

Division of Licensure Services
Architectural Review Section

150 North 18th Avenue, Suite 460
Phoenix, Arizona 85007
(602) 364-2079
(602) 364-4769 FAX

JANICE K. BREWER, GOVERNOR
WILL HUMBLE, DIRECTOR

Application for Construction or Modification of a Health Care Institution

INSTRUCTIONS

HEALTH CARE INSTITUTIONS

General, Rural and Special Hospitals, Nursing Care Institution, Hospice (inpatient), Outpatient Surgical Center, Adult Day Health Care Facility, Assisted Living Center, Recovery Care Center, Infirmary, and Outpatient Treatment Center in a Skilled Nursing Facility or an Assisted Living Center.

1. SUBMIT AN APPLICATION TO THE ARCHITECTURAL REVIEW SECTION FOR:

- A. Initial license of a health care facility -ARS §36-421 (Arizona Revised Statutes) + AAC R9-10-105 (A)(5).
New construction and existing buildings shall meet *new* health care facilities codes and standards in AAC R9-1-412.
- B. Construction or Modification - ARS §36-421(Arizona Revised Statutes) + AAC R9-10-104
 - 1. The building, erection, fabrication, installation, enlargement, reduction, relocation, addition, or other change to a health care institution or its facilities, AAC R9-10-101(16) and (35).
 - 2. An increase, decrease, or reclassification of licensed capacity AAC R9-10-101(35) + (53).
If only a decrease of licensed capacity, then an Architect's seal (page 8) is not required.
 - 3. A change in ownership of a health care institution, AAC R9-10-109 (C)(1) and (D).
 - 4. A change in the address or location of a health care institution that provides medical services, nursing services, or health-related services on the premises, AAC R9-10-109 (C)(2).
 - 5. A change in a health care institution's class or subclass, AAC R9-10-109 (C)(3).
 - 6. A modification involving a change in the physical plant of the institution that will affect compliance with any applicable code or standard for license. AAC R9-10-101 (35) + (53).

2. Multiple construction phases and local building permits: For a large project, one Application shall be submitted to coincide with each City or County building permit issued. If the Shell Building architect is different than the Tenant Improvement, they shall submit a separate Application.

3. Complete the application thoroughly. The application is a legal document and the original shall be submitted with one (1) set of construction documents (full-size or half-size set, CD (dwf), and technical specifications on a CD), a reduced floor plan and site plan on 8.5x11 or 11x17 size paper (scale not required) and the Architectural Drawing Review Fee to:

ADHS – Architectural Review Section Telephone: 602-364-2079 or 2536Receptionist
150 N. 18th Avenue, Suite 460 Fax: 602-364-4769
Phoenix, AZ 85007
Internet website: <http://www.azdhs.gov>

4. Architectural Drawing Review Fee: Pursuant to ARS §36-405(C)(2), and AAC R9-10-122(A) fees for an application shall be charged in accordance with the following schedule:

Refer to Application page 7 of 9 for Estimated Total Project Costs:

\$ 0 to \$ 100,000	Fee: \$ 50.00
\$ 100,000 to \$ 499,999	\$100.00
\$ 500,000 and over	\$150.00

Checks shall be payable to the **Arizona Department of Health Services.**

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5. **Agricultural land near the facility:** See requirements of AAC R9-10-105.A.1.b.
6. **Zoning Authority Clearance** – Complete page 6 of 9, if a City Building Permit is not required.
7. **Building Permit** – applicant shall file a legible copy of a locally issued Building Permit.
8. **Formal parking/traffic study** shall be submitted by a new hospital per AIA Guidelines A7.1.D.

9. **Preliminary Conference** – The ADHS Architects are available to consult with you prior to completion of your architect's construction documents (drawings and technical specifications). A preliminary conference to discuss your application is recommended. The goal is to address applicable ADHS codes and rules concerns for early resolutions. For Medicare, see also item 16.

10. **Outpatient Surgical Center (OSC)** – ARS §36-401(36) definition: "...means a type of health care institution with facilities and *limited hospital services* for the diagnosis or treatment of patients by surgery whose recovery, in the concurring opinions of the surgeon and the anesthesiologist, does not require inpatient care in a hospital." The OSC requires Occupancy I-2, a minimum of Construction Type V-A **plus** Automatic Fire Extinguishing System, and compliance to the NFPA Life Safety Code 101: Chap. 18 – New Health Care Occupancies.

