

**CHANGE LICENSURE  
APPLICATION PACKET  
FOR  
ADULT CARE HOME  
(7 OR MORE BEDS)**

**Return the entire packet to**

**Mailing address of Raleigh Adult Care Licensure Section:**

**Regular Mail:**

Division of Health Service Regulation  
Adult Care Licensure Section  
2720 Mail Service Center  
Raleigh NC 27699-2720  
Attn: License Materials Enclosed

**Express/Overnight Courier(FED-EX, UPS):**

Division of Health Service Regulation  
Adult Care Licensure Section  
805 Biggs Drive  
Raleigh, North Carolina 27603  
Attn: License Materials Enclosed

**Adult Care Licensure Section (Raleigh Office) : 919-855-3765**

**STEPS FOR A CHANGE OF OWNERSHIP  
FOR ADULT CARE HOMES WITH 7 OR MORE BEDS**

*Please read and follow these steps to complete a change of ownership successfully*

1. The applicant or prospective licensee must contact the Certificate of Need with the Division of Health Service Regulation (DHSR):
  - i. To obtain a letter of exemption from review from the Certificate of Need (CON) prior to the obligation to purchase the building (*when the applicant or prospective licensee plans to purchase the building*). Or
  - ii. Notifying CON of the intent to change licensee (*when licensee is changing but ownership of building is not*);
2. The current licensee informs the Adult Care Licensure Section (ACLS), Raleigh office, the county department of social services and the residents or their responsible persons in writing of the proposed change of business ownership and the date of the change. **This contact should be made at least 30 days in advance of the proposed change.**
3. The Construction Section of the DHSR must approve any proposed structural changes of building before a license can be approved. (See page 4 for review form)
4. Unpaid fines for penalties imposed will result in denial of licensure. License applications will not be processed if there are any outstanding/unpaid fines for penalties.
5. The applicant/prospective licensee compile the following information and submit it to the Adult Care Licensure Section, Raleigh office.
  - a. Adult Care Home Licensure Change Application to facilitate compliance history check
  - b. Submit payment for the non-refundable licensure fee \$360.00 plus a per-bed fee of \$17.50 by check, money order or certified check and made payable to the "NC Division of Health Service Regulation."
  - c. Administrator Certificate/License
  - d. Approved fire and building safety inspection reports
  - e. Approved sanitation inspection report
  - f. Upon completion of any construction or renovation, -a certificate of occupancy or certificate of compliance from local building officials
  - g. Letter from previous owner relinquishing ownership (this letter must specify the date of the change in ownership)
  - h. Copy of CON letter (Licensure applications cannot be processed without approval or exemption by CON)
6. **Note:** A compliance history will be conducted on the prospective licensee. Based on the results of this compliance additional information may be requested.
7. New Providers will be required to submit Policy and Procedures for Review. Existing Providers must submit policy and procedures upon request.
8. Upon receipt of the above information or packet, the Adult Care Licensure Section will review and contact the prospective licensee for additional information if needed. If all documentation is complete and approved, the Adult Care Licensure Section will issue a new license to the applicant.

**Any information not included in the packet will render the application incomplete and it will not be processed**

**ADULT CARE HOME**  
**SPECIAL CARE UNIT APPROVAL PROCESS**

**Certificate of Need (CON) Approval**

An adult care home cannot obtain a license with a special care unit designation without first obtaining **CON approval if there will be an increase in the facility's licensed bed capacity.**

To request an increase in capacity, the licensee or designee should contact the CON Section of the Division of Health Service Regulation (DHSR) at 919/855-3873.

The CON Section will determine if the proposed increase in capacity is subject to CON review and approval and require a CON application if applicable.

If there is no increase in the facility capacity please continue to the submission section.

**Submission of Plans and Fees**

If CON approval is granted or if there will be **no increase in bed capacity** for the special care unit, plans for new or renovated construction or conversion of existing building areas for the special care unit should be submitted by the licensee or designee, along with documentation of CON approval if applicable, to the Construction Section of DHSR according to Rule 13F .0304.

Fees for review of construction projects will be invoiced to the provider by the DHSR Construction Section. The Construction Section will notify the licensee or designee when building plans are approved so that construction may begin.

The contact number for the Construction Section is 919/855-3893.

**Submission of Special Care Unit Policies and Procedures**

Facilities that advertise market or otherwise promote themselves as having special care units shall meet the requirements in 10A NCAC 13F .1300 or .1400, depending on the type of unit, including submission of disclosure information, according to G.S. 131D-8 and Rules 13F .1302 or 13F .1402, to the Adult Care Licensure Section of the Division of Health Service Regulation. The submission of Policies and Procedures must be submitted and approved prior to issuance of a special care unit license.

**Submission of Special Care Unit Disclosure**

Facility shall submit the required disclosure statement.

The Adult Care Licensure Section will notify the licensee or designee when the disclosure information has been approved. Approval of the disclosure information is required before a license designating special care unit status can be issued and residents admitted to the unit.

The contact number for special care unit disclosure review is 919/855-3778.

**Issuance of License**

Once the Construction Section has made on-site visits as necessary and given its approval of the completed project, a DHSR consultant and an adult home specialist from the county department of social services will arrange for a joint visit to the facility to survey for compliance with special care unit rules. Once compliance is verified, a license with special care unit designation will be issued to the facility.

## FORMAT FOR SPECIAL CARE UNIT DISCLOSURE STATEMENT

The adult care home special care unit disclosure statement must address the items in order as listed below. It is to be submitted with the Adult Care Home Initial License Application or the Change Licensure Application. Any changes to the disclosure statement as submitted must be reported in writing to the Adult Care Licensure Section and written notification must be provided to the residents.

### I. Special Care Units for Residents with Alzheimer's disease or Related Disorders:

- (1) The philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by the unit which shall address, but not be limited to the following;
  - a) Safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medication;
  - b) A structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities;
  - c) Individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and
  - d) Methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance
- (2) The process and criteria for admission to and discharge from the unit;
- (3) A description of the special care services offered in the unit;
- (4) Resident assessment and care planning, including opportunity for family involvement in care planning, and the implementation of the care plan, including responding to changes in the resident's condition;
- (5) Safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior or other behavior management problems;
- (6) Staffing in the unit;
- (7) Staff training based on the special care needs of the residents;
- (8) Physical environment and design features that address the needs of the residents;
- (9) Activity plans based on personal preferences and needs of the residents;
- (10) Opportunity for involvement of families in resident care and the availability of family support programs and
- (11) Additional costs and fees for the special care provided.

### II. Special Care Units for Residents with Mental Health or Developmental Disabilities

In addition to all of the above, disclosure must address the following;

- (1) Grouping of residents that takes age, interests and behaviors into account;
- (2) Ensuring client rights, choice and service coordination [(See Rule 10A NCAC 13F .1405(3)(a)(b)]; and
- (3) Safeguarding confidential information and ensuring that such information is not further disclosed in accordance with G.S. 122C-55(f).

**Construction Licensure Plan Review  
Information For  
Adult Care Licensure Section**

*Please complete this form only if structural changes to the building have been made*

**Please do not send Construction Section Fee payment for Adult Care Home projects.  
The Construction Section will bill you.**

**PLEASE PRINT**

Current Name of Facility \_\_\_\_\_

New Name of Facility (if applicable) \_\_\_\_\_

Site Address \_\_\_\_\_

Site City, State, and Zip \_\_\_\_\_

County \_\_\_\_\_

Contact Person \_\_\_\_\_

Contact Phone Number(    ) \_\_\_\_\_

Address \_\_\_\_\_

Site City, State, and Zip \_\_\_\_\_

**Requested Information:**

Applicable Licensure Rules:    \_\_\_ Adult Care Rules

Number of beds requested \_\_\_\_\_

Status of Residents:

      \_\_\_ All Ambulatory

      \_\_\_ Non-Ambulatory, 1-3

      \_\_\_ Non-Ambulatory, More than 3

Review For :    \_\_\_ Initial Licensure    \_\_\_ Capacity Increase    \_\_\_ Remodeling    \_\_\_ Other

