Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Nursing Home Facility License Application

The license fee is $359 per licensed bed. For initial applications, this fee is due when the application is submitted. No fee is required for a Change of Ownership (CHOW) AND/OR Medicaid contract applications.

Note: If an applicant chooses to proceed with a change of ownership, please be aware that:

- The applicant will be assuming responsibility for correcting any outstanding violations;
- Any outstanding fines must be paid prior to licensing; and
- If there is a stop placement or a condition on the license, it will attach to the new license, unless the Department determines that lifting the action will not compromise the safety of the residents.

☐ Initial License ☐ Change of Ownership ☐ Relocation of current licensed Nursing Home

CURRENT NURSING HOME NAME	CURRENT NURSING HOME LICENSE NUMBER

1. Nursing Home Information

NURSING HOME NAME	PHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)

PHYSICAL ADDRESS: STREET	CITY	STATE ZIP CODE	COUNTY
		WA	

WEB SITE ADDRESS	ADMINISTRATOR EMAIL ADDRESS	NUMBER OF BEDS TO BE LICENSED	ANTICIPATED OPENING DATE

2. Medicaid and/or Medicare Contract / Certification

1. Are you applying for a Medicaid Certification (Medicaid Contract)? ..... ☐ Yes ☐ No
2. Are you applying for a Medicare Certification (Medicare Contract)? ..... ☐ Yes ☐ No

3. Contact Person Information

CONTACT PERSON'S NAME	PHONE NUMBER (WITH AREA CODE)

EMAIL ADDRESS

4. Contact Person Information (for initial licensing inspection)

CONTACT PERSON'S NAME	PHONE NUMBER (WITH AREA CODE)

EMAIL ADDRESS

5. Sole Proprietor or Entity Application Information

LEGAL NAME OF INDIVIDUAL OR ENTITY	PHONE NUMBER (WITH AREA CODE)

MAILING ADDRESS	CITY	STATE	ZIP CODE
		WA	

6. Sole Proprietor or Entity Business Information

UBI (UNIFIED BUSINESS IDENTIFIER)	FEDERAL EIN (EMPLOYER IDENTIFICATION NUMBER)

7. Sole Proprietor or Legal Entity Information Business Structure

☐ Sole Proprietor ☐ For-Profit Corporation ☐ Limited Partnership ☐ Government agency
☐ General Partnership ☐ Non-Profit Corporation ☐ Limited Liability Company ☐ Group or association

8. Organizational Structure / Chain of Ownership

Provide a chart showing the ownership structure / chain of ownership of the applicant. The chart should show all parent and subsidiary relationships and affiliated entities within the ownership chain.

9. Real Property Ownership Information

1. Does the applicant (currently) own the Real Property or in process of purchasing real property? ☐ Yes ☐ No
   If "yes" purchasing property, attach a purchase and sales agreement.

PROPERTY OWNER'S NAME

ADDRESS	CITY	STATE	ZIP CODE
		WA	

2. Will the applicant lease the facility or operate under an operating agreement? ☐ Yes ☐ No
   If "yes," complete the Lease or Operating Agreement Attestation form and attach a copy of the Lease / Operating Agreement.

10. Management Agreement

1. Will the applicant enter into a management agreement to manage the Nursing Home Facility? ☐ Yes ☐ No
   If "yes," complete the Management Agreement Attestation form and attach a copy of the Management Agreement.

11. Compliance, Business, and Financial History

1. Has the applicant and/or any entity having a direct ownership interest in the Applicant or any person named in the Individuals Affiliated with Applicant Supplemental Information form? If yes, provide the required information as listed below.

a) Owned, managed, or held a license to operate a business providing services to vulnerable adults, or persons with mental illnesses or developmental disabilities within the past 10 years? If yes, provide name of person or entity, name of facility, and the effective dates:	☐ Yes ☐ No
b) Held a contract within the past 10 years providing services to children, vulnerable adults, persons with mental illnesses and/or developmental disabilities? If yes, provide name of person or entity, name of facility, and the effective dates:	☐ Yes ☐ No
c) Had a civil fine or stop placement imposed or had a condition placed on the license, contract, or certification within the past three (3) years? If yes, provide name of person or entity, name of facility, type of action taken, and date action taken:	☐ Yes ☐ No
d) Ever denied a contract, license, and/or license renewal to operate a facility providing care to adults and/or children? If yes, provide name of person or entity, name of facility, type of action taken, and date action taken:	☐ Yes ☐ No
e) Ever had a license or certification not renewed, revoked, suspended, or enjoined? If yes, provide name of person or entity, name of facility, type of action taken, and date action taken:	☐ Yes ☐ No
f) Ever had a Medicaid contract or Medicare provider agreement revoked, canceled, suspended, or not renewed? If yes, provide name of person or entity, name of facility, type of action taken, and date action taken:	☐ Yes ☐ No

