ASSISTED LIVING FACILITY
APPLICATION FORM

ARKANSAS HEALTH SERVICES PERMIT COMMISSION

ARKANSAS HEALTH SERVICES PERMIT AGENCY
MOSAIC TEMPLARS STATE TEMPLE
906 BROADWAY, SUITE 200
LITTLE ROCK, AR 72201
(501) 661-2509

INSTRUCTIONS FOR COMPLETION OF
PERMIT OF APPROVAL APPLICATION FORM

General Instructions

In accordance with adopted policies pursuant to Arkansas Act 593 of 1987, as amended, all parties desiring to obtain a Permit of Approval are required to provide the requested information on this application form. Failure to supply adequate information may result in a delay in the review, a return of the application, or a denial of the application. Please refer to the Health Services Permit Commission's Policies and Procedures for Permit of Approval for details of the scope of coverage, projects subject to review, and specific procedures for processing applications.

1. **Please review the Commission's adopted Assisted Living Facility need standards and criteria before starting the application process.**

2. **The Agency recommends that each applicant meet with a staff member of the Health Services Agency (by appointment) for a pre-submission conference.**

3. **Each question must be addressed fully. Contact the staff before a response of "not applicable" is made in order to insure that it is an appropriate response.**

4. **One (1) original and one (1) copy of the completed application along with the appropriate fee must be submitted to the Health Services Permit Agency in accordance with the established batching schedule. The original must be signed in blue ink. Please do not send applications in binders or folders.**

ASSISTED LIVING FACILITY (ALF)
APPLICATION FORM

Check one: This application is for

- **A new ALF_☐__**
- **A replacement ALF _______☐_________**
- **Additional beds for a currently licensed ALF_☐_ or for an existing RCF_☐**
- **Additional beds for an existing POA ____☐_______**
- **Transfer of a POA __☐____*(Must also attach Request to Transfer Application).***

I. GENERAL INFORMATION

A. Current Facility (*Applies to replacement or additions only*)

Name of Facility:____

Address: ____

City: _________________________Zip Code: __________________

County:____________________ Phone: _______________________

Fax: _________________ Email: _____________________________

B. Proposed Facility *(Applies to replacement or new facilities.)*

Name of Facility:_____________________________

Address:____

City: _________________________Zip Code: __________________

County:____________________ Phone: _______________________

C. Identification of applicant

Name of Applicant:____

Address: ____

City: _________________________Zip Code: __________________

Phone: ___________________ Fax ____________________________

Email ____

D. Application Contact Person: (*This person will be contacted regarding any questions about this application).*

Name: _______________________________________

Corporation/Company____

Title ____

Address: ____

City: ___________________________**Zip Code:** ___________________

Phone: _____________________**Fax:**____________________________

Email: ____

E. Project Contact Person: (*This person will be contacted regarding progress or questions about the project if a POA is awarded)*

Name: _______________________________________

Corporation:_________________________________

Title: ____

Address: ____________________________________

City: ___________________________**Zip Code:** ___________________

Phone: _____________________**Fax:**____________________________

Email: ____

F. Ownership of Facility (Check One):

Individual Owner _☐_ Corporation _☐_
Partnership _☐_ List Names and Addresses of all Partners
____
____
____

- **Parent Organization: ________________________________**

- **Does <u>this company</u> currently own an Assisted Living Facility in Arkansas or in another state? Yes ___☐___ No __☐___**

- **If yes, what is the name, and location of the Facility?**

  ____

  ____

- **Do any of the <u>current owners or partners</u> have an interest or ownership in other Assisted Living Facilities in Arkansas or in another state?**
  Yes__☐____ No__☐______

  - **If yes, please list names of owners / partners and affiliated Assisted Living Facilities.**

  ____

  ____

  ____

- **Does applicant currently manage, own or operate Assisted Living Facilities in Arkansas or in another state? Yes☐ No ☐**

  - **If yes, name and location of facilities.**

  ____

  ____

  ____

II. Project:

A. General Information (<u>All</u> applicants must complete this section)

- **Assisted Living Level I or II**
- **County Bed Need ______________**
- **Number of beds proposed ___________________**
- **Gross square feet to be constructed ____________________**
- **Proposed per square foot construction cost ______________**
- **First year projected annual operating cost: _______________**
- **Estimated project initiation date: ________________**

- **Estimated project completion date: ______________**

- **For new construction:**

  - **provide a letter from the local Planning Commission stating that the property is properly zoned.**

  - **provide documentation that an option has been obtained for the site or documentation of land ownership.**

  - **attach physical description of location such as cross streets, highway intersections, etc.**

F. Project Description (All applicants must complete this section. Failure to complete this section will render your application incomplete and ineligible for review).

