MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG-TERM CARE REGULATION

APPLICATION FOR REGISTRATION AS A QUALIFIED RECEIVER FOR A LONG-TERM CARE FACILITY

PLEASE TYPE OR PRINT IN INK AND RETURN TO
Missouri Department of Health and Senior Services
Section for Long-Term Care Regulation
P.O. Box 570
Jefferson City, MO 65102-0570

I. IDENTIFYING INFORMATION

NAME: LAST	FIRST	MIDDLE	TELEPHONE NUMBER	FAX NUMBER
			( )	( )

ADDRESS	CITY	COUNTY	STATE	ZIP CODE	E-MAIL ADDRESS (OPTIONAL)

SOCIAL SECURITY NUMBER	DATE OF BIRTH	PLACE OF BIRTH - CITY OR COUNTY	STATE	COUNTRY

II. OPERATION OF FACILITY

DO YOU INTEND TO CONTRACT WITH ANOTHER PARTY FOR THE OPERATION OF A FACILITY?

☐ YES ☐ NO

IF YES, LIST THE NAME AND ADDRESS OF THE INTENDED CONTRACTED PARTY AND COMPLETE THE FOLLOWING INFORMATION FOR THE INTENDED CONTRACTED PARTY. IF NO, COMPLETE THE FOLLOWING INFORMATION FOR THE APPLICANT

NAME ADDRESS

III. RECIPROCITY INFORMATION

1. HAVE YOU EVER APPLIED FOR REGISTRATION AS A RECEIVER FOR A LONG-TERM CARE FACILITY IN ANY STATE?

☐ YES ☐ NO If yes and registration is NOT issued, please explain. Use additional sheet if necessary.

If yes, and registration issued:

STATE	DATE REGISTERED	EXPIRATION DATE	STATUS

2. HAVE YOU EVER BEEN OR ARE YOU CURRENTLY AN OWNER, OPERATOR, OR MANAGER OF A LONG-TERM CARE FACILITY IN THIS STATE OR ANY OTHER STATE?

☐ YES ☐ NO If yes, provide details. Use additional sheet if necessary.

STATE	FACILITY NAME	STATE	FACILITY NAME

IV. PROFESSIONAL LICENSES

1. DO YOU NOW HOLD OR HAVE YOU EVER HELD A LICENSE FROM ANY PROFESSIONAL BOARD IN THIS OR ANY OTHER STATE THAT WOULD DEMONSTRATE AN ABILITY TO OPERATE A LONG-TERM CARE FACILITY?

☐ YES ☐ NO If yes, complete the following for each license. Use additional sheet if necessary.

STATE	TYPE OF LICENSE	LICENSE NUMBER	DATE ISSUED	STATUS

2. HAVE ANY PROFESSIONAL LICENSES LISTED ABOVE EVER BEEN DISCIPLINED?

☐ YES ☐ NO If yes, explain and attach a copy of any settlement agreement, contract, etc. that you entered at the time of discipline.

V. EXPERIENCE - List all experience pertinent to operation of a long-term care facility. (Use additional sheet if necessary.)

EMPLOYER NAME	EMPLOYER ADDRESS	STATE	ZIP CODE

DATES OF EMPLOYMENT	JOB DUTIES
FROM TO	
YOUR TITLE	

EMPLOYER NAME	EMPLOYER ADDRESS	STATE	ZIP CODE

DATES OF EMPLOYMENT	JOB DUTIES
FROM TO	
YOUR TITLE	

EMPLOYER NAME	EMPLOYER ADDRESS	STATE	ZIP CODE

DATES OF EMPLOYMENT	JOB DUTIES
FROM TO	
YOUR TITLE	

SECTION FOR LONG-TERM CARE REGULATION

APPLICATION FOR REGISTRATION AS A RECEIVER OF A LONG-TERM CARE FACILITY (CONTINUED)

VI. EDUCATION - List all education pertinent to operation of a long-term care facility. (Use additional sheet if necessary.)

NAME AND LOCATION	DATE	COURSE OF STUDY	LENGTH OF STUDY	DEGREE OR CERTIFICATION
NAME AND LOCATION	DATE	COURSE OF STUDY	LENGTH OF STUDY	DEGREE OR CERTIFICATION
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NAME AND LOCATION	DATE	COURSE OF STUDY	LENGTH OF STUDY	DEGREE OR CERTIFICATION

VII. PERSONAL DATA - Complete for both the applicant and any intended contracted party.

	APPLICANT	INTENDED CONTRACTED PARTY
1. Have you ever been convicted of a felony? If yes, list all action indicating the date, court, county location, nature of offense or violation, and the penalty imposed. Use additional sheet(s) if necessary.	☐ YES ☐ NO	☐ YES ☐ NO
2. Are you authorized to work in the United States?	☐ YES ☐ NO	☐ YES ☐ NO
3. Have you ever owned, managed, or operated a long-term facility that has been forced into or voluntarily applied for bankruptcy or reorganization? If yes, give details.	☐ YES ☐ NO	☐ YES ☐ NO
4. Are you familiar with and willing to comply with all applicable federal and state rules and regulations governing the operation of a long-term care facility?	☐ YES ☐ NO	☐ YES ☐ NO

VIII. FINANCIAL INFORMATION

1. From your most current financial records, what is the value of:

Cash	$	Accounts Payable	$
Accounts Receivables	$	Notes Payables	$
Notes Receivables	$	Taxes Payable	$
Other Current Assets	$	Other Liabilities	$
Property, Plant & Equipment	$	TOTAL LIABILITIES	$
Accumulated Depreciation	$	Fund Balance, Partners' Capital, or Common Stock	$
Other Assets	$	Retained Earnings	$
TOTAL ASSETS	$	TOTAL LIABILITIES AND EQUITY	$

2. Attach a copy of your most recent audited financial statements OR income tax return schedules (IRS Form 1040 Schedule C for sole proprietorship, IRS Form 1065 pages one and four for general or limited partnership, IRS Form 1120 or 1120S pages one and four or IRS Form 1120-A pages one and two for general business corporation, or IRS Form 990, pages one, three, and four for nonprofit corporation.)

3. Attach a statement explaining the means by which expenses will be met.

IX. SIGNATURE

UNDER PENALTY OF PERJURY, I CERTIFY THAT ALL THE INFORMATION CONTAINED IN THIS APPLICATION AND ANY ATTACHMENTS THERETO IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTANDING. FURTHER, I AUTHORIZE THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES TO VERIFY THE INFORMATION CONTAINED HEREIN BY ANY MEANS DEEMED NECESSARY.

MUST BE SIGNED IN THE PRESENCE OF A NOTARY	APPLICANT SIGNATURE	TELEPHONE NUMBER
	TYPED OR PRINTED NAME AND TITLE	DATE

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

FOR OFFICE USE ONLY, PLEASE DO NOT WRITE IN THIS SPACE.