



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES - BUREAU OF MEDICAL FACILITIES LICENSING

In accordance with A.R.S. §41-1030

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.

D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.

E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.

F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution: _____		License No. _____					
Street Address: _____							
City: _____	State: ____	Zip Code: _____					
Mailing Address: _____							
City: _____	State: ____	Zip Code: _____					
Phone No. _____	E-mail: _____						
Select one class or subclass (Listed on A.A.C. R9-10-102):							
General hospital	Rural general hospital	Special hospital					
Behavioral health inpatient facility	Home health agency	Unclassified health care institutions					
Recovery care center	Hospice inpatient facility	Hospice service agency					
Outpatient surgical center	Outpatient treatment center	Abortion clinic					
Substance abuse transitional facility	Respite on the premises capacity: _____	Counseling facility					
Behavioral health specialized transitional facility	Number of dialysis stations: _____						
	Number of observation/stabilization chairs: _____						
What is the health care institution's scope of practice: _____							
Health care institution's days and hours of operation (i.e. 8-5, 8:00a-5:00p):							
	Sun	M	T	W	T	F	Sat
Admv Hours:	_____						
Clinic Hours:	_____						
Respite Hours:	_____						
Is health care institution accredited? YES NO							
Name of accrediting organization (must be from a nationally recognized organization): _____							
Is health care institution requesting certification under Title XIX of the Social Security Act? YES NO							



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II. OWNER INFORMATION

Owner's Name: _____		
Street Address: _____		
City: _____	State: _____	Zip Code: _____
Phone No. _____	Fax No _____	
The owner is a (select one):		
Sole proprietorship	Corporation	Partnership
Limited liability partnership	Limited liability company	Governmental agency
If the owner is a partnership or a limited liability 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 two 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 name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency:		
Name: _____	Title: _____	
Name: _____	Title: _____	
Name: _____	Title: _____	
Has the owner or any 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 previous license application was submitted?		
YES NO		
If yes, indicate:		
The reason for denial, revocation, or suspension:		

The date of the denial, revocation, or suspension: _____		
The name and address of the licensing agency that denied, revoked, or suspended the license or certification:		



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Has the owner or any 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 previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension: _____

The name and address of the licensing agency that denied, revoked, or suspended the license or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? YES NO

SUBMIT applicable fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077.

III SUPPLEMENTAL APPLICATION – HOSPITALS ONLY

If applicable, the licensed occupancy for providing observation/stabilization services to:

Individuals under 18 years of age: _____

Individuals 18 years of age and older: _____

IDENTIFY all medical staff specialties and subspecialties, ATTACH LIST to renewal license application.



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SUPPLEMENTAL APPLICATION – HOSPITALS ONLY (cont'd)

In addition to the supplemental application requirements above and if a hospital is requesting a single group license, authorized in A.R.S. § 36-422(F), the following information for each satellite facility providing medical services, nursing services, or health-related services under the single group license :

Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____
Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____
Name of Satellite Facility: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____
Name of Administrator: _____
Hours of Operation: _____



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IV. SUPPLEMENTAL APPLICATION – BEHAVIORAL HEALTH INPATIENT FACILITIES ONLY

Behavioral health observation/stabilization services including the licensed occupancy requested for providing behavioral health observation/stabilization services to individuals

Under 18 years of age _____

– 18 years of age and older _____

Inpatient services to individuals under 18 years of age, including the licensed capacity requested _____

V. SUPPLEMENTAL APPLICATION – HOSPICE ONLY

For a hospice service agency:

Hours of operation for the hospice’s administrative office: _____

Geographic region served: _____

For a hospice inpatient facility, requested licensed capacity: _____

VI. SUPPLEMENTAL APPLICATION – HOME HEALTH AGENCIES ONLY

For a home health agency:

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

Name of Proposed Branch Office: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Geographic region served: _____

SUBMIT to the Department a copy of a valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1 for the applicant, if the applicant is an individual; or each individual with a 10% or greater ownership of the business organization, if the applicant is a business organization.