Return this form:    Adult Care Licensure Section  
                          2720 Mail Service Center  
                          Raleigh, NC 27699-2720  
                          ATTN: Karen Jones

**Office Use Only**

Date Received \_\_\_\_\_

FID \_\_\_\_\_ LICENSE NUMBER \_\_\_\_\_

Team Supervisor/Branch Manager( C A R L) \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

# Instructions for Completing a Change Licensure Application

## LICENSE APPLICATION FOR ADULT CARE HOMES

### READ ALL INSTRUCTIONS BEFORE COMPLETING APPLICATION

#### Overview

1. These instructions are provided to assist you in completing a change application.
2. Failure to provide all requested information will result in delaying the processing of the application. If the information does not pertain to your facility mark N/A in the area.
3. Change requests must be submitted at least 30 days prior to the anticipated change. Construction related fees will be invoiced to you at a later date (change of capacity).

#### Type of Licensure Application

- Check the appropriate box/boxes for the action you are requesting. If the action is not listed, fill in the blank beside "Other".
- Change of Capacity: if change of capacity is an increase, submit photos, floor plan.
- Change of Facility Name: Complete this application.
- Change of Licensee/Ownership: Complete this application. A fee is assessed for a change of ownership,
- Requested Effective Date of Change: Enter date when you are requesting that the change be effective. This maybe related to other changes that are occurring with your business.

#### Current Information

1. Current Facility Name: Enter name printed on your most current license.
2. Current Facility Site Address: This address is the physical site location as printed on most current license.
3. Current Legal Identity of Ownership/Licensee: This is the name printed on your license as the licensee/owner. Please complete address & phone information.

\*Note fee charge for a change of ownership.

The omission of any information will delay the processing of your application. If you have any questions regarding any area of this application please contact our office 919-855-3765.

---

The following must be submitted to our office in order to obtain Facility License:

- ✓ Original completed application
- ✓ Your licensure fee must accompany this application
- ✓ Signature(s) is required on the application where specified. The application will be returned if not signed and dated
- ✓ Copy of the administrator's current license or certificate
- ✓ Disclosure Statement for Special Care Unit
- ✓ Policies and Procedures for Special Care Unit
- ✓ Plan Review Form for Construction if structural changes have been made to the existing building.
- ✓ New Providers will be required to submit Policy and Procedures for Review.
- ✓ Existing Providers must submit policy and procedures upon request.

### **Part A: Facility Information**

- **Facility Information**-Please complete the current information for the facility .
- **Correspondence Mailing Address**-All correspondence coming from DSHR will be sent to this address.
- **Building Owner**-If you rent or have a lease agreement for the building, please give the name of the building owner, their address and business phone number.

### **Part B: Operation Disclosure**

- A change in licensee **requires** a change application to be submitted with the application
- For a **partnership or limited liability partnership (LLP)**, you **must provide** the name of each partner
- For a **limited liability company (LLC)**, you **must provide** the names of the managing members, attach a list with the names and address of the members of the limited liability company
- For a **corporation**, you **must provide** the name and title of each corporate officer
- Complete information for Management Company, if applicable
- Complete information for Certified Administrator. If more than one Certified Administrator, provide information on separate piece of paper. Submit a copy of each Certified Administrator's Certificate

### **Part C: Ownership Disclosure**

- Leaving this area blank will delay the process of your application
- List all persons separately who are owners of this business
- If you are the sole owner, you must enter your information as owner of this business
- Enter the name, address, etc of other Adult Care and/or Family Care facilities you own in this section

#### **Please note the following:**

- **10A NCAC 13F .0202** All applications for license shall disclose the names of individuals who are co-owners, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity.
- **SECTION 10.40A.(I) G.S. 131D-34: "§ 131D-34. Penalties; remedies (d1)** The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A Violation.

**LICENSE FEE INVOICE**

Please submit your licensure fee with the enclosed application. Failure to submit a completed application with licensure fee will result in a delay of your license being issued.

