

**State of Alaska**  
**Department of Health and Social Services**  
**Division of Health Care Services**  
**Certification & Licensing**



**Application for Renewal of Assisted Living Home License**

*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) 269-3640 to speak with a licensing specialist.*

1. **Name of the Assisted Living Home:** \_\_\_\_\_

2. **Applicant:** The applicant is the individual or legal entity responsible for operation of the assisted living home. If granted, the license will be issued in the name of the applicant.

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

Title of Applicant  
(if applicable): \_\_\_\_\_

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

\_\_\_\_\_  
City State Zip

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

\_\_\_\_\_  
City State Zip

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

Phone Number: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_

Applicant Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Driver's License Number, if any: \_\_\_\_\_ State of Issuance: \_\_\_\_\_

3. **If the applicant is an association, corporation, or other entity**, please provide the following information for each member of its board or governing body and the executive director of the board or governing body. Please attach additional sheets as necessary.

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

Title: \_\_\_\_\_

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

\_\_\_\_\_  
City State Zip

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

\_\_\_\_\_  
City State Zip

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

Phone Number: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_

4. **Please respond to this question ONLY if the applicant is a government entity. Please list the Chief Executive Officer of the applicable governmental unit or subunit.**

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

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

\_\_\_\_\_  
City State Zip

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

Phone Number: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_

5. **Ownership Interest:** Please provide the following information for each person who has an ownership interest in the Assisted Living Home. Attach additional pages as necessary.

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

Title: \_\_\_\_\_

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

\_\_\_\_\_  
City State Zip

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

\_\_\_\_\_  
City State Zip

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

Phone Number: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_

6. **Owner of Premises:** Please identify the owner of the premises (if the applicant is not the owner) in which the assisted living home is located.

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

Title, if applicable: \_\_\_\_\_

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

\_\_\_\_\_  
City State Zip

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

\_\_\_\_\_  
City State Zip

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

Phone Number: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_

7. **Physical Address of the Assisted Living Home:**

Street: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

8. **Facility Phone:** *If licensed, this is the phone number that will be posted on the website listing of* \_\_\_\_\_

licensed facilities. If you do not enter a phone number here, no phone will be listed on the website unless submit a request in the future in writing.

**9. Mailing Address of the Assisted Living Home:**

Street: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

**10. Total number of individuals the home serves:**

*The total number of individuals the home serves may be less than or equal to the maximum occupancy allowed by the fire department but may not be more than the maximum occupancy allowed by the fire department.*

**11. Individuals served in this home are persons who:**

\_\_\_\_\_ have a primary diagnosis of mental illness or developmental disability.  
\_\_\_\_\_ have a physical disability, are elderly, or suffering from dementia, but who are not mentally ill.

*Note:* The total of these 2 categories should equal the total number of individuals the home serves as identified in question number 10 above.

**12. Does the Applicant currently hold, or ever previously held, any other licenses or certifications issued by the Department?** (Example: Child Care License, Foster Care License, Medicaid certification, etc...) If so, please list them below with their expiration dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**13. Administrator:** Please provide information regarding the Administrator of the assisted living home.

Name: \_\_\_\_\_  
Title, if applicable: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City State Zip  
Physical Address: \_\_\_\_\_  
City State Zip  
Email Address: \_\_\_\_\_  
Phone Number: ( ) \_\_\_\_\_  
Fax Number: ( ) \_\_\_\_\_

Please list by name and address, any other assisted living home(s) the Administrator is or has been affiliated with:

\_\_\_\_\_  
\_\_\_\_\_

**14. Resident Manager (if applicable):**

Does the individual identified in question #13 above manage the daily operations of the proposed Assisted Living Home?  Yes  No

If not, please identify the individual who serves as the resident manager and manages the daily operations of the Assisted Living Home.

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

Title, if applicable: \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Phone Number: ( ) \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_

Please list by name and address, any other assisted living home(s) the Resident Manager is or has been affiliated with:

\_\_\_\_\_

**15. Application fees: Please include a check or money order with this application**

- Licensure for one or two residents:** \$25.00
- Licensure for three (3) or more residents:** \$25.00 per resident. *(For example, to apply for licensure to serve five (5) residents, the fee is calculated as follows: \$25.00 for each resident for a total fee of \$125.00)*

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

Return completed applications to:

State of Alaska  
 DHSS/Division of Health Care Services  
 Certification & Licensing  
 4501 Business Park Blvd, Bldg L  
 Anchorage, AK 99503