g) Ever relinquished or returned a license, contract or certification; or did not seek the renewal of a license, contract, or certification following notification by the state agency of initiation of denial, suspension, or revocation of that licenses, contract, or certification? If yes, provide name of person or entity, name of facility, type of action taken, and date action taken:	☐ Yes ☐ No
h) Been excluded from participating in Medicare and/or Medicaid? If yes, provide name of person or entity, name of facility, type of action taken, and date action taken:	☐ Yes ☐ No
i) Been named in a court order and/or administrative order stating the person or entity will not hold a license and/or contract to provide care to children, vulnerable adults, person(s) with mental illness or developmental disabilities for a specific period or number of years from the date of license surrender or relinquishment? If yes, provide name of person or entity and date of court / administrative order:	☐ Yes ☐ No
j) Been subject to disciplinary action board or other disciplinary authority of a health professional licensing agency? If yes, attach a copy of the disciplinary board or disciplinary authority action.	☐ Yes ☐ No
k) Been convicted or had a civil finding of abuse, neglect, exploitation, misappropriation (theft) of property of any person; a crime against children and other persons; or had a finding on a state registry? If yes, provide name of person or entity and date of conviction and/or finding:	☐ Yes ☐ No
l) Filed bankruptcy within the past five (5) years? If yes, provide name of person or entity, type of bankruptcy, date filed and concluded:	☐ Yes ☐ No
m) Been a defendant in a lawsuit resulting in a monetary judgment in excess of $50,000 within the past 10 years? If yes, provide name of person or entity, type of judgment and amount, and date filed and concluded:	☐ Yes ☐ No
n) Subject to liens or warrants in excess of $50,000 filed by the Internal Revenue Service (IRS) or other government agency within the past 10 years? If yes, provide name of person or entity, type of lien or warrant and amount, and date filed and paid:	☐ Yes ☐ No
o) Been an employee of the State of Washington currently or within the last five (5) years? If yes, provide name of person's name, agency or department and job title, and dates of employment:	☐ Yes ☐ No

12. Certification

I/we certify, under the penalty of perjury under the laws of the State of Washington and by my signature, that the information provided in this application and all additional documents and forms required for license of a nursing home are true, complete and accurate. I/we understand that the department may obtain additional information, verification and/or documentation related to the foregoing answers or information.

I/we understand that if I/we enter into an agreement with an individual or entity to manage the facility on a day-to-day basis, I am/we are wholly responsible for the conduct of the individual or entity and its employees. I/we understand that I/we are legally responsible for the operational decisions and care of the residents at the facility.

I/we understand any license of Medicaid contract granted pursuant to this application is nontransferable.

I/we understand that failure to accurately answer or fully complete the questions on this application may result in denial of the application, termination of the license or contract, or other sanctions as allowed by law.

I/we understand and agree that the information I/we give to the department will be used to verify the representations made in this application. Any information I/we give to the department may be used by the department for this purpose.

I/we understand that the department may check the credit of the corporation or business and its principals; obtain a credit report; and verify any responses provided. The department and its contracting process will use such information and may disclose this information to other parts of the department as appropriate to further program purposes. The department may define some or all of such information as public information and also disclose this information to the third parties when requested according to law to the extent that such information is not exempt from such disclosure by state or federal law.

I/we certify that I/we have read, understood and agree to comply with chapters 18.51, 74.42, 74.46 and 70.129 RCW and chapters 388-96 and 388-97 WAC and the Rules, Regulations and standards adopted thereunder.

No residents receiving care and service in the Nursing Home will be subject to discrimination because of race, color, national origin, gender, age, religion, creed, marital status, disabled or Vietnam veteran's status, or the presence of any physical, mental, or sensory disability.