11. **Inpatient Hospice** - Requires Occupancy I-2, a minimum of Construction Type V-A **plus** Automatic Fire Extinguishing System, and compliance to the NFPA Life Safety Code 101: Chap. 18 – New Health Care Occupancies.

12. **Construction Documents** – The required drawings are listed in AAC R9-10-104(A)(3). The documents shall be sealed by an architect licensed by the State of Arizona, and the seals of the professional consultants shall represent the design responsibility for all architectural and engineering work (civil, architectural, structural, mechanical, plumbing, fire protection, electrical, systems, etc.) The adopted Codes and Standards referenced in AAC R9-1-412 A&B shall be listed in their entirety on the title sheet. It is not necessary to list the omitted items and appendices.

13. **Site Visits** – During construction or modification, the ADHS Architects may perform a mid-point and a final site visit, and for existing buildings, may perform a courtesy site visit. The provider is responsible to schedule visits allowing for 2-4 weeks notice.

14. **Construction Closing Documents** (page 9 of 9) – Upon completion, submit for review.

15. **Notice of Administrative Completeness** – After the Construction Closing Documents have been approved by the ADHS architects, per AAC R9-10-108, a notice will be sent to the contact person and project architect when the construction or modification work is *completed*.

16. **Initial License - A. Medicare Certification: During the design phase**, contact the ADHS Deputy Fire Marshal at 602-364-3048 or 602-364-2051 for conformance to the Life Safety Code (2000 NFPA 101, Chapters 18-21). Fire sprinklers shall be provided in all areas of the facility.
B. Contact the licensing program, for application, fee and survey information:
Medical Facilities 602-364-3030, Long Term Care 602-364-2690, Assisted Living 602-364-2639
*An application for license shall be filed at least **sixty days** before the anticipated operation per ARS 36-422(C).*

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Date _____ **Application No.** _____
(ADHS shall assign)

(Provide a concise project description, ie., Renovate Imaging Dept., Building addition for physical therapy, New Assisted Living Center, etc.)

FACILITY NAME (or business name) of the health care institution

Name _____
Address or interim address _____
City _____ State _____ Zip _____ County _____
Telephone (_____) _____ Fax (_____) _____

CONTACT PERSON

Name _____
Firm _____
Address _____
City _____ State _____ Zip _____ **E-Mail** _____
Telephone (_____) _____ Fax (_____) _____

PROJECT ARCHITECT

Firm Name _____
Project Architect _____
Address _____
City _____ State _____ Zip _____ **E-Mail** _____
Telephone (_____) _____ Fax (_____) _____

HEALTH CARE INSTITUTION Class or Subclass (Check as Applicable)

Hospital:	Nursing Care Institution	[]
General [] Rural [] Special []	Outpatient Surgical Center	[]
If Special Hospital, indicate specialty:	Hospice, Inpatient	[]
_____	Adult Day Health Care	[]
Recovery Care Center []	Assisted Living Center:	[]
Infirmary []	Personal Care [] Directed Care	[]

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PROJECT DESCRIPTION and FUNCTIONAL PROGRAM

1a. Provide a brief **project description** below.

1b. For large projects, the health care provider shall **also** attach a **Functional Program** for the facility describing the purpose of the project, the projected demand, staffing patterns, departmental relationships, space requirements, and other basic information relating to fulfillment of the institution's objectives, etc., per the *Guidelines for Design and Construction of Hospital and Health Care Facilities, section 1.1.F (AAC R9-1-412(A)8)*.

2. Describe any new services that the facility will provide.
(In addition, notify the Office of Medical Facilities Licensing of your intent.)

