INSTRUCTIONS FOR COMPLETION OF
PERMIT OF APPROVAL APPLICATION FORM

General Instructions

In accordance with adopted policies pursuant to Arkansas Act 593 of 1987, as amended, all parties desiring to obtain a Permit of Approval are required to provide the requested information on this application form. Failure to supply adequate information may result in a delay in the review, a return of the application, or a denial of the application. Please refer to the Health Services Permit Commission’s Policies and Procedures for Permit of Approval for details of the scope of coverage, projects subject to review, and specific procedures for processing applications.

1. Please review the Commission’s adopted Assisted Living Facility need standards and criteria before starting the application process.

2. The Agency recommends that each applicant meet with a staff member of the Health Services Agency (by appointment) for a pre-submission conference.

3. Each question must be addressed fully. Contact the staff before a response of “not applicable” is made in order to insure that it is an appropriate response.

4. One (1) original and one (1) copy of the completed application along with the appropriate fee must be submitted to the Health Services Permit Agency in accordance with the established batching schedule. The original must be signed in blue ink. Please do not send applications in binders or folders.
ASSISTED LIVING FACILITY (ALF) APPLICATION FORM

Check one: This application is for

- A new ALF [ ]
- A replacement ALF [ ]
- Additional beds for a currently licensed ALF [ ] or for an existing RCF [ ]
- Additional beds for an existing POA [ ]
- Transfer of a POA [ ] (Must also attach Request to Transfer Application).

I. GENERAL INFORMATION

A. Current Facility (Applies to replacement or additions only)

Name of Facility: ___________________________________________

Address: __________________________________________________

City: ________________ Zip Code: ____________

County: ________________ Phone: ______________________

Fax: ________________ Email: ___________________________

B. Proposed Facility (Applies to replacement or new facilities.)

Name of Facility: ________________________________

Address: __________________________________________________

City: ________________ Zip Code: ____________

County: ________________ Phone: ______________________

C. Identification of applicant

Name of Applicant: _______________________________________________

Address: __________________________________________________

City: ________________ Zip Code: ____________

Phone: __________________ Fax _____________________________
D. Application Contact Person: *(This person will be contacted regarding any questions about this application).*

Name: ______________________________________

Corporation/Company________________________________________

Title ________________________________________

Address: _______________________________________

City: ___________________________Zip Code: ___________________

Phone: _____________________Fax:___________________________

Email: _____________________________________________________

E. Project Contact Person: *(This person will be contacted regarding progress or questions about the project if a POA is awarded)*

Name: _____________________________

Corporation:_________________________________

Title: ________________________________________

Address: ___________________________________

City: ___________________________Zip Code: ___________________

Phone: _____________________Fax:___________________________

Email: _____________________________________________________

F. Ownership of Facility (Check One):

Individual Owner □ Corporation □

Partnership □ List Names and Addresses of all Partners

____________________________________________________________

____________________________________________________________

____________________________________________________________
▪ Parent Organization: ________________________________

▪ Does this company currently own an Assisted Living Facility in Arkansas or in another state? Yes ___ No ___

▪ If yes, what is the name, and location of the Facility?
  __________________________________________________________
  __________________________________________________________

▪ Do any of the current owners or partners have an interest or ownership in other Assisted Living Facilities in Arkansas or in another state? Yes___ No___

  ▪ If yes, please list names of owners / partners and affiliated Assisted Living Facilities.
  __________________________________________________________
  __________________________________________________________

▪ Does applicant currently manage, own or operate Assisted Living Facilities in Arkansas or in another state? Yes___ No___

  ▪ If yes, name and location of facilities.
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________

II. Project:

  A. General Information (All applicants must complete this section)

    • Assisted Living Level I or II
    • County Bed Need ____________
    • Number of beds proposed ____________
    • Gross square feet to be constructed ____________
    • Proposed per square foot construction cost ____________
    • First year projected annual operating cost: ____________
    • Estimated project initiation date: ____________
• Estimated project completion date: ______________

• For new construction:
  • provide a letter from the local Planning Commission stating that the property is properly zoned.
  • provide documentation that an option has been obtained for the site or documentation of land ownership.
  • attach physical description of location such as cross streets, highway intersections, etc.

F. Project Description (All applicants must complete this section. Failure to complete this section will render your application incomplete and ineligible for review).

  • Describe the proposed project, including the services you are planning to provide. (Please do not include details of the type of construction.)