I/we understand that if this application for a nursing home license is denied, I/we may request an administrative fair hearing within 20 days of receiving the denial letter from DSHS. I/we understand that a written request for fair hearing must be submitted to: Office of Administrative Hearings, PO Box 42489, Olympia, Washington 98504-2489.

<u>In addition to the above certifications, if applying for a contract:</u>

I/we understand that if a Medicaid contract is granted, I/we as the contractor(s) shall be responsible for compliance with all applicable state and federal laws and regulations, as now existing or hereafter amended, and shall be held responsible by the department for the residents care. I am/we are responsible for day-to-day control of the facility operation and business enterprise.

I/we understand that failure to promptly supply any of the following requested by the department is a basis for the department to deny or terminate my contract: any documentation, any additional information, any verifications or any authorizations to verify or obtain information deemed relevant by the department to this application. I/we understand that misrepresentation, by omission or expressly, of any information on the Medicaid contract application or supporting material is a basis for the department to deny or terminate my Medicaid contract.

SIGNATURE OF OFFICER, DIRECTOR, MEMBER, ETC. OF APPLICANT		DATE
PRINTED NAME	PHONE NUMBER (WITH AREA CODE)	CITY AND STATE WHERE SIGNED

Checklist

Number or letter all attachments and indicate attachment number below. If not applicable, write N/A.

- ☐ Nursing Home Facility license fee is $359 per bed. Initial applications **only**.
- ☐ Copy of Washington State business license showing facility name as a registered trade name. **Attachment** _____
- ☐ Copy of document issued by the IRS showing Federal EIN. **Attachment** _____
- ☐ Copy of certificate showing registration with Washington Secretary of State. **Attachment** _____
- ☐ Individuals Affiliated with Applicant Supplemental Information form. **Attachment** _____
- ☐ Washington Background Check Authorization form (for each person listed on the Individuals Affiliated with Applicant Supplemental Information form who may have unsupervised access to residents. **Attachment** _____
  Use this URL https://fortress.wa.gov/dshs/bcs/. Print a copy of the online form containing confirmation number and submit with application.
- ☐ Agreement Not to Have Unsupervised Access form (for each person listed on Individuals Affiliated with Applicant Supplemental Information form who will not have unsupervised access to residents). **Attachment** _____
- ☐ Consent (Authorization) to Release and/or Use Confidential Information form(s) for each person listed on the Affiliated with Applicant Supplemental Information form. **Attachment** _____
- ☐ Organizational Structure / Chain of Ownership Chart. **Attachment** _____
- ☐ Copy of Purchase and Sale Agreement (only if applicable). **Attachment** _____
- ☐ Lease or Operating Agreement Attestation (only if applicable). **Attachment** _____
- ☐ Copy of Lease or Operating Agreement (only if applicable). **Attachment** _____
- ☐ Copy of Lease or Operating Agreement (only if applicable). **Attachment** _____
- ☐ Management Company Information (only if applicable). **Attachment** _____
- ☐ Individuals Affiliated with Management Company Supplemental Information for (only if applicable). **Attachment** _____
- ☐ Copy of Management Agreement (only if applicable). **Attachment** _____
- ☐ Compliance, Business, and Financial History. **Attachment** _____
- ☐ Financial Attestation form. **Attachment** _____
- ☐ Real Property and/or Building Related to Financing and/or Insurance Attestation form. **Attachment** _____
- ☐ Copy of a Resident Agreement between resident and applicant / licensee. **Attachment** _____
- ☐ Original surety bond or an approved alternative. **Attachment** _____
- ☐ HHS 690 "Assurance of Compliance" proof of electronic submission of HHS-690 to the OCR. **Attachment** _____
- ☐ CMS 1561 "Health Insurance Benefit Agreement." **Attachment** _____
- ☐ CMS-671, Long Term Care Facility Application for Medicare and Medicaid form (if applying for Medicare). **Attachment** _____
- ☐ Copy of CMS 855 - Buyer. **Attachment** _____
- ☐ Copy of CMS 855 - Seller. **Attachment** _____
- ☐ Copy of MAC Recommendation Letter - Buyer. **Attachment** _____
- ☐ Copy of MAC Recommendation Letter - Seller. **Attachment** _____
- ☐ Copy of Bill of Sale – Only applicable if the applicant is purchasing the real property. Must be signed by both Buyer and Seller (two separate signed pages is acceptable). **Attachment** _____
- ☐ Letter from current licensee relinquishment license if a change of ownership is approved (only if applicable). **Attachment** _____
- ☐ Notice to Residents (only if applicable). **Attachment** _____

