Make Payment to : Treasurer, State of Wyoming	
Nursing Care Facility License Fees	
0-50 beds	$100
51-100 beds	$200
101-150 beds	$300
151-200 beds	$400
201 or more beds	$500

Wyoming Department of Health
Aging Division
Healthcare Licensing and Surveys
6101 Yellowstone Rd., Suite 186C
Cheyenne WY 82002
Ph: 307-777-7123 Fax: 307-777-7127
Website: www.health.wyo.gov/ohls

HLS USE ONLY:	
Check #	
Fee Paid	
Appl Approval	

HEALTHCARE FACILITY

ANNUAL RENEWAL

LICENSE APPLICATION
FOR A
NURSING CARE FACILITY

License Application Questions?
E-mail: tammy.schmitt@wyo.gov

INSTRUCTIONS: This application may be completed electronically, however, it must be print it off and **original signatures are required**. We cannot accept an electronic application submission. If you have more than one facility**, a separate check and a separate application must be submitted for each facility.** Credit card payments are not accepted. Payment should be made payable to TREASURER, STATE OF WYOMING. Please return the original signed application and fee to the address listed at the top of this form.

In Microsoft Office Word use the tab key to advance throughout the document. (Revised 04/07/15)

APPLICATION CONTACT			
If we have questions or concerns regarding the information provided on this application, whom should we contact?			
Facility Name			
Contact Person's Name			
Phone Number		**E-mail**	

IMPORTANT NOTE!

If at the time of annual renewal (July 1st) you have any of the following items listed below, please contact our office for further direction before proceeding with this application!

Change in Ownership, Change in # of Beds, Change in Facility Name, Change in Physical Location, Addition/Change of Ancillary Location

GENERAL INFORMATION							
Facility Name (include dba if desired – this will be how the name appears on the facility license so be exact)							
Mailing Address		**City**		**State**		**Zip**	
Physical Address		**City**		**State**		**Zip**	
County		**Fiscal Year End Date**					
Phone #		**Fax #**					
E-mail Address: (This will be the E-mail address used for receipt of survey results, official notices, etc. from this office. Only one e-mail address can be utilized.)							

Facility Name	

Total # of Beds to be Licensed		Certification Designation (Select Only One)	SNF/NF Title 18 & Title 19 beds	☐	SNF Title 18 beds only	☐	NF Title 19 beds only	☐

Medicare Provider # (53xxxx number)		Medicaid Provider #		NPI #	

Admission & Occupancy Data (Use period from April 1 previous year thru March 31 current year) (An example is on page 5)			
Annual Admissions:			
Actual Total Patient Days of Care: (Total Daily Census for the Year)		Available Total Patient Days of Care: (# of licensed beds x # days in year)	
Occupancy Rate Percentage: (Actual Total Patient Days of Care / Available Total Patient Days of Care)			

PERSONNEL INFORMATION			
Administrator		WY Nursing Home Administrator License #	
Director of Nursing		WY Nursing License #	
Medical Director		WY Professional License #	
Maintenance Director		Phone Number	
CEO or COO (If applicable)			

BUILDING INFORMATION			
Main Building Name			
Location (Physical Address)			
List of Nursing Care Facility Services at this Location			
Date these Services Began			
Do you have other ancillary locations the Nursing Care Facility is providing services at?	Yes ☐ No ☐		
Complete the questions below for each Nursing Care Facility ancillary location and attach additional sheets as needed. PLEASE review this information for accuracy before submitting. Do not just attach information from previous years.			
Ancillary Location (Physical Address)			
List of Nursing Care Facility Services at this Ancillary Location			
Have you had any changes at this ancillary location since the previous license renewal? SUCH AS: location change, service change, etc.	Yes ☐ No ☐		
Date these Services Began			
Additional Sheets Attached:	Yes ☐ No ☐		

NOTE ** You must attach one current copy (preferably 8 ½ X 11 size) of the facility floor plan (including ancillary locations) with the facility's name clearly identified on the plans. **

