Instructions for Completing
Health Care Institution Initial Application

<u>**PLEASE TYPE OR PRINT IN BLACK INK.**</u>
The application is not acceptable until every section of the application is completed and the Department receives all required information, attachments and fees. The application is a legal document and if any corrections are required, mark a line through the mistake and initial the line. An incomplete application will delay the licensing process.

I. HEALTH CARE INSTITUTION INFORMATION

"Tax ID number" means a numeric identifier that is used to report financial information to the United States Internal Revenue Services. (When using an individual's Social Security Number, it will be treated as confidential information and redacted from the copy of the application in the facility's public file.)

According to Arizona Revised Statutes, Title 36, Chapter 4, and Arizona Administrative Code, Title 9, Chapter 10, a person applying for a license is to designate a class or subclass of health care institution to be established or operated. Classifications are listed below. <u>Select one of the following classifications and check mark appropriate box on the application:</u>

Adult Day Health Care Facility,
Adult Foster Care,
Assisted Living Center,
Assisted Living Home or
Unclassified Health Care Institution.

II. OWNER INFORMATION

"Owner" means a person who appoints, elects or designates a health care institution's governing authority. "Non-Proprietary" means a health care institution organized and operated exclusively for charitable purposes and no part of the net earning benefit a shareholder or individual; or an institution operated by the state or any political subdivision of the state.

III. GOVERNING AUTHORITY

"Governing authority" means the individual, agency, group or corporation, appointed, elected or otherwise designated, in which the ultimate responsibility and authority for the conduct of the health care institution are vested. The Governing Authority may or may not be the same as the owner.

IV. CHIEF ADMINISTRATIVE OFFICER CERTIFIED MANAGER

"Chief administrative officer" means the individual implementing a governing authority's direction in a health care institution. This is the on-site administrator, or the **certified manager**.

V. SIGNATURES

According to A.R.S. ' 36-422(B) the application <u>must be signed</u>, 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.

ARIZONA DEPARTMENT OF HEALTH SERVICES

DIVISION OF LICENSING SERVICES – OFFICE OF ASSISTED LIVING LICENSING

150 North 18th Ave., Suite 420, Phoenix, Arizona 85007 *** 400 West Congress Street, Suite 116, Tucson, Arizona 85701

INITIAL APPLICATION FOR A HEALTH CARE INSTITUTION LICENSE

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

Facility ID –DHS USE ONLY

I. HEALTH CARE INSTITUTION INFORMATION

Name of health care institution **(Facility Name)**		
Physical address		
City	State	Zip code
Mailing address		
City	State	Zip code
Tax ID #	Phone Number	Fax Number
Requested health care institution class or subclass:(listed in R9-10-102) : [Check One] ☐**Adult Day Health Care Facility** ☐**Adult Foster Care** ☐**Assisted Living Center** ☐**Assisted Living Home** ☐**Unclassified Health Care Institution**		
Requested Licensed Bed Capacity:	**Email Address:**	

A. Is the property upon which the proposed health care institution is located within ¼ mile of agricultural land? (Does not apply to a home health agency, mental health services agency, hospice service agency or a change of ownership).

____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 ¼ mile of the property upon which the proposed health care institution is located.
2. Additionally, if the property upon which the proposed health care institution is located is less than 400 feet from agricultural land, you must include the following with your application:

   A copy of the written agreement between the health care institution owner (license applicant) and the owner or lessee of agricultural land prescribed in A.R.S. § 36-421(D). (Does not apply to a home health agency, mental health services agency, hospice service agency or a change of ownership).

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 (Name of Corporation, LLC, Sole Proprietorship or Partnership)

Owner's name		
Address		
City	State	Zip code
Telephone number		Fax number
The owner is a: (check one)	☐ Proprietary (For Profit)	☐ Non-proprietary (Non-Profit)
The owner is a: (check one)	☐ Sole proprietorship	☐ Partnership
☐ Limited liability company	☐ Corporation	☐ 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 ADMINISTRATOR OFFICER CERTIFIED MANAGER

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)	
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) 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:***______________________________

HEALTH CARE INSTITUTION INITIAL APPLICATION AND REMITTANCE FORM

PLEASE RETURN THIS FORM WITH PAYMENT TO THE ADDRESS BELOW

LEVEL OF CARE OR SERVICES:		FACILITY ID – DHS USE ONLY
APPLICANT/ENTITY NAME:		
FACILITY NAME:		
PHYSICAL ADDRESS:		
CITY:	STATE:	ZIP:
MAILING ADDRESS:	SUITE#:	
CITY:	STATE:	ZIP:

Example 1	*Example 2*	1 to 59 Beds License Capacity Base Fee is $280
$50.00 Initial Application Fee due when the application is submitted.	*Remaining balance due after Initial Inspection.	5 Beds X $70 = $350 ($350+$280) = $630 *

Check One:	Initial Application Fee	Licensed Capacity:	Base Fee: *	Number of Beds X $70.00 each: *	Total Fee Due:
☐	**$50.00**	None	$280.00 +	=	
☐	**$50.00**	1 to 59 beds	$280.00 +	=	
☐	**$50.00**	60 to 99 beds	$560.00 +	=	
☐	**$50.00**	100 to 149 beds	$840.00 +	=	
☐	**$50.00**	150 or more beds	$1,400.00 +	=	
				TOTAL AMOUNT DUE ➔ ➔ ➔	$

Forms of Payment: Cashier's Check or Money Order made payable to:

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES
OFFICE OF ASSISTED LIVING LICENSING
150 North 18th Avenue, Suite 420 – Phoenix, AZ 85007
400 West Congress Street, Suite 116 – Tucson, AZ 85701

Note: Cash, Personal and Starter Business Checks are not accepted.

AMOUNT ENCLOSED	$

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

OFFICE USE ONLY:

COMMENTS:

APPLICATION SUPPLEMENT
Assisted Living Licensing

I. **Level of Care (Check <u>ONLY</u> One):**
Directed __________
Personal __________
Supervisory __________

II. **Total Capacity of Facility: __________**

III. **Name of Sponsor or Certified Manager: ________________________**

IV. **Certified Manager Certificate Number: ______________________**
(If Adult Foster Care Please Write N/A)

____
Signature of Certified Manager or Adult Foster Care Sponsor

____
Signature Date

Please Complete This Form and Return With Your Application.