



**State of Alaska  
Department of Health  
Division of Health Care Services  
Residential Licensing**

**Modification Application for Assisted Living Homes**

**Read this application carefully and answer ALL applicable questions.** If you have questions regarding any information requested on this application, contact: (907) 334-2400 to speak with a licensing specialist or contact your assigned licensing specialist.

1. **Name of Assisted Living Home (as listed on license):** \_\_\_\_\_

2. **Current Owner of License:** The owner is the individual or legal entity responsible for operation of the assisted living home and will be listed as the owner on the license:

Current Owner: \_\_\_\_\_

Current Administrator: \_\_\_\_\_

Name of Person Completing App: \_\_\_\_\_

**Modification: Select the modification(s) the Home is seeking. Note: Additional items may be requested.**

3.  **Change in Ownership, Association, Corporation, or other entity** - Complete and submit the following:

a. Proposed Ownership: \_\_\_\_\_

b. Association, Corporation, or other entity Worksheet.

c. Ownership Interest Worksheet.

d. Current Business License, Certificate of Organization, and most recent Initial/Biennial Report filing.

4.  **Change in Physical Location** - Complete and submit the following documents and provide the physical address of the proposed location: (\$25.00 fee)

a. Floor Plan of Proposed Location.

b. Updated Disaster and Evacuation Preparedness Policy.

c. Certificate of Occupancy (If Applicable).

d. Copy of 90 Day Notice Sent to Residents/Representative.

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\* If the applicant is not the owner of the proposed new location, provide the following information of the property owner:

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

5.  **Change in Mailing Address** - provide the proposed new mailing address of the location.

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

6.  **Change in the Home's Name** - provide the proposed new name of the Home and submit the additional items below:

**Proposed New Name of the Home:** \_\_\_\_\_

7.  **Change in Telephone Number or Email** - provide the new phone number(s).

Website Phone Number: \_\_\_\_\_

Facility Phone Number: \_\_\_\_\_

Administrator Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

8.  **Change in Licensing Type**- indicate the population you wish to serve and submit the additional items below: *(No Fee)*

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

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

Adults, age 18 and older, who have physical disability, are elderly or suffer from dementia and/or have a mental or developmental disability (DU).

Submit the following:

- a. If requesting a change to be Dually Licensed, submit a Safety Plan addressing how the Home will ensure the safety of all residents and provide adequate care for both populations.
- b. Documentation demonstrating the Administrator's qualifications for the population(s) served.
- c. Updated Policies that address the new population served (If Applicable).
- d. Updated Staffing Plan.
- e. Updated staff training to address the new population being served.

9.  **Change in Capacity**- provide the current capacity of the Home and indicate how many beds the Home would like to increase or decrease its capacity by.

*(\$25.00 fee for each addition bed added to current capacity, there is No Fee to increase from 1 to 2 beds or decrease capacity).*

What is the Home's current licensed capacity? \_\_\_\_\_

How many additional beds do you want to increase by? \_\_\_\_\_

How many beds do you wish to decrease by? \_\_\_\_\_

What will be your Home's new proposed total capacity? \_\_\_\_\_

Submit the following:

- a. Updated Floor Plan (If Applicable).
- b. Updated Disaster and Evacuation Preparedness Policy (If Applicable).
- c. Certificate of Occupancy (If Applicable).
- d. There may be additional items requested depending on the capacity requested and your location.

10.  **Change in Administrator, Designee, or Resident Manager**- provide the name of the individual for the proposed change of Administrator, Designee, or Resident Manager.

Administrator: \_\_\_\_\_

Designee: \_\_\_\_\_

Resident Manager: \_\_\_\_\_

Submit the following:

- a. Administrator, Designee, or Resident Manager designation questionnaire with all required documents.

11.  **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. Provide the details of the proposed modification.

**Modification fees:** Contact the 907-334-2400 to pay by phone or include check or money order with this application.

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|--|---|
| <input type="checkbox"/> For increasing capacity from one (1) to two (2) residents or decreasing capacity: | No Fee  |
| <input type="checkbox"/> For increasing capacity from two (2) to three (3) or more residents:              | \$25.00 per resident increased<br>_____ x \$25.00=_____ |
| <input type="checkbox"/> Change of Location:   | \$25.00   |
| <input type="checkbox"/> Major Modification:   | \$25.00   |
| <input type="checkbox"/> All Other Changes:  | No Fee  |
| <b>Total fee enclosed:</b> _____   |   |

**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, or its authorized representatives, upon request.

To permit representatives of the Department of Health, 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.

Printed Name of Authorized Individual: \_\_\_\_\_

Signature of Authorized Individual: \_\_\_\_\_ Date: \_\_\_\_\_