Facility Name	

OWNERSHIP INFORMATION								
NOTE: This is the owner of the healthcare facility business – not the owner of the physical structure.								
Individual Proprietorship	Complete the following or check if separate listing attached				Separate list	☐		
	Owner's Name							
	Address							
	Phone							
Corporation	Complete the following or check if separate listing attached				Separate list	☐		
	Corporation Name							
	Address							
	Phone							
	List All Corporate Officers Names & Titles							
Partnership	Complete the following or check if separate listing attached				Separate list	☐		
	Partnership Name							
	Address							
	Phone							
	List All Names of Partners							
Limited Liability Company	Complete the following or check if separate listing attached				Separate list	☐		
	LLC Name							
	Address							
	Phone							
	List All Members Names & Titles							
Governmental	Check appropriately:							
	State	☐	Hospital District	☐	County	☐	Other (specify)	
	Complete the following or check if separate listing attached				Separate list	☐		
	Entity Name							
	Address							
	Phone							
	List All of the Officers, Board Members, Commissioners etc. by Names & Titles							
Other	Describe Ownership Arrangement/Type:							
	Complete the following or check if separate listing attached				Separate list	☐		
	Entity Name							
	Address							
	Phone							
	List of All Owners Names & Titles							

Facility Name	

OPERATOR INFORMATION			
Is the facility operated/managed by a business entity <u>other than</u> the owner listed above? **(Do not list the administrator/director here.)**		**Yes**	☐
		No	☐
If Yes,	**Operating Entity Name**		
	Address		
	Phone		
	Contact Name		

Has the owner or operator ever had a license to operate a healthcare facility or agency providing healthcare services in this or any other state denied, suspended revoked or otherwise terminated for cause?	**Yes**	☐
	No	☐
Does the facility have in place a documented quality management function to evaluate and improve patient/resident/client care and services?	**Yes**	☐
	No	☐
Did you read and understand the healthcare facility licensure requirements (W.S. 35-2-901 and 902 et seq) outlined in the attachment?	**Yes**	☐
	No	☐

SIGNATURE SECTION

Wyoming statutes requires signature by **two (2) officers** of the organization (or one signature for an individual proprietorship) – or a signature of all managing agents. If signed by managing agents, copies of company documents indicating the individuals signing are managing agents for the company must be attached.

I have read the contents of this application. My signature legally binds the facility's agreement to abide by the rules promulgated by the State of Wyoming for this category of healthcare facility and do hereby state the information provided on this application is true to the best of my knowledge and belief.

The facility further understands the facility is responsible for admitting and retaining only those persons who qualify for this category of healthcare facility as defined in the applicable rules and facility policies and procedures. The facility agrees to allow authorized representatives of the Wyoming Department of Health, upon presentation of proper identification, to enter the facility at any time without a warrant and review any and all facility records and documentation as necessary to ascertain compliance with State licensing laws and rules promulgated by the Wyoming Department of Health.

Note: (Application must have original signatures <u>of two of the officers as listed in the ownership section</u> above. In most cases, a CEO, CFO, and Administrator signatures will not be acceptable.

SIGNATURE #1	
Signature:	
Printed/Typed Name:	
Title:	
SIGNATURE #2	
Signature:	
Printed/Typed Name:	
Title:	

ATTACHMENT

OCCUPANCY RATE % EXAMPLE (April 1 – March 31)	
x = Determine Actual Total Resident Days of Care	Add up the total daily census for the year. Apr 1 = 10; Apr 2 = 15; Apr 3 = 15, etc. TOTAL = x
y = Determine Available Total Residents Days of Care	Take the number of licensed beds X number of days in calendar year 105 lic beds x 365 days = y
z = Determine Occupancy Rate Percentage	(Actual Total Resident Days of Care ÷ Available Total Residents Days of Care) x ÷ y = z
EXAMPLE:	x = 34,659 days (10+15+15+etc.)
	y = 38,325 days (105 x 365)
	z = 90% (34,659 ÷ 38,325)

LICENSE STATUTE

TITLE 35 / PUBLIC HEALTH AND SAFETY
CHAPTER 2 / HOSPITALS, HEALTH CARE FACILITIES AND HEALTH SERVICES
ARTICLE 9 / LICENSING AND OPERATIONS

35-2-901. Definitions; applicability of provisions.

(a) As used in this act:

(i) "Acute care" means short term care provided in a hospital;

(ii) "Ambulatory surgical center" means a facility which provides surgical treatment to patients not requiring hospitalization and is not part of a hospital or offices of private physicians, dentists or podiatrists;

(iii) "Birthing center" means a facility which operates for the primary purpose of performing deliveries and is not part of a hospital;

(iv) "Boarding home" means a dwelling or rooming house operated by any person, firm or corporation engaged in the business of operating a home for the purpose of letting rooms for rent and providing meals and personal daily living care, but not habilitative or nursing care, for persons not related to the owner. Boarding home does not include a lodging facility or an apartment in which only room and board is provided;

(v) "Construction area" means thirty (30) highway miles, from any existing nursing care facility or hospital with swing beds to the site of the proposed nursing care facility, as determined by utilizing the state map prepared by the Wyoming department of transportation;

(vi) "Department" means the department of health;

(vii) "Division" means the designated division within the department of health;

(viii) "Freestanding diagnostic testing center" means a mobile or permanent facility which provides diagnostic testing but not treatment and is not part of the private offices of health care professionals operating within the scope of their licenses;

(ix) Repealed By Laws 1999, ch. 119, § 2.