3. For this project, check all applicable items:

- | | |
|--|--|
| <input type="checkbox"/> Construct a new building | <input type="checkbox"/> Equipment acquisition |
| <input type="checkbox"/> Renovation | <input type="checkbox"/> Capacity change |
| <input type="checkbox"/> Addition to an existing licensed facility | <input type="checkbox"/> Code compliance |
| <input type="checkbox"/> No construction or modification | <input type="checkbox"/> Change of class or subclass |
| <input type="checkbox"/> Establish a health care institution in an existing, unlicensed facility | |

4. International Building Code: Type of Construction _____ Occupancy Type _____
(If an Outpatient Surgical Center, verify with instruction #10 on page 2 of 9)

5. Gross square feet area affected _____

6. Project time: Planned start date _____ Planned completion date _____
If applicable, provide dates for phases _____

Planned date for patient or resident occupancy _____

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HEALTH CARE INSTITUTION REQUESTED LICENSE CAPACITY

	Existing Licensed Capacity	Add (+) new or Delete (-) existing No. of Beds		Revised Net Total of Requested Licensed Capacity
		(+)	(-)	
HOSPITAL				
NICU	_____	[]	[]	_____
PICU	_____	[]	[]	_____
PICU-PEDS	_____	[]	[]	_____
ICU/CCU	_____	[]	[]	_____
ICU/MS	_____	[]	[]	_____
ContinuingCareNursery	_____	[]	[]	_____
Pediatrics	_____	[]	[]	_____
Postpartum	_____	[]	[]	_____
LDRP	_____	[]	[]	_____
Medical/Surgical/Tele.	_____	[]	[]	_____
Psychiatric	_____	[]	[]	_____
Rehabilitation	_____	[]	[]	_____
_____	_____	[]	[]	_____
_____	_____	[]	[]	_____
Total	_____	[]	[]	_____
OUTPATIENT SURGICAL CENTER				
Operating Rooms - A	_____	[]	[]	_____
Operating Rooms - B	_____	[]	[]	_____
Operating Rooms - C	_____	[]	[]	_____
Recovery Beds A	_____	[]	[]	_____
Recovery Beds B	_____	[]	[]	_____
Recovery Beds C	_____	[]	[]	_____
Step-Down Recovery	_____	[]	[]	_____
Endo. Proc. Rooms	_____	[]	[]	_____
Endo. Proc. Recovery	_____	[]	[]	_____
NURSING CARE INSTITUTION	_____	[]	[]	_____
HOSPICE, INPATIENT	_____	[]	[]	_____
RECOVERY CARE CENTER	_____	[]	[]	_____
ASSISTED LIVING CENTER:				
Personal Care	_____	[]	[]	_____
Directed Care	_____	[]	[]	_____

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CITY / COUNTY ZONING AUTHORITY CLEARANCE

Complete this form if a Building Permit is not required by the local city or county government agency
AAC R9-10-104(A)(2)

HEALTH CARE INSTITUTION (Facility name of the health care institution, from page 3 of 9)

Name _____

Street Address _____

City _____ State _____ Zip _____ County _____

Health Care Institution Class or Subclass: _____

List each type of medical service to be provided:

CITY / COUNTY ZONING OFFICIAL:
To be completed by the City / County Zoning Official

1. Is the address/legal description from above properly zoned for the owners intended use? YES [] NO []

2. If not, what requirements will have to be met before the zoning clearance can be obtained?

a. _____

b. _____

3. Has a Special Use Permit been issued? YES [] NO [] Does it authorize the intended use? YES [] NO []

Name _____ Office _____
Please print

Signature _____ Telephone _____

Title _____ Date _____

City or County Zoning Official

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GOVERNING AUTHORITY CERTIFICATION

I certify to the best of my knowledge and belief, that this **building design** for the construction and/or modification of the health care institution complies with the Arizona Revised Statutes and the Arizona Administrative Code. I certify that the facility shall be ready for site visits by the ADHS Architects and/or Licensing Specialists. I certify that the Application is accurate.

Name of Governing Authority _____
(The Owner, Company, Corporation, Agency, Group or Individual having the ultimate responsibility and authority for the health care institution. ARS §36-422(A)(3)).

_____ Date _____
Signature of Authorized Representative(s)

Printed name of Authorized Representative _____

Facility Name _____

Facility Address _____

Telephone (_____) _____ Fax (_____) _____

Interim mailing address _____

Authorized Representative(s) Email _____

Estimated Total Project Costs AAC R9-10-104(A)(4)

(See the Instructions, Page 1 of 9, item 4, Architectural Drawing Review Fee.)

