LOUISIANA DEPARTMENT OF HEALTH

Health Standards Section
License Application
THERAPEUTIC GROUP HOME

☐ *INITIAL* ☐ *RENEWAL* ☐ *OTHER* **(Specify)** _____

LICENSE NUMBER _____ *EXPIRATION DATE* _____

TOTAL FEE AMOUNT INCLUDED _____ *CHECK / MONEY ORDER #* _____

Check & Payment Transmittal Form must be submitted to LDH Licensing Fee, PO BOX 734350, Dallas, TX 75373-4350

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

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. CLINICAL DIRECTOR _____

HOUSE MANAGER _____

IV. TYPE OF OWNERSHIP:

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

V. ***ENTITY / CORPORATION NAME*** _____

MAILING ADDRESS (IF DIFFERENT) _____

CITY / STATE / ZIP _____

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

VI. ***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 #

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5292 • http://ldh.la.gov/

THERAPEUTIC GROUP HOME

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

NAME	*ADDRESS*	*TELEPHONE #*

VIII. ***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 #*

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

X. ***PROGRAM OPERATIONAL INFORMATION (Information as of the date of application)***

 # OF LICENSED UNITS (Bedrooms) _____ # OF LICENSED BEDS _____

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***