

ARIZONA DEPARTMENT OF HEALTH SERVICES

ASSISTED LIVING LICENSING

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

Renewal Application Packet

Includes:

1. Instructions for completing Health Care Institution Application
2. Renewal Application for Health Care Institution License
3. Health Care Institution Renewal and License Fee Remittance Form (Exempt for Adult Foster Care)

Submit the completed Application Packet including the following:

- o Application with signature(s)
- o Renewal and License Fee Remittance Form
- o Application and Licensing Fees, NON-REFUNDABLE (NO PERSONAL CHECKS)

PLEASE RETURN COMPLETE APPLICATION PACKET WITH:

Credit Card Payment Form, Business Check, Cashier's Check or Money Order: MAKE PAYABLE TO
- ARIZONA DEPARTMENT OF HEALTH SERVICES

____ 150 North 18th Avenue, Suite 420 - Phoenix, Arizona 85007
____ 400 West Congress, Suite 116 - Tucson, Arizona 85701

Instructions for completing HCI Application

PLEASE TYPE OR PRINT IN BLACK INK.

Please submit the application, with all required attachments and the required fee. This application will not be complete until all required attachments and fees have been submitted to the Department. If any corrections are made to the application using correction fluid or correction tape, the application will be returned. If you make a mistake filling out the application, put a line through the mistake and initial.

I. HEALTH CARE INSTITUTION INFORMATION

Provide all required information.

“Tax ID number” means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Services. (If you are 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, or Arizona Administrative Code, Title 9, Chapter 10, a person may apply for a license as a **health care institution class or subclass**, which are listed below. **Select one of the following classifications and check mark appropriate box on the application.**

**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 otherwise designates a health care institution’s governing authority. “Proprietary” means an owner or owners. “Non-Proprietary means a leased business, franchise, or in certain instances, a Governmental Agency.

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.

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 **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.

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES – OFFICE OF ASSISTED LIVING LICENSING
 150 N. 18th Avenue, Suite 420, Phoenix, Arizona 85007 *** 400 W. Congress, #116, Tucson, Arizona 85701
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

Facility ID – DHS USE ONLY	License Number	Expiration Date
Name of Health Care Institution (Facility Name)		
Physical Address (optional)	City	State Zip Code
Mailing Address	City	State Zip Code
Telephone number	Fax number	E-mail address (optional)
Health care institution class or subclass: [Check One] <input type="checkbox"/> Adult Day Health Care Facility <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Assisted Living Center <input type="checkbox"/> Assisted Living Home <input type="checkbox"/> Unclassified Health Care Institution		

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.** Is the proposed health care institution located in a leased facility?
 ____ Yes ____ No If yeas, attach a copy of the lease showing rights and responsibilities of the parties.
- C.** 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?
 ____ 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 health care professional license or certificate denied, revoked or suspended since the last application was submitted?
 ____ Yes ____ No.

- E. 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

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) 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.

Signature	Date	Signature	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: _____

HEALTH CARE INSTITUTION RENEWAL APPLICATION AND REMITTANCE FORM

PLEASE RETURN THIS FORM WITH PAYMENT TO THE ADDRESS BELOW

LICENSE#:	LEVEL OF CARE OR SERVICES	FACILITY I.D.#: (OFFICE USE)
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APPLICATION/ENTITY NAME:

FACILITY NAME:

PHYSICAL ADDRESS:

CITY:	STATE:	ZIP:
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MAILING ADDRESS:	SUITE#:
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CITY:	STATE:	ZIP:
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<i>Example ↓</i>	\$50.00 <i>Application Fee +</i>	1 to 59 Beds =	\$280.00 <i>Base Fee +</i>	5 Beds X \$70.00 =\$350.00	\$680.00 <i>Total Amount Due</i>
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Check One:	Application Fee +	Licensed Capacity:	Base Fee:	Number of Beds X \$70.00 each:	Application Fee + Base Fee + Number of Beds Fee:
<input type="checkbox"/>	\$50.00 +	None	\$280.00 +	=	
<input type="checkbox"/>	\$50.00 +	1 to 59 beds	\$280.00 +	=	
<input type="checkbox"/>	\$50.00 +	60 to 99 beds	\$560.00 +	=	
<input type="checkbox"/>	\$50.00 +	100 to 149 beds	\$840.00 +	=	
<input type="checkbox"/>	\$50.00 +	150 or more beds	\$1,400.00 +	=	

TOTAL AMOUNT DUE	\$
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Forms of Payment: Credit Card Payment Form (form attached), Pay by Phone (602) 364-3088, Cashier's Check, Money Order or Business Check 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**

Write the Facility License # on the check. Cash, starter and personal checks are not accepted.

AMOUNT ENCLOSED	\$
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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:
