LICENSE APPLICATON SERVICE

COMPLETE & RETURN:

By Mail: Community Care Options
2580 Sierra Sunrise Terrace
Ste 110
Chico, CA 95928
By Fax: 530-894-2734
By Email: cco@communitycareoptions.com

DIRECTIONS:

We've attached 6 pages of information that we need you to fill out. Please fill out **all** fields to the best of your ability. If you aren't sure about a field, you can always call and ask us.

Please make sure that you are sending back the following things:

- ☐ 6 Pages attached
- ☐ Articles of Incorporation *or* Partnership Agreement (*if applicable*)
- ☐ **Bank Statement**
    - We need to be able to see the bank **name**, the bank **address**, the **account number**, and the **current balance**. We don't need the transaction history.
- ☐ **Credit Report**
    - This is **not** your credit score (3-digit number), but a larger document that shows all **open lines of credit**. If the licensee has no open lines of credit, we don't need this. Just let us know!
- ☐ Return to Community Care Options using one of the methods listed above.

Remember! If the licensee is a corporation, we need the 6 pages, bank statement, and credit report **in the name of the corporation**. If you are applying as an individual, we need those documents in your name.

If you have any questions about what we need or how it works, please call us anytime M-F 8-5 at (530) 894-2114. You can also email us at cco@communitycareoptions.com.

Thank you for choosing Community Care Options to assist in your license application process!

APPLICATION FOR A RESIDENTIAL CARE FACILITY

Please complete this form and return as soon as possible – See fax or email below.

1. Applicant Information

Full Name:

Email:

Phone #: Cell #:

Fax #:

Mailing Address:

City: State: Zip:

Application filed by (choose one): ☐ Individual ☐ Partnership ☐ Non-Profit Corporation ☐ Profit Corporation ☐ Limited Liability Corporation

If Corporation, please provide the following information:

Owner(s) (greater than 10% ownership)

Corporation Name:

Address:

City: State: Zip:

Phone Number(s):

Name(s): Percentage owned:

Address:

City: State: Zip:

Phone Number(s):

Name(s): Percentage owned:

Address:

City: State: Zip:

Phone Number(s):

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Name(s): Percentage owned:

Address:

City: State: Zip:

Phone Number(s):

If Applying as a Corporation List Officers:
One person can hold multiple titles. All Officers must be filled.

President

Name(s):

Address:

City: State: Zip:

Phone Number(s):

Vice-President

Name(s):

Address:

City: State: Zip:

Phone Number(s):

Secretary

Name(s):

Address:

City: State: Zip:

Phone Number(s):

Treasurer

Name(s):

Address:

City: State: Zip:

Phone Number(s):

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2. Facility Information

Facility Name:

Type of Facility: ☐ RCFE ☐ ARF ☐ Home Care Total Requested Capacity: _____

Facility Phone #: # of Non-Ambulatory (if any): _____

Facility Address:

City: State: Zip:

County: Administrator:

Property Ownership: ☐ Own **(add a copy of the deed)** ☐ Lease

*If applying as a corporation, but facility building is owned by an individual, you are LEASING from the individual. Even if that individual is yourself. Please only fill out **OWN** section if your corporation owns the building (or if you are not applying as a corporation).*

If OWN, please complete below

Purchase Date: Purchase Price: Current Value:

Loans Associated with Facility

First $ Monthly Payment: $ Loan #

Second $ Monthly Payment: $ Loan #

Mortgage Company/Companies

Name: Phone #:

Address:

Name: Phone #:

Address:

If LEASE, please complete below

Monthly Payment: $

Property Owner(s) Name(s):

Property Owner(s) Address:

City: State: Zip:

Property Owner(s) Phone Number(s):

Was this facility previously licensed? ☐ Yes ☐ No

If yes, please provide the following:

Facility Name:

License #:

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Source of Water for Human Consumption: ☐ Public ☐ Private

If you currently or previously own(ed) or manage(d) any residential care or health care facilities, please list information below:

Facility Name:

License #:

Facility Name:

License #:

Facility Name:

License #:

Bank Information

***If you are applying as a corporation, we need the bank information associated with the corporation.*

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Bank Name:

Mailing Address:

City: State: Zip:

Account Number:

Current Balance:

APPLICATION FOR A RESIDENTIAL CARE FACILITY – ADDITIONAL ASSETS

If applying as a corporation: Please only list assets and lines of credit that are owned by the corporation, not yourself. If the corporation does not have any assets, ***leave this page blank.***

Other Real Estate or Land owned

Please Print Legibly	**First Property**	**Second Property**	**Third Property**
RCFE / House / Land			
Purchase Date			
Location: Full Address			
Purchase Price			
Current Value			
Mortgage Company			
Loan Number			
Mortgage Balance			
Monthly Payment			

Autos, Boats, or R.V.s owned

Please Print Legibly	**First Auto**	**Second Auto**	**RV**	**Boat**	**Other**
Make / Type					
Purchase Date					
Purchase Price					
Current Value					
Lender					
Loan Number					
Loan Balance					
Monthly Payment					

Credit Cards or Other Loans

Company	**Payment**	**Balance**

Company	**Payment**	**Balance**

PAYMENT and CREDIT CARD CHARGE AUTHORIZATION

Thank you for choosing Community Care Options for your education, training, and licensing needs. Before we can begin your application, payment is required. We accept Visa, MasterCard, Discover, and American Express. **Our fees are as follows:**

Member Price:	**Non-Member Price:**
• **$1,500 for 6 beds or less**	• **$1,850 for 6 beds or less**
• **$2,000 for 7 beds to 49 beds**	• **$2,250 for 7 beds to 49 beds**
• **$2,500 for 50+ beds**	• **$2,500 for 50+ beds**

Additional fees may apply for changes that are not required by Community Care Licensing Division.

Payment Information

Method of Payment *(Circle One)*: ☐Check ☐Credit Card

Credit Card Type *(Circle One)*: ☐Visa ☐MasterCard ☐Discover ☐Amex

Name as it Appears on Credit Card: _____

Credit Card #: _____

Expiration Date: _____ CVN: _____ Issuing Bank: _____

Credit Card Billing Address: _____

City, State, Zip: _____

By completing and signing this authorization form, the card holder acknowledges and understands that all authorized charges will be applied to the above credit card prior to beginning any services. Additionally, credit card charges may be applied to the above credit card prior to any changes which are not required by Community Care Licensing Division.

Community Care Options is authorized to charge $ _____ to the above credit card.

My signature below hereby authorizes Community Care Options to charge the total amount noted above to my credit card. I understand that payment for services in non-refundable and credit will not be given for delivered applications that are not used. All sales are final.

PLEASE SIGN

_____ _____

Authorized Card Holder Signature Date

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