(x) "Health care facility" means any ambulatory surgical center, assisted living facility, adult day care facility, adult foster care home, alternative eldercare home, birthing center, boarding home, freestanding diagnostic testing center, home health agency, hospice, hospital, intermediate care facility for people with intellectual disability, medical assistance facility, nursing care facility, rehabilitation facility and renal dialysis center;

(xi) "Home health agency" means an agency primarily engaged in arranging and directly providing nursing or other health care services to persons at their residence;

(xii) "Hospice" means a program of care for the terminally ill and their families given in a home or health facility which provides medical, palliative, psychological, spiritual and supportive care and treatment;

(xiii) "Hospital" means an institution or a unit in an institution providing one (1) or more of the following to patients by or under the supervision of an organized medical staff:

(A) Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons;

(B) Rehabilitation services for the rehabilitation of injured, disabled or sick persons;

(C) Acute care;

(D) Psychiatric care;

(E) Swing beds.

(xiv) "Intermediate care facility for people with intellectual disability" means a facility which provides on a regular basis health related care and training to persons with intellectual disabilities or persons with related conditions, who do not require the degree of care and treatment of a hospital or nursing facility and services above the need of a boarding home. The term also means "intermediate care facility for the mentally retarded" or "ICFMR" or "ICFs/MR" as those terms are used in federal law and in other laws, rules and regulations;

(xv) "Medical assistance facility" means a facility which provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient care to persons needing that care for a period of no longer than sixty (60) hours and is located more than thirty (30) miles from the nearest Wyoming hospital;

(xvi) "Nursing care facility" means a facility providing assisted living care, nursing care, rehabilitative and other related services;

(xvii) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine or surgery under state law;

(xviii) "Psychiatric care" means the in-patient care and treatment of persons with a mental diagnosis;

(xix) "Rehabilitation facility" means an outpatient or residential facility which is operated for the primary purpose of assisting the rehabilitation of disabled persons including persons with acquired brain injury by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluations and training or any combination of these services and in which the major portion of the services is furnished within the facility;

(xx) "Renal dialysis center" means a freestanding facility for treatment of kidney diseases;

(xxi) "Swing bed" means a special designation for a hospital which has a program to provide specialized in-patient long term care. Any medical-surgical bed in a hospital can be designated as a swing bed;

(xxii) "Assisted living facility" means a dwelling operated by any person, firm or corporation engaged in providing limited nursing care, personal care and boarding home care, but not habilitative care, for persons not related to the owner of the facility. This definition may include facilities with secured units and facilities dedicated to the special care and services for people with Alzheimer's disease or other dementia conditions;

(xxiii) "Adult day care facility" means any facility not otherwise certified by the department of health, engaged in the business of providing activities of daily living support and supervision services programming based on a social model, to four (4) or more persons eighteen (18) years of age or older with physical or mental disabilities;

(xxiv) "Adult foster care home" means a home where care is provided for up to five (5) adults who are not related to the provider by blood, marriage or adoption, except in special circumstances, in need of long term care in a home like atmosphere. Clients in the home shall have private rooms which may be shared with spouses and shall have individual handicapped accessible bathrooms. "Adult foster home" does not include any residential facility otherwise licensed or funded by the state of Wyoming. The homes shall be regulated in accordance with this act and with the Wyoming Long Term Care Choices Act, which shall govern in case of conflict with this act;

(xxv) "Alternative eldercare home" means a facility as defined in W.S. 42-6-102(a)(iii). The homes shall be regulated in accordance with this act and with the Wyoming Long Term Care Choices Act which shall govern in case of conflict with this act;

(xxvi) "This act" means W.S. 35-2-901 through 35-2-912.

(b) This act does not apply to hospitals or any other facility or agency operated by the federal government which would otherwise be required to be licensed under this act or to any person providing health care services within the scope of his license in a private office.

35-2-902. License required.

No person shall establish any health care facility in this state without a valid license issued pursuant to this act.