Submit your application, supporting documents, and application fee (if applicable) to:

For US Postal Mail:

ALTSA Finance and Contracts
PO Box 45600
Olympia WA 98504-5600

For Federal Express or United Parcel Service (UPS):

ALTSA Finance and Contracts
4450 10th Ave SE (Blake West)
Lacey WA 98503

Individuals Affiliated with Applicant Supplemental Information

List each officer, director, member, partner, owner of 5% or more of the applicant entity, Administrator, and the Director of Nursing Services

PERSON'S NAME	HAS CONTROL* OF APPLICANT**	MAY HAVE UNSUPERVISED ACCESS TO RESIDENTS	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH	%
	☐	☐	**Administrator**			
	☐	☐	**DNS**			
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				

* Control means the possession, directly or indirectly, of the power to direct the management, operation, and/or policies of the applicant / licensee or Nursing Home Facility, whether through ownership, voting control, by agreement, by contract or otherwise.

** The Applicant is the Individual / Sole Proprietor or the Entity applying for the Nursing Home Facility license.

INDIVIDUAL'S SIGNATURE	DATE

PRINTED NAME	TITLE

Agreement Not to Have Unsupervised Access

FACILITY NAME			
APPLICANT / LICENSEE NAME			
FACILITY ADDRESS	CITY	STATE **WA**	ZIP CODE

This is an agreement between the Washington State Department of Social and Health Services (DSHS) and the applicant / licensee as listed above.

The applicant / licensee applied to obtain a Nursing Home Facility license through DSHS. Prior to issuing such licenses, DSHS requires background checks for all persons having unsupervised access to Nursing Home Facility residents.

The applicant / licensee agrees that the individual listed below will not have unsupervised access to residents, resident's financial records, resident funds and/or resident medical records at any time. Therefore, the individual listed below is not required to have background check completed.

The applicant / licensee agrees to ensure that the individual listed below will have the required background check completed before he/she has unsupervised access to the Nursing Home Facility residents, resident's financial records, resident funds and/or resident medical records.

APPLICANT / LICENSEE'S SIGNATURE		DATE
PRINTED NAME	TITLE	
INDIVIDUAL'S SIGNATURE		DATE
PRINTED NAME	TITLE	

Lease or Operating Agreement Attestation – Nursing Home Facility

This attestation form must be completed if the applicant / licensee does not own the real property upon which the Nursing Home Facility is located and occupies the property under a lease or operating agreement.

FACILITY NAME	
APPLICANT / LICENSEE NAME	REAL PROPERTY / OWNER NAME
FORM OF AGREEMENT UNDER WHICH APPLICANT / LICENSEE HAS RIGHT TO OCCUPY REAL PROPERTY (LEASE, SUBLEASE, OPERATING, AGREEMENT, ETC.)	
DATE AND TERM OF AGREEMENT SPECIFIED	
PRINTED NAME OF PERSON COMPLETING NAME	TITLE OF PERSON COMPLETING FORM

The person signing the form must initial each statement below.

I certify and declare under penalty of perjury that the following is true and correct:

_____ The applicant / licensee has a written agreement allowing to occupy and operate a licensed Nursing Home Facility upon the real property on which the Nursing Home Facility is located.

_____ The Agreement identifies applicant / licensee as the entity that holds, or will hold, the Nursing Home Facility license.

_____ The Agreement does not authorize or require transfer or assignment of applicant / licensee's Nursing Home Facility license to any other party upon default, termination, or otherwise.

_____ The Agreement does not provide any party or entity other than applicant / licensee with "ownership" rights or interests in resident agreements or records; all resident agreements are between the resident and the applicant / licensee as parties.

_____ The Agreement does not require or permit the transfer of resident agreements or records to any party of entity upon termination of the Agreement without such other party or entity first being licensed by the Department of Social and Health Services to operate the Nursing Home Facility.

_____ The Agreement does not give any party or entity, other than applicant / licensee (or its managing agency), the department, or other parties authorized by law, the right to review resident records.

_____ The Agreement does not provide any party or entity with the right to dictate occupancy levels.

_____ The Agreement does not allocate, assign, or otherwise convey an interest in the "bed rights" to any party or entity other than applicant / licensee or the owner of the real property.

