

**Schedule of Facilities
Owned, Operated or
Managed
Section 232**

**U.S. Department of Housing
and Urban Development
Office of Residential
Care Facilities**

OMB Approval No. 9999-9999
(exp. mm/dd/yyyy)

Public reporting burden for this collection of information is estimated to average 1.5 hours. This includes the time for collecting, reviewing, and reporting the data. The information is being collected to obtain the supportive documentation which must be submitted to HUD for approval, and is necessary to ensure that viable projects are developed and maintained. The Department will use this information to determine if properties meet HUD requirements with respect to development, operation and/or asset management, as well as ensuring the continued marketability of the properties. This agency may not collect this information, and you are not required to complete this form unless it displays a currently valid OMB control number.

Warning: Any person who knowingly presents a false, fictitious, or fraudulent statement or claim in a matter within the jurisdiction of the U.S. Department of Housing and Urban Development is subject to criminal penalties, civil liability, and administrative sanctions.

Project Name: _____ **Entity Name** _____
FHA Project Number: _____ **FHA Project Number** _____

Facility (name, address)	Other Information	Roles	Facility Type
Name of Facility Address Line 1 Address Line 2 Beds:	<input type="checkbox"/> Open judgments or legal actions ² <input type="checkbox"/> Bankruptcy claims <small>Error: Reference source not found</small> <input type="checkbox"/> Open professional liability insurance claims <small>Error: Reference source not found</small> <input type="checkbox"/> Open State findings ³ <small>Error: Reference source not found</small>	<input type="checkbox"/> Owner <input type="checkbox"/> Operator <input type="checkbox"/> Mgmt Agent <input type="checkbox"/> License Holder	<input type="checkbox"/> Independent <input type="checkbox"/> Board & Care <input type="checkbox"/> Assisted Living <input type="checkbox"/> Skilled Nursing
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² If checked, attach a detailed explanation on a separate sheet.

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Additional pages attached.

Initial: _____

³ Only check if there are open instances of actual harm and/or immediate jeopardy (G or higher for skilled nursing)