

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

<b>DHS USE ONLY- Facility ID:</b>		<b>Application #</b>
Name of health care institution		License number
Mailing address		
City	State	Zip code
Telephone number	Fax number	E-mail address
<b>Health care institution class or subclass:</b>		License Expiration Date:

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.

**II. OWNER INFORMATION**

Owner's name		
Address		
City		Zip code
Telephone number		Fax number
<b>The owner is a:</b> (check one)	___ Sole proprietorship	___ Partnership
___ Limited liability company	___ Corporation	___ Governmental Agency

PLEASE LIST IN THE SPACE PROVIDED BELOW (or on a separate sheet of paper):

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

**A.** 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 since the last application was submitted?

[A.R.S. § 36-425(G)]  
 \_\_\_ Yes \_\_\_ No.

**B.** 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 since the last application was submitted?

[A.R.S. § 36-425(G)]  
 \_\_\_ Yes \_\_\_ No

If either of the previous 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
Address

**IV. CHIEF ADMINISTRATIVE OFFICER**

Name	Title
Education (list the highest educational degree obtained)	
Experience (list work experience related to the health care institution class or subclass for which licensure is requested)	

**V. SIGNATURES**

According to A.R.S. § 36-422(B) the 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.

Name	Name
Signature	Signature
Date	Date
Title	Title

**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**

<b>APPLICATION AND LICENSE FEE REMITTANCE FORM</b>				
<b>PLEASE RETURN THIS FORM WITH THE PAYMENT TO THE ADDRESS ABOVE</b>				
<b>Application Fee \$50.00</b>				
<b>License Fees</b> , based on licensed capacity, are as follows: <ul style="list-style-type: none"> <li><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.</li> <li><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.</li> <li><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.</li> <li><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.</li> </ul>				
<b>FEEES</b>				<b>AMOUNT DUE</b>
Application Fee (Please do not submit the application fee if the fee has already been paid.)				\$ 50.00
<b>LICENSED CAPACITY</b>				
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		
<b>TOTAL AMOUNT DUE</b>				<b>\$</b>
<b>Payment should be by cashier's check, money order or business check made payable to: ARIZONA DEPARTMENT OF HEALTH SERVICES</b>				
Write the Facility I.D. # on the check. <b>Cash and personal checks are not accepted.</b>				
<b>AMOUNT ENCLOSED</b>				<b>\$</b>

**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.