_____ The Agreement does not make any party or entity other than applicant / licensee legally responsible for the daily operations of the Nursing Home Facility.

_____ The Agreement does not provide any party or entity other than applicant / licensee with the right to request: 1) an informal dispute resolution in response to state or federal survey reports; or 2) an administrative appeal of deficiencies cited on the state survey or enforcement actions imposed by the Department of Social and Health Services.

_____ The Agreement does not give any party or entity other than the applicant / licensee authority to submit plans of correction for violations of Nursing Home Facility laws and/or regulations or dictate terms of a plan of correction.

_____ The Agreement does not authorize any party or entity other than the applicant / licensee to enter, take possession, and operate the facility as Nursing Home Facility, unless such party or entity first obtains a Nursing Home Facility license from the Department of Social and Health Services.

Check below as applicable:

☐ The Agreement does not provide budget approval to any party or entity other than applicant / licensee; or

☐ The Agreement provides budget approval to another party or entity, but does not prohibit applicant / licensee from expending its own funds to secure regulatory compliance as necessary.

I further certify and declare as follows:

- The applicant / licensee understands and agrees that the applicant / licensee is legally responsible for the daily operations of the Nursing Home Facility.
- The applicant / licensee understands and agrees that nothing in the Agreement, including the authority of a party of entity other than applicant / licensee to approve the facility budget, absolves applicant / licensee of its legal responsibility to ensure compliance with Nursing Home Facility laws and regulations.
- Agreements with residents for Nursing Home Facility care and services are between the applicant / licensee and the resident.
- I am duly authorized to sign this attestation on behalf of the applicant / licensee. I am an officer, director, or owner of 5% or more of the applicant / licensee.

I declare under penalty of perjury under the State of Washington that the foregoing is true and correct to the best of my knowledge.

SIGNATURE	DATE	PRINTED NAME
TITLE		CITY AND STATE WHERE SIGNED

Attachments:

1) Copy of the Lease / Operating Agreement

Management Company Information

Name of Facility	
Name of Applicant / Licensee	
Name of Management Company	
Mailing Address of Management Company	
City, State, Zip Code	
Unified Business Identifier (UBI) of Management Company	
Federal Employer Identification Number (ENI) of Management Company	
Name of Contact Person for Management Company	
Telephone Number of Contact Person	
Email Address of Contact Person	
Management Agreement Effective Date	

Management Agreement Attestation – Nursing Home Facility License

This attestation form must be completed and submitted with a management agreement if the applicant / licensee will use a management company at the Nursing Home Facility.

FACILITY NAME	
APPLICANT / LICENSEE NAME	MANAGEMENT COMPANY NAME

The person signing the form must initial each statement below.

I certify and declare under penalty of perjury that the following is true and correct:

_____ The applicant / licensee has a written management agreement with the above management entity.

_____ The management agreement complies with the Nursing Home Facility licensing requirements in Chapter 18.51 RCW and Chapter 388-97 WAC.

_____ The written management agreement creates a principal/agent relationship between the applicant/licensee and the management entity;

_____ The management agreement does not delegate to the management entity the licensee's legal responsibility to ensure that the Nursing Home Facility is operated in a manner consistent with applicable laws and regulations;

_____ The management agreement does not delegate to the management entity the responsibility to review for accuracy, acknowledge and sign all initial and renewal license applications;

_____ The management agreement does not authorize the management entity to represent itself as the licensee or give the appearance that it is the licensee;

_____ All resident agreements shall be agreements between the resident(s) and the applicant/licensee as parties, even if they are executed by the management entity on behalf of the applicant/licensee;

_____ The applicant / licensee agrees to notify all residents and prospective residents in advance of the identity of the management entity, the fact that the management entity is retained on behalf of applicant/licensee, and shall be given contact information for the management entity and the licensee;

_____ The management entity may use resident records and information to fulfill its obligations under the management agreement, but shall preserve the confidentiality of such records and shall not disclose or release them except as authorized by law. The applicant / licensee shall retain responsibility for such records and shall not transfer such responsibility to the management entity unless the management entity first becomes duly licensed to operate the Nursing Home Facility as licensee.

_____ Applicant / licensee shall provide notice to DSHS in case of any of the following:

- Discharge of management entity;
- Change of management entity;
- Modification of existing management agreement, except regarding a change in the duration of the agreement.

