Check one:
☐ Initial License
☐ Change of Location
☐ Change of Ownership

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
LICENSURE UNIT

Children's Day Health Service (CDHS) Initial Licensure Application

IDENTIFYING INFORMATION

1. FULL NAME OF FACILITY (D/B/A Name): _____
   (Area Code) Phone Number
   ADDRESS: _____
   (Street Address, City, State, Zip)
   E-MAIL ADDRESS: _____ FAX NUMBER: _____
2. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: _____
   (If Not Individual)
3. ADMINISTRATOR NAME & PROFESSIONAL DESIGNATION/LICENSE #: _____
4. DIRECTOR OF NURSING NAME & PROFESSIONAL DESIGNATION/LICENSE #: _____
5. PREFERRED MAILING ADDRESS FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

   _____
   (Street Address, City, State, Zip)
6. TOTAL LICENSED CAPACITY: _____ (Specify Number)
7. ANTICIPATED STARTING DATE OF OPERATION: _____
8. SERVICES PROVIDED **(One or more of the bolded services shown below must be provided in order to operate as a CDHS)**:
   _____ Skilled Nursing Care Services
   _____ Mental Health Services
   _____ Rehabilitation Services: _____ Speech-Language Pathology _____ Occupational Therapy _____ Physical Therapy
   _____ Intravenous Therapy Services
   _____ Aide Services: _____ Children's Day Health Aides _____ Personal Care Aides _____ Medication Aides
   _____ Respiratory Care Service/Department
   _____ Transportation Services
   _____ Other: Please List: _____
9. CDHS patient population **will include** patients dependent on life-support equipment: _____ Yes _____ No

OWNERSHIP INFORMATION

1. OWNERSHIP OF FACILITY: _____
   (Legal Name of Individual or Business Organization)
2. ADDRESS: _____
   (Street Address, City, State, Zip)
3. MAILING ADDRESS OF OWNERSHIP: _____
   (If Different Than Above)
4. BUSINESS ORGANIZATION: (Check one)
   _____ Sole Proprietorship
   _____ Partnership
   _____ Limited Partnership
   _____ Corporation
   _____ Limited Liability Company
   _____ Governmental (_____ State, _____ District, _____County, _____ City or Municipal)
   _____ Other (Please Specify) _____

Financial Category
☐ Profit
☐ Non Profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application and on the attached documents are true and correct and I/we hereby apply for a license. **PLEASE NOTE**: Neb. Rev. Stat. Section 71-433 requires **Applications shall be signed by (1) the owner, if the applicant is an individual or partnership, (2) two of its members, if the applicant is a limited liability company, (3) two of its officers, if the applicant is a corporation, or (4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.**

Sign Here_____ _____ _____ _____
AUTHORIZED REPRESENTATIVE DATE AUTHORIZED REPRESENTATIVE DATE

Sign Here_____ _____ _____ _____
AUTHORIZED REPRESENTATIVE DATE AUTHORIZED REPRESENTATIVE DATE

Revised: 6/5/2017