IDAHO DEPARTMENT OF HEALTH & WELFARE DIVISION OF LICENSING & CERTIFICATION
BUREAU OF FACILITY STANDARDS
3232 ELDER STREET, P.O. BOX 83720
BOISE, ID 83720-0009
APPLICATION FOR
INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

The undersigned hereby makes application for a license to operate an ICF/ID, subject to the provisions of the Idaho State Codes, Section 39-1303a, 39-1307, and 67-6532, as amended, and to the rules, regulations, and standards adopted thereunder by the Board of Health and Welfare.

I CLASSIFICATION

A Identification

Facility

Address

City State: Idaho Zip Code

County Phone Number

B Ownership (***Check only one***) Check the entity that has legal responsibility for operation of the facility.

For Profit ◯ Individual ◯ Partnership ◯ Corporation

Non-Profit ◯ Religious related ◯ Non-profit Corp ◯ Other Non-profit

State or Local Government ◯ State ◯ County ◯ City/County ◯ Hospital District

1. If facility is a corporate facility, give legal corporation name, address, and phone/fax number:

Facility

Address

City State Zip Code

Phone Number Fax Number

2. Please list the names and addresses of those persons with ownership interests in the corporation of facility, and as applicable identify the percentage of ownership. Use extra paper if necessary

Name: Address

Phone Number Fax Number Percent

Name: Address

Phone Number Fax Number Percent

Name: Address

Phone Number Fax Number Percent

3. Please list all other business entities, and the addresses of each, under the same ownership. Use extra paper if necessary.

Name: Address

Name: Address

Name: Address

C Administration

Administrator:

OFFICERS OF THE GOVERNING BOARD

President: Phone Number

Vice-president: Phone Number

Secretary: Phone Number

II BEDS

Licensed Bed Capacity Requested:

III EFFECTIVE DATE

A. **Change of Ownership -** specify date that change of ownership occurs

B. **New Facility -** specify date the facility will begin admitting individuals

IV Fiscal Year End Date

Fiscal Year End Date (mm/dd)

I certify the information herein submitted is true, complete, and correct to the best of my knowledge and belief.

Signature:

Title

Date

Print Form