- **Describe the proposed project, including the services you are planning to provide. (Please do not include details of the type of construction.)**

  (Example: This is new construction of a 15 bed assisted living facility which will have 15 patient rooms, a beauty shop, common dining room, outdoor courtyard, soda fountain, theatre, chapel. We will provide 24-hour supervision, transportation, meals.)

II. COMPLIANCE WITH REVIEW CRITERIA

Unfavorable Review - Please see the Assisted Living Methodology, Unfavorable Review section.(https://www.healthy.arkansas.gov/programs-services/topics/arkansas-health-services-permit-agency); click on the PDF file and go to Assisted Living Methodology)

III. CRITERION #1 "Whether the proposed project is needed"

A. Population Based Need.

1. Please submit a market feasibility study.
At a minimum, the feasibility study should include a narrative description with supporting data and analysis that illustrates the need for and Assisted Living Facility in the proposed service area. Data and analysis should also be included for the following:

- **Population characteristics of the county and targeted service area by age, gender, income, morbidity, functional impairments. You must include a narrative description of the relationship between this demographic data and the population you can expect to enter your Assisted Living Facility.**
- **Market and Payor mix for intended facility.**
- **Proximity to other facilities including Residential Care, Nursing Homes, Hospitals, or clinics.**
- **Current local conditions that favor the occupancy or sustainability of the proposed facility.**
- **Local support for the project**
- **Transportation access to the facility**
- **Resident access to other local health, recreational, or other services.**
- **Special needs of this community.**
- **Special features of this facility.**

IV. CRITERION #2 "Can the proposed project be adequately staffed and operated when completed?"

A. List by type the number of staff required by DHHS Office of Long Term Care (OLTC) to support this project:

B. Explain your plan for recruiting and retaining staff to meet the staffing requirements of OLTC.

V. CRITERION # 3 "Is the proposed project economically feasible?

A. Cost Estimates for Project

Financing and other Cash Requirements

Loans Fees	**$_________________**
Bond Issue Cost	**$_________________**
Legal Fees, Printing, etc.	**$_________________**
Financial Feasibility Study	**$_________________**
Consultant Fees	**$_________________**
Permits (Building, Utilities, Etc.)	**$_________________**
Capitalized Interest During Construction	**$_________________**
Debt Service Reserve Fund	**$_________________**
Other (Specify)	**$_________________**
TOTAL	**$ _________________**

B. Physical Plant Costs

Construction Costs	**$_________________**
Renovation Cost	**$_________________**
Fixed Equipment (not included in construction)	**$_________________**
Architect's Fee	**$_________________**
Engineering Fees	**$_________________**
Contingency Factor (Cost Overrun)	**$_________________**
TOTAL	**$_________________**

C. Working Capital Start-up Cost	**$_________________**
TOTAL EXPENSES	**$_________________**

D. Please indicate the sources of capital funds:

Source	Amount	Percent
Tax Credits	$_______________	_______________
Commercial Loans	$_______________	_______________
Government Grants and Loans (Please Specify)	$_______________	_______________
Retained Earnings	$_______________	_______________
Other Debt Financing	$_______________	_______________
Other	$_______________	_______________
TOTAL	$_______________	**100%**

E. You are required to attach original letters of commitment or agreements that indicate the above financing can be obtained. All submitted documentation must be signed and dated within 90 days of the application due date**.** Depending on your financing plan in Section C above, you must submit at least one of the following:

1. Pre-approved loan for Total Capital and Working Capital Start-up Cost as evidenced by a confirmed loan commitment on bank / lending institution's original letterhead with signature.

2. Proof of bank deposit or financial statement for the amount needed for the project.

3.Audited financial statement showing retained earnings equal to the amount of the project with signature by an accountant not directly employed by the corporation.

F. What are the terms of debt financing?

1. Rate of Interest _______________

2. Term of Debt (years) _______________

3. Annual Debt Service _______________

4. Total Debt Service _______________

5. **Total Annual Depreciation cost for facility ____________________**

G. Budget Requirements

1. **For new Facilities, a three-year pro forma budget is required as an attachment to the application.**

2. **For existing facilities, provide the last three years audited income and expense report.**

VI. CRITERION # 4

How will this project help to contain the costs of healthcare in the local health services community and save state and federal money?

CERTIFICATION

This form completed by: ____

Name Phone

____

Corporation

____

Title

____

Address

____

City State Zip

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

______________________________ ______________________________

Date Signature

____

Title