

**ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES-OFFICE OF LONG TERM CARE LICENSING**

150 North 18th Avenue, Suite 440 Phoenix, Arizona 85007
400 West Congress Avenue Tucson, Arizona 85701

INITIAL APPLICATION FOR A HEALTH CARE INSTITUTION LICENSE

A.R.S. Title 36, Chapter 4 and A.A.C. Title 9

I. HEALTH CARE INSTITUTION INFORMATION

| | | | |
|---|------------|--------------------------|---------------|
| DHS use only-Facility ID | | _____ CHOW _____ INITIAL | Application # |
| Name of health care institution | | | |
| Street address | | | |
| City | Zip code | Phone number | |
| Tax I.D. number | Fax number | E-mail address | |
| Mailing address | | | |
| City | State | Zip code | |
| Requested health care institution class or subclass: (listed in R9-10-102) | | | |
| Requested licensed capacity: | | | |

- A. Is the proposed health care institution (except for a home health agency or a hospice service agency) located within 1/4 mile of agricultural land?
 Yes No If yes:
 1. Include on a separate sheet of paper the names and addresses of owners or lessees of any agricultural land within 1/4 mile of the proposed health care institution, and
 2. Attach a copy of the written agreement between the health care institution owner and the owner or lessee of agricultural land prescribed in A.R.S. ' 36-421(D).
- B. Is the proposed health care institution located in a leased facility?
 Yes No If yes, attach a copy of the lease showing rights and responsibilities of the parties.
- C. If a proposed health care institution is not exempt from submitting architectural plans and specifications pursuant to A.R.S. ' 36-422(E) attach one of the following:
 1. A copy of DHS approval of the proposed health care institution=s architectural plans and specifications, or
 2. The architectural plans and specifications for the proposed health care institution required in A.A.C. R9-10-105(A)(5)(a).
- D. Is the proposed health care institution ready for an inspection by Department representatives?
 Yes No If no, date the proposed health care institution will be ready

II. OWNER INFORMATION

| | | |
|--|--|--|
| Owner's name | | |
| Address | | |
| City | Zip code | |
| Telephone number | Fax number | |
| The owner is a (check one) : | <input type="checkbox"/> Proprietary | <input type="checkbox"/> Non-proprietary |
| The owner is a: (check one) | <input type="checkbox"/> Sole proprietorship | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Limited liability company | <input type="checkbox"/> Corporation | <input type="checkbox"/> Governmental Agency |

A. PLEASE LIST IN THE SPACE PROVIDED BELOW:

If the owner is a partnership, the name of each partner;

If the owner is a limited liability company, the name of the designated manager, or if no manager is designated, the names of any 2 members of the limited liability company;

If the owner is a corporation, the name and title of each corporate officer; or

If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

| | |
|------|-------|
| Name | Title |
| Name | Title |
| Name | Title |
| Name | Title |

B. If applicable, attach a copy of the articles of incorporation, the partnership documents, or the limited liability company documents.

C. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked or suspended?

___ Yes ___ No

D. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked or suspended?

___ Yes ___ No

E. If either of the above questions is answered yes, include on a separate sheet of paper for each yes answer:

1. The reason for the denial, suspension, or revocation;
2. The date of the denial, suspension, or revocation;
3. The name and address of the licensing agency that denied, suspended, or revoked the license.

Statutory agent (or individual designated to accept service of process and subpoenas)

| | |
|---------|------------------|
| Name | Title |
| Address | Telephone number |

III. GOVERNING AUTHORITY

| |
|------|
| Name |
|------|

IV. CHIEF ADMINISTRATIVE OFFICER

| | |
|------|-------|
| Name | Title |
|------|-------|

Education (list the highest educational degree obtained and any instruction related to the health care institution class or subclass for which licensure is requested)

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Experience (list work experience related to the health care institution class or subclass for which licensure is requested)

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V. SIGNATURES

According to A.R.S. ' 36-422(B) an application must be signed, as follows:

- (1) If an individual, by the owner of the institution;
- (2) If a partnership or corporation, by two of the partners or corporate officers; or
- (3) If a governmental unit, the head of the governmental department having jurisdiction.

| | | | |
|-----------|------|-----------|------|
| Signature | Date | Signature | Date |
| Title | | Title | |

Attach:

- 1. Documentation from the local jurisdiction of compliance with all applicable local building codes and ordinances.
- 2. If accredited by a nationally recognized health care accreditation agency, a copy of the current accreditation.

VI. TIME FRAME

Pursuant to A.R.S 41-1075 the applicant agrees to extend the substantive review time frame and overall time frame if necessary. This will not exceed 25% of the overall time frame.

Provider Signature: _____ **Representative of DHS:** _____

For DHS use only: Correct application fee enclosed: ____ Yes ____ No Check #: _____

APPLICATION SUPPLEMENT
Long Term Care

NAME OF INSTITUTION: _____

I. Does this facility provide:

_____ A secured area for residents with Alzheimer's disease or other dementia?

_____ A secured behavioral health services area?

_____ An area for residents on ventilators?

II. Name and license classification of institution(s) operated in conjunction with the nursing care institution:

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Signature of Administrator

Signature Date

**Division of Licensing Services
Office of Long Term Care Licensing
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007
(602) 364-2690 (602) 364-4765 FAX**

| APPLICATION AND LICENSE FEE REMITTANCE FORM | | | | |
|--|--------------------|-----------|-----------------------------------|--|
| PLEASE RETURN THIS FORM WITH THE PAYMENT TO THE ADDRESS ABOVE | | | | |
| Application Fee \$50.00 | | | | |
| License Fees , based on licensed capacity, are as follows: <ul style="list-style-type: none"> <input type="checkbox"/> For a facility with a licensed capacity of one to fifty-nine beds, one hundred dollars plus an additional fee in the amount of the licensed capacity times ten dollars. <input type="checkbox"/> For a facility with a licensed capacity of sixty to ninety-nine beds, two hundred dollars plus an additional fee in the amount of the licensed capacity times ten dollars. <input type="checkbox"/> For a facility with a licensed capacity of one hundred to one hundred forty-nine beds, three hundred dollars plus an additional fee in the amount of the licensed capacity times ten dollars. <input type="checkbox"/> For a facility with a licensed capacity of one hundred fifty beds or more, five hundred dollars plus an additional fee in the amount of the licensed capacity times ten dollars. | | | | |
| FEEs | | | | AMOUNT DUE |
| Application Fee (Please do not submit the application fee if the fee has already been paid.) | | | | \$ 50.00 |
| LICENSED CAPACITY | | | | |
| Check One: | Licensed Capacity: | Base Fee: | Number of Beds x \$25.00 each: | Total base fee plus number of beds fee: |
| | 1 to 59 beds | 100.00 | | |
| | 60 to 99 beds | 200.00 | | |
| | 100 to 149 beds | 300.00 | | |
| | 150 or more beds | 500.00 | | |
| TOTAL AMOUNT DUE | | | | \$ |
| Payment should be by cashier's check, money order or business check made payable to: ARIZONA DEPARTMENT OF HEALTH SERVICES | | | | |
| Write the Facility I.D. # on the check. Cash and personal checks are not accepted. | | | | |
| AMOUNT ENCLOSED | | | | \$ |

ALL FEES ARE NON-REFUNDABLE pursuant to A.R.S. § 36-405(c), 36-882(f) and 36-897.01(c), except as provided in A.R.S. § 41-1077.