ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES

150 N. 18th Avenue, Suite 450, Phoenix, Arizona 85007

INITIAL 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

Name of health care institution		
Street address		
City	Zip code	Phone number
Tax I.D. number	Fax number	E-mail address
Mailing address		
City	State	Zip code
Requested health care institution class or subclass:(listed in R9-10-102)		
Requested Licensed Capacity:		

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:

a. 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.

b. 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, etc.)

Owner's name	
Address	
City	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 ADMINISTRATIVE OFFICER (Facility Administrator)

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.

A.A.C. R9-10-105(A) requires the application signatures to be notarized.

Signature ______________________ Date　　　Signature ______________________ Date

Title ______________________　　　Title ______________________

For DHS use only: Correct application fee enclosed: _____ Yes ______ No Check #:

V. TIME FRAME

Pursuant to A.R.S. § 41-1075 The applicant agrees to extend the substantive review time frame if necessary. This will not exceed 25% of the overall time frame.

Provider Signature:_______________________________________ Representative of DHS:______________________________________

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.

For DHS use only: Correct application fee enclosed: _____ Yes ______ No Check #: