

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

DHS USE ONLY- Facility ID:		Application #	
Name of health care institution			License number
Mailing address			
City	State	Zip code	
Telephone number	Fax number	E-mail address	
Health care institution class or subclass:			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
The owner is a: (check one)	<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Partnership
<input type="checkbox"/> Limited liability company	<input type="checkbox"/> Corporation	<input type="checkbox"/> 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:

--

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**

APPLICATION AND LICENSE FEE REMITTANCE FORM

PLEASE RETURN THIS FORM WITH THE PAYMENT TO THE ADDRESS ABOVE

Application Fee \$50.00

License Fees, based on licensed capacity, are as follows:

- For a facility with a licensed capacity of one to fifty-nine beds, two hundred-ninety dollars plus an additional fee in the amount of the licensed capacity times seventy three dollars.
- For a facility with a licensed capacity of sixty to ninety-nine beds, five hundred-eighty dollars plus an additional fee in the amount of the licensed capacity times seventy three dollars.
- For a facility with a licensed capacity of one hundred to one hundred forty-nine beds, eight hundred-seventy dollars plus an additional fee in the amount of the licensed capacity times seventy three dollars.
- For a facility with a licensed capacity of one hundred fifty beds or more, one thousand, four hundred-fifty dollars plus an additional fee in the amount of the licensed capacity times seventy three dollars.

FEES	AMOUNT DUE
Application Fee (Please do not submit the application fee if the fee has already been paid.)	\$ 50.00

LICENSED CAPACITY				
Check One:	Licensed Capacity:	Base Fee:	Number of Beds x \$73.00 each:	Total base fee plus number of beds fee:
	1 to 59 beds	290.00		
	60 to 99 beds	580.00		
	100 to 149 beds	870.00		
	150 or more beds	1,450.00		

TOTAL AMOUNT DUE	\$
-------------------------	-----------

**Payment should be by cashier's check, money order or business check made payable to:
ARIZONA DEPARTMENT OF HEALTH SERVICES**

Write the Facility I.D. # on the check.

Cash and personal checks are not accepted.

AMOUNT ENCLOSED	\$
------------------------	-----------

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