Long-Term Care Facility Application

Community Development Department-Health Permit Inspections
111 E Maple St
P. O. Box 1019
Independence, MO 64051-0519
Phone: (816) 325-7803 Fax: (816) 325-7770
www.independencemo.org

This form must be completed for all new and change of ownership facilities and for any changes to facility information. **If the information on this application changes, this department is to be notified.** **Picture identification is required to process application (i.e. driver's license, passport, etc.)** PLEASE PRINT LEGIBLY.

Facility Name: (as it will be shown on permit)

Phone: ( )__________
Fax: ( )__________
Cell: ( )__________
Email: __________
Website: __________

Facility Address:

City:__________
Zip Code:__________

Anticipated Opening Date:

How many people can you accommodate? ________

OWNERSHIP INFORMATION

Ownership Legal Type: ☐ LLC ☐ Corporation ☐ Individual ☐ Partnership ☐ Local Government

Owner's Name:

Phone: ( )__________
Cell: ( )__________
Fax: ( )__________
Email: __________
Website: __________

Owner's Address:

City/State:__________
Zip Code:__________

BILLING INFORMATION

Bill to Name or ☐ Same as Site:

Phone: ( )__________
Cell: ( )__________
Fax: ( )__________
Email: __________

Bill to Address:

City/State:__________
Zip Code:__________

AUTHORIZED AGENT/EMERGENCY CONTACT INFORMATION:

Authorized Agent (person affiliated with establishment after opening) for a corporation may sign this document in lieu of owner. No other agent's signature will be accepted.

Primary Agent's Name and Title:

Date of Birth:__________
Home: ( )__________
Cell: ( )__________

Address:

City/State:__________
Zip Code:__________

Secondary Agent's Name and Title:

Date of Birth:__________
Home: ( )__________
Cell: ( )__________

Address:

City/State:__________
Zip Code:__________

The undersigned hereby applies for a permit to operate Long Term Care Facility pursuant to the City of Independence Code and herby certifies that the undersigned has received a copy of the City of Independence Code. The undersigned hereby attest to the accuracy of the information provided in this application, and affirms that the undersigned will comply with the City of Independence Code and allow the Health Authority access to the establishment. **IT IS UNLAWFUL TO PROVIDE FALSE INFORMATION ON THIS DOCUMENT.**

____
Signature

____
Title

____
Printed Name

____
Date