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VII. SUPPLEMENTAL APPLICATION – AFFILIATED OUTPATIENT TREATMENT CENTERS ONLY

In addition to the supplemental application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority of an Affiliated Outpatient Treatment Center, as defined in R9-10-1901, applying for an initial or renewal license for the Affiliated Outpatient Treatment Center shall submit the following information for each counseling facility for which the Affiliated Outpatient Treatment Center is providing administrative support:

Name of Counseling Facility: _____	License No. _____	
Street Address: _____		
City: _____	State: _____	Zip Code: _____
Phone No. _____		
Name of Administrator: _____		
Hours of Operation: _____		
Name of Counseling Facility: _____	License No. _____	
Street Address: _____		
City: _____	State: _____	Zip Code: _____
Phone No. _____		
Name of Administrator: _____		
Hours of Operation: _____		
Name of Counseling Facility: _____	License No. _____	
Street Address: _____		
City: _____	State: _____	Zip Code: _____
Phone No. _____		
Name of Administrator: _____		
Hours of Operation: _____		



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VIII. SUPPLEMENTAL APPLICATION - COLOCATION

R9-10-1031 Colocation Requirements: The following information for each proposed colocator that may share a common area and non-treatment personnel at the collaborating outpatient treatment center. For each proposed associated licensed provider:

Associated license provider's name: _____

Associated licensed provider's license number: _____

OR

Date the associated licensed provider submitted to the department an initial license application for an outpatient treatment center or a counseling facility license: _____

Proposed Scope of Services: _____

Name of associated licensed provider's governing authority: _____

Will the associated licensed provider share medical records with the collaborating outpatient treatment center:
 YES NO

IF the associated licensed provider plans to share medical records with the collaborating Outpatient Treatment Center, specify information (*in the written agreement*) about which party will obtain a patient's:

- General consent or informed consent (if applicable)
- Consent to allow a colocator access to the patient's medical record
- Consent to allow a colocator access to the patient's advance directives

SUBMIT a copy of the written agreement with the collaborating Outpatient Treatment Center and a floor plan that shows each colocator's proposed treatment area and the common areas of the collaborating outpatient treatment center.

Associated license provider's name: _____

Associated licensed provider's license number: _____

OR

Date the associated licensed provider submitted to the department an initial license application for an outpatient treatment center or a counseling facility license: _____

Proposed Scope of Services: _____

Name of associated licensed provider's governing authority: _____

Will the associated licensed provider share medical records with the collaborating outpatient treatment center?
 YES NO

IF the associated licensed provider plans to share medical records with the collaborating Outpatient Treatment Center, specify information (*in the written agreement*) about which party will obtain a patient's:

- General consent or informed consent (if applicable)
- Consent to allow a colocator access to the patient's medical record
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SUBMIT a copy of the written agreement with the collaborating Outpatient Treatment Center and a floor plan that shows each colocator's proposed treatment area and the common areas of the collaborating outpatient treatment center.



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IX. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: _____ Title: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____

X. GOVERNING AUTHORITY

Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

XI. CHIEF ADMINISTRATIVE OFFICER

Name: _____ Title: _____
Highest Educational Degree: _____
Work experience related to the health care institution class or subclass related to licensing requested:



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XII. SIGNATURES

1. If the applicant is an individual, the owner of the health care institution.
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.
3. If the applicant is a governmental agency, the head of the governmental agency

Signature	Title
Signature	Title

XIII. ADDITIONAL DOCUMENTATION

<p>Is health care institution located in a leased facility?</p> <p>YES NO</p> <p>If yes, provide a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility.</p>
<p>Does the licensee have an accreditation report from a nationally recognized accrediting organization?</p> <p>YES NO</p> <p>If yes, SUBMIT a copy of the health care institution's current accreditation report from a nationally recognized accrediting organization.</p>