# Continuing Care Provider Application for Certificate of Authority to do Business in the State of Texas under the Act, §246.022
## (CCRC Form 1)

_____

(Name of Provider)

_____

(Complete Mailing Address of Provider)

_____

(Date)

TO THE COMMISSIONER OF INSURANCE OF THE STATE OF TEXAS:

On behalf of _____

(Full Legal Name of Provider)

doing business as (dba) _____

(Name of Facility)

which facility is located at _____

(Street Address)

in _____

(City)          (State)          (Zip Code)

We hereby apply for a certificate of authority authorizing provider of said facility to be licensed as a Continuing Care Facility in the State of Texas in compliance with Section 246.022 of the Health and Safety Code and the Rules promulgated by the Texas Department of Insurance.

TYPE OF CORPORATION

Profit  ( )          Non-Profit  ( )

Federal Employer ID Number _____

<u>CONTROL OF THE PROVIDER</u>

List the person(s) who possess control, directly or indirectly, through one of the following:

(1)    The power to direct or cause the direction of the management and policies of the Provider.

(2)    Owns, controls, holds with the power to vote or holds irrevocable proxies representing 10 percent or more of the voting securities or authority of the provider.

_____

_____

_____

_____

_____

_____

_____

(If additional space is needed, please attach separate page.)

Any questions concerning this application should be directed to:

_____
(Name)

at  _____
(Complete Mailing Address)                          (Phone Number)

The Filing Fee of $ _____ is enclosed.

We _____ as _____ and
          (Corporate Officer)                   (Title)

_____ as _____ of
          (Corporate Officer)                   (Title)

_____ do
               (Provider)

hereby certify that to the best of our knowledge and belief, the application for certificate of authority presented consists of all items required by the Rules governing said facility and is true, accurate, and complete.

                                                                                      *

(Corporate Seal)              (Officer's Signature)

                                                                                      *

                                    (Officer's Signature)

STATE OF

COUNTY OF

Subscribed and sworn to be the said affiants on the _____ day of _____ 20 _____

                                                          Signature of Notary

(Notary Seal)                                     My Commission Expires: _____

                                                          Notary's Printed Name

*Must be signed by appropriate officers of Provider.

📎 Email filing to CLRFilings@tdi.texas.gov

► **Questions?**

Email us at CompanyLicense@tdi.texas.gov or call 512-676-6365.