State of Alaska
Department of Health and Social Services
Division of Health Care Services
Residential Licensing

Modification Application for Assisted Living Homes

*Please read this application carefully and answer **ALL** applicable questions. Incomplete applications will be returned to the applicant for completion.* If you have questions regarding any information requested on this application, please contact: (907) 334-2400 to speak with a licensing specialist or contact your assigned licensing specialist.

1. **Name of Assisted Living Home:**_____

2. **Applicant:** The applicant is the individual or legal entity responsible for operation of the proposed assisted living home and will be listed owner on the license:

   Applicant:_____

   Name of Person Completing App:_____

   Physical Address:_____

   City:_____ State:_____ Zip Code:_____

   Mailing Address:_____

   City:_____ State:_____ Zip Code:_____

   Email Address:_____

   Phone number:_____ Fax Number:_____

3. **Modification: Please select the modification the Home is seeking**:

   ☐ **Change in Association, Corporation, or other entity-** Please complete the Association, Corporation, or other entity Worksheet with the proposed changes. *(No Fee)*

   ☐ **Change in Physical Location-** Please provide the proposed physical address of the new location. *Note: Additional items may be requested.*

   Physical Address:_____

   City:_____ State:_____ Zip Code:_____

   If the applicant is not the owner of the proposed new location please provide the following information of the owner:

   Name:_____

   Physical Address:_____

   City:_____ State:_____ Zip Code:_____

   Mailing Address:_____

   City:_____ State:_____ Zip Code:_____

   Email Address:_____

   Phone number:_____ Fax Number:_____

   ☐ **Change in Mailing Address-** Please provide the proposed new mailing address of the location Note: Additional items may be requested. *(No Fee)*

   Mailing Address:_____

   City:_____ State:_____ Zip Code:_____

☐ **Change in the Home's Name-** Please provide the proposed new name of the Home. *(No Fee)*

Proposed New Name of the Home: _____

☐ **Change in Telephone Number-** Please provide the new phone number. *(No Fee)*

Website Phone Number: _____

Facility Phone Number: _____

Administrator Phone Number: _____

☐ **Change in Licensing Type-** Please indicate the population you wish to serve. *(No Fee)*

☐ Adults age 18 years of age or older who have a mental health or developmental disability (DD/MH).

Or,

☐ Adults age 18 years of age or older who have physical disability, are elderly, or suffering from dementia, but who are not chronically mentally ill (SS).

☐ **Change in Capacity-** Please provide the total number of individuals the home intends to serve. *($25.00 fee for each addition resident added to current capacity, there is No Fee to increase capacity from 1 to 2).*

Currnet Number of Residents: _____ Proposed Number of Residents: _____

☐ **Change in Administrator, Designee, or Resident Manager-** Please provide the name of the individual for the proposed change of Administrator, Designee, or Resident Manager and complete an Administrator, Designee, or Resident Manager Designation Application. *(No Fee)*

☐ **Administrator:** _____

☐ **Designee:** _____

☐ **Resident Manager:** _____

☐ **Other Major Modifications:** A "major modification" means a change to the home that, during construction of the modification, would adversely affect the residents, services to residents, or emergency evacuation of residents. Please provide the details of the proposed modification.

4. Modification fees: Please include check or money order with this application.

☐ **For increasing from one (1) to two (2) residents:**	No Fee
☐ **For increasing from two (2) to three (3) or more residents:**	$25.00 per resident increased
	_____ x $25.00=_____
☐ **Change of Location:**	$25.00
☐ **Major Modification:**	$25.00
☐ **All Other Changes:**	No Fee

Total fee enclosed:_____

This is to certify that this applicant agrees:

To comply with applicable licensing statutes and regulations, including but not limited to AS 47.05, AS 47.32, AS 47.33, 7 AAC 10 and 7 AAC 75.

To keep records necessary to demonstrate compliance with the statutes and regulations governing licensure of assisted living homes and to make such records available to the Department of Health and Social Services, or its authorized representatives, upon request.

To permit representatives of the Department of Health and Social Services access to inspect the assisted living home, review records, including files of individuals who received services from the assisted living home; interview staff; and interview individuals receiving services from the assisted living home.

I attest that I am a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien authorized by the Immigration and Naturalization Service to work in the United States. By my signature below, I certify that the information contained in this application and applicable attachments is true, accurate, and complete.

Signature of Applicant: _____ Date: _____

Printed Name of Applicant: _____

Notarized by:

Signature of Notary for State of Alaska: _____

Printed Name of Notary: _____

My Commission Expires: _____

Submit Completed Application to:

State of Alaska
DHSS/Division of Health Care Services
Residential Licensing
4601 Business Park Blvd, Bldg K
Anchorage, AK 99503