**Facility Name:**

**County:**

Facility Type	Number of Beds	Base Fee	Per Bed Fee	Total Fee Due
<b>Adult Care Home</b>		<b>\$360.00</b>	<b>\$17.50</b>	

- **A separate check is required for each licensed facility.**
- Payment **must** be by check, money order, or certified check, made payable to: **Division of Health Service Regulation.**
- Remember to write the facility's Adult Care License number on the check. (ie HAL-000-000)

---

**ATTACH THE CHECK HERE**



**N.C. Department of Health and Human Services  
Division of Health Service Regulation  
Adult Care Licensure Section  
2720 Mail Service Center ■ Raleigh, North Carolina 27699-2720**

**CHANGE LICENSURE APPLICATION FOR ADULT CARE FACILITIES**

**TYPE OF LICENSURE APPLICATION: Adult Care Home**   
(7 or more beds)

**CURRENT FACILITY LICENSE Number-** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Change of Facility Name | <input type="checkbox"/> Change of Licensee/Ownership                         |
| <input type="checkbox"/> Change of Capacity      | <input type="checkbox"/> Change to Special Care Unit(specify bed Number)_____ |
|  | <input type="checkbox"/> Other (specify):_____                                |

Requested Effective Date of Change: \_\_\_\_\_  
*Must be at least 30 days prior to the proposed changed*

**Note:** Change in Ownership requires a license fee. Change of Capacity requires a Construction review and fee.

**CURRENT INFORMATION (Prior to Change)**

**1. CURRENT FACILITY NAME:** \_\_\_\_\_

**2. CURRENT FACILITY SITE ADDRESS: (NO P.O. BOXES)**

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

City \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Facility Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_ Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

**3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:**

Name of Owner: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Business Phone # of Applicant/Licensee: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_

DHSR USE ONLY
License#
FID#
Region
Compliance Check Completed [ ] _____
Entry by _____ Reviewed by _____
Date: _____ Date: _____
License Fee:

**PLEASE COMPLETE THE APPLICATION FOR NEW APPLICANT**

**Part A. Facility/Administrator Information**

<b>Facility Name:</b>			
<b>Physical Address:</b>		<b>City:</b>	<b>State:</b>
<b>Telephone Number:</b>	<b>Fax number:</b>	<b>Facility E-mail address:</b>	

**Correspondence Mailing Address: (where you want to receive all correspondence including the license from Division of Health Service Regulation):**

<b>Name:</b>	<b>Title:</b>
<b>Address:</b>	<b>Telephone Number:</b> (    )
<b>City, State Zip Code:</b>	
<b>Email:</b>	

**Building Owner**

**Is the building where services are offered leased/ rented? \_\_\_\_ Yes \_\_\_\_ No. If yes, please complete the following on the building/property owner and provide a copy of the lease agreement.**

<b>Name:</b>		
<b>Street/Box:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Telephone Number:</b> (    )	<b>Fax Number:</b> (    )	

**CERTIFIED ADMINISTRATOR**

<b>Name:</b>	
<b>Telephone Number:</b> (    )	<b>Fax:</b> (    )
<b>Administrator Certificate No.</b>	<b>Expiration Date:</b>

## Part B Operation Disclosure

### LEGAL IDENTITY OF LICENSEE

#### Licensee Information

- Print name, address and phone number(s) for the facility
- The Licensee is the name of the legal entity licensed to operate the business at that site as indicated in **Part A**
- The Licensee is responsible for compliance to State rules and laws governing adult care homes
- The status of the Legal entity will be verified with the NC Office of the Secretary of State

<b>Licensee Name:</b>		
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip code:</b>
<b>Telephone Number:</b>		<b>Fax Number:</b>
<b>The owner is a:</b> (check one)	<input type="checkbox"/> For Profit	<input type="checkbox"/> Non-Profit
<b>The owner is a:</b> (check one)	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership
<input type="checkbox"/> Limited Liability Company (LLC)	<input type="checkbox"/> Corporation	<input type="checkbox"/> Governmental Unit
<input type="checkbox"/> Limited liability Partnership (LLP)		

