AUTHORIZED REPRESENTATIVE SIGNATURE ***DATE***

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