    (Example: This is new construction of a 15 bed assisted living facility which will have 15 patient rooms, a beauty shop, common dining room, outdoor courtyard, soda fountain, theatre, chapel. We will provide 24-hour supervision, transportation, meals.)

II. COMPLIANCE WITH REVIEW CRITERIA

Unfavorable Review - Please see the Assisted Living Methodology, Unfavorable Review section. (https://www.healthy.arkansas.gov/programs-services/topics/arkansas-health-services-permit-agency); click on the PDF file and go to Assisted Living Methodology)

III. CRITERION #1 “Whether the proposed project is needed”

A. Population Based Need.

  1. Please submit a market feasibility study.
     At a minimum, the feasibility study should include a narrative description with supporting data and analysis that illustrates the need for and Assisted Living Facility in the proposed service area. Data and analysis should also be included for the following:
• Population characteristics of the county and targeted service area by age, gender, income, morbidity, functional impairments. You must include a narrative description of the relationship between this demographic data and the population you can expect to enter your Assisted Living Facility.
• Market and Payor mix for intended facility.
• Proximity to other facilities including Residential Care, Nursing Homes, Hospitals, or clinics.
• Current local conditions that favor the occupancy or sustainability of the proposed facility.
• Local support for the project
• Transportation access to the facility
• Resident access to other local health, recreational, or other services.
• Special needs of this community.
• Special features of this facility.

IV. CRITERION #2 “Can the proposed project be adequately staffed and operated when completed?”

A. List by type the number of staff required by DHHS Office of Long Term Care (OLTC) to support this project:

B. Explain your plan for recruiting and retaining staff to meet the staffing requirements of OLTC.

V. CRITERION #3 “Is the proposed project economically feasible?”

A. Cost Estimates for Project

Financing and other Cash Requirements
Loans Fees $________________

Bond Issue Cost $________________

Legal Fees, Printing, etc. $________________

Financial Feasibility Study $________________

Consultant Fees $________________

Permits (Building, Utilities, Etc.) $________________

Capitalized Interest During Construction $________________

Debt Service Reserve Fund $________________

Other (Specify) $________________

TOTAL $________________

B. Physical Plant Costs

Construction Costs $________________

Renovation Cost $________________

Fixed Equipment (not included in construction) $________________

Architect’s Fee $________________

Engineering Fees $________________

Contingency Factor (Cost Overrun) $________________

TOTAL $________________

C. Working Capital Start-up Cost $________________

TOTAL EXPENSES $________________
D. Please indicate the sources of capital funds:

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Credits</td>
<td>$____________</td>
<td></td>
</tr>
<tr>
<td>Commercial Loans</td>
<td>$____________</td>
<td></td>
</tr>
<tr>
<td>Government Grants and Loans (Please Specify)</td>
<td>$____________</td>
<td></td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>$____________</td>
<td></td>
</tr>
<tr>
<td>Other Debt Financing</td>
<td>$____________</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$____________</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$____________</td>
<td>100%</td>
</tr>
</tbody>
</table>

E. You are required to attach original letters of commitment or agreements that indicate the above financing can be obtained. All submitted documentation must be signed and dated within 90 days of the application due date. Depending on your financing plan in Section C above, you must submit at least one of the following:

1. Pre-approved loan for Total Capital and Working Capital Start-up Cost as evidenced by a confirmed loan commitment on bank / lending institution’s original letterhead with signature.

2. Proof of bank deposit or financial statement for the amount needed for the project.

3. Audited financial statement showing retained earnings equal to the amount of the project with signature by an accountant not directly employed by the corporation.

F. What are the terms of debt financing?

1. Rate of Interest   
2. Term of Debt (years)   
3. Annual Debt Service   
4. Total Debt Service
5. Total Annual Depreciation cost for facility

G. Budget Requirements

1. For new Facilities, a three-year pro forma budget is required as an attachment to the application.

2. For existing facilities, provide the last three years audited income and expense report.

VI. CRITERION # 4

How will this project help to contain the costs of healthcare in the local health services community and save state and federal money?

CERTIFICATION

This form completed by: _____________________________________________

Name _____________________________________________ Phone

__________________________________________________________

Corporation

__________________________________________________________

Title

__________________________________________________________

Address

__________________________________________________________

City State Zip

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

__________________________________________________________

Date _____________________________________________ Signature

__________________________________________________________

Title