### PLEASE LIST IN THE SPACE PROVIDED BELOW:

- If the licensee is a **partnership or limited liability partnership (LLP)**, the name of each partner
- If the licensee is a **limited liability company (LLC)**, the names of the managing members, attach a list of the names and address of the members of the limited liability company
- If the licensee is a **corporation**, the name and title of each corporate officer
- If the licensee is a **governmental unit**, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency

<b>Executive Officer, General Partner, Managing Member</b>		
<b>Name:</b>	<b>Telephone Number:</b> (    )	<b>Fax Number:</b> (    )
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>

<b>Name</b>	<b>Title</b>

**MANAGEMENT COMPANY:**

Is the business operated under a management contract? _____ Yes _____ No. If yes, provide name and address of the management company		
<b>Company Name:</b>		
<b>Contact Name:</b>	<b>Telephone number:</b> (     )	
<b>Street/Box:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>

---

---

<b>Part C Ownership Disclosure</b>
------------------------------------

**For the purpose of this application the following definitions apply:**

**The following definitions shall apply throughout this application:**

- (1) **"Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.**
- (2) **"Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.**
- (3) **"Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.**
- (4) **"Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.**
- (5) **"Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.**

**RELATED AND APPLICABLE RULES**

**SECTION 10.40A.(l) G.S. 131D-34:**

**"§ 131D-34. Penalties; remedies**

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A Violation.

## Part C Ownership Disclosure

### OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS, MEMBERS

Complete the information below on **all** individuals who are owners, principles, affiliates, shareholders or members holding an interest of 5% or more of the licensee. Attach additional pages if necessary. **If you are the only owner, complete the information below, listing the percentage interest as 100%.**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Percentage interest in this licensed Facility: \_\_\_\_\_ Title: \_\_\_\_\_  
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Percentage interest in this licensed Facility: \_\_\_\_\_ Title: \_\_\_\_\_  
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Percentage interest in this licensed Facility: \_\_\_\_\_ Title: \_\_\_\_\_  
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Percentage interest in this licensed Facility: \_\_\_\_\_ Title: \_\_\_\_\_  
List the names of other Family Care/Adult Care Home in which you are the owner or affiliate: \_\_\_\_\_  
\_\_\_\_\_

**LICENSED CAPACITY AND SPECIAL CARE UNIT**

Check here if this Adult Care Home serves Only elderly persons.  
*Elderly Persons are defined as persons age 55 OR older or who have a primary diagnosis of Alzheimer's disease or other form of dementia that require assistance with activities of daily living*

Current Licensed Capacity \_\_\_\_\_

Current Licensed Special Care Unit Capacity: \_\_\_\_\_

As defined in **10A NCAC 13F. 1302 SPECIAL CARE UNIT DISCLOSURE**

- a. Only those facilities with units that meet the requirements of this Section may advertise market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders.
- b. The facility shall disclose information about the special care unit according to G.S. 131D-8 and which address policies and procedures listed in Rule .1305 of this Section.

Authenticating Signature: The undersigned submits this application for licensure for the year 2011 in accordance with Article 1 Chapter 131 D-2 of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC 13F) and certifies the accuracy of this information.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Part C Ownership Disclosure – Confidential Information**

The following information will be used for internal compliance history checks as required by G.S. 131D-2.4(b). We ask that you voluntarily provide the last four digits of your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing. Incomplete data will delay the application being processed.

Category	Name	Last 4 digits of SSN	Contact Number	Percentage of interest as reported on pages 2-6
			Cell Number	
Licensee		***_**_ _____ or EIN ____ - _____		
Executive Officer		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		

**Reminder:** *Failure to complete this information will delay the process*

Category	Name	Last 4 digits of SSN	Contact Number	Percentage of interest as reported on pages 2-6
			Cell Number	
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		
owners, principles, affiliates, shareholders or members		***_**_ _____		

Please use additional paper and attach if needed.