I am duly authorized by applicant / licensee to sign this attestation on its behalf. I am an officer, director, or owner of 5% or more of the applicant / licensee.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

SIGNATURE	DATE	PRINTED NAME
TITLE		CITY AND STATE WHERE SIGNED

Attachments:

1) Copy of written Management Agreement

Individuals Affiliated with Management Company Supplemental Information

List each officer, director, member, partner, and owner of 5% or more of the Management Company.

PERSON'S NAME	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH	%

Financial Attestation – Nursing Home Facility License

FACILITY NAME
APPLICANT / LICENSEE'S NAME

The person signing the form must initial each statement below.

I certify and declare under penalty of perjury that the following is true and correct:

_____ The applicant has not been adjudged insolvent or bankrupt in a State or Federal court.

_____ A court proceeding to make a judgment of bankruptcy or insolvency with respect to the applicant is not pending in a State or Federal court.

_____ The applicant will ensure that the Nursing Home Facility operates in a manner consistent with applicable laws and regulations despite any limitation or insufficiency of funds.

_____ Applicant will provide notice to DSHS in the event a State or Federal court proceeding seeking a judgment of insolvency or bankruptcy is initiated with respect to the applicant, a subsidiary, an affiliated entity or its parent entity.

Applicant / licensee shall provide notice to DSHS in case of any of the following:

- Discharge of management entity;
- Change of management entity;
- Modification of existing management agreement, except regarding a change in the duration of the agreement.

I further certify and declare as follows:

I am duly authorized to sign this attestation on behalf of the applicant. I am an officer, director, or owner of 5% or more of the applicant.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

SIGNATURE	DATE	PRINTED NAME

Consent (Authorization) to Release and/or Use Confidential Information

Must be completed by any person named on the Individuals Affiliated with Applicant Supplemental Information form, including the Administrator and Director of Nursing Services (DNS).

☐ Officer ☐ Director ☐ Owner of more than 5% ☐ Administrator ☐ DNS

I consent to the release and use of confidential information about me within Department of Social and Health Services (DSHS) for purposes of licensing and contracting. I grant permission to DSHS and any agency, division, office, or the police to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, mail, or hand delivery.

I am aware that the Department is required to respond to requests for disclosure of information from the public. The Department may not withhold requested information unless required to do so under Chapter 42.56 RCW or other state or federal law. (RCW 42.56, Chapter 388-01 WAC)

The completion of this form allows the use and sharing of confidential information within DSHS. DSHS will be able to disclose and receive confidential information from outside agencies, divisions, offices and/or the police.

This consent is valid for as long as I am an officer, director, owner of 5% or more or the Applicant, or Administrator at the Nursing Home Facility named in this application and located at the address named in this application. A copy of this form is valid to give my permission to release and use this information.

SIGNATURE	DATE	PRINTED NAME

Real Property and/or Building Attestation Related to Financing and/or Insurance

_____ declares and states as follows:
PRINT NAME

1. I am _____ of _____ the ("Applicant"),
TITLE APPLICANT / LICENSEE NAME

which has applied for a Washington State Nursing Home Facility license to operate

_____ (the "Nursing Home Facility").
FACILITY NAME

I make this declaration based on personal knowledge and certify that I have been duly authorized by Applicant to make the representations stated herein.

2. The Nursing Home Facility's real property and/or building are or will be financed and/or insured by private and/or public entities (the "Entities"). "Entities" refer to banks, mortgage lenders, HUD, etc. Applicant has executed or will execute agreements granting such Entities certain rights concerning the Nursing Home Facility. Notwithstanding, Applicant acknowledges full responsibility for operating the Nursing Home Facility and providing care and services to residents as licensee. Applicant may not transfer any of its legal responsibilities as licensee to the Entities or any other person or entity. Applicant is aware that should the Entities unreasonably interfere with the licensed operations at the Nursing Home Facility, the Department of Social and Health Services may deem it necessary to take enforcement action against the Nursing Home Facility as authorized by RCW 18.20.190.

I am duly authorized to sign this attestation on behalf of the applicant. I am an officer, director, or owner of 5% or more of the applicant.

I certify and declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

SIGNATURE OF OFFICER, DIRECTOR, MEMBER, ETC. OF APPLICANT	DATE

PRINTED NAME	PHONE NUMBER (WITH AREA CODE)	CITY AND STATE WHERE SIGNED