\$ _____	Site Acquisition	\$ _____	Fixed Equipment
\$ _____	General Construction	\$ _____	Movable Equipment
\$ _____	Renovation		
\$ _____	AE & Consultant Fees	\$ _____	TOTAL

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Facility Name _____

Application No. _____

(ADHS shall assign)

ARCHITECT CERTIFICATION

I certify to the best of my knowledge and belief, that this **building design** is in **substantial compliance** with minimum licensure requirements of the Arizona Department of Health Services for construction or modification of the health care institution. I certify that I have complied with all provisions of the Rules of Professional Conduct in reviewing the facility. AAC R4-30-301.

_____ Date _____

Signature of Architect

Printed name of Architect _____

Firm name _____

Address _____

Telephone (_____) _____ Fax (_____) _____

The Architect shall provide his/her seal with signature in the space below.

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CONSTRUCTION CLOSING DOCUMENTS

ARS §36-421 and AAC R9-10-104(A)(5)

The documents shall be mailed or delivered. Allow for up to two weeks for review and comments of the following documents which shall be filed at the completion of each construction phase ready for occupancy. Other equipment or systems tests or certifications may be required.

1. Certificate of Occupancy issued by the local building department.
2. The Architect's Certificate of Substantial Completion (AIA Document D401 or G704) including: 2.1 List of deficiencies, 2.2 List of work, under separate contract(s), necessary to complete the construction phase for occupancy. It shall be signed by the architect, the contractor and the owner, per AAC R9-10-104(5).
3. Infection Control Risk Assessment Provide documentation for renovations or new construction per the *Guidelines for Design and construction of Hospital and Health Care Facilities—Chap.5.1 (AAC R9-1-412)*.
4. Fire Alarm System: Certification and Description - NFPA 72. **Forms will be provided.**
5. Automatic Fire Extinguishing System: Contractor's Material and Test Certificate for Under Ground and Above Ground Piping - NFPA 13. **Forms will be provided.**
6. *Reserved*
7. Final HVAC Test and Air Balance Compliance Report. The mechanical engineer shall submit: a) written review of report, b) deficiency list, & c) follow-up letter upon correction.
8. Draperies and cubicle curtains: Flame retardant certification, NFPA 701.
9. Carpet: Flame spread certification, IBC Chap. 804 (NFPA 253 - Class II minimum).
10. Inhalation Anesthetics or Nonflammable Medical Gas System per NFPA 99:
a) Installer & Continuity Certifications for all journeymen, b) Verifier & Inspector Certifications and reports, c) The mechanical engineer shall submit: 1) written review of the reports, 2) deficiency list, & 3) follow-up letter upon correction, d) Contractor's checklist, e) Continuous Observation Reports, f) Materials Certifications, and g) framing installation certification.
11. Installation Acceptance for new Emergency Generator per (1999 ed.) NFPA 110 5-13. Reference NFPA 99 Chap. 3 and NFPA 110 Chap. 3. Indicate: a) KW capacity and b) quantity of transfer switches and c) capacity of on-site fuel storage.
12. International Energy Conservation Code, Sec. 806 – Total New Building Performance Compliance statement that the *proposed design* does not exceed the *standard design*.
13. Kitchen: The Food Establishment License issued by the County Health Department for on-site dietary and for a contracted caterer.
14. Record Drawings & Manuals: Verify to ADHS of the conveyance to the owner, per the *Guidelines for Design and Construction of Hospital and Health Care Facilities (AAC R9-1-412)*. **Do not send these to ADHS.**
15. Pharmacy: License issued by the Arizona Board of Pharmacy.
16. Radiology: After installation, submit a certified Radiation Physicist report of equipment location, testing, and type & amount of radiation protection, per AIA 7.28.A19.
17. Factory-built Buildings: Permit for the foundation and building's permanent installation and Certificate of Occupancy from the Office of Manufactured Housing.
18. Swimming Pool: Pool Permit and Pool Barrier Permit issued by the local jurisdiction.
19. Floor Plan of the project and each phase reduced to 11"x17" paper w/graphic scale.
20. Helipad/Heliport: Hospitals to submit the Federal Aviation Admin. Certificate.